Group Board

Agenda

Meeting in Public on Thursday, 06 November 2025, 12:00 – 15:10

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

Feedback from Board visits					
Time	**Item**	**Title**	**Presenter**	**Purpose**	**Format**
12:00	-	Feedback from visits to various parts of the site	Board members	-	Verbal

Introductory items					
Time	**Item**	**Title**	**Presenter**	**Purpose**	**Format**
12:20	1.1	Welcome and Apologies	Chair	Note	Verbal
	1.2	Declarations of Interest	All	Note	Verbal
	1.3	Minutes of previous meetings	Chair	Approve	Report
	1.4	Action Log and Matters Arising	Chair	Review	Report
12:25	1.5	Group Chief Executive Officer's Report	GCEO	Review	Report

ESTH Soft Facilities Management					
Time	**Item**	**Title**	**Presenter**	**Purpose**	**Format**
12:35	2.1	ESTH Soft Facilities Management Staff Terms and Conditions	DGCEO / GCOFIE	Approve	Report

Quality – Items for Review and Assurance					
Time	**Item**	**Title**	**Presenter**	**Purpose**	**Format**
12:50	3.1	Quality Committees Report	Committee Chair	Assure	Report
13:00	3.2	Group Maternity Services Report	GCNO	Assure	Report

Finance, Performance, Audit and Risk – Items for Review and Assurance					
Time	**Item**	**Title**	**Presenter**	**Purpose**	**Format**
13:10	4.1	Finance and Performance Committees Report	Committee Chair	Assure	Report
	4.2	Finance Report – Month 6	GCFO	Review	Report
13:20	4.3	Integrated Quality and Performance Report	GDCEO	Review	Report
13:45	4.4	Audit and Risk Committees Report	Committee Chair	Assure	Report

People – Items for Review and Assurance					
Time	**Item**	**Title**	**Presenter**	**Purpose**	**Format**
13:50	5.1	People Committees Report	Committee Chair	Assure	Report
14:00	5.2	Group Freedom to Speak Up Report	GCCAO / GFTSUG	Assure	Report

Infrastructure – Items for Review and Assurance					
Time	**Item**	**Title**	**Presenter**	**Purpose**	**Format**
14:10	6.1	Infrastructure Committees Report	Committee Chair	Assure	Report

Strategy and Governance – Items for Review and Assurance					
Time	**Item**	**Title**	**Presenter**	**Purpose**	**Format**
14:20	7.1	CQC Well Led Report	GCCAO	Review	Report
14:30	7.3	St George's Hospital Charity Update	Charity Chair & Charity CEO	Review	Report

Items for Noting					
Time	**Item**	**Title**	**Presenter**	**Purpose**	**Format**
-	8.1	Learning from Deaths Report	GCMO	Note	Report

Closing items					
Time	**Item**	**Title**	**Presenter**	**Purpose**	**Format**
14:40	9.1	New Risks and Issues Identified	Chair	Note	Verbal
	9.2	Reflections on the Meeting	Chair	Note	Verbal
	9.3	Questions from members of the public and Governors of St George's*	Chair		Verbal
	9.4	Any Other Business	All	Note	Verbal
14:50	9.5	Patient / Staff Story	GCNO	Review	Verbal
15:10	-	CLOSE	-	-	-

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

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

Membership and Attendees		
Members	**Designation**	**Abbreviation**
Mark Lowcock	Chair	Chair
James Blythe	Interim Group Chief Executive Officer	IGCEO
Natalie Armstrong	Non-Executive Director – ESTH/SGUH	NA
Mark Bagnall*^	Group Chief Officer – Facilities, Infrastructure and Estates	GCOFIE
Elaine Clancy	Interim Group Chief Nursing Officer	IGCNO
Pankaj Davé	Non-Executive Director - ESTH/ SGUH	PD
Andrew Grimshaw	Group Chief Finance Officer	GCFO
Richard Jennings	Group Chief Medical Officer	GCMO
Stephen Jones*^	Group Chief Corporate Affairs Officer	GCCAO
Yin Jones	Non-Executive Director – ESTH/SGUH	YJ
Khadir Meer^	Non-Executive Director – SGUH	KM
Andrew Murray	Non-Executive Director – ESTH/SGUH	AM
Michael Pantlin*^	Group Deputy Chief Executive Officer	GDCEO
Leonie Penna*	Non Executive Director – SGUH and ESTH (Associate)	LP
Bidesh Sarkar	Non-Executive Director – ESTH and SGUH	BS
Thirza Sawtell*	Managing Director – Integrated Care	MD-IC
Alex Shaw*	Interim Managing Director – ESTH	IMD-ESTH
Kate Slemeck^	Managing Director – SGUH	MD-SGUH
Victoria Smith*^	Group Chief People Officer	GCPO
Claire Sunderland Hay^	Associate Non-Executive Director – SGUH	CSH
Phil Wilbraham	Associate Non-Executive Director – ESTH	PW
In Attendance		
Liz Dawson	Group Deputy Director Corporate Affairs	GDDCA
Dan Pople	Group Deputy Chief Communications Officer	GDCCO
Apologies		
Observers		

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

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

Minutes of Group Board Meeting

Meeting in Public on Friday, 05 September 2025, 12:45-15:30

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

PRESENT		
Mark Lowcock	Group Chair	Chair
Jacqueline Totterdell	Group Chief Executive Officer	GCEO
Natalie Armstrong	Non-Executive Director	NA
Mark Bagnall*^	Group Chief Facilities, Infrastructure and Environment Officer	GCFIEO
Ann Beasley	Non-Executive Director, Vice Chair – ESTH / SGUH	AB
James Blythe*	Managing Director – ESTH	MD-ESTH
Pankaj Davé	Non-Executive Director – SGUH	PD
Richard Jennings	Group Chief Medical Officer	GCMO
Stephen Jones*^	Group Chief Corporate Affairs Officer	GCCAO
Yin Jones	Non-Executive Director – ESTH / SGUH	YJ
Peter Kane	Non-Executive Director – ESTH / SGUH	PK
Khadir Meer^	Associate Non-Executive Director – SGUH	KM
Michael Pantlin*^	Deputy Group Chief Executive Officer	IGDCEO
Thirza Sawtell*	Managing Director – Integrated Care	MD-IC
Kate Slemeck^	Managing Director – SGUH	MD-SGUH
Victoria Smith*^	Group Chief People Officer	CPO
Claire Sunderland-Hay^	Associate Non-Executive Director – SGUH	CSH
IN ATTENDANCE		
Lizzie Alabaster	Site CFO – ESTH	CFO-ESTH
Elizabeth Dawson	Group Deputy Director of Corporate Affairs	GDCCA
Theresa Matthews	Site CNO-ESTH	CNO-ESTH
Nicola Shopland	Site CNO-SGUH	CNO-SGUH
APOLOGIES		
Andrew Grimshaw	Group Chief Finance Officer	GCFO
Andrew Murray	Non-Executive Director – ESTH/SGUH	AM
Phil Wilbraham*	Associate Non-Executive Director – ESTH	PW
OBSERVERS		
Leonie Penna	Non-Executive Director Designate	
Bidesh Sarkar	Non-Executive Director Designate	
Anna Macarthur	Group Chief Communications Officer	GCCO

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

Chair Approved

		Action
1.0	**INTRODUCTORY ITEMS**	
1.1	**Welcome, introductions and apologies**	
	The Chair welcomed everyone to the meeting. Thanks were recorded to: • Peter Kane, Chair of the Audit and Risk Committees, whose term of office as a Non-Executive Director at both trusts would end on 30 September 2025. • Ann Beasley, Group Vice Chair, Chair of Finance & Performance Committees and Infrastructure Committee, whose term of office would end on 12 October 2025. • Ralph Michell whose 6 month role as an executive had ended, returning to his substantive role as Group Chief Transformation Officer. • Arlene Wellman, Group Chief Nursing Officer, who had left the group to take up a role on secondment to the Florence Nightingale Foundation. AB led tributes to the GCEO who would be leaving gesh in mid September to become CEO of NHS Wales. Her commitment to the trusts, first joining SGUH as CEO and taking it out of Special Measures, before becoming Group CEO had always been patient focused and with a determination to always do the right thing. The GCEO would be missed and was wished well in her new role. Apologies were received from Andrew Grimshaw. Andrew Murray and Phil Wilbraham.	
1.2	**Declarations of Interests**	
	The standing interests in relation to shared roles across the St George's, Epsom and St Helier University Hospitals and Health Group of the following directors was noted, which have previously been notified to the Board: • Mark Lowcock as Group Chair. • Natalie Armstrong, Ann Beasley, Yin Jones and Peter Kane as non-executive Directors; • Jacqueline Totterdell, Mark Bagnall, Richard Jennings, Stephen Jones, Michael Pantlin and Victoria Smith as Executive Directors. There were no other declarations other than those previously reported.	
1.3	**Chair's Update**	
	The Chair reported that the process to recruit a successor for the GCEO was underway. In the interim, James Blythe, MD-ESTH had been appointed to lead the group. The Board recorded congratulations to MD-ESTH on this appointment.	

Chair Approved

1.4	**Minutes of the Previous Meeting**
	The minutes of the Group Board meeting on 3 July were approved as a true and accurate record.
1.5	**Action Log and Matters Arising**
	PUBLIC20250901.1 The GCPO reported that the group were currently reviewing all mandatory learning in line with guidance from NHS England. This review needs a clear process to ensure the decisions we make are robust and justifiable and Freedom To Speak Up (FTSU) will be one of the subject topics used as an example. A recommendation will be taken to Mandatory Learning Oversight Group which needs to sign off any proposals on mandatory training. The Board agreed with the proposal that this action be postponed until November 2025. The remaining action, PUBLIC20241107.2, to develop timelines for a FTSU and whistleblowing strategy was not yet due.
1.6	**Group Chief Executive's Officer (GCEO) Report**
	The GCEO took her report, which included a range of updates and assurance matters, as read and highlighted the following events: • Gesh Care Awards: Nominations were now open for the second annual gesh Care Awards. With thanks to the generosity of sponsors, the event on 9 December 2025 was fully funded at no cost to the Group. • Filming was due to begin shortly on the next series of 24 Hours in A&E. • Michael Pantlin had been appointed as the substantive Group Deputy Chief Executive Officer. During discussion the GCEO was asked about the focus in the NHS 10 Year Plan and the shift from hospital to community and how this aligned with the greater patient acuity that was being seen. GCEO responded that the ICB clinical strategy would support how services worked together – too many long-term health conditions were not being managed properly with patients then needing to come into hospital. There had been a lot of discussions over the last 18 months on the shift to community but the biggest indicator of where there was a shift, or more gradual journey would be when information on the unwinding of the block funding was clear. MD-ESTH added that he and MD-IC had been reflecting on this and could see the continuing theme of neighbourhood health but that the challenge would be make that safe and consistent for every patient. MD-IC continued that the intention behind the Plan was clear but translating this into reality was much harder. However, although the challenge shouldn't be underestimated, gesh was well placed to respond. **The Group Board noted the GCEO report.**

Chair Approved

2.0	**Quality and Safety - Items for Review and Assurance**
2.1	**Quality Committees Report**
	In the absence of the Committee Chair, PK reported on the recent meeting of the Quality Committees. The Committee had discussed four main areas: maternity services, Never Events, the CQC Inspection reports and the annual reports on patient experience, the latter which had many positive messages that would continue to be built on. PK said that there had been a lengthy discussion on maternity services, which was an item later on the agenda. It had been agreed that a maternity sub committee would be established to provide more time to focus on this service and the improvement plans that were being actioned. The CQC reports on the SGUH ED, maternity services and theatres were later on the agenda, with PK noting that the Committee had considered these and that although there had been improvements since the inspections there was more to be done. On Never Events, the GCMO reported that good progress had been made in a number of areas but some needed further work. Mitigations were in place which had resulted in a number of 'near misses' showing their effectiveness. Removal of skin lesions and equipment failure were two areas that needed more focus. The ICB had provided an external perspective and had recommended that fewer, tighter actions could be better to support further improvements. CNO-SGUH added that there were also robust conversations around the quality priorities relating to pressure ulcers at SGUH and VTE and ED flow at both trusts. CNO-ESTH added that falls and ED flow would be topics for future Committee deep dives. AB raised a question on the report that SGUH had deviated from the national guidance by not routinely performing symphysis-fundal height (SFH) measurements in low-risk women for fetal growth. GCMO responded that SGUH used ultrasound to assess fetal growth, but this was not considered reckless or poor practice. What had been highlighted was that the governance around why the decision to deviate from national guidance had been taken was unclear. GCMO made clear that it had not been recommended that SGUH change this practice but that they should have evidence as to why ultrasound was being used. If there was any indication that the current practice was worse than national it would have been stopped. Consideration also had to be given to midwives in training, who would not be experienced in national practice if they had only spent time at SGUH. It was confirmed that this matter would be discussed by the Quality Committee maternity sub group.
2.2	**Care Quality Commission Inspection Reports**
	CNO-SGUH referred the meeting to the reports, noting that overall SGUH remained as Requires Improvement. A section 28A notice had been received in December 2024, following the inspections of maternity and ED, and immediate action had been taken. In response to a question from PD, CNO-SGUH said that people did look at the CQC ratings and the rating of Inadequate for safety in maternity would

Chair Approved

	be of a concern. However, the inspections had taken place many months ago and sustained improvements had been made in a number of key areas, with more to be done. The trust needed to be honest with service users and staff and that the services was still on a journey of improvement. GCEO added more follow through was needed, looking more at outcomes rather than inputs. Some issues were related to compliance and cultured and these had to be addressed. **The Board noted the reports and that they would also be discussed by the SGUH Council of Governors.**	
2.3	**Group Maternity Services Quality Report**	
	GCMO acknowledged that the report was too long, making it difficult to identify the key issues – this would be addressed in future reports. GCMO highlighted that an area of focus was post-partum haemorrhage where SGUH was an outlier – even when the more complex cases seen by the service were discounted. MD-SGUH added that the trust were working with NSSP to improve reporting and the integrated action plan as all were clear that this could not be a 'tick box' exercise. GCEO said that the action plan had to capture the culture and leadership issues within the service. New staff were being appointed who could grip the areas that needed to be addressed – this included a Group Chief Midwifery Officer and a governance lead. **The Board noted the report.**	
2.4	**Responsible Officer Report on Medical Appraisal and Revalidation**	
	GCMO explained that every licensed doctor who practices medicine must revalidate through the GMC, every 5 years to maintain a license to practice. Revalidation is based on a system of annual appraisal. The Responsible Officer for each trust prepares the for presenting to the Board for review before submitting to NHS England. With the Board's endorsement, the remaining small amount of data would be added and then the required compliance statement could be signed by the GCEO. GCMO assured the Board that rigorous revalidation processes were in place across the group. In the absence of national guidance, SGUH had set its own appraisal completion target of 90%, falling just short at 89%. YJ noted the low appraisal rate for bank doctors and queried whether enough was being done with this group. GCMO responded that he was more confident with the process for those that were locally appointed but it was more difficult to capture all bank staff – actions were in place to address this. **The Board noted the report and endorsed that the GCEO signs the report for submission to NHS England.**	

3.0	**Finance and Performance - Items for Review and Assurance**	
3.1	**Finance and Performance Committees Report**	
	AB, as Committee Chair, took the report as read, highlighting that both trusts were on plan for M4 but this was a very tough year. There had been a step change in how CIPs were being identified with some brave, and controversial decisions taken. As the year progressed it would get harder but there was a need to identify cash releasing savings if we were to be on plan at the end of the year – if not, there could be serious repercussions. AB welcomed the work that was being done by the Executive to turn the finances around, with the need to drive productivity improvements being made clear. The Chair said that there had been a change from NHSE, with anxiety about group being off balance. If they lacked confidence in the plans they could impose their own actions. AB informed the Board that the Committee had also considered the timeline for the preparation of the 2025/26 Winter Plan to NHSE. These plans should be reviewed by the Board. To allow maximum time for the site leadership prepare the plans it was requested that the Finance and Performance Committee be given delegated authority to review the plans on behalf of the Board. **The Board:** • **noted the report, the scale of the task and the limited assurance on delivery of the plan.** • **delegated authority to the Finance and Performance Committee to approve the submission of the Winter Plan ahead of the 30 September deadline.**	
3.2	**Finance Report – Month 4**	
	CFO-ESTH informed that both trusts were reporting being on plan in M4 but delivery of the CIP remained a key risk. Cash releasing savings, over and above what had already been done, had to be found. GDCEO added that the expectations around the controls environment were clear. Productivity improvements across all areas, including care, had to be made whilst keeping patients as the focus. He noted that thinking had begun on the 2026/27 plan. **The Board noted the report.**	
3.3	**Integrated Quality and Performance Report (IQPR)**	
	GDCEO explained the changes to data collection as detailed in the report, noting that the challenges and pressures faced by the Trusts were clear. He noted that the NHS Oversight Framework had been updated and that in the league tables to	

be released the following week, both trusts would be in tier 3 as the financial position was a limiting factor within the Framework.

For SGUH, MD-SGUH reported that in the Emergency Department (ED) and Urgent Care, the 4 hour wait time was generally being met but there was ambition to do better than the previous year. Through earlier intervention it was anticipated that corridor care could be reduced with a new frailty ward seeing patients directed to care that was more appropriate than ED.

The 52 and 65 week Referral to Treatment metric was not going well, partly due to the number of out of area referrals being received – an upcoming meeting with NHSE would include this issue. All patients waiting over 40 weeks now had an appointment date although it should be noted that due to the financial constraints all waiting list initiatives had been stopped. The use of AI to improve productivity was being looked at. The winter plan was being developed and would incorporate actions to maintain a good flow during a period of high demand.

At ESTH, MD-ESTH said that as had been anticipated, the introduction of the new Electronic Patient Record (EPR) system had had an impact on activity and data. Triangulation of data was underway for assurance reporting. Theatre utilisation had dipped and acute medicine was being looked at, with the EPR issues also being connected to an increase in the those waiting more than 52 or 65 weeks for treatment. MD-ESTH continued that the ED and Urgent Care at ESTH had been placed in NHSE Tier 2 which meant that there would be additional support and oversight. A report on this would be submitted to both the Finance & Performance Committee and the Quality Committee.

MD-IC highlighted that Integrated Care were seeing a change in the demographics with an increase in over 75s. NHSE had launched a national frailty collaborative which included our area and it was hoped that this would help drive some positive behaviours. Virtual wards and their role in looking after acute needs in the community was key – issues with data had been resolved. Children and young people was an area that needed more focus, long waits for therapy services could have an impact on safety so different ways of reviewing the waiting list were being looked at.

In questions from the Board, a query was raised on the plan for winter vaccinations. CNO-SGUH responded that all staff would be offered a flu vaccination, however, covid vaccines were not on offer this year. Low take up in the general population was an issue and it was felt that the post covid legacy would take some years to work through. GCMO added that trust leaders would be communicating in a positive way to all staff the importance of being vaccinated and that both the RCN and GMC stated to their members that vaccination was an expectation.

A discussion on the data for ED and Urgent Care wait times considered the dangers of normalising corridor care and that working closely with ED colleagues and monitoring was needed. Site MDs agreed that although EDs were set up to provide corridor care this should not be the norm and improving flow and directing patients to more appropriate care was key. CNO-SGUH said that site teams needed to be empowered to challenge ambulance handovers if they were being pressurised to take patients before space was available.

The Board noted the report.

4.0	**People - Items for Review and Assurance**	
4.1	**People Committees Report**	
	YJ, the Committees Chair, took her report as read. The Committee had had a detailed review of the Workforce Race and Disability Equality Standard Reports recognising improving metrics in some areas at both trusts. However, the global majority remained underrepresented at both executive and VSM level. To help address this, as had been agreed by the Board previously, a group of staff from underrepresented groups would be identified to mirror board meetings with the aim of readying them to working at the most senior levels in the NHS in the future. GCPO highlighted that nominations for the gesh CARE awards were now open. **The Group Board noted the report.**	
4.2	**Workforce Race and Disability Equality Standard Reports**	
	GCPO spoke to the importance of the metrics in the two reports as part of the group's work on equality, diversity and inclusion (EDI). As had been discussed at the People Committees, BME staff remained underrepresented at the most senior levels in the group. The Workforce Race Equality Standard report a SGUH showed an improvement in 4 indicators from 2023, 4 have remained static, and 1 has declined. There had been slight improvements in recruitment, disciplinary, and perceptions of career progression, however, these metrics had declined at ESTH. At ESTH 3 indicators had improved, 5 declined and 1 remained static with experiences of harassment, bullying, and abuse, and reductions in discrimination from managers having reduced. In the Workforce Disability Equality Standard, the majority of metrics had improved at SGUH (9 out of 13), with 5 of the 13 metrics at ESTH had improved. Improvements included the relative likelihood of candidates with a disability being appointed and a reduction in bullying and harassment. However, both trusts saw a slight decline in satisfaction with reasonable adjustments. In discussion the Board considered that the demographics of staff had changed over the last 5 years with the majority now from a BME background that was not reflected at VSM level. The activity in EDI was recognised but it was queried why this was not having an impact. GCPO responded that consideration was being given to have a smaller number of more targeted approaches rather the work being too thinly spread and having less of an impact. The GCEO added that the data did not capture LGBTQI colleagues or the experience of women in the workforce so how EDI was looked at holistically was important. GMCO highlighted that as well as the short to medium actions, thought had to be given to those who may want to enter the medical profession in the future. Working with the university to look at ways to support those from different socio-economic or and/or Afro-Caribbean backgrounds who were less likely to apply to medical school should be considered.	

	It was agreed that listening to the experiences of, and suggestions from, staff was vital so that answers could be found. Improved connections with the staff groups would be part of this.	
5.0	**Infrastructure - Items for Review and Assurance**	
5.1	**Infrastructure Committees Report**	
	AB, Committee Chair, referred the meeting to the report highlighting the success of the EPR. The issues that had been discussed earlier in the meeting had been anticipated and these should not distract from the overall quality of the project. New leadership in digital had seen a step change and plans to integrate the trust teams were in progress. AB reminded the Board that the meetings alternated between and IT and Estates focus with the latter taking a bit of time to find its rhythm. The quality of the estate, and the amount of work to be done, meant a focus on the real issues was needed. A flood in Hunter Wing, which had severely impacted the university and the need to monitor this was noted. During the Board discussion it was recognised that further reflection on how the interdependencies between finance and estates could be best captured by both these committees would be useful. This also raised the question of how capital projects were considered at executive level. MD-ESTH responded that both trusts had well established capital projects teams but suggested that bringing this together at a strategic level in 2026/27 be considered. **The Board noted the report.**	
6.0	**Items for noting**	
6.1	**Complaints and PALS Annual Report**	
	The report, which had been considered by the Quality Committee showed an improving picture for addressing complaints with it being noted that more could be done at the first point of contact to resolve issues before they became formal complaints. **The Board noted the report.**	
6.2	**Patient Experience Annual Report**	
	The Board noted the report that had been discussed by the Quality Committee.	
6.3	**Safeguarding Annual Report**	
	MD-ESTH made the Board aware of the complexity of the safeguarding issues that arose and recognised the skill and experience that the team brought to keep people safe. CSH commented on the excellent metrics in the report.	

	The Board noted the report.	
7.0	**CLOSING ITEMS**	
7.1	**New Risks and Issues Identified**	
	No new risks or issues had been raised.	
7.2	**Questions from members of the public and Governors of St George's**	
	In addition to the questions responded to earlier in the meeting the following questions were raised by members of the public. Questions were submitted in advance from Mr Caddick who was not present at the meeting. The GCPO responded: 1. Is the NHS in its treatment of their African member of staff institutionally racist on the grounds of failing to protect a member from racist verbal abuse? We do not tolerate racism towards our colleagues and have robust processes in place for dealing with instances of racist verbal abuse if that happens. This is a priority for us. The GCEO has been leading a task force to continue to strengthen our response to any form of aggression or abuse and this has resulted in a new policy and procure which will be launched very soon. 2. And are African member of staff passed over for promotion opportunities. And is there reasonable representation of African members of staff in management positions and senior management positions? As we've discussed in this Board, whilst our overall ethnic diversity is strong, we do not represent the diversity of our workforce at the most senior and Executive level of our organisation and we know that we need to address that. Our talent strategy and EDI action plan cover a range of initiatives aimed at improving this – including introducing career conversations, better succession planning and reviewing our recruitment processes to ensure they are inclusive and deliver improved outcomes. 3. And can people of faith work for the NHS when they are asked to comply with something they do not agree with on religious grounds ie to say to some you are a woman when they were born a man. This is not homophobia but the truth. Ie you are asking your members of staff to lie and therefore it is a question of conscience. We want everyone who works for us to feel that they belong at gesh, and gender critical beliefs, alongside other religious beliefs, are protected under the Equality Act. It is also important that we all uphold the professional standards expected of us in our job roles, for example, nurses and health care support workers are expected to ask our patients how they would like to be referred to and respect that. Our aim is to offer high quality, inclusive, patient centred care where all our patients are treated with dignity and respect at all times. Alfredo Benedicto, Lead Governor, asked whether bullying and harassment had been increasing as this had been an issue that the CQC had commented on.	

Chair Approved

	GCPO responded that the metrics in the WRES and WDES had been reflected on and there was always more that could be done. The aim was that all members of staff were treated fairly.	
7.3	**Reflections on meeting**	
	At his last meeting, PK reflected that he had joined in the middle of covid and there had never been a return to business as usual. The professionalism of the executive and the support from the NEDs did much more than just keeping the show on the road. He would miss the camaraderie and working with a team with a shared sense of purpose and he hoped that addressing health inequalities would remain a focus – thanks were due to the trust charities for their funding in this area. During the meeting today, PK said there had been a sense of a board working together with trust and openness. There had been constructive challenge to get to a better place over a range of issues, with perhaps more work to be done on the balance between what was taken in the private and public sessions.	
8.4	**Patient Story**	
	Laura Hunt, gesh Head of Chaplaincy and Voluntary Services, Buvana Dwarakanathan, Paediatric ICU Consultant and Louise Mahon, Paediatric Nurse, spoke to the Board about a 14 year old patient that was admitted to PICU in May 2021 after attempted suicide by hanging. He had a number of neurological tests which showed irreversible brain damage, and this damage progressed over time. He also had repeated infections, severe dystonia and could not keep his airway open without the breathing tube. There were complicated social issues and difficulties in communicating with some of the family, including an eventual refusal to engage with the hospital by one of his parents over a period of many months. It was explained the Trust attended Court hearing in January 2023 regarding withdrawal of treatment and palliation, after multiple expert opinions. Sadly, this young patient died whilst in our care after withdrawal of life sustaining treatment in January 2023. It was expected he might live for some minutes after extubation, but he breathed independently for three weeks until his death in February 2023. During discussion, the staff shared the deep impact that this case had had on them as individuals and as team and the lessons that had been learnt. These included going to court sooner as the processes had taken a long time when there had been disengagement of a parent and implementation of staff support sessions for long-term difficult situations. Each patient in the PICU now had a named consultant who would communicate with the family so that mutual trust could be developed. Each patient also had a named nurse who would get to know the family. Through the process they had grown as a unit. The Board thanked the team for their powerful presentation, recognising the profound impact this situation had had on the team and how isolated they had felt due to court restrictions on discussing the matter. The Chair concluded by commending the team on how they exemplified the values of the trust, being kind and compassionate to the patient, their family and each other.	

Draft Approved

CLOSE		
The meeting closed at 3.55pm.		

Chair Approved

Group Board (Public) - Updated November 2025

Action Log

ACTION REFERENCE	MEETING DATE	ITEM NO.	ITEM	ACTION	WHEN	WHO	UPDATE	STATUS
PUBLIC20250901.1	09-Jan-25	3.6	Group Freedom to Speak Up Report	The Mandatory Training Group to review the current mandatory training requirements package to ensure there is a consistent approach to MAST across the group, particularly in key areas such as Freedom to Speak Up training. (GCPO)	04/09/2025 Revised date of 6 November 2025 agreed. Revised date of Spring 2026 proposed.	GCPO	**Update 05/09/2025** We are currently reviewing all of our mandatory learning in line with guidance from NHS England (available in the Reading Room). This review needs a clear process to ensure the decisions we make are robust and justifiable. That process has been designed and is being tested with stakeholders. FTSU will be one of the subject topics we'll be using as an example. We may get a clear decision in conjunction with testing the decision-making tool. Otherwise, we'll take FTSU as one of the first topics to be officially applied to the new process and approved by the wider Mandatory Learning Oversight Group membership which needs to sign this off. Revised date of 6 November proposed. November Update: Proposals are currently being drafted and will be submitted to the relevant committees early in the new year	**REVISED DATE PROPOSED**
PUBLIC20241107.2	07-Nov-24	3.1.5	Interstitial Lung Disease at ESTH	The Board requested that a report detailing the timescales of when systems and functions to support whistleblowing and FTSU are to be embedded into the organisation, be presented at a future meeting to allow the Board to track the progress of this.	04/07/2025 Revised date of October 2025 proposed. Revised date of spring 2026 proposed	GCCAO	This was orginally proposed as an action for the March meeting but is to be brought to the Group Board for review alongside the draft FTSU strategy for the Group, this would be the July meeting. July update: Given that it would be beneficial to have sight of the CQC Well Led Inspection Report so that any feeedback can be incorporated, it is proposed that this now come to the Board in the autumn. November update: The CQC Well Led report was not recieved until the end of October. To allow time for engagment with staff and a co-ordinated approach a revised date of Spring 2026 is proposed.	**REVISED DATE PROPOSED**

Group Board

Meeting in Public on Thursday, 06 November 2025

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

Executive Summary

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

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

Action required by Group Board

The Group Board is asked to note the report.

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

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

Group Chief Executive Officer's Report

Group Board, 06 November 2025

1.0 Purpose of paper

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

2.0 National Context and Updates

Planning Framework for the NHS in England

2.1 In support of the delivery of the NHS 10 Year plan, NHS England has issued the anticipated new guidance entitled 'Medium Term Planning Framework – delivering change together 2026/27 to 2028/29'. The 3-year roadmap sets out the NHS plan to get back to delivering against its constitutional standards on elective care, which will see 2.5 million fewer patients waiting more than 18 weeks for treatment by March 2029.

It will ensure 85% of people with a cancer diagnosis receive their first treatment within 2 months of a referral – up from 70% today. There will also be immediate action to improve GP access and tackle unwarranted variation between practices. The Framework also sets an ambitious target for 80% of community health service activity within 18 weeks – tackling long waiting times for community services, which have seen a surge in the number of adults and children waiting for more than 2 years for care.

This will be supported by shifting more resources into community services for people with highest needs – such as frailer older people – reducing unnecessary hospital admissions and helping them manage their health at home.

Other areas in the guidance include ending unnecessary outpatient appointments – freeing up clinicians to see the patients that need to see them most. Areas of the country that fail to progress on unnecessary follow ups will be performance managed.

More patients will get appropriate care as part of the 'Advice and Guidance' scheme which allows GPs to get specialist clinical advice from leading experts at the touch of a button – rather than sending the patient for a hospital appointment which sometimes isn't needed.

The Group Board continues to discuss the implications of the NHS 10 Year Plan and its implementation within our medium-term plans, the development of which are well underway with a requirement to make a number of submissions to NHSE in December.

3.0 Our Group

CQC report for services at St George's

3.1 The Care Quality Commission (CQC) published its report on the planned "well led" inspection at St George's between 25 and 27 February 2025. The final report was published on 31 October 2025. Overall and the Trust remains as 'Requires Improvement'. The report does not reflect where we want to be. Our priority is to ensure our staff are supported and empowered to do

their jobs. They should be confident in coming forward to raise issues, knowing that we, as leaders, will take them seriously and take action. It is clear that this hasn't always been the case.

The report, and our initial response to its findings are an item for discussion later in the meeting but I would like to record my thanks to all those that were involved with the inspection and to our leaders who I know are committed to driving forward the improvements we need to see.

Review of historic staff contracts, pay and conditions at Epsom and St Helier

3.2 As discussed at previous public Boards, we are proud of the diversity of our workforce and as a London Living Wage employer, have actively increased rates of pay for our lowest-income earners. This includes porters, cleaners, catering and patient transport colleagues at ESTH who, when brought in-house in 2018 and 2021, received improved pay and conditions. However, this did not include the full Agenda for Change terms and conditions and this resulted in colleagues being paid differently for doing similar work. Our colleagues should have also been invited to join the NHS Pension when they joined the Trust, and we are sorry this did not happen at the time. We have inherited a difficult issue at a time when NHS finances are extremely challenging and are carrying out a full review of staff contracts, pay and conditions. We will discuss the next stages of this review later in this meeting and are speaking openly and regularly with our staff and trade unions.

Interstitial Lung Disease (ILD)

3.4 As previously reported to the Board, last year, we reviewed the care of all patients treated by a respiratory consultant in St Helier between 2019 and 2023 and identified 216 who may not have been on the right treatment plan. We took this extremely seriously and arranged for an independent panel of experts, approved by the Royal College of Physicians (RCP), to look into what happened and make any further recommendations. The RCP's draft findings are currently being reviewed. When a final report is issued by the RCP, in the near future, we will share it with the Board. We will continue our open and transparent approach, and we are working on arrangements to keep patients and families updated and to inform patients, stakeholders and the media about the actions we have taken and will be taking, to maintain confidence in our care.

4.0 Events, Appointments and Our Staff

Black History Month

4.1 October was Black History Month, a time to honour, reflect on, and celebrate the achievements, culture, and contributions of Black communities across the UK and beyond. This year's theme was "Standing Firm in Power and Pride" and our gesh sites hosted a series of events to celebrate, reflect, and connect. Along with the Daphne Steele Memorial Lecture delivered by our former Group Chief Nursing Officer and careers and networking events, GB Olympian Michelle Griffith-Robinson gave a talk on sports as a vehicle for race inclusion and her career journey.

Freedom To Speak Up Month

4.2 The Freedom to Speak Up (FTSU) Guardians have planned FTSU Month for November 2025 and are engaging with staff across all sites hosting drop-in sessions, awareness stands, and team visits to discuss speaking up and listening well. These activities provide opportunities for colleagues to share experiences, ask questions, and learn more about how the FTSU service supports them in raising concerns safely and confidently.

A central theme of this year's FTSU Month was psychological safety which is the foundation of a healthy, high-performing workplace and links directly to the findings of the St George's CQC report highlighted above.

There is also a "main event" planned for 19th November which is an online conference for all staff to attend as much or as little as they can (poster attached) where guest speakers and senior leaders throughout the organisation will attend to support speaking up and psychological safety throughout gesh.

Gesh CARE Awards 2025

4.3 Over 900 nominations were received for the gesh CARE awards this year, almost double that from last year. The quality of nominations has been excellent and all staff who were nominated will receive an email with their nomination details. The shortlist is due to be announced at the end of October, with invitations to follow for our finalists. Our host this year is radio and TV star, Elle Osili-Wood, from hosting the Oscars red carpet to the Royal Coronation on the BBC and ITV, who is generously giving her time for free. The gesh CARE awards is generously sponsored by our hospital charities and local businesses to thank our teams for the care their provide every day.

NHS Staff Survey

4.4 Last year our trusts were two of the most improved in the country in the NHS Staff Survey, with SGUH moving up more than 30 places to 10th most improved and ESTH up 8 places to 15th. The number of staff recommending us as a preferred place of work was up at both trusts, and our reward and recognition scores significantly higher, not least dur to our gesh CARE awards (see above) and other initiatives to celebrate our people. But we recognise there is more to do and with growing demands on our NHS, we are encouraging all gesh staff to make their voice heard and complete this year's NHS Staff Survey (taking place between 6 October – 29 November). By promoting local 'you said, we did' actions, engaging with HR Business Partners and Trust working groups, we are highlighting the reasons why staff should share their anonymous feedback.

24 Hours in A&E

4.5 We were proud to welcome the popular Channel 4 series back to St George's. After several weeks of planning, filming recently finished in the Emergency Department, where 136 cameras and 150 microphones captured the life-saving work of our dedicated teams. We have received positive feedback from our ED colleagues and the teams that work with them, who are excited to show viewers the care and compassion they deliver every day. Follow-up interviews with staff and patients will continue over the coming months, with the broadcast date to be confirmed.

Winter Flu Vaccination

4.6 In October we launched our Winter Flu Vaccination Programme across the group. While the flu vaccine isn't compulsory for health and social care staff, it provides important protection for staff and the patients and visitors to the hospitals. Drop-in clinics are available at all of our hospital sites and are being promoted by staff across the group.

Recent leadership changes

4.7 Andrew Grimshaw, Group Chief Finance Officer, will be stepping down from his role in November to take up a new position at Mid and South Essex NHS Foundation Trust. Recruitment for an interim replacement has begun.

Following the departure of Arlene Wellman, we recently welcomed Elaine Clancy as interim Group Chief Nursing Officer. Elaine is currently the most senior nurse in south west London and has joined gesh on an interim secondment while permanent recruitment continues.

Two new Non-Executive Directors have been appointed to our Board of Directors. Dr Leonie Penna was the Chief Medical Officer at Kings College Hospital NHS Foundation Trust for 5 years and has over 20 years' clinical experience working at King's as a consultant in high-risk obstetrics and fetal medicine. Bidesh Sarkar brings more than two decades of board experience as an executive director in government, private, public and non-profit organisations. Existing Non-Executive Director, Pankaj Davé who is a member of the St George's Trust Board has also joined the Board at Epsom and St Helier.

5.0 Recommendations

5.1 The Group Board is asked to note the report.

Group Board

Meeting on Thursday, 06 November 2025

Agenda Item	2.1	
Report Title	**Soft Facilities Management - Pay, Terms and Conditions Review**	
Executive Lead(s)	Michael Pantlin GDCEO. Mark Bagnall GCOFIE	
Report Author(s)	Jenni Doman GDCOFIE and others.	
Previously considered by	n/a	-
Purpose	**For Approval / Decision**	

Executive Summary

Soft Facilities Management (Soft FM) services are an essential enabler of the Epsom and St Helier NHS Trust's (ESH) clinical operations, encompassing cleaning, catering, portering, helpdesk, and non-emergency patient transport (NEPT). Nearly 600 staff deliver these critical services, underpinning patient safety, hospital flow, and overall patient experience. Without them, hospital operations could not function effectively.

Over the past decade, Soft FM provision has undergone several structural changes. Services were outsourced in 2018 to address pay inequities and cost pressures, then brought back in-house in 2021 to strengthen equity, quality, and local control. A new local pay model was implemented in 2023 to formalise pay structures and ensure compliance with the London Living Wage. Inequities persist, and industrial relations challenges have grown. These changes resulted in pay increases for staff at the time.

Colleagues that work in the Soft FM team at ESTH feel undervalued and that they are being treated less favourably than colleagues that are working within the Trust and are employed under Agenda for Change terms and conditions.

The current workforce is fragmented across three contractual groups: static Agenda for Change (AfC) contracts (these are contracts representing national terms and conditions at the time of the TUPE and frozen since), local Trust contracts with locally determined terms (non-AFC), and other legacy arrangements. Non-AfC employees are disadvantaged in key employment areas, including pensions, unsocial hours enhancements, sickness pay, annual leave and recognition of continuous service.

Non-Emergency Patient Transport (NEPT) services, brought in-house in 2018, operate under similar but distinct contractual conditions. Variations in leave entitlements and allowances between Soft FM and NEPT staff further contribute to perceived inequity.

The situation was compounded by a pension enrolment error confirmed in July 2025. Staff transferred in 2018 and 2021 were incorrectly enrolled in the National Employers' Savings Trust (NEST) scheme instead of the NHS Pension Scheme. Although the issue is being rectified, it has caused significant reputational damage and attracted scrutiny from MPs, unions, and regulators.

Maintaining the status quo, by keeping staff on a myriad of contracts, is no longer viable.

Four strategic options have been evaluated:

- Do Nothing - retain current local contracts.
- Outsource - retender to private providers (TUPE applies).
- Immediate AfC Alignment - implement AfC terms in full immediately, with no backdating.
- Phased migration to AfC, with no back-dating

Backdating is not recommended, as current contracts are legally compliant and retrospective application would be financially unfeasible.

Of these, Option 4: Phased AfC Alignment is the preferred approach, confirmed by the Group Executive Committee on 21 October. It offers a financially sustainable, strategically aligned, and operationally deliverable pathway that balances fairness with affordability. It will also reduce industrial relations risk and advance the Group's Strategy 2028 objectives of empowered staff, inclusivity, and outstanding care.

However, the financial analysis indicates that the proposed change is potentially only partially funded. While it meets a proportion of the requirements necessary to deliver full AfC alignment, it does not fully close the gap when additional pension costs are taken into account. As a result, the anticipated efficiencies and benefits to the Cost Improvement Programme (CIP) are reduced. It is also felt that the non-financial merits of this case should be prioritised. As an anchor organisation with responsibilities and obligations for tackling inequity, the retention of inconsistent terms and conditions for NHS employees, which disproportionately affect the most diverse and low paid workforce, is not sustainable.

The next steps require Board approval, via the Finance & Performance Committee, authorising progression to formal consultation and negotiation on this proposal. The outcomes of this process will feed into the 2026/27 financial planning cycle, with final approval subject to inclusion in the Board's 2026/27 Annual Plan submission during Q4 2025/26.

This case has significant implications for the Trust, the Group, and wider system stakeholders, including the Integrated Care Boards (ICBs), acute partners, NHS London, and NHS England, particularly in light of current NHS financial constraints. A clear and structured engagement and governance process will be essential throughout.

A verbal update will be provided at the meeting following any relevant information from the FIPC and Private Board.

Action required by Group Board

The Board is asked to:

a) Consider the contents of the executive summary and the verbal update.

Appendices	
Appendix No.	**Appendix Name**
Appendix 1	n/a

Implications				
Group Strategic Objectives				
☒ Collaboration & Partnerships			☒ Right care, right place, right time	
☒ Affordable Services, fit for the future			☒ Empowered, engaged staff	
Risks				
The key risks are set out in the attached paper. However, they include financial, service delivery, employee relations, reputational as well as legal.				
CQC Theme				
☒ Safe	☒ Effective	☒ Caring	☒ Responsive	☒ Well Led
NHS system oversight framework				
☐ Quality of care, access and outcomes			☒ People	
☒ Preventing ill health and reducing inequalities			☒ Leadership and capability	
☒ Finance and use of resources			☐ Local strategic priorities	
Financial implications				
The financial implications of this proposal are complex.				
Legal and / or Regulatory implications				
The Trust has obtained several sets of legal advice on this matter and it is legally privileged.				
Equality, diversity and inclusion implications				
This case impacts a number of BAME and female colleagues.				
Environmental sustainability implications				
None				

Group Board

Meeting on Thursday, 06 November 2025

Agenda Item	3.3	
Report Title	**Group Maternity Services Quality Report** **June, July, August 2025 data**	
Executive Lead(s)	Elaine Clancy, Group Chief Nurse and Director of Infection Prevention and Control	
Report Author(s)	Fiona Walkinshaw, Deputy Director of Midwifery Annabelle Keegan, Director of Midwifery, ESTH and Interim at SGUH Nicola Shopland, Site Chief Nurse SGUH Theresa Matthews, Site Chief Nurse ESTH	
Previously considered by	Gesh Quality Committee in Common 31/10/25	
Purpose	**For Assurance**	

Executive Summary

1.0 Purpose

This report is submitted to the Quality Committees-in-Common in accordance with the requirements of the **Maternity and Perinatal Incentive Scheme (MIS)** and the **NHS England Perinatal Quality Surveillance Model (PQSM, December 2020)**. Its primary purpose is to facilitate regular oversight and discussion of maternity key performance indicators (KPIs) by the designated sub-committee of the Group Board across St George's University Hospital and Epsom and St Helier University Hospitals.

Appendix 1 presents a **two-page PowerPoint snapshot** setting out the *priority headlines, risks and areas for Board attention* for each site. **Appendix 2** contains the **full Perinatal Quality Oversight Model (PQOM) report**, including the detailed datasets, Perinatal Mortality Review Tool (PMRT) findings, and CNST/Maternity Incentive Scheme (MIS) Year 7 updates required by NHS England. Together, these provide a concise summary of progress, assurance and ongoing areas for focus across the Group's maternity and neonatal services.

The full PQOM report is structured into three core sections:

- **Quality, Safety, and Outcomes**
  Summary of PQOM data and key performance indicators
- **Regulatory Oversight and Compliance**
  Updates on inspections, statutory notifications, progress against action plans, and CNST compliance status across both Trusts

- **Local Service Updates**
  Specific developments, risks, and service-level concerns, including the **Maternity Safety Support Programme (MSSP)** action plan following the recent review and reset meeting

2. SGUH – Key Highlights, Risks and Actions

- CQC / Regulatory Status: CQC Inspection (Oct 2024): Safety rated Inadequate; overall Requires Improvement. Section 29A conditions remain open but progress evident through Maternity Oversight Group.
- CNST / MIS Year 7: Likely compliance with 9 of 10 Safety Actions. Risk to SA1 (PMRT timeliness) – two late reports; SPEN Portal now live (Sept 2025). SA7 (MNVP engagement) – below required standard due to limited commissioned hours.
- Digital Systems: iClip Pro implementation issues affect data quality (1,400 records pending migration). MEWS default error logged as High Risk (12); Cerner fix due Dec 2025.
- Safety and Outcomes: PMRT learning shared weekly via tracker. Stillbirth and neonatal death rates within expected range per MBRRACE. STAN CTG storage issue mitigated via OmniView backup – risk downgraded to Moderate.
- Workforce and Training: 10 Band 5 midwives recruited; 2 Band 6 requested. PROMPT/NLS catch-up sessions booked for Nov 2025 to reach > 90 % compliance. Active culture programme ("Outstanding Unit" co-design).
- Other Concerns: Lanesborough Wing lift failures affecting patient flow – contingency in place. Flooding at training venue delayed simulation sessions.

3. ESTH – Key Highlights, Risks and Actions

- CQC / Regulatory Status: CQC Inspection (Aug 2023): Most actions closed except one MUST Do (Estates) monitored via MSSP. Single Maternity & Neonatal Improvement Plan in place with clear accountabilities and progress dashboards.
- CNST / MIS Year 7: Safety Action 1 – 8 perinatal deaths since July; 5 PMRT eligible. SA2 – provisionally compliant (formal confirmation pending). SA3 – Transitional Care Phase 2 live at St Helier (91% reduction in ward attenders); Epsom project continuation targeting 60% reduction. SA4 – Obstetric & neonatal workforce compliant; >70% QIS trained. SA5 – BirthRate+ review Nov 2025. SA6 – 99% Saving Babies Lives compliance. SA7 – MNVP underfunded, recruitment to Surrey Heartlands co-chair post in progress.
- Safety and Incident Themes: No moderate harm in June; 12 in July–Aug (mostly PPH >1500ml & IUFDs). Readmission of babies and PPH remain top themes, equity gap in stillbirth outcomes under EDI review.
- Workforce and Training: GMC 87%; PROMPT attendance improving; neonatal training compliance improving following targeted plan.
- Service User Feedback / MNVP: 10 complaints (themes: birth care, postnatal communication, homebirth). FFT positive; staff praised for kindness. MNVP concerns on induction info & perinatal mental health. Website redesign in progress.
- Culture and Engagement: 64% midwives would recommend care to family; 63% recommend as workplace. Listening events underpin improvement plan.

4. Group-Level Summary and Key Messages for Executives

Theme	Current Position (SGUH + ESTH)	Group Action / Ask
Regulatory / CQC	SGUH – Section 29A open; ESTH – one outstanding Estates action.	Maintain bi-monthly Oversight Group and track CQC progress.
CNST / MIS Year 7	SGUH – 9/10 compliant; ESTH – 9/10 compliant. SA7 – not compliant	Align Group evidence for joint submission by Dec 2025.
Safety and Outcomes	ESTH – above average stillbirth for one month; SGUH – within expected range.	Targeted equity review via LMNS Q3 2025/26.
Digital Data Quality	SGUH – iClip issues; ESTH – BadgerNotes review under way but working well overall.	Deliver Group digital maternity data assurance plan by Q4 2025.
Workforce and Training	Recruitment & PROMPT compliance improving; neonatal training lagging ESTH. Plan in place	Maintain MDT training focus and leadership capacity.
Service User Voice / MNVP	Both below Safety Action 7 standard due to funding.	Escalate to ICB for MNVP commissioning.
Culture & Engagement	Positive staff feedback at both sites; listening events ongoing.	Continue cross-site sharing into Phase 2 Improvement Plan.

5. Implications

- Financial: Potential loss of MIS reimbursement if full compliance not achieved.
- Regulatory: Ongoing Section 29A oversight (SGUH) and MSSP monitoring (ESTH).
- Equality, Diversity & Inclusion: High level review of any inequality (ESTH) underway.
- Environmental: Estates issues (triage works, lifts) mitigated locally.

6. Recommendations

- Note progress and remaining risks in both services.
- Review CNST Year 7 cross-site position and support a joint submission plan.
- Endorse continued oversight through Group Maternity Oversight Group and executive walk-rounds.

Action required by gesh Quality Group

The Board of Directors/Trust Board/Quality Committee is asked to receive and discuss the content of the report.

a) Note the maternity service updates and the key risks and points for escalation including the Maternity Improvement Pan
b) Consider any aspects where further assurance is required
c) Endorse ongoing oversight through the Group maternity Oversight Group and executive walk-rounds

Committee Assurance

Committee	Quality Committees
Level of Assurance	Not Applicable

Appendices

Appendix No.	Appendix Name
Appendix 1	**Priority Headlines for October 2025 Maternity Oversight Report SGUH and ESTH**

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 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

SGUH: There has been a late reported case for PMRT which will result in the maternity declaring at best compliance with 9 out of 10 safety actions for MIS Year 7. If the safety actions are not all fully met this will have financial implications.
Legal and / or Regulatory implications
SGUH: There is an ongoing requirement to achieve compliance in the MUST and SHOULD Do actions issued by the CQC 2023 inspection at SGH maternity services in line with the Health and Social Care Act 2008 (Regulations 2014) and CQC Registration Regulations. In January 2025, SGUH maternity received a section 29A following their CQC inspection in October 2024. Maternity have completed an action plan, which is being monitored via the maternity oversight group. CQC Inspection Report October 2024 was published in September 2025. Overall SGH maternity services were rated as Requires Improvement which demonstrates some improvement although concerningly CQC theme Safe remained at Inadequate.
Equality, diversity and inclusion implications
Environmental sustainability implications
SGUH: One or more of the two patient lifts in the Lanesborough Wing has been frequently out of service and for prolonged periods. This appears to be currently fixed. The contingency in place is the use of the service lift in the event of further lift failure issues.

Maternity Perinatal Quality Oversight Model Executive Summary - October *2025*

Epsom and St. Helier Hospitals

CQC Maternity Ratings Last assessed- 2022	OVERALL	SAFE	EFFECTIVE	CARING	RESPONSIVE	WELL LED
	Requires Improvement	Requires improvement	Good	Good	Outstanding	Requires improvement

Proportion of midwives who 'agree or strongly agree' on whether they would recommend their trust as a place to work or receive treatment (reported annually)	Midwifery response 64.3%
Proportion of specialty trainees in Obstetric & Gynaecology responding with 'excellent or good' on how they would rate the quality of clinical supervision out of hours (reported annually)	87% from National GMC Training survey

Maternity Safety support programme Y/N	Y

MSSP Action Plan: Includes Second Maternity Theatre at EGH, Triage works at EGH, Triage works at STH, MATAU moving to maternity block, Evening Obstetric triage cover (5-8pm) at STH, Second RM for homebirth rota, NET Student Survey data, MNVP payment process, Obstetric PA for Governance, DoM portfolio.
All the above actions are included in the Unified Plan for oversight and completing

Maternity Overview

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

Response to Moderate Harm Incidents

In ***June 2025*** there were no incidents reported which resulted in moderate or above harm as a result of a PSI.

In ***July 2025***, we have had 5 moderate harm outcomes reported, 3 of which have been closed. One case was a late miscarriage at 17+6 weeks' gestation and 3 cases related to intrauterine death and are undergoing PMRT review. In line with the Trust decision, these have all been grading as 'incident causing death' but it is important to note that this is not in line with national guidance.

The remaining case related to a laceration to a baby following forceps delivery (which is a known risk) and an open and honest letter has been sent.

In August 2025, there were 7 outcomes reported as moderate and above harm; one related to a baby with a brain injury and the investigation is being taken forward by MNSI. Four related to postpartum haemorrhage and are under review; these incidents will be downgraded if there has been no PSI.

One case related to a neonatal death at 19+4 weeks' gestation and one case was an intrauterine death and will be investigated through the PMRT process.

Training – Most staff groups meet or exceed **90% compliance** for PROMPT, CTG, and NLS training. Obstetric trainee compliance dipped to **80%** in August – all scheduled for Oct or Nov.

Type of Training and % compliance	Staff Group	ESTH Jun 25	ESTH Jul 25	ESTH Aug 25
PROMPT 90%	Midwifery Staff	96%	95%	95%
	Maternity Support Workers	93%	94%	91%
	Consultant Obstetricians	96%	93%	89%
	Trainee and Staff Grade Obstetricians	89%	89%	80%
	Anaesthetics	93%	97%	91%
CTG Training 90%	Midwifery Staff	9%	96%	90%
	Obstetricians	89% Cons/100% MG	93% Cons/100% MG	93% Cons/91% MG
NLS (Newborn Life Support) 90%	Midwifery Staff	96%	95%	95%
NLS (Newborn Life Support) 90%	Neonatal Nursing Staff	100%	83%	84%
NLS (Newborn Life Support) 90%	Neonatal Medical Staff	100%	100%	100%

Staffing – Obstetrics, Midwifery, Neonatal

Staff Group	Measure	Jun 2025		Jul 2025		Aug 2025	
Midwifery	Fill rate (target >94%)	ESTH STH	ESTH EGH	ESTH STH	ESTH EGH	ESTH STH	ESTH EGH
		88%	95%	88%	96%	88%	96%
Obstetric	Expected v Fill	100%		100%		100%	
Band 7 supernumerary MW allocated at start of shift	Shift allocation 100%	100%		100%		100%	
Triage Staff 1 wte per shift	Shift allocation 100%	100%		100%		100%	
Neonatal Nursing		98%	100%	96%	100%	96%	99%
Neonatal Medical		96%	98%	98%	98%	98%	99%

Safe Staffing: Midwifery fill rates at EGH consistently meet targets (96%), while STH remains below (88%). Obstetric and neonatal staffing consistently meet expectations.

Key messages

- **Moderate and Above Harm Incidents**: July and August saw **12 incidents**, including **brain injury, intrauterine deaths, and postpartum haemorrhage**. All deaths are graded as 'incident causing death' to align with Duty of Candour expectations.
- **Top Incident Themes**: Consistent issues include **baby readmissions**, **blood loss >1500mls**, and **guideline non-compliance**. A **deep dive audit** on readmissions is underway.
- **Staff Survey**: Only **63% of midwives** would recommend the Trust as a place to work. A **cultural improvement plan** is in place, addressing fairness, communication, and leadership

Staff feedback to Maternity Safety Champions – visit in June 2025. Overall – very positive

Lead	Timeline	Action
A Keegan	Completed	Quarterly engagement events and walk-arounds are embedded.
A Keegan	Nov-25	Triage room upgrades and bathroom modernisation to be included in the Unified Plan.
A Keegan	December 2025	Triage room upgrade – work commenced at EGH, quotes underway for STH.
A Keegan	December 2025	Bathroom modernisation – STH site estates review required.

Progress in achievement of CNST 10 – Launched April 2025

SA1		SA6	
SA2		SA7	Declaring unable to meet requirement for MNVP attendance at all governance meetings due to lack of availability of MNVP Lead
SA3		SA8	Obs training scheduled for expected compliance
SA4		SA9	Received NHSR confirmation
SA5		SA10	

St. Georges Maternity

Maternity Perinatal Quality Oversight Model Executive Summary - October *2025*

CQC Maternity Ratings Last assessed- 2024	OVERALL	SAFE	EFFECTIVE	CARING	RESPONSIVE	WELL LED
	REQUIRES IMPROVEMENT	INADEQUATE	REQUIRES IMPROVEMENT	REQUIRES IMPROVEMENT	GOOD	REQUIRES IMPROVEMENT

Proportion of midwives who 'agree or strongly agree' on whether they would recommend their trust as a place to go work or receive treatment (reported annually)	Trust response 79.7%
Proportion of specialty trainees in Obstetric & Gynaecology responding with 'excellent or good' on how they would rate the quality of clinical supervision out of hours (reported annually)	91.41% from National GMC Training survey

Maternity Safety support programme Y/N	Y

MSSP Action Plan:
- Includes debrief service review, leadership development, MEWS/VTE compliance.
- Next review: Nov 30, 2025.

Maternity Overview

KPI	Latest month	Measure	Target	Variation	Assurance	Mean	Lower process limit	Upper process limit
HIE per 1000 births	Aug 25	6	1			2	-5	9
Stillbirth rate per 1000	Aug 25	6.20	4.01			4.97	-5.91	15.85
Neonatal death rate per 1000	Aug 25	9.30	2.90			3.22	-4.58	11.01
3&4 degree tears (per 1000)	Aug 25	32.0	50.0			25.3	-0.5	51.2
PPH >1500 (per 1000)	Aug 25	22.0	40.0			34.4	9.1	59.6
Moderate and above harm incidents	Aug 25	24	25			26	2	49

Response to Moderate Harm Incidents

There were 63 incidents rated moderate harm and above in June, July and August which are under review.

2 Cooled babies: one on palliative care pathway

31 PPH

1 ITU admission- medication error

PSIRF response: MDT review PPH (PPH awareness week, additional training and input blood transfusion, review IOL and labour management), MDT ADM to NNU: therapeutic cooling (identifying potential themes and issues CTG management) and MDT medicines management (external chair linking in with Trusts pharmacy quality transformation project).

Training – Additional training days x 2 in Nov mean SGH will be over 90% and therefore complaint

	Midwives	Obstetricians (split by consultant/ other Dr)		MSWs	Anesthetists (split by consultant / resident Dr)		Neonatal medics	Neonatal nurses (Nrs/ ANNP)	
Saving Babies Lives Care Bundle	92%								
Fetal monitoring and surveillance	95%	95%	97%						
Multi professional Maternity Emergencies training (PROMPT)	85%	89%	100%	77%	94%	100%			
Neonatal resus training	91%	89%	100%	77%	94%	100%	100%	90%	100%

Staffing – Obstetrics, Midwifery, Neonatal covering June, July and August 2025

Staff group	Vacancy rate
Midwifery	18.35%
Midwife Support workers	22.22%
Obstetric consultants	Nil
Resident doctors	-0.24% (funded SHO tier)
Neonatal Nurses	2.6%
ANNP	0%
Neonatology consultants	0%
Resident doctors	0%
Obstetric anaesthetists	
Resident doctors	-0.022%
Sickness	**% rate**
Obstetrics – Long Term	2.07%
Short Term	1.42%

Midwives

10 x B5 Midwife posts are currently being recruited to
Request for x2 Band 6 midwives has been submitted
22 Band 5 midwives who will move to B6 - January 2026 onwards
Adjustments to establishment - outstanding following Birthrate+

Obstetricians

Consultant presence extended to 08:00–22:00 daily. 2nd consultant ward round

Anaesthetists

100% compliance with 24/7 availability and supervision standards

Neonatal Staffing

- Medical: fully compliant with BAPM standards
- Nursing: QIS trained staff at 70% (QIS compliant)

Key messages

- CQC inspection rated 'Safe' as inadequate; medicine management and safety checks under review.
- iClip Pro implementation issues: incomplete data migration, MEWS scoring defaults to NEWS, 43 unresolved IT tickets. New risk identified since last report
- PMRT compliance risk for MIS Year 7 due to late case reporting. Work underway to resolve including leadership oversight
- SPEN portal launched to streamline event reporting. First case reported with no concerns
- STAN CTG monitoring issues mitigated via Omni View
- Positive feedback in GMC survey – see slide 1
- GCMO appointed to support leadership across GESH for maternity

Staff feedback to Maternity Safety Champions – next visit in Sept 2025

iClip issues	In progress
Timely Dr review on AN ward	Completed
DAU staff morale	In progress
Closure of Birth Centre – communication to staff	In progress
TC referrals from midwifery	Completed

Progress in achievement of CNST 10 – Launched April 2025

SA1	2 cases missed reporting timeframe	SA6	121 in care labour audit data difficult to extract for this due to iclip documentation issues
SA2		SA7	
SA3		SA8	X2 PROMPT training cancelled due to flooding in Hunter Wing St George's and City University)
SA4		SA9	Safety champions actions log not shared widely with staff before 1st July 2025
SA5		SA10	

Group Board Meeting (Public)

Meeting on Thursday, 06 November 2025

Agenda Item	4.4	
Report Title	**Audit and Risk Committee-in-Common report to the Group Board**	
Non-Executive Lead	Pankaj Davé, Chair of the Audit and Risk Committee	
Executive Lead(s)	Stephen Jones, Group Chief Corporate Affairs Officer Andrew Grimshaw, Group Chief Finance Officer	
Report Author(s)	Pankaj Davé, Chair of the Audit and Risk Committee	
Previously considered by	n/a	
Purpose	**For Assurance**	

Executive Summary

The report sets out the key issues discussed and agreed by the Audit and Risk Committee at its meeting held on the 17 September 2025

External Audit :
The Committee reviewed the process of how the external audit of the accounts for the two trusts for 2024/25 had gone and whether there were any lessons to be learnt. Generally, the process was felt to have gone well, with both finance teams and the external auditors Grant Thornton, clearly working in partnership. Actions were identified to try and continue to make the audit process in future years as smooth as possible.

Internal Audit
The Committee reviewed three internal audit final reports, one for Group and two for SGUH. The Committees discussed how to ensure that actions were completed within the time agreed and that no more than one extension should be agreed. Details of the progress on the internal audit plan were received. Additionally, the Committee received an update on the actions being completed in respect of the SGUH internal audit on Pressure Ulcers. This audit had received partial assurance when it was finalised, and the Committee received assurance that the actions arising from the audit were being completed.

The Committee discussed the subject of request for an extension to actions. It was agreed that these should generally be agreed with the relevant Executive. However, if the action relates to a high-risk area and the proposal is to extend for a significant period of time, then there was a role for the Audit Committee in terms of seeking assurance around what were the implications of that extension.

Risk Assurance Group
The Committees received their first update from the gesh Risk and Assurance meeting which had been established earlier in the year and learnt about the work taking place across the Group on Risk. This included ensuring that there was there was alignment of risk scores and review of mitigations across the two Corporate Risk Register.

Action required by Group Board
The Board is asked to: a. Note the report

Committee Assurance	
Committee	Audit and Risk Committees
Level of Assurance	Choose an item.

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

Implications				
Group Strategic Objectives				
☐ Collaboration & Partnerships			☐ Right care, right place, right time	
☐ Affordable Services, fit for the future			☒ Empowered, engaged staff	
Risks				
[…]				
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				
[…]				

Audit and Risk Committee Report to Group Board

Group Board, 06 November 2025

1.0 Purpose of paper

1.1 The gesh Audit and Risk Committee met on 17 September 2025. The Committees agreed to bring the following matters to the attention of the Group Board.

2.0 Audit Risk Committee Report from meeting held on the 17 September 2025

2.1 External Audit Lessons Learnt 2024/25

2.1.1 The Committee received a paper outlining the lessons learnt through the External Audit of the accounts for the two trusts for 2024/25. The report was jointly written by the trust's finance teams and the External Auditors, Grant Thornton.

Two key areas were identified to continue to make the audit process in future years as smooth as possible. This included ensuring dates were in place in a timely manner to aid planning and to undertake a review to see if any of the audit processes could be streamlined. Also include in the report were updates on the actions agreed upon as part of the 2024/25 Audit.

The Committee agreed that there had been a more stable and mature audit for both trusts for 2024/25. This had been excellent and credit to the teams involved. There had been issues identified quite late in the process relating to the concerns over pension provision for some estates and facilities staff at ESTH, however helpful guidance had been received from the Grant Thornton Team.

2.2 Internal Audit

Several sections of the meeting agenda were dedicated to discussion of aspects of the Internal Audit work being undertaken across the two trusts with the Internal Audit Team from RSM.

2.2.1 Internal Audit Progress Update and Recommendations Tracker

The key messages from the Internal Audit Progress Report included :

- That there had been significant progress against plans, as it was halfway through the year there were several audits in progress.
- For SGUH
  - One draft report had been issued
  - Six audits were in progress
  - Two audits were yet to start
- For ESTH :
  - One final report had been issued
  - Two draft reports had been issued
  - Three audits were in progress
  - Four audits were yet to start.

Details of the position of actions were shared for both trusts.

Thematic Analysis

The team from RSM had undertaken a thematic analysis regarding all the actions raised across gesh in 2024/25 and had produced details of some key themes. These included: Governance, Policies, Lessons learnt and Training. These were similar to the key points highlighted in the Healthcare Benchmark report which RSM had produced from analysis of all NHS organisations which they undertake Internal Audit work for.

In terms of the level of assurance of the reports issued in respect of Internal Audits for SGUH and ESTH the RSM team had issued fewer reasonable assurance reports compared to other trusts and more partials. However, the trusts did receive a level two opinion which was in line with others in terms of the head of audit opinion for the year. Overall, it was agreed that Internal Audit resources were being used in the right areas.

Recommendations re Internal Audit work across gesh.

In discussion the following points and recommendations were made by the Committees:

- A rolling 18-month programme of Internal Audits should be considered. This would help to address some of the back ended issues and the considerable effort often needed to close down audits by the year end date.
- Reference was made to the fact that there were a number of overdue actions with revised implementation dates and questions were raised as to whether or not the procedures were robust enough to pick up the overdue actions. Culturally it was important that when dates are set that they are implemented, unless there was a really extraneous external factor which had prevented it happening. It needed to be recognised that when designing controls, it was important to be realistic about management capacity to deliver these.

Final Internal Audit Reports

During the meeting three final Internal Audit Reports were presented:

SGUH - Cyber Assessment Framework (CAF)-aligned Data Security and Protection Toolkit (DSPT) Independent Assessment
ESTH - Data Security Protection Toolkit Final Internal Audit Report:

These had assessed the trust's work on preparing for the DSPT submission and had received the same audit opinion. These were a high-risk rating but that the confidence level was medium.

Within the reports the following concerns were noted :

- A lack of recorded evidence, including no centralised record of supplier risks and threat intelligence gathering and ensuring key contacts for system partners were available.
- For the Cyber Incident response plans it was not clear when it was last updated, approved and distributed.

SGUH : Controlled Drugs

The SGUH Internal Audit Report on Controlled Drugs had received reasonable assurance. There had been some good progress in terms of policies and the governance arrangements for monitoring and managing controlled drugs. It was also confirmed that the ordering process was robust. There were a few key findings outlined, but nothing of significant concern.

One concern was that the process for record keeping was quite manual and therefore the RSM team had asked the management to consider making changes to processes to make it more efficient. Appropriate action plans to address the concerns had been agreed with the trust and were now in place.

The Committee noted that the section 29A from the CQC Inspection into the ED at SGUH included concerns around controlled drugs. Therefore, it needed to be recognised that it had already been identified that there was considerable work relating to controlled drugs across organisations being undertaken.

SGUH - Theatre Productivity

The Committee received and noted the report into Theatre Productivity at SGUH. The assurance level was reasonable with some key findings for trust management to consider. Whilst conducting the audit RSM had considered 100% of the population data and some of that testing showed that at the time of the audit it showed that the theatre utilisation rate was below the minimum standard. There were various sessions which started late and cases where the patient journey was quite prolonged. Management were looking into these findings. Additionally, a review of the quality of the data which was being produced needed to be undertaken to make sure it was complete and accurate, as well as. the reasons for cancelled operations needed to be undertaken.

The Committee welcomed the actions being undertaken across the trust to improve theatre utilisation.

Six-Month Review of Progress on Partial Assurance Internal Audit Reports: SGUH Pressure Ulcers

The Site CNO – SGUH shared the update on the six-month review of progress on Partial Assurance on Internal Audit Reports – SGUH Pressure Ulcers. The Action Planhad 10 overarching actions with seven sub actions. 13 actions were now green and closed with relevant evidence submitted. Four actions were now amber, and proposals to extend the dates on those areas had been agreed. The areas where there had been less progress were creating a gesh wide Pressure Ulcers Group and also developing a Group wide Policy. Overall work was underway to align processes across the group including a new assessment tool, with support awaited from IT.

2.3 Counter Fraud Update

The quarterly update from the Counter Fraud Team at RSM was received.

The Committee noted the progress of the Counter Fraud Plan for the year and confirmed that they felt good progress was being made. One of the proposed reviews. A joint review with the Internal Audit Team into debtors had been completed. The following reviews had also been scoped:

- Certificates of sponsorship – joint with Internal Audit
- Expenses and credit cards
- Declarations of interest

RSM were also undertaking other benchmarking exercises into single tender waivers and declarations of interest. These reports would be brought to the Committee for review in due course.

The Counter Fraud Team had undertaken a review of the policies for both organisations as there had been new legislation introduced from the 1 September 2025 relating to failure to prevent fraud.

24 new referrals had been received across both organisations, 20 for SGUH and four for ESTH. 18 referrals had been closed over the period and 19 were ongoing. The general themes relate to recruitment, right to work, documentation issues, payroll, working while sick. Many of the HR related concerns were more appropriately dealt with by the People Team in the first instance and the process for this had been refreshed.

RSM confirmed that neither trust was an outlier in terms of the type of number of referrals.

The Committee confirmed that they felt assured by the work undertaken under the remit of Counter Fraud and good progress was being made with the annual plan. Where there were areas of concern steps were being taken to address these.

2.4 **Finance Report - Losses & Special Payments, Breaches and Waivers and Aged Debt**

A summary of the key points from the Finance Report which covered Losses & Special Payments, Breaches and Waivers and Aged Debt was received by the Committee.

- Debt, including aged debt continued to have a focus across the Group and was regularly reviewed at the Finance and Performance Committee.
- A monthly debt recovery meeting had been set up and was helping to drive actions.
- In respect to losses and special payments, a lot of high-cost devices particularly relating to Cardiology, and high-cost drugs with a short shelf life go through this area. Additional close monitoring and stringent controls are now in place for these areas. These would be reviewed in a few months to see if there is any impact.

The Committee also noted that there had been good progress on the Purchase Order process and that the Finance Teams were beginning to get some traction in this area. At ESTH 10% of invoices did not have Purchase Order, and 2% at SGUH.

2.5 **Cyber Security and Information Governance Update**

In respect of Cyber Security – a new Cyber Assessment Framework had been introduced as part of the NHS Digital Data Security Protection Toolkit. Its main objective is to improve cyber resilience within organisations, and it focuses on people, process and technology. For SGUH there were six outstanding actions to meet with improvements plans in place. Four were medium rated and two low. At ESTH there were seven outstanding actions – six medium rated and one low. The trusts had until December 2025 to complete the actions and to report back to NHSE. It was further noted that over the next three years there would be new standards introduced which would be more difficult to meet.

For Information Governance the main issue for both trusts was achieving compliance with the training requirements. To successfully achieve the Digital Date Security Protection Toolkit 90% of all trust staff, have to undertake the relevant Information Governance training. This had reduced from 95% in previous years. Continued review was undertaken and ways to complete the training enabled such as giving access to computers, and managers ensuring that staff have time in working hours to complete their training.

2.6 **Update from the gesh Risk Assurance Group and on the Corporate Risk Register**

This group is executive led and considers oversight of risk across the group and for the two trusts. Reviewing the trusts Corporate Risk Registers had been the major focus of the work of the Group since its establishment and this work was ongoing. It was beginning to consider risks relating to corporate services and some of the risks which were currently at a divisional level. Currently a review into categories of risk was being undertaken and at that point it was expected there would be significant changes to the Corporate Risk Registers.

Current considerations and work on risk included:

- The number of risks on the current corporate risk registers for the two trusts . The current numbers of 31 and 34 were felt to be too high and needed to consolidate.
- The balance of risks – e.g. currently there were a large number of people risks and only a small number related to quality.
- Alignment of extreme risks on Division Risk Registers and the trust Corporate Risk Registers
- Review of risk scores to ensure that they are appropriate and that they are in line with the new group risk management policy.

The Committee supported the approach to risk which was being adopted by gesh to risk and that it was in a stronger position than previously. It built on the work of the Board Assurance Framework (BAF) and was ensuring that there was coherence from the BAF into the corporate risk register and down to Directorate level registers. Whilst it was acknowledged that there was more to be done the progress made over the last few months was welcomed.

3.0 Recommendations

3.1 The Board is asked to:

a) Note the report of the Audit and Risk Committee meeting held on 17 September 2025.

Pankaj Davé

Audit and Risk Committee Chair, NED

Group Board Meeting (Public)

Meeting on Thursday, 06 November 2025

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

Executive Summary

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

Group Chief People Officer (GCPO) Report

The Committees received a comprehensive verbal update from the Group Chief People Officer (GCPO) covering topics such as the NHS Job Evaluation initiative for the nursing and midwifery workforce, Resident Doctors 10 Point Plan and the dispute with Unison over the back pay for Band 2 and 3 healthcare support workers.

People Policies

The Committees welcomed the good progress that had been made with the process of reviewing people policies across both organisations with the aim of developing and agreeing gesh versions that would be applicable to all within the group. For recently approved policies, including Managing Attendance (Sickness) and Disciplinary, the focus was on implementing communication plans and providing appropriate support to operational managers to ensure their successful implementation.

Designated Body Annual Report and Statement of Compliance

The Committees endorsed this report that provided the Designated Body Annual Report and Statement of Compliance that each Designated Body is required to submit to NHS England to assure their compliance with the regulations and commitment to continual quality improvement in the delivery of professional standards. The report contained the information and metrics for both ESTH and SGUH Designated Bodies.

Workforce KPI Performance Report

The Committees noted the updates on vacancy rates, turnover, sickness absence, core skills compliance and appraisal compliance. In September 2025, the Group deployed 18,386 WTE, representing a reduction of 124 WTE compared with August. The vacancy rate at 7.7% remained within the 10% threshold, with substantive staff remaining stable in month.

Action required by Group Board

The Group Board is asked to note the issues escalated to the Group Board and the wider issues on which the Committees received assurance in October 2025.

Committee Assurance	
Committee	People Committees
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				
People risks were not reviewed at this meeting.				
CQC Theme				
☐ Safe	☐ Effective	☐ Caring	☐ Responsive	☒ Well Led
NHS system oversight framework				
☐ Quality of care, access and outcomes			☒ People	
☐ Preventing ill health and reducing inequalities			☒ Leadership and capability	
☒ Finance and use of resources			☐ Local strategic priorities	
Financial implications				
As set out in paper.				
Legal and / or Regulatory implications				
CQC Well Led Inspection Report is expected to be published on 31 October 2025.				
Equality, diversity and inclusion (EDI) implications				
CQC Well Led Inspection Report is expected to include findings about EDI.				
Environmental sustainability implications				
N/A				

People Committees Report
Group Board, 06 November 2025

1.0 Purpose of paper

1.1 This report sets out the key issues considered by the People Committees at its meeting in October 2025 and includes the matters the Committees specifically wish to bring to the attention of the Group Board.

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

2.0 Items considered by the Committees

2.1 At its meeting in October 2025, the Committees considered the following items of business:

23 October 2025

- Group Chief People Officer Report
- Designated Body Annual Report and Statement of Compliance for ESTH and SGUH
- Guardian of Safe Working (GoSW) Reports for ESTH and SGUH
- Freedom to Speak Up Report Q1 & Q2
- People Policies Update
- Health, Wellbeing and Staff Support
- Workforce KPI Performance Report
- GMC National Training Survey
- Undergraduate Medical Education Update
- Covid and Flu Vaccination Programme 2025

2.2 The Committees, chaired by Yin Jones, meet every two months as agreed by the Group Board. An informal meeting between the Chair and GCPO takes place in the month between two public Committee meetings. The meeting on 23 October was quorate.

3.0 Key issues for escalation to the Group Board

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

a) Group Chief People Officer Update

The Committees received a comprehensive verbal update from the Group Chief People Officer (GCPO) covering topics such as the NHS Job Evaluation initiative led by the Royal College of Nursing (RCN) and other staff side organisations, aimed at ensuring up-to-date and accurate job evaluation of job descriptions for nursing and midwifery colleagues (Bands 4-9).

Secondly, supported by the commitment to staff under the recently published 10 Year Health Plan for England, NHS England recently set out 10 ways in which resident doctors' working conditions would be improved. The plan is explicitly designed to address unacceptable working practices and tackle long-standing issues that undermine morale, such as incorrect pay, poor access to rest facilities, and excessive administration associated with rotation. Trusts are required to report formally on their progress in delivering these changes. The plan

sets out actions for both NHS England and individual trusts. To ensure meaningful progress, it will be formally incorporated into the new NHS Oversight Framework.

b) Health & Wellbeing, Occupational Health & Staff Support Counselling Services Update

The Committees reviewed the report which provided assurance on the effectiveness and strategic alignment of Health & Wellbeing, Occupational Health, and Staff Support Counselling & Mediation Services across the Group. The update outlined activities, challenges, and future priorities over the past year from September 2024 to September 2025, highlighting their contribution to promoting the occupational, mental, and health and wellbeing of staff.

c) Designated Body Annual Report and Statement of Compliance

The Committees endorsed this report that provided the Designated Body Annual Report and Statement of Compliance that each Designated Body is required to submit by NHS England in the form of a set template. The report, that the organisations are expected to report through their Higher-Level Responsible Officer to assure their compliance with the regulations and commitment to continual quality improvement in the delivery of professional standards, contained the information and metrics for both ESTH and SGUH Designated Body.

4.0 Key Issues on which the Committees received assurance

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

a) Workforce KPI Performance Report

The Committees noted the updates on vacancy rates, turnover, sickness absence, core skills compliance and appraisal compliance. In September 2025, the Group deployed 18,386 WTE, representing a reduction of 124 WTE compared with August. A reduction in permanent staff (-16), and Bank (-110) offset against an increase in Agency (+2) were the drivers. September 2025 represented the first month a reduction in total workforce was achieved following two consecutive months of increased workforce deployment. The vacancy rate at 7.7% remained within the 10% threshold, with substantive staff remaining stable in month.

b) Guardian of Safe Working (GOSW)

The Committees noted the Q1 and Q2 Reports for ESTH and Q2 Report for SGUH. At ESTH, there were 87 Exception Reports in Quarter 1 and 151 in Quarter 2. Themes were similar to previous reports where FY1 doctors were the most likely to fill an exception report and in General Medicine.

At SGUH, there was a steep rise in number of exception reports, mainly in AMU (acute medical unit) due to ongoing issues with pressures on staff to cover acute admissions and A&E as well as the acute wards. A meeting is planned for November 2025 to discuss with the resident doctors plans to review the work flow in the department, as per the report received last year.

c) People Polices Update

The Committees welcomed the fact that good progress had been made with reviewing people policies across both organisations with the aim of developing and agreeing gesh versions that will be applicable to all within the group. 14 gesh People policies are now in place, a further 6 in active review and 15 requiring reviews throughout 2025/26. Operational demands on key stakeholders influence the timelines, but it is anticipated that all people policies will be in active

review by the end of March 2026, with sign off throughout 2026/27. The Committees noted the contents of the update and confirmed the level of assurance in respect of progress with gesh People policies.

d) Group Freedom to Speak Up Report Q1-Q2 2025/26

The Committees noted that the reduction in reports in Q1 and Q2, compared to the previous year, was due to a drop in team capacity and proactive work to encourage staff to first attempt to resolve issues formally within their local areas. It was noted that staff at ESTH tended to use FTSU more readily than SGUH staff, who are more likely to raise concerns locally first. The Committees expressed concern about the timeliness of resolution of concerns, particularly for historical and complex cases and decided on a split assurance level, providing Reasonable Assurance for the FTSU resourcing and structure and Limited Assurance for the timely resolution of concerns.

5.0 Other issues considered by the Committees

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

GMC National Training Survey 2025

The Committees noted the findings of the survey, the improvements made overall, and the action plans for improvement in areas of concern. Both Trusts maintain strong quality assurance processes to ensure high standards in medical education and training. These processes provide clear oversight of both training successes and areas needing improvement.

Undergraduate Medical Education Update

The Committees noted the key issues, and the sources of assurance regarding the management, delivery and quality of undergraduate education, and decided that the level of assurance provided was reasonable and that this area was well-managed and delivered.

Covid and Flu Vaccination Programme 2025

The Committees noted this report which provided an update on the delivery of the Autumn Vaccination Campaign at St George's and Epsom and St Helier hospitals (the Group). The campaign was designed in line with guidance issued by NHS England (NHSE) earlier in the year setting out the schedule to deliver the Seasonal Influenza (Flu) autumn campaign between 1 October 2025 and 31 March 2026. The presented Data was sourced from NHS Federation data Platform.

6.0 Recommendations

6.1 The Group Board is asked to note the issues escalated to the Group Board and the wider issues on which the People Committees received assurance on 23 October 2025.

Group Board

Meeting on Thursday, 06 November 2025

Agenda Item	5.2	
Report Title	**Group Freedom to Speak Up Report Q1-Q2 2025/26**	
Executive Lead(s)	Stephen Jones, Group Chief Corporate Affairs Officer	
Report Author(s)	Karyn Richards-Wright, Group Freedom to Speak Up Guardian	
Previously considered by	People Committees	23rd October 2025
Purpose	**For Assurance**	

Executive Summary

This report provides the Group Board with a thematic analysis of concerns raised with the Freedom to Speak Up Guardians across the gesh Group during Q1 and Q2 2025/26.

St George's:

- A total of 41 concerns were raised with the FTSU Guardian over the first half of the year.
- The staff groups which raised the highest number of concerns were: Administrative and Clerical staff (13 concerns – 31.71%); and Nursing and Midwifery staff (9 concerns – 21.95%).
- In terms of concerns raised across the Divisions:
- 16 concerns (39.02%) were raised from Children's Women's Diagnostics and Therapies (CWDT), the largest Division,
- SNCT and Corporate both had 8 concerns each (19.51%) per division;
- MedCard had 7 concerns (17.07%);
- SWL Pathology had 1 concern raised (2.44%)
- The main types of concern raised were: Management Conduct 15 (36.59%); HR Policies and systems and processes both had 11 concerns (26.83%) B & H, 10 concerns (24.39%) patient safety, 7 concerns (17.07%); worker safety 3 (7.31%) and detriment, 2 concerns (4.88%); discrimination, 2 concerns (4.88%);

Epsom and St Helier

- A total of 71 cases were raised with the FTSU Guardian over the same period.
- The staff groups which have raised the highest number of concerns were; and Administrative and Clerical staff (22 concerns – 30.99%). Nursing and Midwifery (14 concerns – 19.72%)
- In terms of concerns raised across the Divisions:
- 20 concerns (28.17%) were raised by staff within Medicine
- 8 concerns each (11.27%) were raised by staff within Estates and Facilities and Cancer Services
- 6 concerns (8.45%) were raised by staff within Pathology
- 5 concerns each for Corporate and Surgery Divisions (7.04%)
- 4 concerns each for Sutton Health and Care, Women's and Children's and Unknown (5.63%)
- 2 concerns for SWLEOC (2.82%)
- 1 concern each for Bank, Community, Pharmacy, Renal and Surrey Downs Health and Care (1.51%)

- The main types of concerns raised were: Management Conduct 40 (56.34%), Bullying and harassment 33 (46.48), Discrimination 25 (35.21%), Patient experience 19 (26.76%) Patient safety/quality 18 (25.35%), Detriment 15 (21.13%), Worker Safety 14 (19.72), Colleague Concerns 9 (12.68%) and System and process 8 (11.27%).
- At present, the Speak Up training at ESTH is not mandatory.

We adopted the new national Freedom to Speak Up Policy as one of the first Group-wide policies, in line with national guidelines from NHS England in early 2025. We have also developed a standardised process, within the team, for triaging concerns raised to the FTSU service to help ensure consistency in the way in which concerns are dealt with and escalated, which includes clarity on how the service escalates immediate patient safety concerns and its process for undertaking an early stage assessment of the risk of concern raisers encountering detriment. We have seen an increase in staff raising that they fear detriment due to raising concerns as opposed to actually suffering detriment. As such, in line with national guidance from the National Guardian's Office, our triage process also sets out our process for checking in with concern raisers six and 12 months after raising a concern.

Timely resolution of concerns, especially for complex or historical concerns, confidentiality of concerns and effective communication with the Guardian remain issues Group-wide. We will continue working with our colleagues to ensure that managers are equipped with the information in knowing what to do when staff in their areas raise concerns.

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

Action required by Group Board

The Group is asked to:

a. Note the number of concerns reported to the FTSU Guardians in Q1 and Q2 2025/26 for both SGUH and ESTH and the staff groups reporting.
b. Note the themes emerging from FTSU cases in this period.
c. Note the recommendations of the Group FTSU Guardian as set out in section 3 of the report
d. Note the priorities of the Group FTSU service in the coming months.

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

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

Implications

Group Strategic Objectives

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

Risks

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

CQC Theme

☒ Safe	☒ Effective	☒ Caring	☒ Responsive	☒ Well Led

NHS system oversight framework

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

Financial implications

There are no specific financial implications relating to this report.

Legal and / or Regulatory implications

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

Equality, diversity and inclusion implications

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

Environmental sustainability implications

There are no specific environmental sustainability implications of this report.

Group Freedom to Speak Up Report, Q1-Q2 2025/26
Group Board, 06 November 2025

1.0 Purpose

1.1 This report provides the Group Executive with a thematic analysis of concerns raised with the Freedom to Speak Up Guardians across the Group during Q1 and Q2 25/26. The report sets out key themes and trends in the number, type and origin of concerns and highlights cross cutting and emerging issues.

2.0 Background

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

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

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

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

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

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

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

2. We will make it safe for our staff to speak up
3. We will investigate concerns promptly, fully and fairly
4. We will ensure that speaking up makes a difference
5. We will support the positive development of our organisational culture

2.5 There is currently no corresponding FTSU vision and strategy approved by the Board for ESTH, but the principles and approach adopted in the SGUH strategy could equally apply at ESTH, and the paper sets out the development of a Group-wide FTSU vision and strategy as an important step in strengthening our approach to speaking up.

3.0 Current SGUH and ESTH FTSU activity and themes

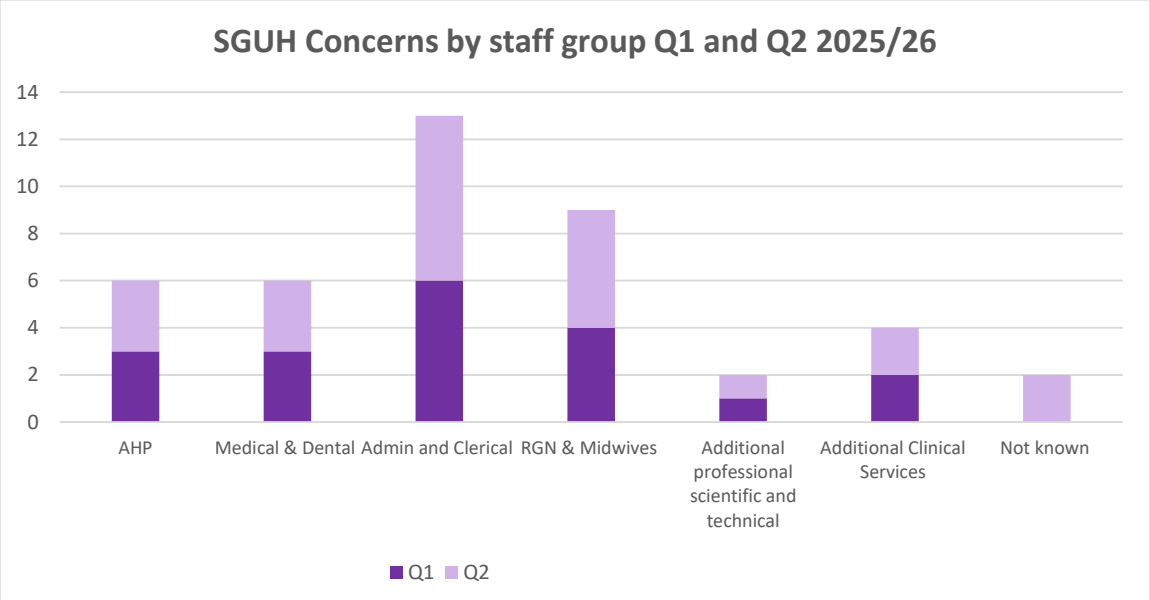
(a) Total number of concerns raised via Freedom to Speak Up in Q1 & Q2 2025/26

3.1 Between 1 April 2025 and 30 September 2025, a total of 112 concerns were raised with the FTSU Service across the gesh Group. SGUH staff raised a total of 41concerns, 19 concerns in Q1 and 23 concerns in Q2. In the same period, 71 concerns were raised from ESTH staff, with 41 concerns raised in Q1 and 30 in Q2.

3.2 Comparing to the same period last year when there were a total of 165 this shows a 32.12% reduction. There has been a notable reduction in Freedom to Speak Up (FTSU) cases compared to the same period last year, decreasing from 165 to 112. This reduction maybe linked to the reduced capacity within the team due to absences and subsequent vacancies. Proactive measures in the coming months will be taken to monitor this.

(b) Concerns raised by staff group in Q1 & Q2 2025/26

3.3 The following charts show the concerns raised via FTSU by different staff groups at SGUH, both over the course of Q1 and Q2.

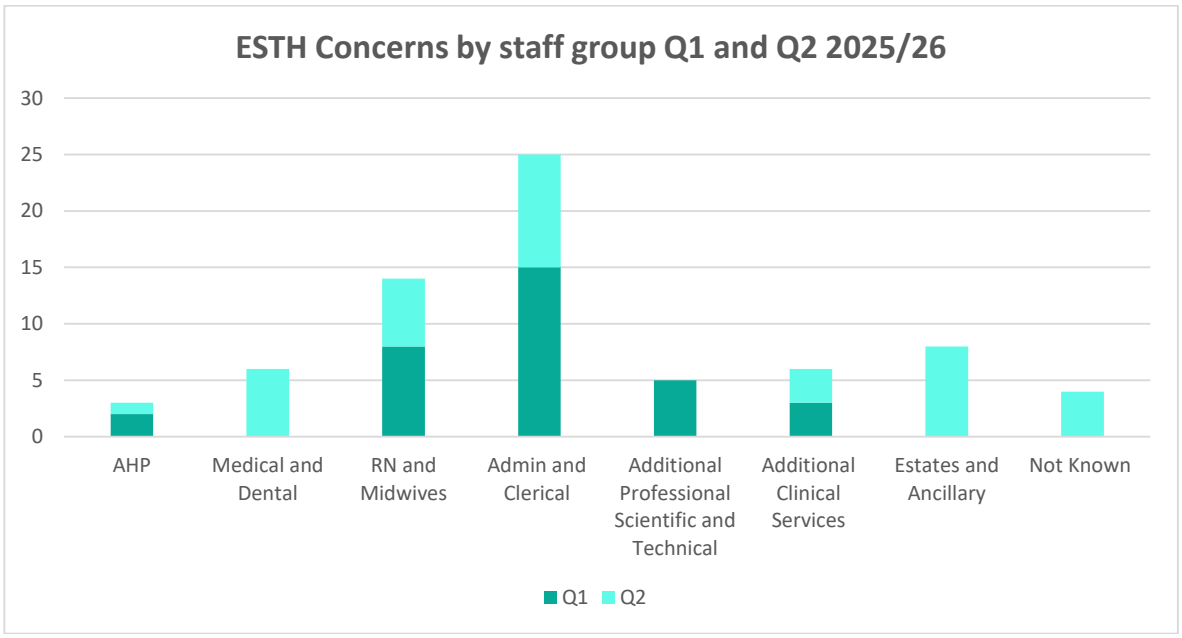


3.4 Staff groups at SGUH who have raised concerns with the FTSU Guardian over Q1 & Q2:

- **Administrative and Clerical staff** are the staff group which raised the highest number of concerns to the FTSU Guardian over the past 2 quarters. A total of 13 concerns (31.71%) were raised by this staff group with 6 concerns raised in Q1 and 7 in Q2.
- **Nursing and Midwifery** staff raised the second highest number of concerns in Q1 & Q2 with 9 concerns (21.95%). 4 concerns were raised in Q1 and 5 concerns in Q2.
- **AHPs** raised a total of 6 concerns (14.63%), 3 in Q1 and 3 in Q2.
- **Medical & Dental staff** also raised 6 concerns (14.63%) with 3 raised in each quarter .
- **Additional clinical services** had 4 concerns raised 2 in each of the quarters (9.76%).
- **Additional Professional Scientific and Technical concerns** had 2 concerns (4.88%), 1 in each quarter.
- **Unknown staff group** There were 2 concerns in Q2 (4.88%)

(c) Concerns raised by staff group in Q1 and Q2 (ESTH)

3.5 The following charts show the concerns raised via FTSU by staff groups at ESTH:



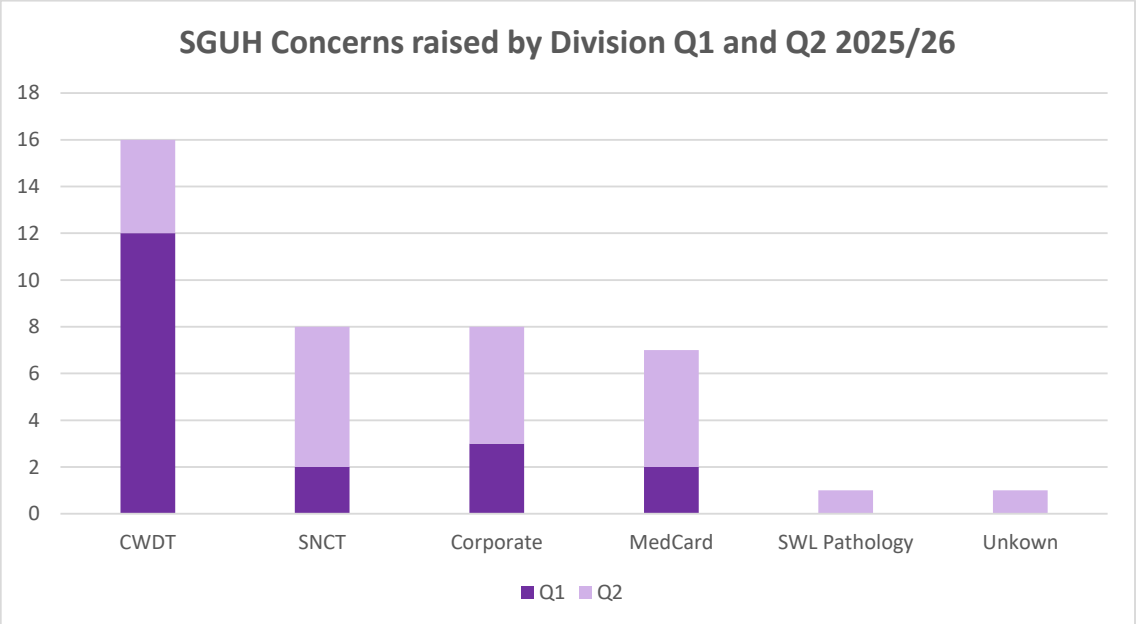
3.6 Staff groups which have raised concerns with the FTSU Guardian at ESTH over the past year shows that:

- **Administrative and Clerical staff** are the staff group which raised the highest number of concerns to the FTSU Guardian over the past 2 quarters. A total of 25 (35.21%) concerns were raised by this staff group with 15 concerns raised in Q1 and 10 in Q2.

- **Nursing and Midwifery** staff raised the second highest number of concerns in Q1 & 2 with 14 concerns (19.72%) raised,8 concerns were raised in Q1 and 6 concerns in Q2.
- **Estates, Facilities & Ancillary** raised a total of 8 concerns (11.27%) all raised in Q2.
- **Medical and Dental** staff raised a total of 6 concerns (8.45%) all raised in Q2
- **Additional Clinical Services** staff also raised 6 concerns (8.54%) 3 in each quarter
- **Additional Professional Scientific and Technical** staff raised 5 (7.04%) concerns all raised in Q1
- **Unknown staff group** have 4 Concerns raised in Q2 (5.63%).
- **AHP** staff raised 3 concerns (4.23%) 2 in Q1 and 1 in Q2.

(d) <u>Concerns raised by Divisions in Q 1 & 2 2025/26 (SGUH)</u>

3.7 The following chart shows the number of concerns raised by Division at SGUH over the 2 quarters:



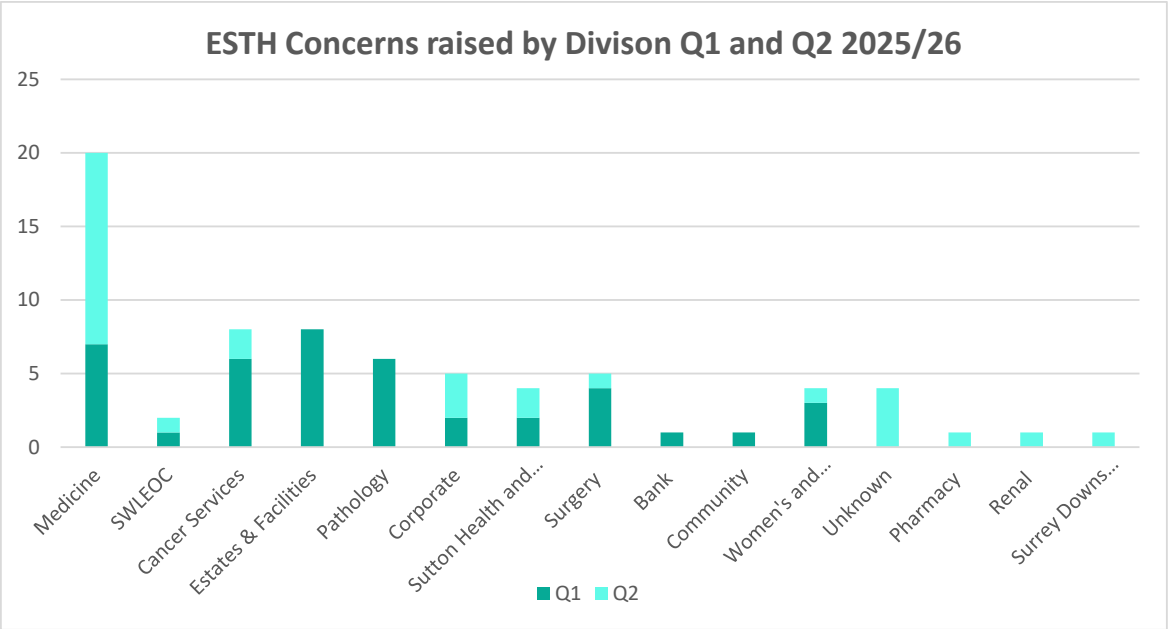
3.8 An analysis of the concerns raised by Division with the FTSU Guardian over the 2 quarters at SGUH shows that:

- Staff from the **Children's, Women's Diagnostics and Therapies (CWDT) Division (the largest division)** raised a total of 16 concerns out of a total of 41, (39.02%) of total SGUH concerns.
- **SNCT and Corporate Division** staff raised the second highest number of concerns with 8 concerns raised for each division (19.51%).

- **MedCard staff** raised 7 concerns (17.07%).
- **SWL Pathology and Unknown** staff group raised 1 concern each (2.44%)

(e) Concerns raised by Division (ESTH)

3.9 The following chart shows the number of concerns raised by Division at ESTH over the past 2 quarters:



3.10 An analysis of concerns raised by division at ESTH shows that:

- **Medicine Directorate** staff raised the most concerns, a total of 20 concerns (7 in Q1 and 13 in Q2) out of a total of 71 across the Trust as a whole (28.17%).
- **Estates and Facilities** staff raised the second highest number of concerns, with 8 concerns, all raised in Q1 (11.27%).
- **Cancer Services** staff also ranked second with 8 concerns raised, 6 in Q1 and 2 in Q2 (11.27%).
- **Pathology staff** raised 6 concerns all in Q1 (8.45%).
- **Corporate staff** raised 5 concerns 2 in Q1 and 3 in Q2 (7.04%)
- **Surgery staff** raised 5 concerns 4 in Q1 and 1 in Q2 (7.04%)
- **Women's and Children's** staff raised 4 concerns 3 in Q1 and 1 in Q2 (5.63%)
- **Sutton Health and Care** staff raised 4 concerns, 2 in each quarter (5.63%)
- **Unknown** staff group raised 4 concerns all in Q2 (5.63%)

- **SWLEOC** staff raised 2 concerns 1 in each of the quarters (2.82%)
- **Bank and Community** staff groups raised 1 concern each in Q1 (1.41%)

- **Pharmacy, Renal and Sutton Health and Care** staff all raised 1 concern in Q2 (1.41%)

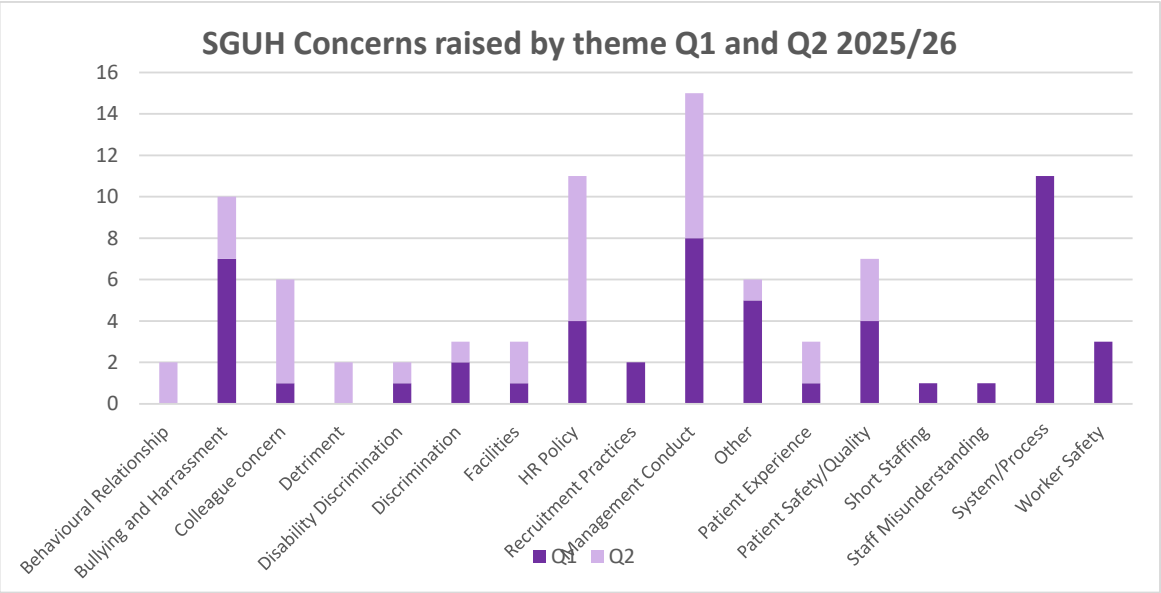
(f) **Themes in concerns raised with the Group FTSU Guardians in Q1 and Q2 2025/26**

SGUH Themes

3.11 As well as analysing concerns raised by staff group and division, we also look at the types of concern being raised and the themes within these. Across SGUH, the key themes in the concerns raised via FTSU in Q1 & Q2 2025/26 are:

SGUH Theme	Number associated with concerns
Management Conduct	15 (36.59%)
HR Policy	11 (26.83%)
System / Process	11(26.83%)
Bullying and Harassment	10 (24.39%)
Patient Safety/Quality	7 (17.07%)
Colleague Concern	6 (14.63%)
Patient Experience	3 (7.32%)
Worker Safety	3 (7.32%)
Facility Issues	3 (7.32%)
Behavioural Relationship	2 (4.88%)
Detriment	2 (4.88%)
Disability Discrimination	2 (4.88%)
Recruitment Practices	2 (4.88%)
Short staffing	1 (2.44%)

3.12 The charts below illustrates the themes of concerns raised during Q1 & Q2, 2025/26.



Analysis of the main three themes SGUH – System and Process, Management Conduct and HR Policy

3.13 The themes and frequency of these concerns appear to be influenced by several interrelated organisational factors:

a) Trust Financial Position and Organisational Pressures:

- The Trust's challenging financial position has meant increased scrutiny around resources, staffing levels, and cost saving measures.
- This has contributed to heightened tension within teams, with some staff perceiving that decisions driven by financial pressures are impacting fairness, especially within those teams where consultations are underway. Examples of concerns relating to transparency, by not understanding how a decision has been made, lack of response to questions relating to consultations or changes and wellbeing in the workplace with staff reporting feeling anxious and or stressed.
- This creates feelings of insecurity and mistrust in management who in turn have voiced concerns relating to the challenges of managing teams undergoing changes.

b) Structural and Team Changes:

- Recent and ongoing changes to team structures and leadership roles have caused uncertainty and anxiety among staff.
- These changes have, in some cases, led to concerns about management behaviour, communication and decision-making.

c) Perceived Inconsistencies in Policy Interpretation and Application

- Some concerns relate to HR policies, particularly regarding how policies are interpreted and applied across departments.
- Staff have raised issues suggesting a lack of clarity or consistency in areas such as performance management, sickness absence, and grievance or disciplinary procedures.
- This perceived inconsistency has contributed to feelings of unfair treatment and a lack of confidence in management and HR processes.

d) Systems and Process Challenges:

- Concerns about systems and processes often overlap with HR and management issues.
- Staff have highlighted delays, lack of transparency, and perceived procedural errors in areas such as investigations, communication of outcomes and timely communication. Some staff report not understanding or having explained to them what information will be shared with them at the end of a grievance they have raised and have been left frustrated and confused.
- These issues indicate that existing processes may not always be followed in a timely or robust manner, this in turn affects staff confidence and produces further concerns.

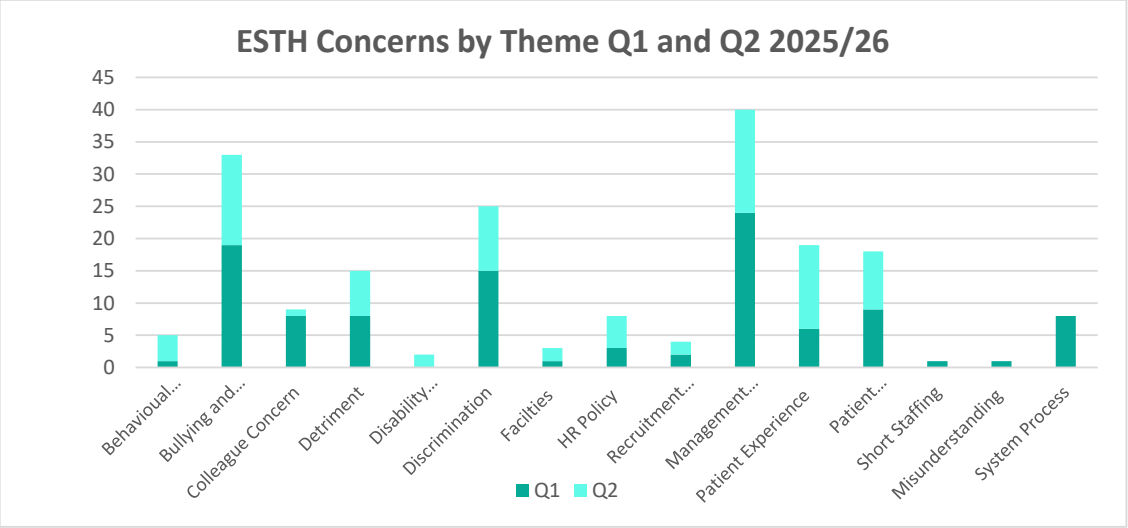
e) Historical Grievances and Outstanding Outcomes:

- Several concerns relate to longstanding or unresolved historical grievances where outcomes remain pending or unclear.
- The length of time some cases have been open has created frustration and a sense of injustice among staff. Whist the Guardian acknowledges that the increase in investigating officers is a positive step there is still a way to go until staff see the result of these improvements and staff currently and already within long-standing processes may not see the benefit of the improvements.
- The impact of this is that there is a perception that staff voices are not being heard effectively or taken seriously.

ESTH Themes

3.14 Across ESTH, the key themes in concerns raised to the FTSU Guardian were:

ESTH Theme	Number associated with concerns
Management Conduct	40 (56.34%)
Bullying and Harassment	33 (46.48%)
Discrimination	25 (35.21%)
Patient Experience	19 (26.76%)
Patient Safety/Quality	18 (25.35%)
Detriment	15 (21.13%)
Worker Safety	14 (19.72%)
Colleague Concern	9 (12.68%)
System / Process	8 (11.27%)
HR Policy	8 (11.27%)
Behavioural Relationship	5 (7.04%)
Nepotism	5 (7.04%)
Recruitment Practices	4 (5.63%)
Facility Issues	3 (4.23%)
Disability Discrimination	2 (2.82%)
Short staffing	1 (1.41%)
Pay Issues	1 (1.41%)



a) **Analysis of the main three themes ESTH:** Over recent months, there has been a noticeable increase FTSU concerns raised by staff regarding management conduct, bullying and harassment, and discrimination. Analysis of the themes and patterns emerging from these concerns indicates that several interlinked factors are contributing to this trend.

b) **Historical Cultural Issues: C**ertain departments within the organisation have longstanding cultural challenges that have not been fully addressed over time. These include poor behaviours and communication between management and staff and a lack of psychological safety to raise concerns without fear of reprisal.

   This historical context in certain areas has created an environment where some staff feel that negative behaviours have been normalised or overlooked.

c) **Management Conduct and Leadership Style:** A recurring theme across the concerns raised relates to management behaviour including perceived inconsistency, favouritism (especially where friendships have been formed or families working together) and poor people management skills.

d) **Bullying, Harassment, and Discrimination:** A number of concerns have referenced experiences of bullying and harassment including being undermined, isolated (i.e. both socially by not being included in invitations and professionally by being “intentionally kept out of the loop)”, or subjected to negative comments including within earshot of patients and or colleagues.

   Some staff with health conditions or disabilities have expressed that adjustments have been applied inconsistently or there is an unreasonable delay in implementation. Also reports that requests are declined without clear rationale, and that there is a lack of fairness between teams. For example some staff perceived as not having to complete flexible working requests and working flexibly but others advised that they have to formally request changes.

e) **Collective Concerns:** Admin and Clerical staff raised the most concerns 25 (35.21%) some through collective concerns. This pattern of collective concerns within certain departments and staff groups suggests systemic or cultural problems rather than isolated incidents.

   Staff within one particular area both clinical and admin have collectively reported feeling that their concerns have historically been ignored or minimised, leading to a loss of confidence in local resolution processes. This may not be the case however, is the perception of some staff. As such, this has led to a preference for escalating matters collectively through FTSU or formal routes such as grievances. The Guardian is working with the senior leaders within departments and within the Raising Concerns Oversight and Triangulation Group to address issues relating to both patient safety and negative behaviours within teams.

4.0 Recommendations for improvement

4.1 Timely Resolution of Concerns

The FTSU Guardian continues to recommend that all concerns are addressed in a timely and proportionate manner, ensuring that staff feel heard and confident that their issues are being taken seriously. A key focus is on early engagement and prompt allocation of cases, alongside clearer accountability for actions and feedback to those who have spoken up. Ensuring that expectations v reality especially around outcomes is clear with staff raising concerns and grievances. The Guardian advocates for continued collaboration between divisional leaders, HR, and FTSU to prevent unnecessary delays and ensure that concerns are resolved swiftly at the most appropriate level.

4.2 **Focus on Support for Managers**

The Guardian encourages focus being placed on supporting managers to effectively lead and respond to concerns raised within their teams. Recognising the pressures that managers face, the Guardian recommends the organisation is ensuring that all managers are offered regular one to one sessions with their own line managers to provide guidance, reflection, and emotional support. The rise across both organisations in complaints against managers evidence the importance of robust management support. Managers should be encouraged to discuss challenges, explore learning, and build confidence in handling difficult situations. The Guardian raises this issue as a result of feedback from managers that some feel unsupported.

5.0 Positive Improvements

5.1 **Positive Effect of the Raising Concerns Oversight and Triangulation Group**

The establishment of the Raising Concerns Oversight and Triangulation Group has had a positive and measurable impact on improving responsiveness to concerns. This group has played a key role in unblocking barriers to progress, ensuring that issues raised are considered from multiple perspectives and that appropriate action is taken promptly. The triangulation of data from FTSU, HR, and site leaders has enhanced the opportunity for better organisational learning. The Guardian has emphasised that the focus over the next few months will be around learning.

5.2 **Positive Effect of Continued Training of Investigating Officers**

Ongoing investment in the training and development of Investigating Officers has had a significant positive effect on the investigation process. With more trained officers available, cases can be allocated more swiftly, reducing waiting times which has been a great concern coming from staff historically.

6.0 Speak Up, Listen Up, Follow Up Training

6.1 In late 2021 at SGUH, the Trust incorporated training on raising concerns into its MAST Training programme, meaning it is now a mandatory training module for all staff. It is important that all workers are given protected time to complete the required training to ensure that workers are aware of how to raise concerns and that managers are aware and confident in applying their responsibilities to concerns raised with them. Following a national directive that all organisations should offer all workers regular mandatory training on how to speak up safely, how to respond to concerns and how to learn and reflect from these concerns. All 3 parts of the required training have now been released.

6.2 The Guardian has regularly updated the committee on the disparity between staff across gesh who have completed the FTSU training. Consistently over 90% of staff at SGUH have completed the training whereby less than 1% at ESTH. The training is mandatory at SGUH and not at ESTH. While training alone will not be sufficient to equip staff and managers in raising and responding to concerns, low training levels mean concerns, and particularly complex concerns, are not always being appropriately addressed, this could also be an indicator for the consistently higher number of concerns from ESTH staff compared with staff at SGUH with one of the issues being understanding of Freedom to Speak Up. The Guardian continues to recommend that the training is made mandatory at ESTH in line with current arrangements at SGUH.

7.0 Resources within the FTSU Service

7.1 The FTSU service has recently experienced a reduction in resources due to several vacancies within the team, which has inevitably placed additional pressure on the remaining members and impacted capacity. To address this and ensure the sustainability of the service, a new more cost efficient structure is being implemented that introduces dedicated FTSU Advisor roles. These roles will enhance front line support for staff raising concerns and provide earlier intervention and guidance, ensuring that individuals continue to receive timely, and consistent support. The introduction of these advisor roles will also enable the Group Deputy Guardian and Group Guardian to focus more strategically on learning and cultural development priorities.

7.2 The service is progressing with the implementation of a new case management system, which will significantly strengthen operational effectiveness by improving case tracking, data analysis, and reporting capabilities. This enhanced infrastructure will support a more robust governance framework, assist with facilitating better learning from themes and trends, and ultimately contribute to a more transparent, responsive, and efficient FTSU service across the organisation.

8.0 Priorities for FTSU Service Going Forward

8.1 In terms of the priorities of the Group FTSU Service over the rest of the year and into 2026/27, we are focused on:

a) There will be a strengthened focus on learning from concerns raised through FTSU process. This will include a thematic review of recent cases to identify recurring issues, trends, and opportunities for organisational learning.

b) To enhance accountability and transparency, monthly divisional reporting will be introduced. This will provide a consistent mechanism for monitoring FTSU activity, tracking progress against actions, and highlighting areas requiring additional support. Divisional leads will receive feedback and guidance to help maintain a proactive speaking-up culture and ensure timely resolution of concerns.

c) Regular meetings are being arranged with the new Group Employee Relations Lead to agree on a more streamlined and collaborative process for managing FTSU concerns that progress into HR pathways.

d) Having a group wide Vision and Strategy further assists in clarity of the function. The current SGUH vision and strategy remains broadly fit for purpose 4 years on from approval by the Board, but would benefit from a refresh. ESTH has not historically had a Board approved FTSU vision and strategy place. As such, a Group FTSU Vision and Strategy is being developed, with an ambition to agree and launch this in early 2026.

9.0 Recommendation

7.1 The Board is asked to:

a) Note the number of concerns reported to the FTSU Guardians in Q1 and Q2 for both SGUH and ESTH and the staff groups reporting.
b) Note the themes emerging from FTSU cases in this period.
c) Note the recommendations of the Group FTSU Guardian as set out in section 4 of the report.
d) Note the priorities of the new Group FTSU service in the coming months.

Group Board Meeting (Public)

Meeting on Thursday, 06 November 2025

Agenda Item	6.1
Report Title	**Infrastructure Committees Report to Group Board**
Non-Executive Lead	Claire Sunderland Hay, Associate Non-Executive Director (SGUH), Chair of IT focused meetings. Phil Wilbraham, Associate Non-Executive Director (ESTH), Chair of Estates focused meetings.
Report Author(s)	Claire Sunderland Hay, Associate Non-Executive Director (SGUH) Phil Wilbraham, Associate Non-Executive Director (ESTH)
Previously considered by	n/a
Purpose	**For Assurance**

Executive Summary

This report sets out the key issues considered by the Infrastructure Committees at their meetings on 19 September 2025 (Estates & Facilities focus) and 24 October 2025 (IT focus). The key issues the Committees wished to highlight to the Board are:

1. **Group Chief Officer - Facilities, Infrastructure & Environment (GCOFIE) Update**
   The Committees received a written update from the Group Chief Officer - Infrastructure, Facilities and Environment Officer which included updates about a new piece of legislation called Martin's Law, which stems from the Manchester Arena bombing, the Estate Safety Fund that will be provided by government for the next four years to address critical infrastructure and safety risks in NHS hospital buildings and the LFB (London Fire Brigade) Enforcement Notice.
2. **Digital Strategy Development**
   The Committees received an update on the digital strategy development and noted that it was on track for Board engagement in December 2025 and sign-off in January 2026.
3. **PACS Project Update**
   The Committees noted the ongoing work with the new vendor Optum, which involved active and positive contract negotiations for a Contract Change Notice (CCN). GCFO confirmed that the funding was in place, and that the internal team was working on the implementation plan.

Action required by Infrastructure Committees

The Group Board is asked to note the issues escalated by Infrastructure Committees to the Group Board and the wider issues on which the Committees received assurance in September and October 2025.

Committee Assurance	
Committee	Infrastructure Committees
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				
See section 5.1 - Digital Risk Management Update				
CQC Theme				
☐ Safe	☐ Effective	☐ Caring	☐ Responsive	☒ Well Led
NHS system oversight framework				
☐ Quality of care, access and outcomes			☒ People	
☐ Preventing ill health and reducing inequalities			☒ Leadership and capability	
☒ Finance and use of resources			☐ Local strategic priorities	
Financial implications				
Set out in the paper.				
Legal and / or Regulatory implications				
Set out in the paper.				
Equality, diversity and inclusion implications				
N/A				
Environmental sustainability implications				
N/A				

Infrastructure Committees Report
Group Board, 06 November 2025

1.0 Purpose of paper

1.1 This report sets out the key issues considered by the Infrastructure Committees' meetings on 19 September 2025 and 24 October 2025 and includes matters the Committees specifically wish to bring to the attention of the Group Board.

2.0 Items considered by the Committees

2.1 At its meetings on 19 September 2025 and 24 October 2025, the Committees considered the following items of business:

19 September 2025 (Estates & Facilities focus)	24 October 2025 (IT focus)
• Group Chief Officer - Facilities, Infrastructure & Environment Update • ESTH 6 Facet Survey Update Report • SGUH Estate and Facilities Update • ESTH Estate and Facilities Update (Fire Safety and Water Safety) • Deep Dive – Ventilation at St George's Hospital • Deep Dive - Health & Safety (non-clinical) across gesh • QMH Property Update	• Digital Delivery Update • Digital Strategy Development • Digital Risk Management Update • PACS Project Review • Digital forward look

2.2 The Committees were quorate on 19 September 2025 but not on 24 October 2025. All decisions made during inquorate meetings are ratified by email.

3.0 Key issues for escalation to the Group Board

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

3.1 **Group Chief Officer - Facilities, Infrastructure & Environment Update**

The Committees received a written update from the Group Chief Officer Facilities, Infrastructure and Environment (GCOFIE) on the following key developments:

- A new piece of legislation called Martin's Law, which stems from the Manchester Arena bombing, places a significant planning and risk assessment obligation on large venues, including hospitals, for a terror attack response. An update on the preparations for this law will be presented at a future meeting.
- The Estate Safety Fund will be provided by government for the next four years to address critical infrastructure and safety risks in NHS hospital buildings. The Estates Safety Fund will invest in relatively small scale but important building safety works, including fixes to

leaking roofs, upgrades to faulty electrical wiring and addressing fire safety requirements, new air handling units and other schemes identified by systems as local priorities.

- ESTH received the LFB (London Fire Brigade) Enforcement Notice with a date to complete all deficiencies by 7th September 2026.
- SGUH had received a draft programme from Vanguard for the completion of the ITU building. This programme showed a completion date of March 2026. This is a considerable delay from the current contractual completion date of June 2025.
- As part of our commitment to continuous improvement and delivering an excellent patient experience, the annual PLACE (Patient-Led Assessments of the Care Environment) reviews took place across our sites in October 2025.

The Committees noted the update and requested an update on the budget for the BAU (business as usual) estates and facilities work.

3.2 SGUH Estate and Facilities (E&F) Update

The Committees reviewed the report which provided the latest updates from the Estates, Facilities and Medical Physics and Clinical Engineering teams with more of a focus on Estates and Engineering compliance for St George's Hospital. The team was concentrating on more detailed investigations into risk management processes, particularly around risk reduction, scheduling, and remediation and was doing a lot of assurance work following inspections by the Care Quality Commission (CQC). The level of assurance overall was agreed as Reasonable at this time for the St Goerge's areas of the gesh E&F group.

3.3 ESTH Estate and Facilities Update (Fire Safety and Water Safety)

The Committees noted the fire safety report that provided assurance that many of the actions had been completed, such as housekeeping issues and fire strategy completion. The challenge with face-to-face fire training as part of new staff induction was highlighted and it was noted that a project manager would be appointed to develop a long-term programme in agreement with the fire service for more invasive issues like fire stopping.

The Committees also reviewed the water safety report and noted that an independent review by GSTT's team and Dr. Surman-Lee concluded that the area was safe with existing mitigations. The review also suggested additional monitoring of outlets in Critical Care areas to build a temperature and contamination profile. The Committees noted the report and requested a clear rationale for decisions made based on expert advice.

3.4 Digital Strategy Development

The Committees received an update on the digital strategy development and noted that it was on track for Board engagement in December 2025 and sign-off in January 2026. The strategy is built on two core themes:

- Rock solid foundations - ensuring core systems like Wi-Fi and clinical systems work reliably without issue, and
- Supporting the medium term plan and focusing on innovation, using AI and data to become a data-driven organisation, and developing its stance as an Integrated Health Organisation (IHO) within the broader SW London system.

The Committees supported the direction of travel, noting the importance of aligning the strategy's pace with the wider 10-year plan and the SW London system and noted that "rock solid foundations" would likely rely on normal capital allocations, while the more innovative projects might qualify for external central funding, particularly those that meet multiple purposes.

4.0 Key Issues on which the Committees received assurance

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

4.2 **Queen Mary's Hospital Property Update**

The Committees reviewed the report which provided an update on the Queen Mary's Hospital (QMH) property in Roehampton. It was noted that QMH was built though the Private Finance Initiative scheme, opened in 2004, to provide community healthcare. The Trust is a tenant in the building, and the contract with NHS Property Services is until 2034. Quarterly contract monitoring meetings are held between the Trust and NHS Property Services Ltd.

4.3 **ESTH 6 Facet Survey Update**

Following the previous report to the Committees about the backlog survey carried out of the Epsom and St Helier acute Hospital Estate between December 2023 to March 2024 by the Oakleaf Group, this report provided an update and answers to questions raised by the Committees. The Committees noted that the 20% review had not yet been ordered but that it would be completed this financial year (2025/26). The top priorities for infrastructure investment this financial year are Fire safety, Water safety, particularly in the E Block, Electrical Infrastructure and Ventilation. This prioritisation is driven primarily due to the risk of non-compliance with regulations. Building roof and window integrity are also priority areas for investment this year as indicated in the prioritisation tool.

4.4 **Digital Risk Management Update**

The Committees noted that the gesh Digital Governance Group reviewed 8 SGUH and 15 ESTH IT / Infrastructure risks at their meeting on 25 September 2025. The Committees requested another review of the risks at the next IT focused meeting to ensure clarity and proper attention was given to critical areas. CDIO felt that two key risks should be added to the Board Assurance Framework (BAF): Cybersecurity and Failure of Digital Infrastructure.

5.0 Other issues considered by the Committees

5.1 **PACS Project Update**

The Committees noted the ongoing work with the new vendor Optum, which involved active and positive contract negotiations for a Contract Change Notice (CCN). GCFO confirmed that funding was in place, and that the internal team was working on the implementation plan. GCFO explained that CDIO Martin Ellis was now heavily involved and was the logical person to provide future updates. The programme lead for the SW London digital diagnostics programme would also be available to provide updates. The Committees requested that payments be made based on well-defined milestones to ensure proper delivery, and a robust programme governance to effectively manage triggers in the contract.

5.2 **Deep Dive – Ventilation at St George's Hospital**

The Committees reviewed the report on Ventilation at St George's Hospital and noted that the policy was up-to-date and governance was in place, with annual audits and verifications. A recent independent Authorised Engineer (AE) audit found the Trust had moved from limited assurance to reasonable assurance, noting that, while some plant had passed their life cycle, they were still safe.

5.3 **Digital Delivery Update**

The Committees noted this report that summarised the business of the last Digital Governance Group meeting that took place on 26 September 2025. The decision on the Federated Data Platform (FDP) was deferred because further assurance was needed on reporting, IG, and operational flexibility. An update on the risk status for the Windows 11 roll out per site was also discussed, and mitigations were in place to reduce risk.

All staff engaged positively and constructively with the Phase 2 of the Corporate Services Integration process (Leadership and Senior Management), providing detailed feedback and consideration of the proposed new structure. TUPE transfer and implementation of new structures would start from the beginning of November 2025.

5.4 **Deep Dive - Health & Safety (non-clinical) across gesh**

The Committees reviewed this report that provided an overview of main health and safety activities (including fire safety) across the group in order to provide assurance against the legal requirements under the Health and Safety at Work Act 1974 and regulations which support the overarching legislation. This was the first report which provide data across both St Georges and Epsom & St Helier NHS Trusts.

5.5 **Digital Forward Look**

The Committees reviewed the Digital Forward Look, noting that it was a developing framework, and that its details would be further informed by the new steering groups and the digital strategy. The Committees acknowledged the benefit of having this document to help teams stay focused and transition from a reactive approach to a more disciplined, portfolio management approach.

6.0 Recommendations

6.1 The Group Board is asked to note the issues escalated by the Committees to the Group Board and the wider issues on which the Committees received assurance in September and October 2025.

St George's Hospital Charity Report to the GESH Trust Board

Executive Summary

This paper provides:

- An overview of the development and current position of St George's Hospital Charity
- Our plans for continued growth and impact; and
- The support we need from the Trust to strengthen our partnership and maximise our fundraising and the charity's impact

St George's Hospital Charity became an independent charity in 2017, before the gesh Group was formed. Its Articles of Association include supporting St George's University Hospitals NHS Foundation Trust, St George's, University of London (now City St Georges), and the communities the Trust serves. See Appendix 1 for our Charity's story. The Charity has developed into a key strategic partner to the Trust. We work closely across St George's to ensure our funding delivers genuine value and impact through alignment with the Trust's leadership, ensuring our work reflects its strategic direction; through steering groups that bring together staff, leaders, patients, and subject-matter experts to inform our strategic decision-making and shape how charitable funds are used; and by focusing on the Trust's priority areas of excellence, including cardiac care, neurosurgery, brain tumours, and lymphoedema, where charitable investment achieves the greatest impact. We are very grateful for the significant time and support we get from the Trust.

This collaborative approach proved pivotal during the Covid-19 pandemic, which doubled our income and deepened our partnership with the Trust. We have since built on that momentum, creating a stronger, more agile organisation capable of sustaining growth and impact even in a challenging economic environment.

The charity launched a new strategy in 2024 after consultation with the Trust, Healthier Together. It has four priorities:

1) Staff and patient wellbeing
2) Research and Innovation
3) Health Equity
4) Improving the Hospital Environment

These areas align closely with the Trust's vision and ambitions of the NHS 10-Year Plan.

Our goal is to raise £5 million per year by 29/30 - the end of the current strategic period, and we are firmly on track to achieve it. Forecast income for 2024–25 is £3.8 million, a 42% increase on the previous year, reflecting both the loyalty of our supporters and the effectiveness of our new fundraising strategy.

By continuing to work together, we can grow the scale and impact of charitable funding, ensuring every pound raised delivers meaningful benefit for patients, staff, and the wider community.

We have four key asks:

1. **Champion and advocate for the completion of the Children's Appeal**
   We ask for visible leadership and advocacy from the Trust Board and senior leaders to help secure the final **£1.4 million** by December 2026 required to complete the transformation of the children's wards.
2. **Enhance engagement and visibility of the Charity across the Trust**

We ask the Board to support efforts to raise awareness of the Charity's role and impact through internal communications, staff inductions, and patient-facing materials.

3. **Maximise the opportunity presented by City St George's on-site presence**
   We ask the Trust Board to work with the Charity to actively explore and leverage the unique opportunity of having City St George's, University of London embedded within the hospital site. The University, NHS and Charity paradigm could be an excellent foundation to build joint initiatives that build upon our joint resources of world-class researchers, clinicians and a business school.
4. **Shared priorities:** continue to work with us to agree annual priorities and involve the Charity early in project design so funding is focused where it adds the greatest value.

3. How we use our funds: supporting the hospital and delivering impact

All charitable expenditure is directed through the four strategic objectives of our *Healthier Together* strategy, ensuring that every pound we spend delivers measurable benefit for patients, staff, and the wider community.

Strategic Objective 1: Driving Solutions on the Ground

Frontline staff are the driving force of the NHS and the Trust. They understand best what patients need and where challenges lie, which is why we empower them to shape where our support goes. We're delivering targeted staff-led grants that improve care for patients and wellbeing for staff. In 2024/25 we invested £565,000 across 123 frontline projects, and 95% of staff surveyed said the Charity helps them feel more supported. Examples of impact include:

- **Small items, big difference:** Working with the Major Trauma Ward team, we funded sensory tools, activity kits, and orientation boards to reduce anxiety and aid recovery for 250 trauma patients — easing demand on staff and mental health services.
- **Celebrating staff excellence:** The Charity funded the gesh Care Awards, hosted by Myleene Klass, bringing together 400 staff to honour 36 nominees and 12 winners. 94% of attendees said the event made them feel truly valued.
- **Innovation in rehabilitation:** A £40,000 anti-gravity treadmill for the Physiotherapy Gym is helping patients begin rehabilitation earlier and recover faster. Up to half of all gym users are expected to benefit, with 70% already reporting improved outcomes.

Strategic Objective 2: Advancing Research and Innovation

Research and innovation are vital to the future of the NHS, and the Trust and University are leading the way in many clinical areas with national and global impact. We're proud to work alongside them to support the development of future treatments, drive forward world-class research, and bring cutting-edge innovations to our community. The charity is currently funding **28 live research projects across the hospital and university, with £239,644 distributed in grants in 2024/25**. Our funding has resulted in over £3.6 million in additional external funding being secured- over £3 for every £1 invested by the Charity. Our funding continues to drive innovation across St George's in a number of flagship areas:

- **Lymphoedema:** A £5 million multi-year grant for Lymphoedema Research will facilitate advanced translational research, establishing St George's as a national Centre of Excellence.
- **Cardiology:** Our flagship AVATAR research project (Aortic Valve Replacement Versus Conservative Treatment in Asymptomatic Severe Aortic Stenosis) is leading the world in research into ventricular tachycardia (VT), a rare and life-threatening heart rhythm disorder. Led by Dr Saba, the project is enabling him to share his expertise with other clinicians in this field and pioneering the use of MRI scans to improve our understanding of the condition and enable better treatment for patients. This led to the first 3D wideband MRI scanning of patients with implantable cardiac devices in the UK at St George's Hospital.
- **Neurology and brain trauma:** A £820,000 legacy-funded programme in neuro-intensive care is funding translational research in the NICU to improve patient outcomes, whilst a legacy received this year will be used

to fund posts focused on Traumatic Brain Injury (TBI) and ITU care – areas with limited national investment. St George's is one of the only clinical TBI centres in the UK, making it uniquely positioned to lead in this area and create a model of care with national relevance.

Strategic Objective 3: Improving Health Equity

The Charity has made health equity a defining feature of its funding and in 2024/25 gave out £77,495 towards bridging healthcare gaps:

- We have provided multi-year funding to support the appointment of the Trust's first Health Equity Lead, embedding this focus in strategic planning.
- We are funding the first ever Trust-wide Health equity open grant round, aiming to seed fund innovations in health equity.
- We continue to fund initiatives that address disparities in access and outcomes across South West London. For example, we work with the Trust Social Work team year-round to help vulnerable patients return home from hospital safely, funding items they need to look after themselves such as food, bedding and toiletries. In one case, a fridge freezer, bedding and food were bought for a man with no next of kin and no means to purchase them himself. Without this help, he may have stayed in hospital for one to two extra weeks, at great cost to the NHS. Every £1 spent on items such as this is estimated to save £20–£30 by reducing delays and preventing readmission.

This work aligns directly with the NHS 10-Year Plan's commitment to prevention and fairness in care.

Strategic Objective 4: Enhancing the Hospital Experience

We want everyone who visits our hospitals to have the best possible experience. Through our arts programme, engagement activities, and improving hospital spaces, we are making the hospitals more welcoming, and more effective for delivering high-quality care. Last year we spent £822,015 to revitalise 21 indoor spaces and 51 outdoor spaces. Examples include:

- Our £538k project to refurbish the roof terraces outside the Neuro Intensive Care Unit and William Drummond Ward is now well underway. The transformation will turn unused spaces into welcoming terraces filled with plants, seating, and areas for patient beds, creating a welcoming space for neurology patients and staff.
- We created a new Dementia Garden to provide a calming space away from the wards for patients with dementia, their families, and the staff who care for them.
- The Arts St George's programme reached over 6,000 participants last year through performances, workshops, and exhibitions — improving wellbeing, inclusion, and connection across the hospital community.

Collectively, these projects illustrate how our charitable resources are used: to improve the day-to-day experience of care, enable research and innovation that changes lives, promote equity and inclusion, and build an environment where patients and staff can thrive.

4. The NHS 10 Year Plan

The Charity's Healthier Together strategy aligns closely with the priorities of the NHS 10-Year Plan — innovation, prevention, health equity, and community partnership. Through our funding and collaborations, we are supporting the translation of these national ambitions into meaningful local outcomes.

Our investment in innovation enables new models of care and greater clinical efficiency. For example, the charity funded Home Video Telemetry project in Neurophysiology allows patients to undergo EEG monitoring at home, reducing waiting times from a year to just 3-4 weeks and cutting the waiting list from 122 to 11, despite higher referrals. We are also advancing health equity by supporting leadership and community-based programmes that embed fairness and inclusion in how services are delivered.

Through wellbeing and outreach initiatives, the Charity contributes to prevention and early intervention, while our partnerships with schools, faith groups, and local organisations strengthen the Trust's connection with the

communities it serves.

In this way, the Charity's *Healthier Together* acts as a local delivery mechanism for the NHS 10-Year Plan, enabling the Charity and the Trust to work jointly on prevention, innovation, and equity, and to extend St George's impact well beyond the hospital gates. There is significant opportunity to continue to develop our work alongside the Trust in this area.

5. Our Future Plans

Over the coming years, our focus will be on consolidating delivery of the *Healthier Together* strategy and deepening alignment with the Trust's vision and priorities. The Charity is now in a strong position — financially, operationally, and strategically — to expand its role as a facilitator for innovation, wellbeing, and community impact.

Delivering on our strategic ambitions

We will continue to drive progress against our four strategic objectives:

The next phase of delivery will focus on:

- **Completing the Children's Appeal:** This remains our foremost fundraising and delivery priority. With only £1.4 million left to raise, we will work closely with the Trust to secure the final funding by December 2026 and ensure the redevelopment of the children's wards is completed to the highest standard, transforming care for young patients and their families.
- **Building flexibility and resilience:** We will grow unrestricted income to give the Charity and the Trust greater agility, enabling rapid responses to emerging needs, the testing of new ideas, and the sustainability of impact in a challenging financial environment.
- **Deepening community and system engagement:** We will strengthen partnerships with local organisations, schools, and faith groups to raise funds and support prevention, health equity, and population health, reflecting the NHS 10-Year Plan's focus on integrated care and community wellbeing. This will help ensure St George's remains not only a centre of clinical excellence but also support its connection to the local community.
- **Fostering collaboration and innovation:** We will work with the Trust's clinical and operational leaders to co-design projects that address shared priorities and deliver long-term change. By combining charitable flexibility with clinical expertise, we can accelerate innovation and attract further external investment.
- **Enhancing impact and transparency:** We will continue to strengthen our grant-making framework, ensuring decisions are evidence-based, equitable, and demonstrably linked to outcomes. Improved impact measurement will show the difference charitable funding makes and build further confidence among supporters and partners.
- **Raising visibility and engagement:** A key goal is to ensure that every member of staff, patient, and visitor understands the Charity's role and feels able to take part. We will build awareness through joint campaigns, improved internal communications, installing / updating charity branding across site (in collaboration with Estates & Facilities colleagues), and alignment with the Trust's messaging.

Looking ahead

By delivering these priorities, the Charity will not only achieve its strategic target of raising £5 million per year but will also help the Trust advance its ambitions for innovation, equity, and community health. Together, we can ensure that charitable investment continues to drive measurable improvements for patients and staff, and that St George's remains at the heart of a healthier, more connected community.

These priorities will guide the Charity's next phase of growth and form the foundation for our mid-strategy review in 2026, ensuring that our direction, performance, and partnership with the Trust remain strong and future-focused.

St George's Hospital Charity

6. Working Together with the Trust

We cannot achieve these ambitious plans without the input and support of the Trust. By supporting us you help us increase the level of funding that will come back into the Trust and have a direct benefit to staff, patients and the communities you serve.

We have developed a strong working relationship across the Trust and have identified several key areas where your continued support is particularly crucial:

1. **Shared priorities:** continue to work with us to agree annual priorities and involve the Charity early in project design so funding is focused where it adds the greatest value.
2. **Children's Appeal:** Maintain visible leadership and advocacy as we raise the final £1.4 million needed to complete the children's wards redevelopment and deliver on this transformational project.Ensure the money raised is utilised promptly.
3. **Special Purpose Funds:** Support our drive to release and use SPF balances more efficiently, focussing funds where they are most needed and make most impact.
4. **Visibility and engagement:** Champion the Charity through Trust communications, staff induction, and patient-facing materials to strengthen awareness and participation. Support physical visibility of the Charity in the Trust.
5. **Information sharing:** Keep the Charity informed of planned service or structural changes so we can plan effectively, protect investments, and deliver long-term impact.

Championing collaboration: Keep the Charity in mind with collaboration initiatives with City St George's, to fully harness the opportunities of our shared site. With your active support in these areas, we can significantly increase the scale and value of charitable funding across the Trust, ensuring every pound raised delivers the maximum possible benefit for the people of St George's.

7. Conclusion

Since independence in 2017, St George's Hospital Charity has developed into a key strategic partner to the Trust, aligning its work with hospital priorities and national policy through our 2024 strategy *Healthier Together*. Our strong financial performance, improving efficiency, and commitment to innovation and equity demonstrate the Charity's growing maturity and impact.

With the Trust's continued engagement — through aligned priorities, delivery of the Children's Appeal, timely use of SPFs, and strengthened visibility — we are well placed to deliver the next phase of our strategy and support the Trust in realising the ambitions of the NHS 10-Year Plan.

Together, we can ensure that St George's continues to be recognised not only for clinical excellence, but also for compassion, creativity, and community impact.

St George's Hospital Charity

Appendix 1: St George's Hospital Charity's Story

I. Overview

In 2017, St George's Hospital Charity became an independent organisation dedicated to supporting St George's University Hospitals NHS Foundation Trust, St George's, University of London, and the communities the Trust serves. Since 2017, we raised an average of £2-3 million per year, awarding a similar amount in grants.

The Charity holds £11.1 million in reserves, largely made up of restricted and designated funds for specific clinical areas or purposes. Unlike many hospital charities, we do not hold endowment property assets, meaning that sustained fundraising performance and careful cost management are vital to our long-term sustainability.

In 2019, the hospital's arts programme joined the Charity, significantly enhancing our visibility and embedding creativity and wellbeing into daily hospital life.

II. Our Finances and Financial Stewardship

In 24/25 our top three sources of fundraising income were:

- Legacies (£828k)
- Trusts and Foundations (£743k)
- Community and Events (£399k)

Major new funding in 25/26 financial year included a £5 million grant over five years for Lymphoedema Research, establishing St George's as a national Centre of Excellence, £237,000 from NHS Charities Together to enhance the wellbeing of night-shift workers, and £250,000 raised from our *Time for a Change* Fundraising gala. These significant gifts underscore both the scale of our ambition and the growing confidence of external funders in St George's Hospital Charity.

Our Individual Giving programme continues to go from strength to strength thanks to a Face To Face giving campaign. on site at hospitals and in the wider community. Now in it's third year, we have generated 3,000 regular donors through this and are aiming to recruit 1,600 new donors this year. We are projecting to raise £227k unrestricted income this Financial Year and £492k total cumulative income since the campaign started.

Prudent financial management has ensured that growth is sustainable. Fundraising efficiency continues to improve, with ROI rising as new programmes mature, and fundraising costs sitting at 27% of fundraising income- a reduction of 16% from the prior year. Given the benchmark for UK charities is generally accepted as an average return of £4 for every £1 spent on fundraising, we are content with this ratio, but will endeavour to continue to bring this down and aiming for 20% by 26/27. .Reserves remain within policy limits, providing both stability and flexibility to respond to emerging opportunities.

III. The Children's Appeal: Time for A Change

Launched in 2022 with the Trust's support, the Children's Appeal aims to raise £5 million to redevelop the children's wards and family spaces at St George's. To date, £3.6 million has been secured through philanthropy, community fundraising, and events, leaving £1.4 million remaining. We aim to raise this remaining £1.4m by December 2027. With continued joint leadership and the support of the Trust, the refurbishment of the Nicholls and Pinkney wards will transform paediatric care, creating bright, modern, and family-centred environments.

St George's Hospital Charity Report to the GESH Trust Board

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George's is one of the only clinical TBI centres in the UK, making it uniquely positioned to lead in this area and create a model of care with national relevance.

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The Charity has made health equity a defining feature of its funding and in 2024/25 gave out £77,495 towards bridging healthcare gaps:

- We have provided multi-year funding to support the appointment of the Trust's first Health Equity Lead, embedding this focus in strategic planning.
- We are funding the first ever Trust-wide Health equity open grant round, aiming to seed fund innovations in health equity.
- We continue to fund initiatives that address disparities in access and outcomes across South West London. For example, we work with the Trust Social Work team year-round to help vulnerable patients return home from hospital safely, funding items they need to look after themselves such as food, bedding and toiletries. In one case, a fridge freezer, bedding and food were bought for a man with no next of kin and no means to purchase them himself. Without this help, he may have stayed in hospital for one to two extra weeks, at great cost to the NHS. Every £1 spent on items such as this is estimated to save £20–£30 by reducing delays and preventing readmission.

This work aligns directly with the NHS 10-Year Plan's commitment to prevention and fairness in care.

Strategic Objective 4: Enhancing the Hospital Experience

We want everyone who visits our hospitals to have the best possible experience. Through our arts programme, engagement activities, and improving hospital spaces, we are making the hospitals more welcoming, and more effective for delivering high-quality care. Last year we spent £822,015 to revitalise 21 indoor spaces and 51 outdoor spaces. Examples include:

- Our £538k project to refurbish the roof terraces outside the Neuro Intensive Care Unit and William Drummond Ward is now well underway. The transformation will turn unused spaces into welcoming terraces filled with plants, seating, and areas for patient beds, creating a welcoming space for neurology patients and staff.
- We created a new Dementia Garden to provide a calming space away from the wards for patients with dementia, their families, and the staff who care for them.
- The Arts St George's programme reached over 6,000 participants last year through performances, workshops, and exhibitions — improving wellbeing, inclusion, and connection across the hospital community.

Collectively, these projects illustrate how our charitable resources are used: to improve the day-to-day experience of care, enable research and innovation that changes lives, promote equity and inclusion, and build an environment where patients and staff can thrive.

4. The NHS 10 Year Plan

The Charity's Healthier Together strategy aligns closely with the priorities of the NHS 10-Year Plan — innovation, prevention, health equity, and community partnership. Through our funding and collaborations, we are supporting the translation of these national ambitions into meaningful local outcomes.

Our investment in innovation enables new models of care and greater clinical efficiency. For example, the charity funded Home Video Telemetry project in Neurophysiology allows patients to undergo EEG monitoring at home, reducing waiting times from a year to just 3-4 weeks and cutting the waiting list from 122 to 11, despite higher referrals. We are also advancing health equity by supporting leadership and community-based programmes that embed fairness and inclusion in how services are delivered.

Through wellbeing and outreach initiatives, the Charity contributes to prevention and early intervention, while our partnerships with schools, faith groups, and local organisations strengthen the Trust's connection with the communities it serves.

In this way, the Charity's *Healthier Together* acts as a local delivery mechanism for the NHS 10-Year Plan, enabling the Charity and the Trust to work jointly on prevention, innovation, and equity, and to extend St George's impact well beyond the hospital gates. There is significant opportunity to continue to develop our work alongside the Trust in this area.

5. Our Future Plans

Over the coming years, our focus will be on consolidating delivery of the *Healthier Together* strategy and deepening alignment with the Trust's vision and priorities. The Charity is now in a strong position — financially, operationally, and strategically — to expand its role as a facilitator for innovation, wellbeing, and community impact.

Delivering on our strategic ambitions

We will continue to drive progress against our four strategic objectives:

The next phase of delivery will focus on:

- **Completing the Children's Appeal:** This remains our foremost fundraising and delivery priority. With only £1.4 million left to raise, we will work closely with the Trust to secure the final funding by December 2026 and ensure the redevelopment of the children's wards is completed to the highest standard, transforming care for young patients and their families.
- **Building flexibility and resilience:** We will grow unrestricted income to give the Charity and the Trust greater agility, enabling rapid responses to emerging needs, the testing of new ideas, and the sustainability of impact in a challenging financial environment.
- **Deepening community and system engagement:** We will strengthen partnerships with local organisations, schools, and faith groups to raise funds and support prevention, health equity, and population health, reflecting the NHS 10-Year Plan's focus on integrated care and community wellbeing. This will help ensure St George's remains not only a centre of clinical excellence but also support its connection to the local community.
- **Fostering collaboration and innovation:** We will work with the Trust's clinical and operational leaders to co-design projects that address shared priorities and deliver long-term change. By combining charitable flexibility with clinical expertise, we can accelerate innovation and attract further external investment.
- **Enhancing impact and transparency:** We will continue to strengthen our grant-making framework, ensuring decisions are evidence-based, equitable, and demonstrably linked to outcomes. Improved impact measurement will show the difference charitable funding makes and build further confidence among supporters and partners.
- **Raising visibility and engagement:** A key goal is to ensure that every member of staff, patient, and visitor understands the Charity's role and feels able to take part. We will build awareness through joint campaigns, improved internal communications, installing / updating charity branding across site (in collaboration with Estates & Facilities colleagues), and alignment with the Trust's messaging.

Looking ahead

By delivering these priorities, the Charity will not only achieve its strategic target of raising £5 million per year but will also help the Trust advance its ambitions for innovation, equity, and community health. Together, we can ensure that charitable investment continues to drive measurable improvements for patients and staff, and that St George's remains at the heart of a healthier, more connected community.

These priorities will guide the Charity's next phase of growth and form the foundation for our mid-strategy review in 2026, ensuring that our direction, performance, and partnership with the Trust remain strong and future-focused.

6. Working Together with the Trust

We cannot achieve these ambitious plans without the input and support of the Trust. By supporting us you help us increase the level of funding that will come back into the Trust and have a direct benefit to staff, patients and the communities you serve.

We have developed a strong working relationship across the Trust and have identified several key areas where your continued support is particularly crucial:

1. **Shared priorities:** continue to work with us to agree annual priorities and involve the Charity early in project design so funding is focused where it adds the greatest value.
2. **Children's Appeal:** Maintain visible leadership and advocacy as we raise the final £1.4 million needed to complete the children's wards redevelopment and deliver on this transformational project.Ensure the money raised is utilised promptly.
3. **Special Purpose Funds:** Support our drive to release and use SPF balances more efficiently, focussing funds where they are most needed and make most impact.
4. **Visibility and engagement:** Champion the Charity through Trust communications, staff induction, and patient-facing materials to strengthen awareness and participation. Support physical visibility of the Charity in the Trust.
5. **Information sharing:** Keep the Charity informed of planned service or structural changes so we can plan effectively, protect investments, and deliver long-term impact.

Championing collaboration: Keep the Charity in mind with collaboration initiatives with City St George's, to fully harness the opportunities of our shared site. With your active support in these areas, we can significantly increase the scale and value of charitable funding across the Trust, ensuring every pound raised delivers the maximum possible benefit for the people of St George's.

7. Conclusion

Since independence in 2017, St George's Hospital Charity has developed into a key strategic partner to the Trust, aligning its work with hospital priorities and national policy through our 2024 strategy *Healthier Together*. Our strong financial performance, improving efficiency, and commitment to innovation and equity demonstrate the Charity's growing maturity and impact.

With the Trust's continued engagement — through aligned priorities, delivery of the Children's Appeal, timely use of SPFs, and strengthened visibility — we are well placed to deliver the next phase of our strategy and support the Trust in realising the ambitions of the NHS 10-Year Plan.

Together, we can ensure that St George's continues to be recognised not only for clinical excellence, but also for compassion, creativity, and community impact.

Appendix 1: St George's Hospital Charity's Story

I. Overview

In 2017, St George's Hospital Charity became an independent organisation dedicated to supporting St George's University Hospitals NHS Foundation Trust, St George's, University of London, and the communities the Trust serves. Since 2017, we raised an average of £2-3 million per year, awarding a similar amount in grants.

The Charity holds £11.1 million in reserves, largely made up of restricted and designated funds for specific clinical areas or purposes. Unlike many hospital charities, we do not hold endowment property assets, meaning that sustained fundraising performance and careful cost management are vital to our long-term sustainability.

In 2019, the hospital's arts programme joined the Charity, significantly enhancing our visibility and embedding creativity and wellbeing into daily hospital life.

II. Our Finances and Financial Stewardship

In 24/25 our top three sources of fundraising income were:

- Legacies (£828k)
- Trusts and Foundations (£743k)
- Community and Events (£399k)

Major new funding in 25/26 financial year included a £5 million grant over five years for Lymphoedema Research, establishing St George's as a national Centre of Excellence, £237,000 from NHS Charities Together to enhance the wellbeing of night-shift workers, and £250,000 raised from our *Time for a Change* Fundraising gala. These significant gifts underscore both the scale of our ambition and the growing confidence of external funders in St George's Hospital Charity.

Our Individual Giving programme continues to go from strength to strength thanks to a Face To Face giving campaign. on site at hospitals and in the wider community. Now in it's third year, we have generated 3,000 regular donors through this and are aiming to recruit 1,600 new donors this year. We are projecting to raise £227k unrestricted income this Financial Year and £492k total cumulative income since the campaign started.

Prudent financial management has ensured that growth is sustainable. Fundraising efficiency continues to improve, with ROI rising as new programmes mature, and fundraising costs sitting at 27% of fundraising income- a reduction of 16% from the prior year. Given the benchmark for UK charities is generally accepted as an average return of £4 for every £1 spent on fundraising, we are content with this ratio, but will endeavour to continue to bring this down and aiming for 20% by 26/27. .Reserves remain within policy limits, providing both stability and flexibility to respond to emerging opportunities.

III. The Children's Appeal: Time for A Change

Launched in 2022 with the Trust's support, the Children's Appeal aims to raise £5 million to redevelop the children's wards and family spaces at St George's. To date, £3.6 million has been secured through philanthropy, community fundraising, and events, leaving £1.4 million remaining. We aim to raise this remaining £1.4m by December 2027. With continued joint leadership and the support of the Trust, the refurbishment of the Nicholls and Pinkney wards will transform paediatric care, creating bright, modern, and family-centred environments.

Group Board meeting (Public)

Meeting on Thursday, 06 November 2025

Agenda Item	8.1	
Report Title	**gesh Learning from Deaths Quarterly report: Q4 (January – March) 2024/25 and Q1 (April – June) 2025/26**	
Executive Lead(s)	Richard Jennings, Group Chief Medical Officer	
Report Author(s)	Kate Hutt, Group Head of Mortality & Effectiveness Amy Christensen, Group Senior Manager Learning from Deaths Dr Martine Meyer, AMD for Quality (ESTH) Dr Stanislaw Jankowski, Lead Mortality Reviewer (ESTH) Dr Ashar Wadoodi, Learning from Deaths Lead (SGH) Bill Phillips, Lead Medical Examiner Officer (ESTH) Jayathri Wijayarathne, Principal Clinical Analyst (ESTH) Laura Rowe, Lead Midwife for Clinical Governance and Risk (ESTH) Dr Dwynwen Roberts, Chair Resuscitation Committee (ESTH)	
Previously considered by	Quality Committees	30 October 2025
Purpose	**For Report**	

Executive Summary

A summary of the key points in this paper that may be drawn out for further discussion at Quality Committee is as follows:

- The key high-level indicator of patient safety, the SHMI, continues to be “lower than expected” (i.e. good) at SGUH, and has now improved at ESTH from being “higher than expected” to “as expected”.
- Particular services and areas in which focused improvement work is being carried out are highlighted in the paper.
- The NHS Blood and Transport (NHSBT) triggered review of the St George’s renal transplant service made broadly positive and assuring findings, although there were some helpful improvement recommendations, including improving internal referral communications between ESTH and SGUH.
- The Mortality and Morbidity (M&M) governance team, which was set up five years ago, and which is now Group-wide, is being reviewed to make sure that its current functions optimally meet the Group’s current needs.

National Guidance on Learning from Deaths, issued by the National Quality Board, requires Trusts to collect, scrutinise and publish specified information on deaths on a quarterly basis. This group paper summarises key activity at each Trust to ensure we are learning from deaths, the key data and learning points.

At Epsom and St Helier (ESTH) mortality governance and learning from deaths is overseen by RADAH (Reducing Avoidable Death and Harm). At St George's (SGH) this oversight is provided by MMG (Mortality Monitoring Group).

Summary Hospital-Level Mortality Indicator

- SHMI is a national statistic and is one of the metrics incorporated in the new NHS dashboards.
- The latest SHMI covers discharges from May 2024 to April 2025.
- St George's mortality is lower than expected at 0.85.
- ESTH mortality is as expected at 1.13.

Key messages from ESTH:

- RADAH oversees analysis of mortality at diagnosis group level. A number of areas have been selected for investigation, involving Clinical Coding and the Mortality Review Team.
- There is variance in the SHMI across the two acute sites which is being explored through an agreed programme led by the Group Head of Mortality and Site Lead Mortality Reviewer.
- Themes emerging from SJRs relate to the recognition of end of life care and DNACPR and ceiling of care decision making. This triangulates with information from the resuscitation team and has been shared at Quality Half Days. A working group has been convened to plan and implement improvements within the Medicine division.

Key messages from SGH:

- SJR methodology was used to complete focused investigations (Caesar Hawkins and transfers), and a good level of care was observed with no adverse themes identified.
- NHSBT visited Renal Transplant services and found results overall were good and do not indicate any systemic concerns.

Group wide and national issues:

- SHMI is one of the metrics incorporated in the new NHS dashboards. In the first quarterly publication (September 2025) our SHMI score is 2, as mortality was as expected in the reported period (April 24 - March 25).
- The Hospital Standardised Mortality Ratio (HSMR) is not a national statistic and in line with the wider NHS we focus our investigation on SHMI. The HSMR measure has not been included in this report.

Action required by Group Board

The Board is asked to:

a. Note the report.

Committee Assurance	
Committee	Quality Committees (30 October 2025)
Level of Assurance	Reasonable

Appendices	
Appendix No.	**Appendix Name**
Appendix 1	Structured judgement review summary data
Appendix 2	ESTH Mortality overview
Appendix 3	SGH National Quality Board Learning from Deaths dashboard
Appendix 4	SHMI by age, sex and deprivation

Implications

Group Strategic Objectives

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

Risks

Failure to achieve high standards in mortality governance presents a risk to the delivery of safe and effective patient care.

CQC Theme

☒ Safe	☒ Effective	☐ Caring	☐ Responsive	☒ Well Led

NHS system oversight framework

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

Financial implications

None identified

Legal and / or Regulatory implications

National guidance on learning from deaths, issued by the National Quality Board demands the publication and discussion of data at Board level, and is regulated by the CQC

Equality, diversity and inclusion implications

Analysis of SHMI mortality data by age, sex and ethnicity is possible using HED (Appendix 2). At ESTH across these characteristics mortality which is higher than the 95% confidence interval is observed in a number of groupings. This is high level analysis, and we will develop an approach to improve our understanding of this data and any required actions as a result. The new MCCD includes recording of ethnicity which may support improved data.

Environmental sustainability implications

None identified

gesh Learning from Deaths Quarterly Report
Q4 2024/25 (October – December 24) and Q1 2025/26 (January – March 25)
Quality Committees 30 October 2025

1.0 Purpose of paper

1.1 The purpose of this report is to provide the committee with an update on progress against the Learning from Deaths agenda, as outlined in the guidance issued by the National Quality Board.

1.2 The report describes sources of assurance that gesh is scrutinising mortality and identifying areas where further examination is required. We are working to ensure that opportunities for learning are identified and, where appropriate, co-ordinated action is taken to realise improvements.

2.0 Summary Hospital-Level Mortality Indicator (SHMI) [source: NHSE]

2.1 SHMI, is an official statistic, produced by NHS England. It is one of the metrics incorporated in the new NHS dashboards, with scoring reflecting whether mortality is higher than expected, as expected, or lower than expected when compared to the national baseline.

2.2 The latest SHMI, published 11th September 2025, covers discharges from May 2024 to April 2025.

Trust	SHMI value	Banding	Spells	Observed deaths	Expected deaths
ESTH	1.13	As expected	40,400	1,725	1,525
SGH	0.85	Lower than expected	68,245	1,680	1,970

2.3 NHSE provide analysis of mortality at site level, which reveals a difference in SHMI between Epsom and St Helier hospitals. NHSE advise that careful interpretation is required and note the importance of considering variance in the context of other factors that may affect a trust's SHMI (and is not adjusted for in the risk modelling), such as the quality of data, additional patient characteristics and the organisation of services.

Site	SHMI value	Banding	Spells	Observed deaths	Expected deaths
St Helier	1.09	As expected	23,705	1,030	945
Epsom	1.22	Higher than expected	12,935	695	575

RADAH is overseeing a programme of exploration to understand the differences in mortality across the sites. Initial investigations into whether differences in practice in SDEC reporting contribute to this variance has suggested that this is not likely to be a key factor. This requires careful analysis and it will take time to develop our understanding of what this data can and can't tell us about mortality at each site and across the Trust as a whole.

ESTH submit same day emergency care (SDEC) as part of the Emergency Care Data Set (ECDS) and as previously reported have seen an increase in the SHMI level as it is calculated using the Admitted Patient Care (APC) dataset and removal of SDEC activity impacts the value.

This is caused by two factors. Firstly, the observed number of deaths is likely to remain approximately the same as mortality in the SDEC cohort is very low. Secondly, the expected number of deaths decreases as a large number of spells are removed which would have had a small, but non-zero risk of mortality.

We have conducted analysis to establish whether there is any apparent difference between SDEC reporting at Epsom and St Helier which may account for the variance. We looked to see if there hast been a change to discharge numbers at either site, as if SDEC were a factor we might expect to see a change as activity shifts from Inpatient to ED. Discharge numbers have remained within normal variation for both sites, suggesting that there has not been a change to SDEC activity reported at either site.

The Group Head of Mortality and Effectiveness and the Site Lead Mortality Reviewer are analysing the differences in diagnosis groups to identify areas to focus further investigation where there may be unwarranted variation and lead to opportunities for quality improvement programmes.

2.4 NHSE provide analysis of 10 diagnosis groups. These groups are selected as they have high numbers of deaths and statistical models that are considered to have sufficiently explained the expected variation due to the case-mix adjustment.

Across both trusts mortality is as expected for the majority of groups, with lower than expected mortality in 3 and higher than expected in 1.

Diagnosis group	**ESTH**		**SGH**	
	SHMI	**Banding**	**SHMI**	**Banding**
Septicaemia (except in labour), Shock	1.14	As expected	0.88	As expected
Cancer of bronchus; lung	1.51	Higher than expected	0.61	Lower than expected
Secondary malignancies	1.45	As expected	1.02	As expected
Fluid and electrolyte disorders	0.97	As expected	0.74	As expected
Acute myocardial infarction	0.63	Lower than expected	0.91	As expected
Pneumonia (excluding TB/STD)	1.03	As expected	0.72	Lower than expected
Acute bronchitis	1.48	As expected	1.03	As expected
Gastrointestinal haemorrhage	0.87	As expected	0.99	As expected
Urinary tract infections	1.29	As expected	0.71	As expected
Fracture of neck of femur (hip)	0.87	As expected	0.91	As expected

2.5 In order to understand SHMI at a granular level both trusts use the benchmarking

system, HED (Healthcare Evaluation Data), to look at all 144 SHMI diagnosis groups. Information is shared with RADAH and MMG at each meeting for agreement of diagnosis groups that require further investigation.At ESTH identification of groups with the highest volumes and the largest gap between observed and expected deaths is well established. Building on this we now interrogate the data to identify which diagnosis groups show statistically significant difference to the national benchmark, supporting us to prioritise areas for investigation and potential action. We will continue to develop this approach and have engaged with HED to automate this analysis and generate alerts highlighting which groups are potentially driving mortality ratios.

An investigation methodology has been outlined, informed by NHSEs recommended approach which utilised the pyramid of investigation for special cause variation and is in use at SGH. Both the Head of Coding and the Lead Mortality Reviewer are supporting this work, which begins with an audit of the clinical coding of deceased patients. Alongside this we are able to examine the quality of care received using the SJR methodology.

The diagnosis groups selected for initial review are upper respiratory diseases, intestinal infection, and cardiac dysrhythmias. The selection of these groups was informed by benchmarking data alongside clinical insight from the Lead Mortality Reviewer. It is supposed that in these discrete areas we may be able to resolve the alerts and test our approach.

At SGH MMG are carrying out initial review of two diagnosis groups: Aortic, peripheral and visceral artery aneurysms, and leukaemia. As per our established investigation approach we are first looking at the data to develop an understanding of the groupings and the services included. The Lead Medical Examiner is supporting an initial review by looking at the prospective scrutiny of each death.

3.0 Priority workstreams and signals

3.1 Mortality and Morbidity (M&M) governance

At SGH the central M&M team has driven improvements and consistency in M&M practice across clinical services through facilitating meetings, producing quality minutes and initiating and monitoring action trackers. A one-page guide describing high quality M&M meetings is being finalised which will provide the standard against which services can evaluate their mortality governance activity.

The team are now focussed on the identification and sharing of learning from deaths. Data derived from M&M discussions provides a rich source of intelligence that can be triangulated with other measures and learning tools, supporting learning via PSIRF. Collaboration with divisional governance processes is a priority. This is delivered in several ways:

- Provision of information, such as mortality reviews and M&M minutes, for the review of incidents and to inform learning responses.
- Reports summarising M&M activity and highlighting learning, which in some areas extends to drawing out themes. This data can be used for assurance of quality of care and to identify areas for improvement.
- Formulating a common reporting approach across all divisions to support better triangulation, allowing us to develop an understanding of practice across the trust and identify areas of unwarranted variance. These data will begin to be shared by divisions in their integrated governance reporting to the Patient Safety and Quality

Group.

Following integration of corporate services, the Group Senior Manager Learning from Deaths has led a project at ESTH to establish current M&M practice. An implementation plan was agreed at RADAH in February 2025, a 6 month evaluation of which has shown some progress and areas where greater focus and effort is required.

There has been partial progress in developing a detailed mapping of M&M activity, including how learning is captured and shared. In some areas this has not been adequately completed through lack of engagement from governance colleagues. These areas will be further supported by the site CMO to enable full mapping which will be completed by December 2025.

Significant progress in supporting ESTH M&Ms has been made in planned care, particularly with the M&M team minuting discussions and resulting actions in services such as Urology, T&O and General Surgery.

The M&M team are working with divisions to promote best practice, such as use of a core dataset, templates to guide discussions and action trackers to ensure learning is captured and used for improvement. The one page guide currently in development will support dissemination of these standards. This will be presented initially at a Medicine Governance meeting, following strong engagement from the Divisional Medical Director. This will be vital to reach the level of governance of M&Ms which in embedded in practice at St George's Hospital and will reduce the unwarranted variation in practice across gesh. This is a significant gap and will require the knowledge and experience of the M&M team working with the divisional medical directors to achieve this. It will continue to be monitored by RADAH and escalated to PSQG and gesh quality group for oversight.

3.2 Community mortality reviews (ESTH)

An innovative project in partnership with colleagues in Sutton Health and Care and the ICB was undertaken to review mortality in the community, post discharge from either St Helier Hospital or Epsom Hospital. ESTH Lead Mortality Reviewer and Lead Medical Examiner Officer supported this review to identify both potential areas for improvement and best practice, whether within the acute hospital, in community care or the interface between the two. The case review of 66 deaths has concluded, and the final report is awaited, but key learning has been identified in relation to the use of the Universal Care Plan and community DNACPR (Do Not Attempt Cardiopulmonary Resuscitation) decision making. Further information will be included in the next report.

3.3 Resuscitation Team: Cardiac Arrest outlier (ESTH)

As reported previously, results from the National Cardiac Arrest Audit (NCAA) show that at ESTH cardiac arrests on wards and in the emergency departments is higher than similar hospitals nationally. Additionally, a higher rate of our patients aged over 75 undergo resuscitation attempts.

All patients admitted acutely should have a decision on ceiling of care within 72 hours of admission, as detailed in the Managing Acutely Ill Patients policy. However, several audits have demonstrated that documentation of the ceiling of care is variable across both sites, resulting in the high number of 2222 calls to the resuscitation team, as reflected in the NCAA results.

It should be noted that in line with recommendations at ESTH 2222 calls are initiated for all patients in cardiac arrest, regardless of location. Some trusts have elected not

to make 2222 calls for patients that arrest in ED, however this practice is followed at Epsom Hospital and St Helier Hospital to ensure consistent and safe management of cardiac arrest which does not adversely impact the care of other patients. Trusts with different staffing and resources, such as 24/7 consultant cover, may not follow this guidance and we are aware that practice is variable across our neighbouring trusts. This may contribute to a higher incidence of 2222 calls at ESTH.

Themes related to workload, environment, documentation, communication and decision making have emerged from the audits and reviews that have been conducted. This triangulates with issues revealed by structured judgement reviews related to decision making around end of life care and DNACPR (section 4.4).

- Conversations regarding escalation and resuscitation are time intensive, compounded by an increase in the number and acuity of patients. This makes it difficult to have discussions with patients on pressured ward rounds.
- The number of patients with a long stay in temporary escalation areas in ED, such as corridors, results in a lack of privacy to have sensitive conversations with patients and their loved ones. This may result in discussions being delayed until the patient has been moved to a more suitable environment.
- Different documentation is used at each site – PTEP and DNACPR at St Helier and ReSPECT at Epsom. Although we moved to an electronic patient record across the Trust in May, ReSPECT is not available in iClip and is the preferred document in the community for Surrey Downs patients.
- Clinicians report concerns regarding difficult conversations with patients and relatives and the potential for complaints and litigation. There is sometimes a lack of confidence in undertaking these conversations, making decisions about ceilings of care and being able to access a second opinion.

A working group within Medicine has been initiated, involving Clinical Directors, the Quality Lead, Resuscitation Clinical Lead, and Divisional Medical Director. This group has been tasked with bringing together the various workstreams and projects underway in order to drive forward improvements. Several actions are ongoing, under this leadership.

- Emergency Medicine consultants are supporting decision making on ceilings of care for patients in ED and will initiate discussions for patients under their care.
- We have recently moved to a 24/7 CCOT (Critical Care Outreach Team) at each site and data will be reviewed to see if this has a positive impact.
- Discussions are underway to adapt the Advanced Communication Skills training to provide a short course on difficult conversations in the context of treatment escalation decisions.

3.4 Special focus review: Caesar Hawkins mortality (SGH)

In response to concerns raised by the family of patient a quality review was undertaken related to care on Caesar Hawkins. As part of this work, deaths on Caesar Hawkins were reviewed using the structured judgement review (SJR) methodology. Ongoing mortality monitoring had not revealed any concerns and deaths had not been observed as significantly higher than usual.

- 16 patients died during Q1 2025/26 and SJRs were completed for each death
- Care was assessed as good in the majority of cases, and across all phases. Excellence was noted in a number of instances. There was no poor or very poor care, and the lowest rating was adequate ongoing care in one instance.
- 9 problems in healthcare were identified, but none were felt to have led to harm.

- 15 deaths were judged to be 'definitely not avoidable'. In the 1 death that was felt to be 'possibly avoidable, but not very likely (less than 50:50)' the reviewer contacted the clinical team and asked them to complete a mortality review. The specialty review satisfied the reviewer, and no further action was required.

A large proportion of the deaths were in relation to patients that had significant co-morbidities prior to admission and had limited treatment options. Several patients were admitted to Caesar Hawkins for conservative or palliative management. Based on reviews, no concerns about the care provided on the ward were identified. MMG agreed that this special review should be closed and not extended into the next quarter.

3.5 Special focus review: Patient Transfers (SGH)

During Q1 2025/26 the mortality review team completed SJRs for patients that had been transferred to St George's from another provider. This cohort was selected as it included a range of specialties and diagnoses and was not in response to any concerns.

Twelve cases were reviewed. The mean age of the patients was 63 years old, with the oldest patient being 87 and the youngest 38. 8 patients were male and 4 were female. The mean length of stay was 12.2 days with the longest stay being 43 days and the shortest 1 day. Transferring hospitals were Kingston (3 patients), Ashford & St Peters (2 patients), St Helier (2 patients), Epsom, East Surrey and Royal Surrey.

The most common reason for transfer was for further cardiological support, which included but was not limited to an elective CABG and a possible pacemaker. Other reasons include surgical intervention, cancer recurrence, possible PE and sepsis, management of hypotension and acute respiratory failure. 5 cases fell under CWDTCC division, 4 under MedCard and 3 under SNTC. Patients were cared for across several wards with the most common being CTICU.

Of the 12 patients, 10 cases were graded as having good overall care and 2 as excellent. In 11 cases the death was judged to be unavoidable, and in 1 as possibly avoidable but not very likely. This case has been shared with the clinical team, who had already reported and reviewed the incident (DW227144).

The data and grading did not highlight any issues in care, themes or trends with transferred patients during this period. Several of the reviewers complimented the patients care, documentation and MDT discussions. In light of this the review has not been extended.

3.6 External alert: Renal transplant (SGH)

Following the NHS Blood and Transplant (NHSBT) alert reported previously, NHSBT visited the SGH renal transplant unit on 10th April 2025. The visit was conducted according to the Organ and Tissue Donation and Transplantation (OTDT) standard operating procedure, whereby an in-person visit is triggered in response to a mortality CUSUM alert. The alert related to 2 patient deaths and 2 kidney losses with 30 days of implantation. These cases underwent internal review, with detail provided in a previous version of this report.

The aim of the visit was to identify any potential systemic issues that may have contributed to the outcomes identified. The panel's role was to be supportive, enable reflection by the team, and to find ways in which the NHSBT OTDT team could help.

The panel met with the multiprofessional team, including surgeons, nurses and

managers and senior leaders. They reviewed the unit's response to all deaths and graft losses which triggered the alert, plus new cases since the initial alert. Comparison data for peer centres was considered and relevant unit protocols and process documentation were reviewed.

An overview of outcomes found that graft survival at 1 year is average, and patient survival is average. 5-year graft survival is just below average and 5-year patient survival is above average. Overall, there is average 1-5 years graft and patient survival. The panel commented that results overall were good and do not indicate any systemic concerns.

The panel considered the service's approach to M&M and recognised that all complications are collected by the Governance lead, with a weekly surgical meeting to highlight cases to be discussed. There are 3 monthly M&M meetings each year and an extra monthly meeting when there are more complications that need further discussion. It was noted that resident doctors are encouraged to prepare cases to present, and all discussions are recorded and documented, with presentations and minutes accessible to the team. These factors demonstrate adherence to Trust standards. It was further noted that for graft losses and deaths, the consultant complete a root cause analysis which is sent to the Clinical Lead and Governance Lead. Additionally, following this alert there has been an agreement to report transplant mortality annually to MMG, as a means of providing internal oversight of data submitted externally.

The panel recognised the committed participation of the team in the review process. A number of suggestions for local improvement, including reinforcement of supervision and support for new and locum consultants, were put forward by the panel and will be revisited in 6 months. They reiterated that no systemic issues had been revealed and acknowledged that the team had learned from the cases which triggered the alert and made changes where needed. The clinical team did not raise any specific issues and reflected that the review had been useful for examining transplant patient care in more detail.

4.0 Sources of assurance: Outputs of mortality governance processes

4.1 Mortality Review Processes

The Mortality Review Teams (MRT) at both trusts play a key role in improving patient care by conducting Structured Judgement Reviews (SJR). Insights are discussed at RADAH and MMG, to identify areas for improvement, and inform actions to enhance patient safety and care.

Reviews are performed for all deaths that meet the National Quality Board criteria, including those where significant concerns have been raised, either by the Medical Examiner, clinical team, or bereaved. To support understanding and scrutiny of higher mortality ESTH also has locally defined triggers, such as cardiac arrest, nosocomial covid and deaths subject to inquest.

This accounts for the variance in the proportion of deaths subject to SJR. Both trusts periodically select additional cases for review in response to specific concerns.

SJRs completed	Q4 2024/25		Q1 2025/26	
	Number	Percentage of deaths	Number	Percentage of deaths

ESTH	120	30.0%	119	32.4%
SGH	39	10.5%	47	12.7%

The SJR methodology requires assessment of different stages of care, from initial admission to end of life, and an overall assessment of care. Reviewers are also required to look for problems in defined aspects of healthcare and assess whether or not these problems led to harm. At SGH, based solely on case note review an initial assessment of whether there is any indication that the death may have been avoidable is also made. Specific learning gathered through the SJR process is detailed below for each trust, with summary data presented in Appendix 1.

4.2 Learning from mortality reviews at ESTH

Deaths where a member of the MRT find overall care to be poor or very poor are subject to a second SJR by another reviewer. Additionally, these deaths are recorded on Datix as a patient safety incident and escalated to the division for further investigation under the Patient Safety Incident Review Framework (PSIRF). Quality Managers are required to submit deaths where poor care has been noted to their weekly Divisional Incident Review Group (DIRG) meeting for review and consideration of a PSIRF learning response. In the reporting period this applied to 8 deaths (ref: 4879, 4923, 5129, 5106, 5120, 5258, 5243, 5261, 5495, 5476, 5546)

Reviewers liaise directly with the responsible consultant to suggest cases which require discussion in M&M meetings and provide positive feedback when excellent care is observed.

In addition to providing feedback and acting on a case by case basis, the MRT draw out themes from SJRs. These are reported to RADAH monthly and fed back to clinical services twice a year via Quality Half Days.

SJRs have revealed delays in the recognition of end of life, along with poor documentation of DNACPR decision making and treatment escalation plans. Reviewers identified DNACPR documentation is less robust at St Helier Hospital and particularly in Acute Medicine. The reviewers noted that this led to delayed end of life care and missed opportunities to support patients with symptom control appropriately. This triangulates with feedback from the next of kin and from audit by the resuscitation team. Once end of life is recognised, the quality of palliative care was consistently scored as good, including communication with next of kin, which emphasises the importance of earlier, timely discussions as outlined earlier in this paper.

The themes, along with cases studies and suggestions for improvement, have been presented for discussion to the relevant teams in Medicine, ED, Planned Care, Critical Care and Anaesthetics.

Concerns had been raised by the Medical Examiners that nasogastric tubes were being placed inappropriately in individuals who were at the end of their lives. The mortality review team particularly focused on this as a theme and were reassured by the reviews that this was not a system issue that was occurring regularly.

4.3 Learning from mortality reviews at SGH

Mortality reviewers come together on a regular basis to review any patient judged to have received poor care, or where there is an indication that death may have been avoidable. The details of each case are presented for discussion, and a decision is taken regarding the need for notification to the Patient Safety Team, if that has not already been done, and/or referral to the clinical team for M&M discussion. This process helps to triangulate medical examiner scrutiny, structured judgement reviews,

the M&M process and patient safety processes within the trust to achieve learning from deaths.

Individual SJRs are shared with clinical teams regardless of outcome so good practice can also be shared with the specialty group. A quarterly summary report is provided for each division, encouraging transparency and triangulation of learning.

In Q4 2024/25 there were 2 deaths where the reviewer judges the death was more than likely avoidable. These are summarised below.

#8110 (DW223760) STEIS 2025/1654 MI-040236	Reason for further review	Problems in relation to monitoring & communication led to harm. Poor overall care Probably avoidable
	SJR concern	This was a maternal death. The reviewer flagged serious concerns about safety and quality of care, with poor care identified at initial assessment and with ongoing care. Late recognition of the seriousness of the patient's condition, late escalation and slow response from the clinical team were identified.
	Outcome	This death is subject to a Maternity & Newborn Safety Investigation (MNSI) which is ongoing. Locally, an After Action Review learning response is also ongoing and is expected to be completed at the end of October.

#8094 (DW221970)	Reason for further review	Adequate overall care but judged to be strong evidence of avoidability
	SJR concern	This was a death by suicide. The reviewer noted the complexities of the case with significant baseline morbidity. They did not identify any issues with the care delivered and noted that physical issues were well looked after during the long admission. However, they did note that there was no psychology review, although there had been previous mental health issues and due to the nature of their long standing injury there would have been a risk of significant emotional and psychological impact.
	Outcome	This case was discussed in detail by the division at their incident review group (DIRG) and escalated to the central incident review group (CIRG). It was felt that an MDT Focus Group was the most appropriate learning response. This is due to be held in September or October and will identify any learning.

In Q1 2025/26 there was 1 death where the SJR concluded that there was poor care overall and evidence of avoidability.

#8143 (DW228982)	Reason for further review	Poor overall care Probably avoidable
	SJR concern	This case was flagged by the mortality review team at Epsom & St Helier (ESTH) as the

		patient died there following repatriation from St George's following cardiac surgery. The SGH reviewer identified concerns with imaging and recording of medical history in the initial referral from ESTH. The reviewer asked the SGH surgical team to consider the appropriateness of surgery based on the operation note.
	Outcome	A SWARM was carried out on 11th September and the outcome reviewed at the MedCard Divisional Incident Review Group (DIRG). The SWARM confirmed that surgery was appropriate, given the imaging and available medical history. Clear learning was identified around the ability to access imaging appropriately and securely, in an emergency situation. The service will engage with Radiology and also Neurosurgery, where such processes are in place. Feedback will also be provided to ESTH regarding the CT imaging.

4.4 Perinatal Mortality Review Tool (PMRT)

NHS Resolution's Maternity Incentive Scheme supports safer maternity and perinatal care by driving compliance with ten Safety Actions, which support the national maternity ambition to reduce the number of stillbirths, neonatal and maternal deaths, and brain injuries from the 2010 rate by 50% before the end of 2025. Safety Action One considers if trusts are using the National PMRT to review perinatal deaths to the required standard. Reports are received by RADAH and MMG detailing compliance and potential learning.

4.5 ESTH PMRT summary

ESTH has continued to demonstrate full compliance with the Clinical Negligence Scheme for Trusts (CNST) Safety Action One, as evidenced by the bi-monthly Perinatal Mortality Review Tool reports. In addition to summarising compliance, each report also details potential areas for learning and improvement. Over the year there were no clear themes identified which contributed to the outcomes in these cases.

During Q4 2024/2025 and Q1 2025/2026 there were 11 stillbirths reported to MBRRACE-UK, 2 early neonatal deaths and 1 late neonatal death. Of the neonatal deaths, 2 were at <24 weeks' gestation (i.e. late miscarriage) and one was attributed to SUDI (sudden unexpected death in infancy). In 2 cases, the panel identified care issues which they felt may have caused a difference in the outcome. Issues identified included incorrect advice given by the Call A Midwife Triage Line and incorrect management of a high-risk pregnancy.

The Lead Midwife for Clinical Governance and Assurance presented a summary to RADAH of the MBRRACE-UK perinatal mortality report of 2023 births which was published in February 2025. The key messages were:

- ESTH's stabilised and adjusted stillbirth, neonatal death and extended perinatal mortality rates were around average for similar Trusts and Health Boards.
- When deaths due to congenital abnormalities were excluded, ESTH's rates for

stillbirth and extended perinatal mortality was 5% higher than other similar Trusts and Health Boards; the neonatal death rates were around average.

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

A PMRT review was completed for all eligible cases and 14 of the 17 reviews (82%) included an external panel member. Of the cases reported in 2023, 1 case had issues identified which the panel concluded may have made a difference to the outcome. The woman was not given explicit advice of the signs of infection and when to re-attend the unit. The panel felt that had the woman been given clearer information she may have attended sooner, and this could have changed the outcome. This has been shared and strengthened guidance is now in place in line with RCOG.

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

Review of the cases showed that 3 women did not receive any maternity care from ESTH up to the point that the baby died. Inclusion of these cases adversely affected our stabilised and adjusted mortality rate when congenital abnormalities are excluded. Had they been excluded the rate would have been similar to other Trusts.

It was noted that 8 of the 15 cases who received care from ESTH occurred in women from a non-white background, indicating that the perinatal mortality rate is higher for women from a Global Majority background in this period. Analysis of 2024 cases has shown improvement.

The review, completed as advised by MBBRACE, did not identify any themes.

4.6 SGH PMRT summary

The latest reports received by MMG cover July 2024 to June 2025, and compliance with standards is summarised below.

Report period	Summary	Compliance with standards

July 2024 – September 2024	• 6 cases reported, 3 concluded. • 2 cases PSIRF learning response (1 PSII, I AAR); 1 MNSI investigation One case reviewed where no care issues were identified, one case care issues were identified which would have made no difference to the outcome. There was one case where the review group identified care issues which they considered may have made a difference to the outcome of the baby.	Full compliance with standards
October 2024 – December 2024	• 10 cases reported, 7 concluded. • 2 cases did not meet CNST criteria; 1 PSIRF learning response (PSII) 3 cases were reviewed where no care issues were identified, and 4 cases care issues were identified which would have made no difference to the outcome.	Not compliant with requirement that all eligible deaths be notified to MBRRACE-UK within 7 working days. Achieved in 90% of cases. Not compliant with requirement that 95% of reviews be started within 2 months of death. Achieved in 87.5% of cases.
January 2025 – June 2024	• 12 cases reported, with 7 concluded. • 3 cases did not meet CNST criteria; 1 MNSI investigation; 1 PSIRF learning response (MDT) In these cases the panel concluded that there were no care issues identified.	Not compliant with requirement that 95% of reviews be started within 2 months of the death. Achieved in 89% of cases.

Actions taken to address non-compliance with Safety Action One include implementing a tracker to support timely reporting of cases. Since this has been introduced no further breaches have occurred. It is anticipated that the introduction of the Submit a Perinatal Event Notification (SPEN) portal will also have a positive impact on timely reporting as multiple reporting systems, including MBBRACE, have been amalgamated.

In the most recent report, we exceeded the target of involving an external member in 50% of PMRT discussions, achieving this for 78% of deaths reviewed.

Issues that were identified across the reports include the bereavement checklist not being completed, anomaly scans taking place at a later gestational age than recommended in guidance, progress of labour not being documented on the partogram, although documented in the labour notes; and carbon monoxide readings not taken at booking. The site CMO has asked that future reports present triangulation from PMRT with other sources of information where there has been judged to be issues with care, in order that actions can be clearly linked to the maternity improvement plan.

5.0 Medical Examiner (ME) Service

5.1 Medical Examiner (ME) activity

Sutton and Epsom (S&E) Medical Examiner (ME) service is hosted by ESTH and Merton and Wandsworth (M&W) ME service is hosted by SGH. Both services function independently of the host trust. All ME offices report directly to their Regional Medical Examiner and are accountable to the National Medical Examiner. ICBs and NHS trusts are required to provide resources for an appropriately staffed and resourced medical examiner office, as described within the standard NHS contract.

Each quarter ME offices are required to make a return directly to the office of the National ME providing summary data from deaths scrutinised. Over the last two quarters both the S&E and the M&W services met all the required KPIs and milestones.

Deaths scrutinised	Q4 2024/25		Q1 2025/26	
	Acute	Community	Acute	Community
Sutton & Epsom (ESTH)	370	263	371	241
Merton & Wandsworth (SGH)	400	284	364	206

5.2 Out of hours service

The M&W ME service has continued to deliver a limited out of hours service, approved by the National ME. The service operates between 8 and 11 am each weekend and Bank Holiday (excluding Christmas day), aligned with the Wandsworth and Merton registrars opening hours. The principal driver of this extended service is to support requests for rapid release of the deceased, usually to meet faith requirements. The out of hours service has completed the urgent scrutiny of all requested cases, and the ME service has not contributed to any delays in the release of bodies out of hours.

Between September 2024 and June 2025, the S&E ME service ran out of hours service on a trial basis. In the trial period the service was contacted on just one occasion. Evaluation of the trial showed that the service was not cost effective and therefore it has not been continued.

5.3 Supporting learning

Both ME services remain positively engaged with Trust Learning from Deaths processes and are the primary routes through with deaths requiring SJR are identified.

Deaths flagged for SJR	Q4 2024/25	Q1 2025/26
Sutton & Epsom (ESTH)	55	61

Merton & Wandsworth (SGH)	32	20

In order to maximise the learning that can be gained from scrutiny of deaths the Lead MEs are members of the relevant group which oversees learning from deaths in their host organisations, i.e. RADAH and MMG. They and their teams each support trust level projects to further this goal.

The M&W Lead ME is currently supporting the initial high level review of two SHMI diagnosis groups as detailed in section 2.5.

The S&E Lead MEO actively supported the ICB's Sutton Community Mortality Review program, providing guidance on the processes currently undertaken at ESTH to inform a similar for community deaths which will be led and managed by the ICB. Both the Lead ME and MEO attend the quarterly MRT meetings to share knowledge and learning with the wider team.

6.0 Recommendations

6.1 The Group is asked to:

- Note achievements against the Learning from Deaths framework and the key areas of learning and development identified, along with the actions taken to address these.
- To support the drive to enhance triangulation and collaboration with divisional teams to maximise the learning and assurance derived from the full range of mortality governance activity.
- Support the work at ESTH to strengthen our methodology for the investigation of mortality at diagnosis group level and to understanding the variation in mortality ratios across the Trust.

Appendix 1: Structured judgement review summary data

ESTH

Overall care judgement	Q4 2024/25		Q1 2025/26	
	Number	Percentage	Number	Percentage
Excellent care	7	5.8	1	0.8
Good care	76	63.3	75	63.0
Adequate care	29	24.2	40	33.6
Poor care	8	6.7	3	2.5
Very poor care	0	0	0	0
Total	120		119	

Concern in care and level of concern	High		Moderate		Minor		Total	
	Q4 24/25	Q1 25/26	Q4 24/25	Q1 25/26	Q4 24/25	Q1 25/26	Q4 24/25	Q1 25/26
Assessment	2	2	5	6	1	1	8	9
Medication	1	0	2	1	1	0	4	1
Treatment	2	2	10	6	2	2	14	10
Infection control	0	0	2	1	0	0	2	1
Procedure	0	0	0	1	0	0	0	1
Monitoring	0	0	0	0	0	0	0	0
Resuscitation	0	0	0	5	0	1	0	6
Communication	1	3	1	4	1	0	3	7
Other	2	0	4	3	1	0	7	3
Total	8	7	24	27	6	4	38	38

SGH

Overall care judgement	Q4 2024/25		Q1 2025/26	
	Number	Percentage	Number	Percentage
Excellent care	5	12.8	8	17.0
Good care	29	74.4	37	78.7
Adequate care	4	10.3	1	2.1
Poor care	1	2.6	1	2.1
Very poor care	0	0	0	0
Total	39		47	

Problem in healthcare	No harm		Possible harm		Harm		Total	
	Q4 24/25	Q1 25/26	Q4 24/25	Q1 25/26	Q4 24/25	Q1 25/26	Q4 24/25	Q1 25/26
Assessment	2	3	3	1	0	0	5	4
Medication	1	5	1	3	0	0	2	8
Treatment	1	4	6	2	0	0	7	6
Infection control	0	0	1	1	0	0	1	1
Procedure	0	0	0	2	0	0	0	2
Monitoring	1	0	2	1	1	0	4	1
Resuscitation	0	0	0	0	0	0	0	0
Communication	1	1	1	0	1	0	3	1

Other	0	1	0	1	0	0	0	2
Total	6	14	14	11	2	0	22	25

Avoidability	**Q4 2024/25**		**Q1 2025/26**	
	Number	**Percentage**	**Number**	**Percentage**
Definitely not avoidable	33	84.6	40	85.1
Slight evidence of avoidability	3	7.7	4	8.5
Possibly avoidable but not very likely (less than 50:50)	1	2.6	2	4.3
Probably avoidable (more than 50:50)	1	2.6	1	2.1
Strong evidence of avoidability	1	2.6	0	0
Definitely avoidable	0	0	0	0
Total	39			

APPENDIX 2: ESTH MORTALITY OVERVIEW

Source: Healthcare Evaluation Data

Note: Data consists of monthly values for SHMI/HSMR, intending to illustrate trends, and differs from the 12-month rolling values within the report.

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APPENDIX 3: SGH NATIONAL QUALITY BOARD LEARNING FROM DEATHS DASHBOARD

NHS

St George's University Hospitals NHS Foundation Trust: Learning from Deaths Dashboard - June 2025-26

Description:
The suggested dashboard is a tool to aid the systematic recording of deaths and learning from care provided by NHS Trusts. Trusts are encouraged to use this to record relevant incidents of mortality, number of deaths reviewed and cases from which lessons can be learnt to improve care.

Summary of total number of deaths and total number of cases reviewed under the Structured Judgement Review Methodology

Total Number of Deaths, Deaths Reviewed and Deaths deemed more likely than not due to problems in care (does not include patients with identified learning disabilities)

Total Number of Deaths in Scope		Total Deaths Reviewed		Total Number of deaths considered more likely than not due to problems in care PRISM Score<=3 or equivalent measure	
This Month	Last Month	This Month	Last Month	This Month	Last Month
110	141	12	21	0	0
This Quarter (QTD)	Last Quarter	This Quarter (QTD)	Last Quarter	This Quarter (QTD)	Last Quarter
367	361	43	30	1	2
This Year (YTD)	Last Year	This Year (YTD)	Last Year	This Year (YTD)	Last Year
367	1346	43	152	1	3

Time Series: Start date 2017-18 Q1 End date 2025-26 Q1

Total Deaths Reviewed, categorised by SJR Avoidability Score

Score 1 Definitely avoidable			Score 2 Strong evidence of avoidability			Score 3 Probably avoidable (more than 50:50)			Score 4 Probably avoidable but not very likely			Score 5 Slight evidence of avoidability			Score 6 Definitely not avoidable		
This Month	0	0.0%	This Month	0	0.0%	This Month	0	0.0%	This Month	0	0.0%	This Month	2	16.7%	This Month	10	83.3%
This Quarter (QTD)	0	0.0%	This Quarter (QTD)	0	0.0%	This Quarter (QTD)	1	2.3%	This Quarter (QTD)	2	4.7%	This Quarter (QTD)	4	9.3%	This Quarter (QTE	36	83.7%
This Year (YTD)	0	0.0%	This Year (YTD)	0	0.0%	This Year (YTD)	1	2.3%	This Year (YTD)	2	4.7%	This Year (YTD)	4	9.3%	This Year (YTD)	36	83.7%

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St George's University Hospitals NHS Foundation Trust: Learning from Deaths Dashboard - June 2025-26

Summary of total number of learning disability deaths and total number reviewed under the LeDeR methodology. Please note that all LD deaths are reviewed using our standard approach, pending reviews as directed by the LeDeR process. The outcome of these local reviews is displayed in the second data grouping below.

Total Number of Deaths, Deaths Reviewed and Deaths Deemed more likely than not due to problems in care for patients with identified learning disabilities

Total Number of Deaths in scope		Total Deaths Reviewed Through the LeDeR Methodology (or equivalent)		Total Number of deaths considered more likely than not due to problems in care	
This Month	Last Month	This Month	Last Month	This Month	Last Month
0	1			0	0
This Quarter (QTD)	Last Quarter	This Quarter (QTD)	Last Quarter	This Quarter (QTD)	Last Quarter
4	9			0	0
This Year (YTD)	Last Year	This Year (YTD)	Last Year	This Year (YTD)	Last Year
4	23			0	0

Total Number of Deaths in scope		Total Deaths Reviewed Through the Local Review Methodology		Total Number of deaths considered more likely than not due to problems in care	
This Month	Last Month	This Month	Last Month	This Month	Last Month
2	2	2	2	0	0
This Quarter (QTD)	Last Quarter	This Quarter (QTD)	Last Quarter	This Quarter (QTD)	Last Quarter
4	3	4	3	0	0
This Year (YTD)	Last Year	This Year (YTD)	Last Year	This Year (YTD)	Last Year
4	19	4	19	0	0

Time Series: Start date 2017-18 Q1 End date 2025-26 Q1

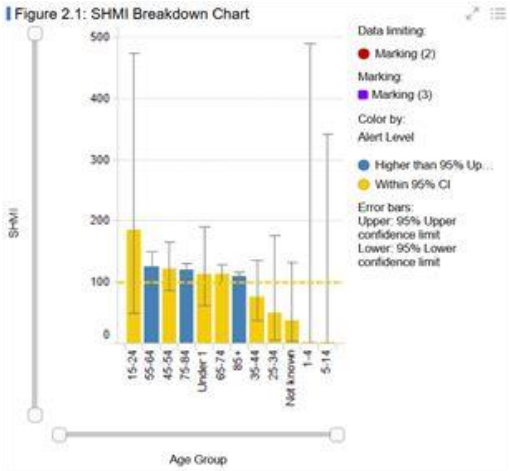
APPENDIX 4: ANALYSIS OF SHMI BY AGE, SEX AND DEPRIVATION

Source: Healthcare Evaluation Data (HED)

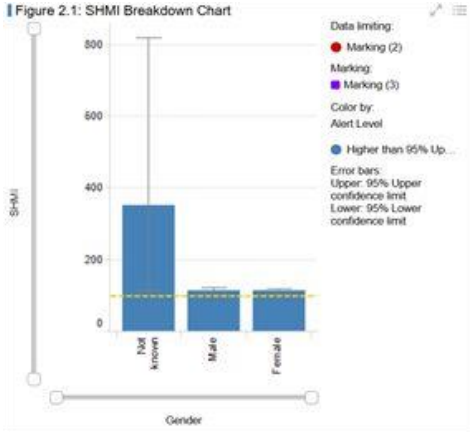
ESTH:

Mortality above the 95% CI is seen for both sexes, for a number of older age groups and deprivation quintiles of average and above

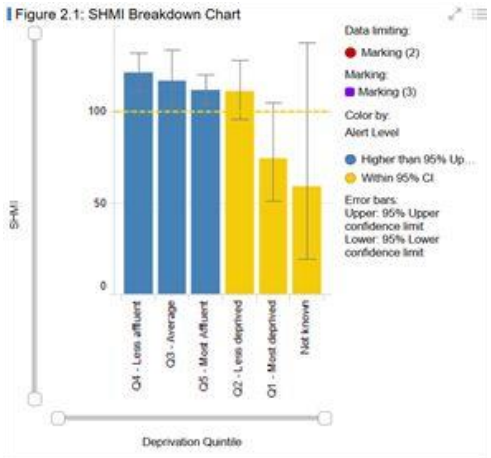
SHMI by age



SHMI by sex



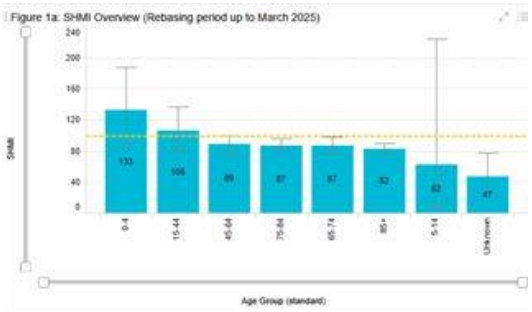
SHMI by deprivation



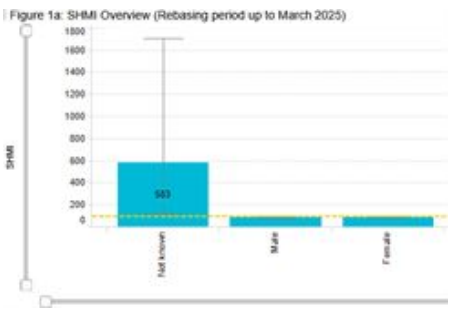
SGH:

Mortality is either as expected, or lower than expected

SHMI by age



SHMI by sex



SHMI by deprivation