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	GCEO	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)

		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.	

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.**

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

	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.	

	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.	

CLOSE		
The meeting closed at 3.55pm.		

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 (Public)

Meeting on Thursday, 06 November 2025

Agenda Item	3.1	
Report Title	**Quality Committees Report**	
Executive Lead(s)	Richard Jennings, Group Chief Medical Officer	
Report Author(s)	Andrew Murray	
Previously considered by	n/a	05 April 2025
Purpose	**For Assurance**	

Executive Summary

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

1. Quarterly Maternity Services Report: The Committees noted that 3 out of the 15 must do actions regarding the CQC section 29a notice are still rated as amber and have not been approved by the gesh Evidence Assurance Panel (EAP). The intention was set for these final actions to be approved when the EAP next meets in December 2025
2. Key Issues Report – Winter Plan: Committees members noted that as the Finance Committees were granted delegated authority from the Group Board to approve the Winter Plan, the plan has not been reviewed by the Quality Committees. It was agreed that to ensure that the quality impact assessment risks associated with the plan receive appropriate oversight and review from a quality-specific lens, these risks would be presented to the Committees at the meeting in November.
3. Patient Safety Incident Report Framework: In response to the never events, key meetings with SWL ICB and ESTH and SGUH Trust leads have taken place in regard to the never event learning review. It was agreed that a group report will be prepared and submitted to the Quality Committee for review in December 2025.

Action required by Group Board

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

Committee Assurance	
Committee	Quality Committees

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

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

N/A

Legal and / or Regulatory implications

N/A

Equality, diversity and inclusion implications

As set out in the paper

Environmental sustainability implications

N/A

Quality Committees Report
Group Board, 06 November 2025

1.0 Purpose of paper

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

2.0 Background

2.1 At its meetings on 25 September 2025 and the 30 October 2025 the Committees considered the following items of business:

25 September 2025 (Focus Session)	30 October 2025
• Falls • A Focus on Safety in ED • Concerns regarding St Helier Acute Medicine	• Key Issues Report • Maternity Services Report • Patient Safety Incident Report Framework • Integrated Quality Performance Report • Learning from Patient Death Report • Regulatory Bodies • Robotic Surgery Report

2.2 The Committees was quorate at the meetings in September and October 2025.

3.0 25 September 2025 – Key issues to which the Committees received assurance

3.1 Falls

3.1.1 The Quality Committees received the report, which noted that falls prevention is included as a targeted Quality Priority for 2025-26. It was noted that despite both Trusts performing better than the national average in 2024/25, performance in 2025/26 has shown early signs of deviation from the target trajectory.

3.1.2 The Key Risks and Challenges related to fall prevention are as follows:
Performance off trajectory with monthly performance not accurately reflecting planned improvements.
Variability in practice across falls risk assessments, post-falls management, governance, and training.
Data quality concerns, including errors in reported figures, highlighting the need for stronger validation processes.
Inconsistent assurance and oversight, with variability in incident investigations, audit compliance, and governance structures (e.g., no Falls Steering Group at ESTH).
Deliverability of the improvement plan, given the number of actions and resource limitations.

3.1.3 As a result of these challenges, the Committees endorsed the following action:

1. **Strengthen Data Quality and Validation:** Implement a robust validation process for falls data to avoid reporting errors and consider reporting data one month in arrears to ensure accuracy.
2. **Refine Performance Thresholds:** Review and adjust monthly thresholds to reflect realistic improvement trajectories while maintaining ambition.
3. **Prioritise Key Improvement Areas:** Focus on six critical themes: falls risk assessments, enhanced care, flat floor lifting equipment, governance, training, and post-falls management. And streamline the current improvement plan to ensure deliverability.
4. **Enhance Governance & Oversight:** Establish a Falls Steering Group at ESTH to ensure parity with SGUH. And standardise incident investigations, hot debriefs, and documentation to strengthen organisational learning.
5. **Standardise Clinical Practice:** Finalise and embed the Group Falls and Bed Rails Policy.
6. **Maximise Specialist Resources:** Deploy the 3.0 WTE site-based falls clinical nurse specialists strategically across both Trusts to drive improvement.
7. **Embed Continuous Learning Culture:** Improve compliance with audits, peer reviews, and training and share lessons from falls incidents consistently across both sites to reduce variability in care.

3.1.4 The Committees welcomed the update, agreeing that limited assurance could be taken with regards to the appropriate mitigations being in place to effectively manage fall preventions.

3.2 A Focus on Safety in ED

3.2.1 A paper was presented to the Committees, which provided an update to the Quality Committees regarding quality and safety in the gesh Group's Emergency Departments, and the actions taken to address the concerns raised by the Care Quality Commission following the inspections of the St George's University Hospital Emergency Department in late 2024.

3.2.2 The Committees discussed the key improvements which have since been made to St George's, which include:

- **Streaming:** Triage wait times reduced from 27 – 8 minutes with additional Registered Nurse, escalation process and electronic registration.
- **Medicines Management:** SOP and stock review completed. Prescribing standards circulated. CD Audit improved from 80 to 94%.
- **Falls and Pressure Ulcers:** Targeted Interventions have reduced falls. Only 1 moderate harm fall in 2024/25 and 0 category 3 or above pressure ulcers in last 6 months.
- **Governance:** Regular ED Quality meetings chaired by Site Chief Nursing Officer, Nicola Shopland; Strengthened Mortality and Morbidity meetings; Ward accreditation and Quality Dashboard in place to monitor performance

3.2.3 Following discussion, the Committees felt it able to take reasonable assurance that the quality and safety risks in the three EDs are understood and are being appropriately managed and mitigated, and that the CQC inspection findings at St George's are being effectively addressed.

3.3 Concerns regarding St Helier Acute Medicine

3.3.1 The Committees were advised that concerns have been raised about the quality of the St Helier Acute Medicine service, specifically the consultant medical team, over the previous years. Many interventions and improvement initiatives have been undertaken in recent years, and these concerns and responses have from time to time been highlighted to sub-committees of the Board (for instance, in papers about trainee doctor feedback in the GMC survey that have been considered at both People Committees and Quality Committees).

3.3.2 Whilst many previous interventions have had some positive effects, and whilst external regulatory scrutiny and support (for instance, from Health Education England) has varied over time, this has not let to sufficient or sustained change. It has become clear that a more substantive intervention is now required, and this is taking the form of a Quality Turnaround Programme. The goals of the turnaround programme are as follows:

1. Improve clinical quality and patient safety
2. Improve resident doctor education and training experience
3. Improve medical team culture, consistency, and work ethic

3.3.3 The Committees noted that in regard to receiving assurance on this issue, there will be an on-site face-to-face progress meeting, which the consultants will attend, led by the Site CMO and Group CMO. There will also be quarterly progress assurance reporting to the ESTH Senior Leadership Team, the gesh Quality Group, the gesh Group Executive Committee and Quality Committees-in-Common, for the next one year.

3.3.4 The Committees agreed that **reasonable** assurance could be taken that appropriate actions are being taken to mitigate the concerns raised about the quality of the St Helier Medicines Service.

4.0 30 October 2025 – Key Issues for Escalation to the Group Board

4.1 Key Issues Report

4.1.1 Winter Plan - Committees members noted that as the Finance Committees were granted delegated authority from the Group Board to approve the Winter Plan, the plan has not been reviewed by the Quality Committees. It was agreed that to ensure that the quality impact assessment risks associated with the plan receive appropriate oversight and review from a quality-specific lens, these risks would be presented to the Committees at the meeting in November.

4.1.2 The Committees agreed that **reasonable** assurance could be taken that the appropriate actions are in place to mitigate the issues raised in the report.

4.2 Maternity Services Report

4.2.1 The Committees discussed the priority headlines, perinatal quality oversight model (PQOM) and the Maternity and perinatal incentive scheme (MIS) for both SGUH and ESTH.

4.2.2 When discussing the Maternity Improvement Plan, Committees members were in agreement that 3 sections of the plan were to be closed down due to achieving 100% compliance, these were ‘baby falls’, ‘transitional care’ and ‘MBRACE 2020’. The Committees took assurance that the Maternity Oversight Group has robust oversight of the improvement plan and will escalate any issues in these areas should any concerns arise.

4.2.3 The Committees noted that 3 out of the 15 must do actions regarding the CQC section 29a notice are still rated as amber and have not been approved by the gesh Evidence Assurance Panel (EAP). These actions are relating to ‘medicine safety’, ‘appraisals’ and ‘standard of documentation’. The Committees agreed that it would be able to take a higher level of assurance that the Maternity Improvement Plan is improving the quality of the maternity services once these 3 must-do actions are completed, requesting an update on these actions in the next Maternity Services report.

4.2.4 Committees members felt that as not all must-do actions from the SGUH CQC section 29a notice have been approved as of yet, only **limited** assurance could be taken that all mitigations are in place to improve quality in the maternity services at SGUH. It was agreed that a higher level of assurance could be taken once all 15 must-do actions are approved and set the intention for this to be achieved the next time the gesh Evidence Assurance Panel meets in December 2025.

4.2.5 The Committees noted that the ESTH single improvement plan has a number of red-rated at risk/not yet started actions. It was advised that the ESTH improvement plan started 6 months after the SGUH plan, and so cannot be directly compared in this respect. The Committees received assurance that work is ongoing to implement all the actions for this plan and an update will be provided in the next report.

4.2.6 Committees members agreed that **limited** assurance could be taken on the quality of the maternity services at ESTH, noting that this assurance could be increased once a higher number of actions listed in the plan have been implemented.

4.2 Patient Safety Incident Report Framework

4.2.1 The Committees welcomed the report, which covered the period of June-August 2025. There have been no further Never Events at ESTH in this reporting period, but there have been further Never Events at St George's.

4.2.2 In response to the never events, key meetings with SWL ICB and ESTH and SGUH Trust leads have taken place in regard to the never event learning review. It was agreed that a group report will be prepared and submitted to the Quality Committee for review in December 2025.

4.2.3 It was noted that there are still delays in undertaking the Patient Safety Incident investigations and urged that these investigations were undertaken sooner. It was noted that the initial delay is around the logistics of being able to arrange a time for the panel to meet, but work is ongoing to facilitate these panels going forward.

4.2.4 Committees members **agreed** that reasonable assurance could be taken that appropriate mitigations are in place with regards to patients safety incident investigations. However, with regards to the mitigations and prevention of never-events across gesh, only **limited** assurance could be taken on this specific matter.

4.3 Learning from Patient Death Report

4.3.1 Committees members reviewed the report, which highlighted the following for SGUH and ESTH:

Key messages from ESTH:

- 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.

4.3.2 The Committees felt that **reasonable** assurance could be taken that the mechanisms are in place to be able to learn from patient deaths.

5.0 30 October 2025 – Key issues to which the Committees received assurance

5.1 Group Integrated Quality & Performance Report (IQPR)

5.2.1 The Committees noted that Elective care at SGUH and ESTH remains under pressure, with rising 52-week waits, challenges with 65-week waiters, and declining 18-week RTT compliance. Committees members requested that data is included in the report on 65-week waits going forward, as this cohort of patients are at particular risk.

5.3 Regulatory Bodies

5.3.1 The Committees received a paper, which described the steps that the gesh Group is taking to strengthen our oversight and monitoring processes for our statutory mandated regulatory responsibilities, and reduce unwarranted variation, across our two Trusts.

5.3.2 It was agreed that an annual update on regulatory bodies will be presented to the Committees, noting that the Audit and Risk Committees will also seek assurance on this matter.

5.4 Robotic Surgery Report

5.4.1 This paper gave an update regarding the quality and safety governance arrangements in place for Robotic Surgery across the gesh Group.

5.4.2 The Committees welcomed the report, agreeing that **reasonable assurance** could be taken that appropriate governance arrangements are in place to oversee the safe maintenance and expansion of robotic assisted surgery across gesh.

7.0 Recommendations

7.1 The Group Board is asked to note the issues escalated by the Quality Committees to the Group Board, and note the update on wider issues discussed at the Committees meetings in September and October 2025.

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 on Thursday, 06 November 2025

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

Executive Summary

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

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

Action required by Group Board

The Board is asked to:

a) Note the paper

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

Appendices	
Appendix No.	**Appendix Name**

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

Finance and Performance Committee Report
Group Board, 06 November 2025

1.0 Purpose of paper

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

2.0 Background

2.1 At its meetings on 26th September and 31st October 2025, the Committee considered the following items of business:

26th September 2025	31st October 2025
PUBLIC MEETING • GCFO briefing • Integrated Finance report M5 • FRB update and forecast • Productivity update • Business Planning 2026/27 • Business Case update • Winter plan	**PUBLIC MEETING** • GCFO briefing • Integrated Finance report M6* • FRB update and forecast • Procuring Ambient Voice Technology • IQPR

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

2.2 The Committee was quorate for both meetings.

4.0 Sources of Assurance

4.1

a) Financial Performance M6

Both trusts have reported being on plan at month 6. As in previous months, additional non-recurrent benefit has been added to help support that position. At ESTH this is £3.5m and SGH YTD £5.7m together with £4.5m additional income. This brings forward other planned benefits and means the challenge for later in the year increases. Committee members noted the challenge at SGH, and executive colleagues emphasised the commitment to delivering the financial plan despite the challenges noted.

b) Productivity update

The Committee noted the latest productivity update.

c) Business Planning 2026/27

The committee noted the paper and the importance of transformational schemes.

d) Business Case update

Colleagues discussed the major updates in Big Projects for the group.

e) Escalation to Tier 1 Elective performance – The Committee discussed that both SGH and ESTH have been placed in Tier 1 for Elective Recovery, as set out in letters received on 23 October 2025. This reflects the Trusts' projected 65-week waits to exceed 100 patients at the end of October and the national priority to eliminate all such waits by December 2025.

f) Operational Performance

Performance across Urgent and Emergency Care measures remains variable. SGUH continues to maintain compliance with the 4-hour standard at 78.1%, and ESTH remains below trajectory, with a performance of 74.1% in September 2025. UEC transformation remains a key priority for gesh, with several initiatives underway to improve flow, reduce 12-hour waits, and enhance patient experience.

g) Winter Plan

The Committee discussed and approved the Winter plans for each organisation including the relevant assurance statements at the September meeting as agreed by the Group Board in early September.

5.0 Implications

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

5.2 The Committee has suggested no changes to the BAF finance risk SR4 - Achieving financial sustainability and recommended no changes to the score of '25' and limited assurance. The target for the year end remains '20' and Reasonable assurance.

6.0 Recommendations

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

Group Board

Meeting in Public on Thursday, 06 November 2025

Agenda Item	4.2	
Report Title	**Integrated Finance Report M6**	
Executive Lead(s)	Andrew Grimshaw, Group Chief Finance Officer	
Report Author(s)	Andrew Grimshaw, Group Chief Finance Officer Lizzie Alabaster, Site Chief Finance Officer – ESTH George Harford, Site Chief Finance Officer – SGUH	
Previously considered by	Finance and Performance Committee	31 October 2025
Purpose	**For Review**	

Executive Summary

- Both organisations remain on plan at M6.
- The Group Executive remains committed to work to deliver the financial plans for both trusts as agreed but recognises there are challenges in achieving that. Work is underway to identify ways to mitigate those risks.
- At M6 the year end forecasts remain in line with plan

Action required by Group Board

The Board is asked to:

a) Note the paper

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				
[Set out summary of risk and state link to Board Assurance Framework]				
CQC Theme				
☐ Safe	☒ Effective	☐ Caring	☐ Responsive	☒ Well Led
NHS system oversight framework				
☐ Quality of care, access and outcomes			☐ People	
☐ Preventing ill health and reducing inequalities			☐ Leadership and capability	
☒ Finance and use of resources			☐ Local strategic priorities	
Financial implications				
As set out in paper.				
Legal and / or Regulatory implications				
N/A				
Equality, diversity and inclusion implications				
N/A				
Environmental sustainability implications				
N/A				

gesh

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

Group Board-in-Common – Public
6th November 2025

Integrated Finance Report M6

GCFO/Site CFOs

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

2.1 ESH – Executive Summary page 1

gesh

- Trust is on plan at YTD at M6 but it has had to use additional non recurrent technical action of £3.5m YTD (on top of £3.1m technical action plan) mitigating the £2.8m adverse underlying position on CIP and £0.7m mitigation of cost of Industrial Action.
- The Group Executive remains committed to work to deliver the financial plan as agreed but recognises there are challenges in achieving that. Work is underway to identify ways to mitigate those risks. At M6 the year end forecasts remains in line with plan.

Performance £'000	YTD Plan	Actual	Variance
Income	362,130	363,992	-1,862 F
Total Pay	**-249,223**	**-249,839**	**616 A**
Non-Pay	-125,196	-126,681	1,485 A
Non Operating Items	-3,072	-2,833	-239 F
Performance Target	**-15,361**	**-15,361**	**0**

Performance £'000	Annual Plan	Forecast	Variance
Income	733,034	733,033	-1 F
Total Pay	**-493,469**	**-493,469**	**0**
Non-Pay	-238,237	-238,236	1 A
Non Operating Items	-7,028	-7,028	-0 F
Performance Target	**-5,700**	**-5,700**	**0**

Performance £'000s	YTD Plan	Actual reported	Variance
Substantive	-219,580	-215,418	-4,162 F
Bank	-24,647	-30,234	5,587 A
Agency	-3,923	-3,195	-728 F
All Other pay	-1,073	-992	-81 F
Total Pay	**-249,223**	**-249,839**	**616 A**

Workforce	YTD Plan WTE	Actual WTE	Variance WTE	Move from M05 WTE
Substantive	6,373	6,424	-51 A	12 F
Bank	709	871	-161 A	41 F
Agency	64	65	-1 A	-4 A
Total	**7,146**	**7,360**	**-214 A**	**49 F**

Key Metrics		Plan	Actual	Variance	M5 actual	Movement
Bed Number	**No**	**571**	**600**	**-29 A**	**607**	**-7**

Income

- The YTD overperformance in Patient Care income is driven by £0.7m of plan phasing which will unwind in H2, £0.4m ERF provision release , £0.2m true up of Cancer Drug Fund (relates to prior year), £0.1m of unplanned income for each of the Renal Pilot Programme, SWLEOC Revision Hub, accrued SWL income in respect of Clock-stop Validation Sprints ,24-25 true up by South East London ICB and income in respect of Martha's Rule.

Non pay

- Non pay overall is £1.5m adverse to plan YTD but with an overspend of £2.5m in non pay relating to EPR offset by underspend in clinical supplies. An initial review indicates some benefits from stock control within cardiology, audiology and some related to activity. Clinical supplies costs can be spikey and there is a risk that this normalises.

Pay and workforce

- Trust is 214 WTE adverse to plan, 49 favourable to M5 (driven by c. 30 QN and HCA following ward closure and redeployment) and soft FM. Fully developed CIP are delivering. The adverse position is the failure to move opportunity CIP to fully developed and then into delivery.
- Pay overall is reported £616k adverse to plan which does not triangulate to the adverse position on WTE due to use of £3.8m of non recurrent pay technical actions reported in substantive pay position. The underlying pay position is closer to £4.5m adverse.
- £5.6m adverse position on bank spend largely triangulates with the WTE variance but c. £1.0m is a plan error between substantive and bank planned budget (the overall total is correct, while the mix is misstated). This is being reviewed. The in month adverse position on bank has improved in line with the 41 WTE reduction.

Other key metrics

- G&A beds M6 are 600 compared to 571 plan and a favourable movement of 7 since M5. The plan included a reduction in 48 G&A beds in M4 based on closing one ward on each site. Site reconfiguration plans changed post QIA and one ward at Epsom has closed and focus at St Helier is on corridor care and escalation areas.

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3.1 SGH – Executive Summary page 1

gesh

- Trust is on plan at YTD at M6 but it has had to use brought forward and additional non recurrent technical action of £5.7m YTD, as well as £4.5m YTD of additional NR SWL monies.
- The Group Executive remains committed to work to deliver the financial plan as agreed but recognises there are challenges in achieving that. Work is underway to identify ways to mitigate those risks. At M6 the year end forecasts remains in line with plan.

Performance	Plan £'000s	Actual £'000s	Variance £'000s
Income	647,468	647,133	-335
Total Pay	-414,389	-416,694	-2,305
Non-Pay	-237,834	-235,282	2,552
Non Operating Items	-10,417	-10,329	88
Performance Target	**-15,172**	**-15,172**	**0**

Performance	Annual Plan £'000s	Forecast £'000s	Variance £'000s
Income	1,288,179	1,288,179	0
Total Pay	-803,767	-803,767	0
Non-Pay	-463,698	-463,698	0
Non Operating Items	-20,714	-20,714	0
Performance Target	**0**	**0**	**0**

Workforce YTD	Plan £'000s	Actual £'000s	Variance £'000s
Substantive	-384,297	-390,257	-5,960
Bank	-23,557	-22,571	986
Agency	-5,200	-2,529	2,671
Other Pay	-1,335	-1,337	-2
Total	**-414,389**	**-416,694**	**-2,305**

Workforce	Plan WTE	Actual WTE	Variance WTE	Move from M05 WTE
Substantive	9,622	10,019	-397	-1
Bank	645	698	-54	69
Agency	58	68	-10	3
Total	**10,325**	**10,785**	**-460**	**71**

Key Metrics	Plan	Actual	Variance
Bed Numbers	**797**	**797**	**0**

Income

- Income is £0.3m adverse YTD, with patient care income £1.0m favourable and other operating income £1.4m adverse.
- Patient Care income is driven by £0.7m industrial action income and £0.2m of Pathology income, both offset by expenditure.
- Other Operating Income is driven by Pathology (£0.6m) and Pharmacy (£0.7m) which are both offset by additional expenditure.

Non pay

- Non-Pay is £2.6m favourable YTD. This is driven by a £1.6m negative CIP target variance, together with other non-pay reserve release of £1.0m.

Pay and workforce

- Trust is 460 WTE adverse to plan in M6 due to decrease in WTE plan from M4 onwards of 425 WTE linked to stepped increase in CIP target.
    - 438 CIP shortfall in line with £ performance and stepped increase in CIP target in M4. The adverse position is the failure to move opportunity CIP to fully developed and then into delivery.
    - 23 favourable TUPE – 23 fewer than the plan ESTH staff moved to SGH as part of the corporate consolidation.
    - 46 seasonality based on the Q4 reduction expected
- The movement from M5 shows significant improvement in bank WTE with less enhanced care, sickness, and annual leave in ward areas.
- Pay is £2.3m adverse to plan YTD. This is driven by a £1.6m adverse CIP target variance and a £0.7m underlying adverse variance driven by medical pay and underperformance against vacancy factor.
- Bank and Agency both remain below plan with CIPs focussed on temporary staff reduction.

Other key metrics

- G&A beds M6 are 797 which is in line with the plan.

Group Board

Meeting on Thursday, 06 November 2025

Agenda Item	4.3	
Report Title	**Group Integrated Quality & Performance Report (IQPR)**	
Executive Lead(s)	Michael Pantlin, Group Deputy Chief Executive Officer	
Report Author(s)	Ed Nkrumah, Group Director of Performance & PMO	
Previously considered by	Choose an item.	Click or tap to enter a date.
Purpose	**For Review**	

Executive Summary

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

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

The NHS Oversight Framework for Q1 2025/26, published on 9 September 2025, confirmed both Trusts as Segment 3, indicating they are off-track on key metrics or in financial deficit. SGUH, excluding the finance override, achieved Segment 1 due to strong performance across most domains. ESTH remained in Segment 3, mainly due to challenges in the UEC pathway and productivity. Work is underway to address both challenges as well as metrics at risk of deteriorating in the coming months. The accompanying Provider Board Capability Assessment exercise is now underway following publication of national guidance and release of a self-assessment templates for Trusts to complete. In line with the key principles of the Oversight Framework, NHSE is conducting mid-year review meetings with providers to seek assurance on delivery against key national priorities for the second half of the year. The NHSE H2 Review meeting with gesh, held on 22 October, focused on finance and performance. Ahead of the review meeting, NHSE requested revised trajectories for 52-week wait performance from SGUH, and a summary of key actions to improve UEC performance from ESTH (4 and 12 hr waits) and SGUH (12 hr waits) with a view to returning to plan by year-end. These were submitted on 10 October.

Elective care at SGUH and ESTH remains under pressure, with rising 52-week waits, challenges with 65-week waiters, and declining 18-week RTT compliance. Recovery efforts include waiting list validation, tele-dermatology pilots amid growing demand, and capacity optimisation—though progress is constrained by financial challenges. SGUH's long waits are concentrated in high-demand areas like Neurosurgery, General Surgery, and Gynaecology. At ESTH, RTT performance has been affected by the ICLIP Pro rollout, which temporarily reduced activity and delayed outcome data. PTL growth at both sites began to stabilise in September.

Both SGUH and ESTH have been placed in Tier 1 for Elective Recovery, as set out in letters received on 23 October 2025 (attached). This reflects the Trusts' projected 65-week waits exceeding 100 patients at the end of October and the national priority to eliminate all such waits by 21 December 2025. Tier 1 status involves regular oversight with regional and national teams, immediate

improvement actions, and targeted support (including GIRFT). Monitoring will continue until all 65-week waits are cleared, with progress reviewed through the national quarterly tiering cycle. The Group CEO is leading the Trusts' response and engagement with this enhanced oversight process.

Across the Group, patient satisfaction within outpatient services remains high at over 90%, with further work needed to realise additional productivity benefits – including reducing follow-up rates, increasing PIFU activity and reducing missed appointments (Did Not Attend rates). Improving Theatre Utilisation is also a key metric to improve productivity and reduce admitted pathway RTT waits. As part of a collaborative initiative across gesh, the Group is preparing to launch the Pre-Operative Assessment (POA) Patient Health Screening form via patient portals in December. This digital integration is expected to streamline pre-operative processes, improve data capture, and support more efficient scheduling and utilisation of theatre capacity.

Performance across Urgent and Emergency Care measures remains variable. SGUH continues to maintain compliance with the 4-hour standard at 78.1%, and ESTH remains below trajectory, with a performance of 74.1% in September 2025. UEC transformation remains a key priority for gesh, with several initiatives underway to improve flow, reduce 12-hour waits, and enhance patient experience. SGUH implemented a wide range of operational improvements including expanded Same Day Emergency Care (SDEC) and enhanced triage with further initiatives being implemented through October. ESTH launched a comprehensive UEC Transformation Programme aimed at improving patient flow and support operational delivery throughout winter, with various workstreams now supported by NHSE/ECIST.

Cancer Standards performance continues to decline across both SGUH and ESTH, with neither site meeting the 28-Day Faster Diagnosis Standard in August—SGUH reported 64.4% and ESTH 62.3%—primarily due to seasonal referral surges in Dermatology and delays in Gynaecology pathways, particularly around access to first appointments and one-stop diagnostics. At SGUH, diagnostic performance (DM01) in Gynae Ultrasound significantly deteriorated, driven by unplanned short- and long-term sickness within Imaging teams and under-resourcing, reflecting both local and London-wide challenges. SGUH's 62-Day Treatment Standard fell to 69.8%, impacted by limited theatre access and delays in diagnostics, while ESTH reported 81.8% with ongoing issues with diagnostic capacity and complex pathways. In response, the Trust has deployed RMP resilience funding, optimised pathways, and implemented recovery plans, alongside additional actions including weekend and ad-hoc clinics, expansion of tele-dermatology, engagement with private sector diagnostic providers, and development of business cases to enhance endoscopy services.

The notable increase in referrals to Urgent Community Response (UCR) teams at Sutton Health and Care is being reviewed to inform future planning. Both Sutton Health and Care and Surrey Downs Health and Care exceeded the national UCR target of 70% in September, reflecting strong operational delivery. Virtual ward occupancy continues to consistently exceed the 80% target. These services—UCR teams and virtual wards—remain critical enablers of our broader improvement programme, supporting timely interventions and reducing avoidable hospital admissions. Sustained progress will require ongoing collaboration with local system partners to drive integrated care outcomes.

A key success in recent months in relation to quality and effectiveness of care, is reducing mortality rate as measured by the Summary Hospital-level Mortality Indicator (SHMI). SGUH improved to a ratio of 0.85, placing the Trust in the 'better than expected' range. ESTH remained 'as expected' seeing a further reduction in rate after a prolonged period of elevated rates which was partly attributable to a change in reporting. Mortality performance will continue to be closely monitored at both sites.

VTE risk assessment rates across the Group remains a key focus with both Trusts performing significantly below target. Site Chief Medical Officers are leading improvement work across gesh including a review of the reporting logic, which currently uses the Decision to Admit (DTA) time as the clock start for patients admitted via Emergency Departments.

Technology remains a key focus, with ESTH's EPR stabilisation following its May 2025 rollout marking a major digital shift across the Group. While long-term benefits such as improved care delivery are emerging, challenges persist around data quality, reporting, and performance. The report outlines ongoing actions to address current issues.

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

The format and content of this report will continue to evolve throughout 2025/26 to reflect both national and local priorities.

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

Action required by Group Board

The Board is asked to note this paper.

Committee Assurance

Committee	Finance Committee and Performance Committee
Level of Assurance	Not Applicable

Appendices

Appendix No.	Appendix Name
Appendix 1	IQPR Full Report
Appendix 2	Tier 1 Letter

Implications

Group Strategic Objectives

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

Risks

Failure to deliver NHS Priorities and Constitutional Standards

CQC Theme

☒ Safe ☒ Effective ☒ Caring ☒ Responsive ☒ Well Led

NHS system oversight framework

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

Financial implications

Failure to meet statutory financial duties

Legal and / or Regulatory implications

N/A

Equality, diversity and inclusion implications

N/A

Environmental sustainability implications

N/A

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

Group Integrated Quality & Performance Report

September 2025

Outstanding Care, Together: Our strategy 2023 to 2028

Publication Date: 24th October 2025 Contact: gesh.performance@stgeorges.nhs.uk

gesh CARE Board: Board Level Improvement Priorities for 2025/26

C **Collaboration & Partnership:** Work with other teams to reduce delays in patient journeys through our services

A **Affordable healthcare, fit for the future:** Live within our means: innovating, working more efficiently and cutting costs

R **Right care, right place, right time:** Keep our patients safe – including those waiting for our care

E **Empowered, engaged staff:** Make our team a great and inclusive one to work in

Reduce average Non-Elective LOS: Sep 25

	Actual	Plan	Trend
SGUH	9.8 days	9 days	normal variation
ESTH	10.9 days	tbc	normal variation

Deliver Financial Plan (month 6)

	Variance to plan	Assurance on deliverability
SGUH	£0.0m (on plan)	Very challenging
ESTH	£0.0m (on plan)	Very challenging

Improve VTE Risk Assessment Rates: Sep 25

	Actual	Plan	Trend
SGUH	68.8%	95%	increasing trend
ESTH	67.3%	95%	downward trend

Staff recommending gesh as an employer 2024 v 2023

	Actual 2023	Actual 2024	Trend
SGUH	59.50%	63.20%	Improved
ESTH	59.30%	61.46%	Improved

Reduce delays between planned and actual discharge (inc zero delays): August 25

	Actual	Plan	Trend
SGUH	0.5 days	-	normal variation
ESTH (May)	0.7 days	-	normal variation

Improve (Implied) Productivity Mar 25

	YoY Change	National Benchmark
SGUH	5.20%	Top Quartile
ESTH	0.20%	Lowest Quartile

Reduce RTT 52-week waiters: Aug 25

	Actual	Mar 2026 Plan	Trend
SGUH	2.54%	1.6%	increasing trend
ESTH	1.8%	1.0%	increasing trend

Reduce staff sickness absence rates

	Actual	Plan	Trend
SGUH	4.7%	4%	normal variation
ESTH	5.2%	4%	normal variation
Sutton	6.0%	4%	normal variation
Surrey Downs	5.6%	4%	decreasing trend

Increase Referrals to Urgent Community Response Teams: Sep 25

	Actual	Trend
Sutton	508	increasing trend
Surrey Downs	538	normal variance

Deliver CIP Target (month 6)

	YTD Delivery	Note
SGUH	£32.5m to date	In line with plan. Includes £2.8m of NR B/f and £1.7m of NR additional to support
ESTH	£21.3 to date	Includes £2.8m of non-recurrent balance sheet to support the non-delivery of planned CIP

Maintain 12-Hour waits in ED at or below 24/25 level: Sep 25

	Actual	Plan	Trend
SGUH	10.4%	13.0%	normal variation
ESTH	12.9%	10.8%	normal variation

Improve Cash Position (month 6)

	Current Balance	Cash stress expected based on current cash flow
SGUH	£60.5m (£12.7m favourable)	Early Q4
ESTH	£29m (£16m favourable)	Early Q4

National Oversight Framework

The NHS Oversight Framework provider segmentations and league tables for Q1 were published on 9 September 2025.

The Framework places trusts into one of four segments. Segment 1 represents organisations facing the fewest challenges, while Segment 4 includes those with the most significant challenges.

Segmentation is determined by performance across key domains: access, effectiveness, patient safety, workforce, and finance. **Only organisations demonstrating financial stability are placed in Segments 1 or 2.**

Metric scores (1 to 4) reflects relative performance.

Assessment Period: Q1 2025/26			SGUH	ESTH
		Trust Segment (adjusted)	3	3
		Ranking (Acute Trusts)	37/134	61/134
		Unadjusted Segment (pre finance override	1	3
		Overall Metric Score (breakdown below)	2.05	2.41
Domain	**No.**	**Metric**	**Data Period**	**Metric Scores**	**Metric Scores**
Access	1	RTT 18 weeks Performance	Jun-25	2.34	1.81
	2	RTT 18 weeks Performance vs Plan	Jun-25	1.00	1.12
	3	RTT 52 Weeks Performance	Jun-25	2.73	2.32
	4	Community Services - % waits over 52 Weeks	Jun-25	1.00	2.35
	5	Cancer - 28-Day Faster Diagnosis Standard	Q1-25/26	2.20	2.04
	6	Cancer - 62-Day Treatment Standard	Q1-25/26	1.00	1.00
	7	A&E 4-Hour Wait Standard	Q1-25/26	1.00	3.37
	8	A&E 12-Hour Waits (from arrival)	Q1-25/26	2.82	3.78
	9	Annual change in CYP accessing MH services	R12 - Jun-25	N/A	2.34
Effectiveness & experience of care	10	Summary Hospital Level Mortality Indicator	R12 - Mar-25	2.00	2.00
	11	Average number of days between planned and actual discharge date	Jun-25	1.74	Not Reported (DQ)
	12	CQC inpatient survey satisfaction rate	2023	2.00	2.00
	13	Urgent community response 2-hour performance	Q1-25/26	N/A	2.24
Patient Safety	14	NHS Staff Survey -raising concerns sub-score	2024	3.12	2.78
	15	CQC safe inspection score (if awarded within the preceding 2 years)	N/A	N/A	N/A
	16	Rates of MRSA infections	R12 -Jun-25	2.37	2.63
	17	Rates of C-Difficile infections	R12 -Jun-25	3.62	2.62
	18	Rates of E-Coli infections	R12 -Jun-25	3.39	2.05
People and workforce	19	Sickness absence rate	R12 -Mar-25	1.72	2.44
	20	NHS Staff Survey engagement theme score	2024	2.38	2.20
Finance and productivity	21	Planned surplus/deficit	Apr-25	4.00	4.00
	22	Variance year-to-date to financial plan	YTD Jun-25	1.00	1.00
	23	Implied Productivity Level	YTD Mar-25	1.74	3.26

Executive Summary
Safe, High-Quality Care

St George's Hospital

Key Messages

- **Patient Safety Incident Investigations (PSII) and Never Events:** There were no new Never Events declared at SGUH in September 2025. Two new Patient Safety Incident Investigations (PSIIs) were declared at during the month, both relating to unexpected admissions to Neonatal Unit for patients on the Delivery Suite.
- **VTE Risk Assessments:** The rate of VTE risk assessment within 14 hours of admission showed a sustained improvement to 68.8% in September 2025, against the national ambition of 95%. Site Chief Medical Officers are leading a review of the reporting logic, which currently uses the Decision to Admit (DTA) time as the clock start for patients admitted via Emergency Departments.
- **Falls Prevention and Management:** In September 2025, there were two moderate harm falls. One fall occurred on Kent ward where the patient sustained pubic rami fractures. The second fall was on Amyand ward with the patient sustaining fractured ribs and has since been discharged home. All incidents have been or will be investigated using the SWARM (safety incident huddle that takes place as close as possible in time and place to the incident), approach with themes shared across divisions.
- **Pressure Ulcers:** There were no category 4 pressure ulcers and six category 3 pressure ulcers reported in September 2025. Cases reported have been below the target of 7 for three consecutive months and below the mean for the past seven months showing sustained improvement.
- **Infection Prevention and Control (IPC):** No MRSA bacteraemia cases were reported in September 2025. One case has been reported so far in 2025/26, on Trevor Howell ward associated to source IV line. Seven cases of C. difficile have been reported in September 2025, YTD 32 against an annual threshold of 43. Continuous reviews are addressing training needs. Three hospital-acquired MRSA cases were reported on Special Care Baby Unit; ribotyping is identical for 2 cases. No invasive infections. Suppression therapy started and weekly screening continues. Enhanced cleaning is in place, and the ward is under IPC Increased Surveillance.
- **Complaints:** In September 2025, the complaints team experienced significant staffing issues which adversely impacted performance. An action plan is in place to support staffing shortfalls and ensure acknowledgement and response rates return to target.
- **Mortality:** Mortality rate, as measured by the Summary Hospital-level Mortality Indicator (SHMI), stands at 0.85, indicating performance better than expected. However, the forthcoming change to Same Day Emergency Care (SDEC) data reporting, with SGUH go-live scheduled for 22 October 2025, may negatively affect future SHMI results.
- **Family and Friends Tests:** FFT scores remain strong across Inpatient, Outpatient, Maternity, and Community services at SGUH. Scores for Emergency Department, however, continues to track below the 90% target. Improvement measures include analysing patient feedback, offering comfort packs, and implementing a digital check-in system.

Epsom & St Helier

Key Messages

- **Patient Safety Incident Investigations (PSII) and Never Events:** No new PSIIs or Never Events were reported in September 2025.
- **VTE Risk Assessments:** The Trust's VTE performance declined during the iClip Pro go-live period. Work is ongoing across gesh to improve workflows and risk assessment compliance to address the root causes which are multifaceted. Focused work has commenced to ensure compliance data from the Maternity system – Badgernet - is included.
- **Falls Prevention and Management**: One moderate harm and one severe harm fall occurred in September 2025. The moderate harm was on C3 ward (St Helier) where the patient sustained a right pubic rami fracture and the severe harm fall resulted in a fractured hip on Chuter Ede ward (AMU) at Epsom. All incidents have been reviewed with a SWARM (safety incident huddle that takes place as close as possible in time and place to the incident) and discussed at relevant DIRG (Divisional Incident Response Group) meetings.
- **Pressure Ulcers:** There was 1 hospital-acquired category 3 pressure ulcer in September 2025. The patient was admitted with a category 2 pressure ulcer (following a long lie) which further developed during their inpatient stay on A3 ward.
- **Infection Prevention and Control:** No MRSA bacteraemia reported in September 2025, YTD 3. Two cases of C. difficile have been reported in September YTD 35, against an annual threshold of 63. An overarching C. difficile action plan has been drafted. Continuous reviews are underway, with specific training needs being identified and addressed.
- **Complaints:** In September 2025, 100% of complaints were acknowledged within three working days which represents best practice. Complaints responded to within 35 working days has continued to be above the target of 85%. There is a continued drive to maintain this level of performance.
- **Mortality:** The latest SHMI for the 12-month period from May 2024 to May 2025 is now as expected level at 1.12 (rather than above expected.) This continues to be closely monitored and reviewed but is on the background of an improving trend for SHMI.
- **Family and Friends Tests:** FFT scores remain positive across all services except the Emergency Department, where results fall below 90%. Actions include analysing trends in negative feedback and proposing the involvement of volunteers to support feedback collection in the Emergency Department.

Executive Summary

Operational Performance & Productivity

St George's Hospital

Successes

- SGUH capped theatre utilisation has improved, placing it in the top quartile of the national rankings.
- DNA Risk Model Pilot - A predictive model has been developed with the Trust Business Intelligence (BI) Team. An implementation plan is under way to launch the "bot" to identify patients that meet the algorithm of a high probability of not attending.
- The Trust has maintained average length of stay in line with plan while sustaining the closure of 83 beds.
- The 4-hour emergency department standard continues to be maintained achieving 78.1% in September 2025. This is supported by reduced times for ambulance handover.
- The closure of 4 theatres at QMH was delivered successfully.

Challenges

- Performance pressures persist across key RTT metrics, with a high volume of >52-week waits, but we remain on track in line with our RTT plan / trajectory. Targeted actions are underway and overseen by the Senior Leadership Team (SLT). Detailed actions can be found in slide 23.
- There is a known risk to RTT performance with the pause of the theatres at QMH from the 1st September, staff and sessions are being re-allocated to reduce the impact.
- Cancer performance remains below trajectory, with 28-day performance at 64.4%, and 62-day performance at 69.8%. Key challenges include seasonal referral surges in Dermatology referrals impacting access to clinic and minor ops; service recovery plan in place, with additional resilience funding to support waiting list initiatives. This is being overseen in line with Tier 1 actions, commencing in October.
- Cardiac MRI and Ultrasound capacity issues through August 2025 impacted DM01 performance, increasing long waits. This was driven by equipment failure, rising demand, and unplanned staff absences. Mitigation actions are underway through September to support recovery.

Epsom & St Helier

Successes

- Cancer performance standards achieved in August 2025: 31-day (100%)
- Theatres have seen improved day case rates from 77.9% in December 24 to 81% in March 25, the team is working towards perioperative pathway enhancements with digital triage and running pilots to improve start times, along with initiatives to strengthen staff wellbeing and civility.
- Diagnostic performance has improved compared to the previous month and is expected to improve further next month. Recovery plans remain in place supporting increasing activity and working through on-going workflow issues. Echo and Endoscopy remain the most challenged modalities.
- Average ambulance handover times remained static in month of September 2025 at 24 mins.
- Non-elective LOS for September 2025 is reported at 10.9 days, reflecting a 0.2-day increase compared to August 2025. However, this figure should be viewed positively, as it represents a 0.3-day reduction from July 2025. This improvement was not acknowledged in the previous month's IQPR report. It is important to note that a data quality refresh was undertaken in September, which has retrospectively altered baseline data for the period May to August 2025. The September LOS figure, therefore, reflects updated and more accurate data, reinforcing the significance of the reduction from July.

Challenges

- iClip Pro implementation, supported by a six-week activity reduction, has impacted performance. Our teams are actively resolving workflow and data challenges, and we anticipate steady recovery as improvements take effect.
- RTT Patient Tracking List increased in August, but is stabilising post iClip Pro implementation, however there is an increase in >52-week waits. Data quality issues are inflating the list; validation and activity plans are in progress. Financial constraints limit extra sessions, so recovery efforts focus on boosting core sessions. Dermatology remains the most challenged speciality.
- Cancer 62-day Standard performance was 81.8%, below the 85% national target and 28-day Faster Diagnosis was 62.3% below 77% national target , primarily due to capacity constraints .
- Capacity pressures in Dermatology and Gynaecology continue to impact 14-day and FDS targets. Endoscopy delays and anaesthetic staffing shortages are affecting GI pathways, while the lung cancer diagnostics remain constrained by external wait times of up to four weeks for navigational bronchoscopy and endobronchial US.
- Despite improvements, 4-hour performance remains off-trajectory. Data quality improvements are ongoing, and the 2025/26 UEC programme is advancing rapidly to support recovery.
- Work is progressing with NHS England and to agree Tier 2 Urgent Emergency Care reporting requirements and support. Emergency Care Improvement Support Team (ECIST) feedback from their visit has highlighted the use of ED SDEC and the teams are currently undertaking a review of the clinical pathways.
- Theatre utilisation remains below pre-iClip levels (74% in Sept vs >80% pre-iClip), with ongoing challenges in scheduling, procedure timing accuracy, dashboard data reliability, and on-the-day cancellation reporting.

Executive Summary

Integrated Care

Safe, High-Quality Care Key Messages

Sutton Health & Care (SHC)

- Safety and Infection control indicators remain strong with zero cases across MRSA, CDiff, Ecoli and falls with harm in September 2025.
- Community FFT results are positive, and complaints remain low showing a steady performance
- Special school governance review undertaken with action plan formulation in progress.
- Based on the informal feedback from the Coroner case work is ongoing to strengthen the missed insulin dose pathway

Surrey Downs Health & Care(SDHC)

- In September we held another successful Community Assess and Support Day (CASD). This collaborative approach continues to strengthen local connections and empower residents to take charge of their health.
- COVID is increasing community wide so increased vigilance especially in the bedded care units.
- Challenges of insulin administration where there are comorbidities that impacts the team ability to administer the medication. Devised an interim refusal process while the final process is ratified.

Community Wide Issue:

- Pressure ulcer improvement plan continues with increased focus on prevention.

Operational Performance Key Messages

Sutton Health & Care (SHC)

- Continued progress has been achieved in addressing long waits for the Children's Speech and Language Therapy (SALT) Service, with the number of patients waiting over 52 weeks successfully reduced to zero as of the end of September 2025. Overall waiting list size for children's services remains high with a consolidated action plan in development across SWL in conjunction with ICB commissioners.
- Technical data issues caused the 2 Hour UCR performance to reduce significantly in July 2025. This has now been resolved by EMIS and the 70% target was achieved in September with a performance of 72.8%. Increases in referral patterns are being reviewed to understand the cause, particularly in the out of hours periods and at weekend with a continued focus to ensuring the service meets targets vis a vis its capacity to deliver.
- Virtual Ward occupancy rate exceeded target of 85% achieving 88.2% with admissions remaining above the mean.
- Appraisal Rate for non-medical staff remains below target at 71%. Increased sickness in SHC has caused some of this impact. Mitigation plans are in place across teams to improve performance.

Surrey Downs Health & Care(SDHC)

- Service consistently achieves the 2 –hour Urgent Community Response (UCR) target with a performance of 88.1% in September 2025 against a national target of 70%.
- Virtual ward admissions remains above average with occupancy targets being met.
- Reduction in waiting list size across the month and no patients waiting over 52 weeks for specialist services.

Quality & Safety

Safe, High-Quality Care & Patient Experience

Matrix Summary

SGUH Safe, High-Quality Care & Patient Experience

VARIATION	ASSURANCE: P	ASSURANCE: ?	ASSURANCE: F	No Target
H / L	Mortality - SHMI FFT - Outpatient Score	Pressure Ulcers Acquired Category 3&4 % Births PPH >1.5 L Neonatal deaths per 1,000 births	VTE Risk Assessment	
	FFT - Inpatient Score	Never Events Patient Safety Incident Investigations Infection Control - Number of MRSA Infection Control - Number of Cdiff Infection Control - Number of E-Coli % Births with 3rd or 4th degree tear Stillbirths per 1,000 births Complaints - Acknowledgement within 3 workings days FFT - Maternity Score	Number of complaints not completed within 6 months from date of receipt FFT - Emergency Department Score	Moderate and Severe Harm from Falls 30-Day Emergency Readmission Rate HIE per 1,000 births
H / L		Complaints - Responded to within 35 working days		

ESTH Safe, High-Quality Care & Patient Experience

VARIATION	ASSURANCE: P	ASSURANCE: ?	ASSURANCE: F	No Target
H / L		Complaints - Responded to within 35 working days Complaints - Acknowledgement within 3 working days	Mortality - SHMI	Neonatal deaths per 1,000 births
	Pressure Ulcers Acquired Category 3&4 FFT - Inpatient Score FFT-Outpatient Score	Never Events Patient Safety Incident Investigations Infection Control - Number of MRSA Infection Control - Number of Cdiff FFT - Maternity Score	FFT - Emergency Department Score	Moderate and Severe Harm from Falls 30-Day Emergency Readmission Rate % Births with 3rd or 4th degree tear % Births PPH >1.5 L Stillbirths per 1,000 births HIE per 1,000 births
H / L		Infection Control - Number of E-Coli	VTE Risk Assessment	

Safe, High-Quality Care

Overview Dashboard

St George's

KPI	Latest month	Previous Month Measure	Latest Month Measure	Target	Variation	Assurance	Benchmark
Never Events	Sep 25	1	0	0			N/A
Patient Safety Incident Investigations	Sep 25	0	2	0			N/A
Moderate and Severe Harm from Falls	Sep 25	2	2	-			N/A
Pressure Ulcers - Acquired Category 3&4	Sep 25	6	6	7			N/A
Infection Control - Number of MRSA	Sep 25	0.0	0.0	0.0			3rd Quartile
Infection Control - Number of Cdiff - Hospital & Community	Sep 25	4	7	5			2nd Quartile
Infection Control - Number of E-Coli	Sep 25	12	3	9			Lowest Quartile
30-Day Emergency Readmission Rate	Aug 25	13.5%	13.8%	-			TBC
VTE Risk Assessment	Sep 25	67.0%	68.8%	95.0%			N/A
Mortality - SHMI	May 25	0.85	0.85	1.00			Better than Expected
% Births with 3rd or 4th degree tear	Sep 25	3.5%	2.2%	5.0%			3.0%
% Births Post Partum Haemorrhage >1.5 L	Aug 25	3.7%	2.8%	4.0%			3.0%
Stillbirths per 1,000 births	Sep 25	0.0	6.3	2.0			3.3
Neonatal deaths per 1,000 births	Sep 25	3.2	3.2	2.0			1.6
HIE (Hypoxic ischaemic encephalopathy) per 1,000 births	Sep 25	0.0	0.0	-			N/A

Epsom & St Helier

Latest month	Previous Month Measure	Latest Month Measure	Target	Variation	Assurance	Benchmark
Sep 25	0	0	0			N/A
Sep 25	1	0	0			N/A
Sep 25	3	4	-			N/A
Sep 25	0	1	7			N/A
Sep 25	0	0	0			3rd Quartile
Sep 25	4	2	6			2nd Quartile
Sep 25	7	6	5			2nd Quartile
Mar 25	6.0%	5.9%	-			TBC
Sep 25	65.0%	67.6%	95.0%			N/A
May 25	1.13	1.12	1.00			As expected
Sep 25	1.09%	0.52%	-			2.7%
Sep 25	4.5%	4.1%	-			3.2%
Sep 25	10.7	5.8	-			3.30
Sep 25	0.0	0.0	-			1.60
Sep 25	3.4	0.0	-			N/A

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

Mortality: SDEC reporting will be introduced at SGUH over the next few months and likely to have an adverse impact on SHMI performance .The number of trusts submitting SDEC via ECDS. Is now 57 and counting

* Never Events are a subset of PSIIs

Safe, High-Quality Care

Overview Dashboard

St George's

KPI	Latest month	Previous Month Measure	Latest Month Measure	Target	Variation	Assurance	Benchmark
Complaints - Responded to within 35 working days	Sep 25	97.4%	79.0%	85.0%			N/A
Complaints - Acknowledgement within 3 working days	Sep 25	100.0%	37.0%	100.0%			N/A
Number of complaints not completed within 6 months from date of receipt	Sep 25	1	2	0			N/A
Friends and Family Test - Inpatients Score	Sep 25	98.4%	98.1%	90.0%			Top Quartile
Friends and Family Test - Emergency Department Score	Sep 25	83.0%	79.8%	90.0%			2nd Quartile
Friends and Family Test - Outpatients Score	Sep 25	94.5%	95.4%	90.0%			3rd Quartile
Friends and Family Test - Maternity Score	Sep 25	92.5%	84.2%	90.0%			2nd Quartile

Epsom & St Helier

Latest month	Previous Month Measure	Latest Month Measure	Target	Variation	Assurance	Benchmark
Sep 25	88.0%	84.6%	85.0%			N/A
Sep 25	100%	100%	100%			N/A
Sep 25	8	13	0			N/A
Sep 25	97%	96%	90%			Top Quartile
Sep 25	47.8%	61.1%	90.0%			Quartile 1
Sep 25	92.1%	96.5%	90.0%			Top Quartile
Sep 25	100.0%	100.0%	90.0%			Top Quartile

Sutton Healthcare

KPI	Latest month	Previous Month Measure	Latest Month Measure	Target	Variation	Assurance
Patient Safety Incidents Investigated	Sep 25	0	0	0		
Number of Falls with Harm (Moderate and Above)	Sep 25	0	0	-		
Pressure Ulcers Category 3&4	Sep 25	3	6	-		
Infection Control - Number of MRSA	Sep 25	0	0	0		
Infection Control - Number of Cdiff	Sep 25	0	0	-		
Infection Control - Number of Ecoli	Sep 25	0	0	-		
Complaints	Sep 25	1	1	-		
Community FFT	Sep 25	97%	95%	90%		

Surrey Downs

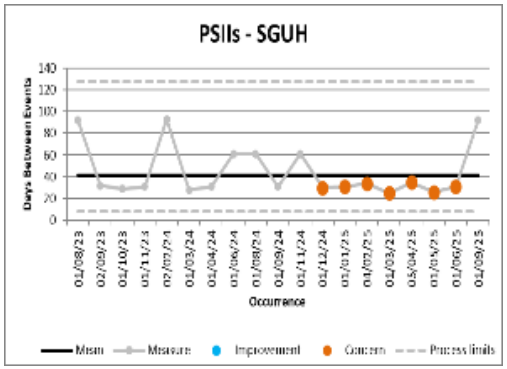
Latest month	Previous Month Measure	Latest Month Measure	Target	Variation	Assurance
Sep 25	0	0	0		
Sep 25	0	0	-		
Sep 25	8	8	-		
Sep 25	0	0	0		
Sep 25	0	0	-		
Sep 25	0	1	-		
Sep 25	0	1	-		
Sep 25	97.8%	95.4%	90.0%		

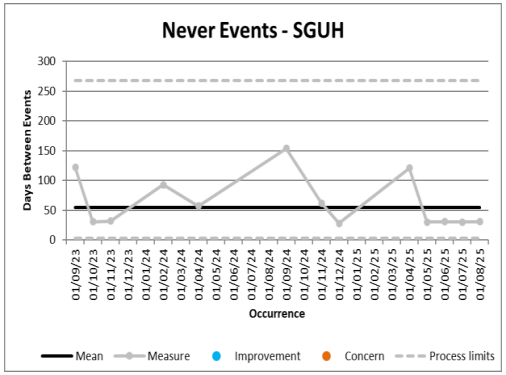
- Community FFT is a subset of Epsom and St Heliers FFT data.
- IC (Dorking and Molesey Hospitals – community do not have set national trajectories for HCAIs although all cases are reviewed and investigated)

Safe, High-Quality Care

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

St George's





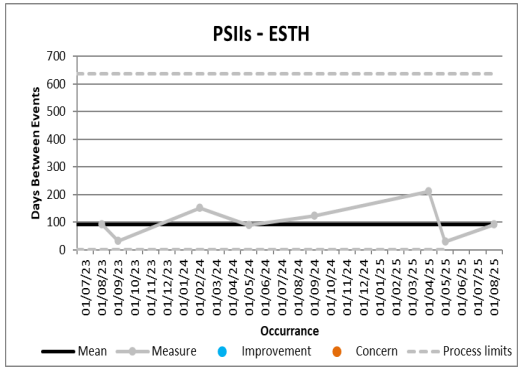
Summary & Actions

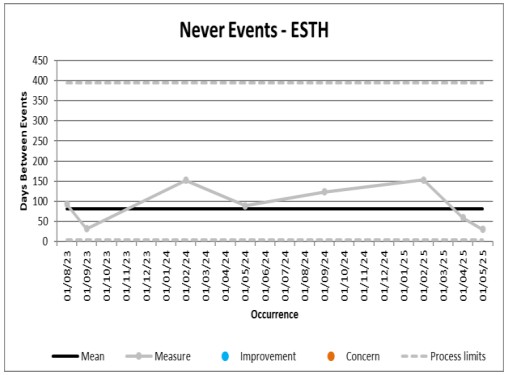
Two new Patient Safety Incident Investigations (PSIIs) were declared at SGUH in September 2025.
Both involved unexpected admissions to Neonatal Unit (NNU) for patients on the Delivery Suite.
These cases have been accepted for investigation by the Maternity and Newborn Safety Investigations (MNSI) programme, replacing the standard Trust investigation process.

Summary & Actions

There were no new Never Events declared at SGUH in September 2025.

Epsom & St Helier





Summary & Actions

No new Patient Safety Incident Investigations (PSII) were declared at ESTH in September 2025.

One PSII (Never Event cluster) was signed off in September 2025.

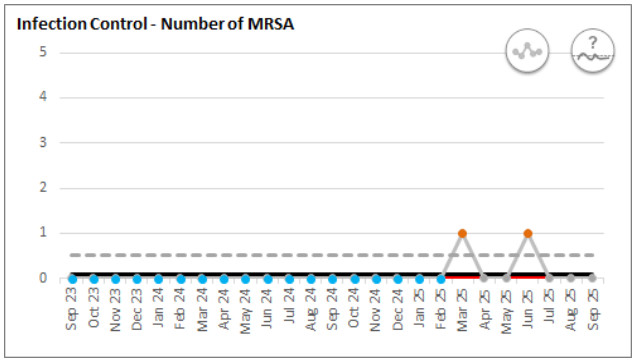
Summary & Actions

No new Never Events were reported at ESTH in September2025.

Safe, High-Quality Care

Exception Report| SGUH - Infection Prevention and Control

St George's



SGUH - Summary & Actions

Healthcare Associated MRSA Bacteraemia:

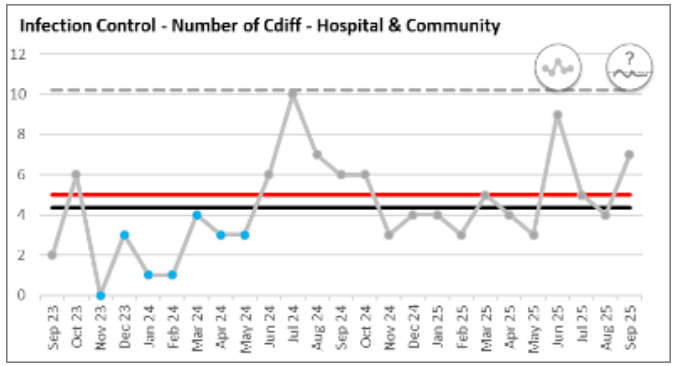
Trust	Sep-25	MRSA Cases YTD (M5)	Annual Threshold
SGUH	0	1	0

No MRSA bacteraemia reported in September, YTD 1, source line related.

Actions in place include:

- Refresher IV line training for staff including documentation.
- IV line spot checks by senior nursing team.
- Cannulation competency process to include sign-off by senior nurse/practice educator.

Three hospital-acquired MRSA colonisation cases were reported on Special Care Baby Unit; ribotyping is identical for 2 of the cases. No invasive infections. Suppression therapy started and weekly screening continues. Enhanced cleaning is in place, and the ward is under IPC Increased Surveillance. No further cases since 25/8/25.



SGUH - Summary & Actions

Healthcare Associated CDIs– Hospital & Community

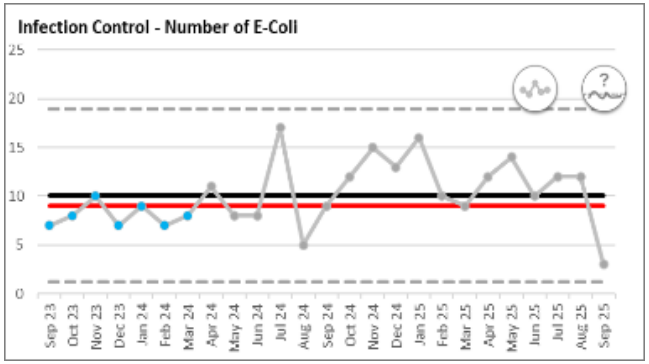
Trust	Sep-25	CDI Cases YTD (M5)	Annual Threshold
SGUH	7	32	43

In September 2025, 7 Cdiff incidents were reported with a YTD total of 32 against an annual threshold of 43.

Actions in place include:

An overarching group C diff action plan has been drafted, continuous reviews are underway, with specific training needs being identified and addressed.

Case reviews to identify outbreak themes/learning, IPC period of increased surveillance and audit for all HOHA cases, adjunct environmental cleaning with hydrogen peroxide vapor. Additional C. difficile education delivered across key forums and training groups.



SGUH - Summary & Actions

Healthcare Associated Ecoli Cases

Trust	Sep-25	Ecoli Cases YTD (M5)	Annual Threshold
SGUH	3	62	109

In September 2025, 3 Ecoli bloodstream infection incidents were reported with a YTD total of 62 against an annual threshold of 109 '

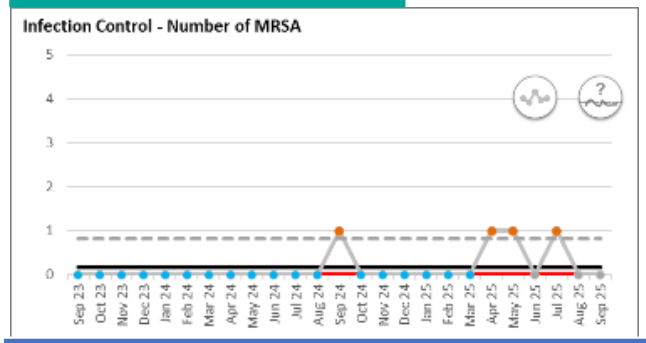
Actions in place:

- Ecoli Bloodstream Infection source surveillance and
- Urinary catheter training for Healthcare Assistants (HCAs)

Safe, High-Quality Care

Exception Report | ESTH - Infection Prevention and Control

Epsom & St Helier



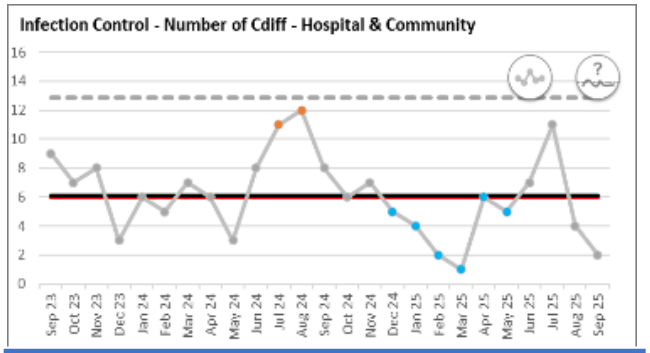
ESTH - Summary & Actions

Healthcare Associated MRSA Bacteraemia:

Trust	Sep25	MRSA Cases YTD (M6)	Annual Threshold
ESTH	0	3	0

MRSA: No incidents were reported in September, 3 YTD

Actions in place include
- Refresher IV line training for staff including documentation.
- Daily IV line spot checks by senior nursing team.
- Cannulation competency process to include sign-off by senior nurse/practice educator.



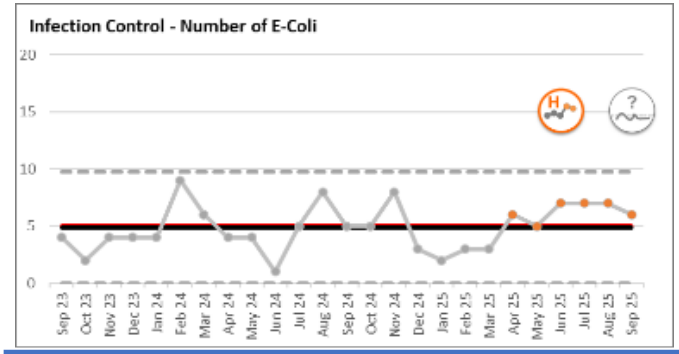
ESTH - Summary & Actions

Healthcare Associated CDIs:

Trust	Sep25	CDI Cases YTD (M5)	Annual Threshold
ESTH	3	36	63
IC	0	0	0

C. Difficile: 3 incidents reported in September.

Actions in place include:
- An overarching group C diff action plan drafted,
- Continuous reviews are underway, with specific training needs being identified and addressed.



ESTH - Summary & Actions

Healthcare Associated E. coli

Trust	Sep25	Ecoli Cases YTD (M5)	Annual Threshold
ESTH	6	37	57
IC	1	1	0

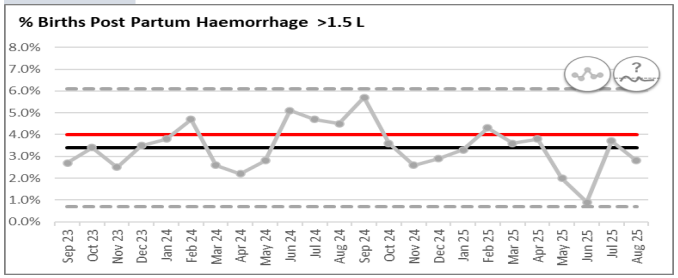
E.coli: 6 E. coli incidents report in September with a YTD total of 37 against an annual threshold of 57. Performance shows special cause variation of a concerning nature.
- Governance and leadership: Participate in sector wide approach involving SW London Integrated Care System.
- -Antibiotic/antimicrobial stewardship - Focused ward rounds in areas of non-compliance and areas with high consumption such as haematology unit
- -Urinary tract infection (UTI) and catheter-associated urinary tract infection (CAUTI) - Collaboration with the Trust Continence Lead Nurse and rolling out of urinary catheter passport and link with SW London digital passport group and ensure engagement with nursing/residential care facilities
- -Hydration - Work in collaboration with the Nutrition Nurse in improving patient hydration

Recovery - all already in place but needs continious monitoring. Catheter passport - looking into making it a digital on iClip - Dec 2025.

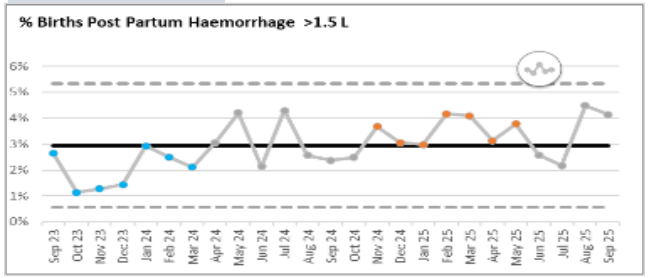
Safe, High-Quality Care

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

St George's



Epsom & St Helier

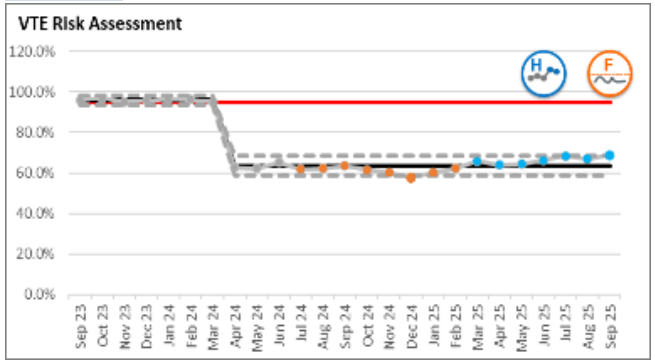


Site & Metric	Cause of variance/ non-compliance	Actions: Completed since last update, New, and Ongoing	Recovery Date	Data Quality
SGUH The percentage of births with Post Partum Haemorrhage >1.5L shows normal variation.	For the maternity metrics there are no national targets for outcomes (they were removed nationally years ago as they are largely outside the Trust control). In August 2025, the percentage of births with PPH >1.5L at SGUH was 2.8% — below the local target of 4%, and below the peer average of 3.2%. The data for September is currently under review due to data quality concerns and will be updated next month.	2024 data show that while established risks remain—such as SGUH's role as a placenta accreta spectrum referral centre and caesarean sections in patients with BMI ≥50—most PPH cases followed induced vaginal births, often linked to forceps deliveries and significant perineal trauma. SGUH received confirmation from the **National Maternity and Perinatal Audit (NMPA)** that, following review of the evidence submitted in response to the *alarm-level alert*, the Trust **will remain at alarm-level status**. Continuous monitoring of PPH >1.5L is ongoing to provide local and divisional assurance. **Actions and Interventions:** **-PPH Awareness Week (13/10/25):** Daily teaching sessions, Thromboelastography (TEG) training, simulations, and safety huddles. **-Resources:** Posters and "Five Facts" shared Trust-wide on 13/10/25. **-Escalation Tool:** Proforma developed to guide timely intervention and discussion. **-MDT Review:** Thematic analysis of all PPH cases in progress. **-Blood Transfusion Team:** Supporting blood-related simulation training. **-Deep Dive Audit:** Focus on induction of labour (IoL) and instrumental deliveries; action plan in place addressing identified themes.	There are early indicators these interventions are working but this will be reviewed regularly and reported over time.	Sufficient for assurance
ESTH In June 2025 performance changed from Special cause variation of a concerning nature, to normal variation	In recent months postpartum haemorrhage (PPH) rates have fluctuated, occasionally surpassing the peer average of 3.2%. A five-year retrospective audit revealed no major issues except the need to ensure consistent completion of PPH proformas.	• The rise was reviewed at the maternity risk meeting, with continued actions to maintain rates below 3%. • Preventive measures remain the priority, beginning in the antenatal period. • Staff are reminded to conduct risk assessments at booking, optimise haemoglobin (Hb) with oral iron, and administer parenteral iron at 34 weeks if levels remain low—an approach implemented promptly. • Active management of the third stage is encouraged, with tranexamic acid and carbetocin offered for operative births where appropriate. Measures and reminders have been communicated to anaesthetists and the Obstetrics and Gynaecology team.	N/A	Sufficient for assurance

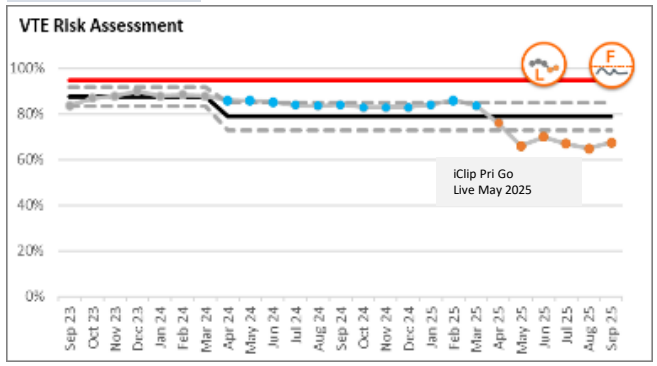
Safe, High-Quality Care

Exception Report | SGUH & ESTH VTE Risk Assessment

St George's



Epsom & St Helier

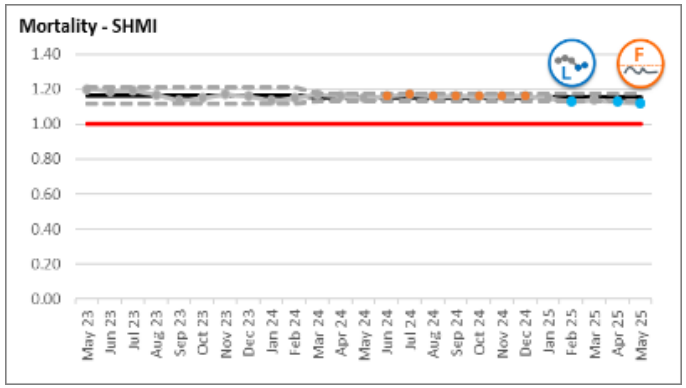


Site & Metric	Cause of variance/ non-compliance	Group Actions: Completed since last update, New, and Ongoing	Recovery Date	Data Quality
SGUH: VTE 68.8%. Not meeting target of 95%, improving trend	• In April 2024, the national definition for this metric changed to recommend VTE assessments be done within 14 hours of admission or deciding to admit. This cause a significant drop in performance. • VTE assessment alerts do not go off in the Emergency Department causing delays. Also in other areas, the alert system can sometimes be skipped incorrectly • The required on-line training (MAST) for doctors and scientists is not being fully completed. Other team members don't have to do this training yet	• Site Chief Medical Officers are leading improvement actions including a review of the reporting logic, which currently uses the Decision to Admit (DTA) time as the clock start for patients admitted via Emergency Departments. • VTE champions form a multiprofessional group to boost assessment compliance, aiming for a 5% increase by October 2025, with further gains by December. • A joint workshop with thrombosis leads and VTE champions from both trusts will be held within 3 months to assess challenges and align assessments before iClip updates. • Shared digital VTE risk assessment tool, rules and controls to be developed to improve compliance but current change freeze. • Improve MAT (Medication Administration Tool) compliance and targeted support for underperforming areas • gesh VTE policy to be developed • At ESTH, iClip Pro now includes VTE reminders, and a similar engagement model will be introduced under the CMO's guidance, with a later timeline due to iClip implementation. A new consultant thrombosis lead joined ESTH in September 2025 to drive these actions.	Trajectories under review for 2025/26	Sufficient for assurance

ESTH: VTE 67.6% Not meeting target of 95%	• The ESTH risk assessment data for ESTH has been significantly impacted by iClip Pro go-live:
	  ○ Maternity risk assessments do not match national guidance, Badgernet being used for post pregnant and birthing people, this data has not pulled through to PBI for August or September – The Business Intelligence Team (BI)I team aware and working to rectify
	  ○ Issues with incorrect coding of low-risk cohorts ongoing – meeting with BI team
	  ○ Patient tracker boards including VTE risk assessment completion not easily found on iClip Pro; VTE nurses working with services to support with re-imbedding this
			Trajectories under review for 2025/26	Not sufficient for assurance

Safe, High-Quality Care

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

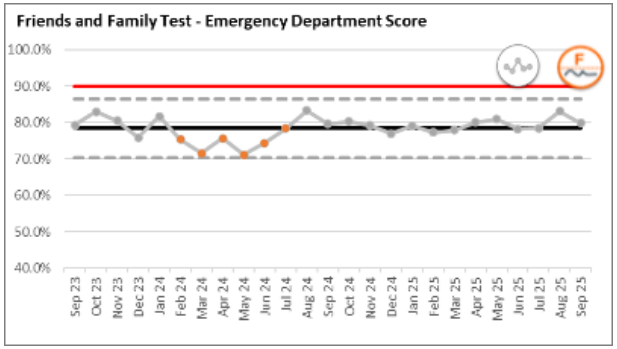


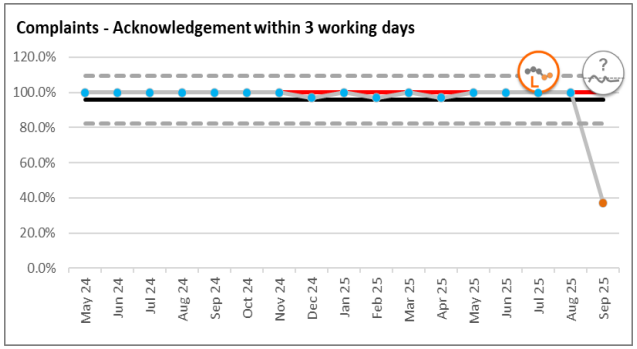
SHMI Source NHS Digital data based on rolling 12 months-June 2024 to May 25 reported in October 2025. There were 260 more deaths than expected

Site & Metric	Cause of variance/ non-compliance	Actions: Completed since last update, New, and Ongoing	Recovery Date	Data Quality
ESTH SHMI: Special cause improving variation and consistently above expected rate. However, ESTH is now within expected range.	In 2020, ESTH reclassified Same Day Emergency Care (SDEC) activity as non-inpatient. This reduced the total spell count used in the SHMI model, leading to a decrease in the expected number of deaths—a trend observed since the change. The latest SHMI for June 2024 to May 2025 is now within the expected range at 1.12, rather than above expected, based on the 95% confidence interval shown in the funnel plot. Other Trusts with SDEC services were initially expected to adopt the same reporting approach by July 2024. and the national data indicated that around half were yet to do so. NHSE extended the implementation deadline to July 2025. In recent week there has been a step change in the number of trust submitting SDEC via ECDS a total of 57 and counting.	Comprehensive deep dives and thematic analyses of outlying areas have been conducted, covering electrolyte imbalances, UTIs, COPD, and pneumonia. The findings did not indicate any quality concerns. An in-depth review of themes from Structured Judgement Reviews (SJRs) has highlighted areas for improvement. Any identified care concerns are reported and thoroughly investigated Clinical leads in Sepsis and the Deteriorating patient have been appointed to support improvement work. Plans are underway for the recruitment of additional staff to ensure 24/7 Critical Care Outreach on both sites. Collaboration between clinicians and coders will be highly beneficial in improving record accuracy. The implementation of iClip Pro is expected to lead to improvement in coding as experienced in other Trusts. Several enhanced monitoring workstreams are in place, including mortality reviews and medical examiner scrutiny.	Now within expected range, and closely monitored	Sufficient for assurance

Safe, High-Quality Care

Exception Report| SGUH Patient Experience (Satisfaction & Complaints)

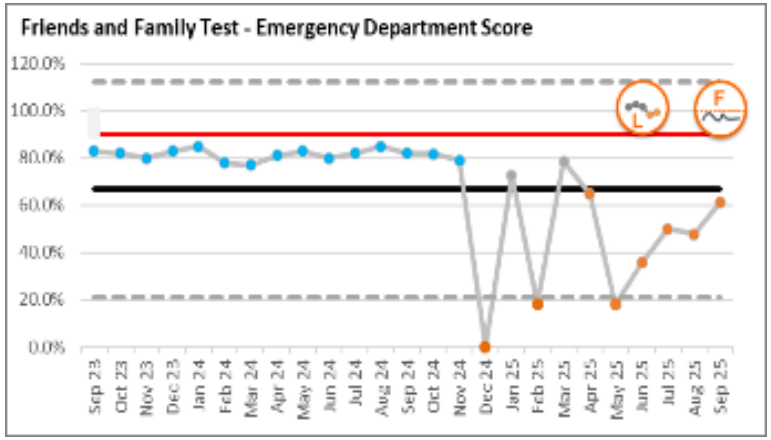




Site & Metric	Cause of variance/ non-compliance	Actions: Completed since last update, New, and Ongoing	Recovery Date	Data Quality
SGUH FFT ED Score	In September 2025, 80% of patients said they would recommend the department to friends and family. This is comparable to the most recent national data, which shows a national average of 80%. The ED FFT survey response rate remains significantly higher than the national average, with 1,054 patients participating in the survey in September 2025.	1. Review of patient feedback with the relevant leads to identify areas where improvement is required - ongoing 2. Corridor care checklist and intentional rounding – ongoing 3. Standardised documentation template for corridor care by Registered Nurses to ensure consistent records and risk assessments. All patients offered a comfort pack (eye mask, ear plugs) – ongoing 4. ED matron assurance checklist on RATE – completion for each area during Matron of the day rounds with focus on red crosses, enhanced care, safety checks, fire warden and quality/safety huddles - ongoing 5. Consultant Referral and Triage (RAT) rota ongoing. Rota amended so RAT shift is covered Mon-Fri 11:00-19:00 to give patients a more senior review sooner and redirect if necessary - ongoing 6. Patient Check-In (a digital check in tool) launched in January 2025 to make the checking in process more efficient 7. Same Day Emergency Care (SDEC) –10 new medical pathways launched to redirect patients appropriately. Surgical SDEC started in June, streaming patients to Nye Bevan Unit clinic – ongoing	Ongoing	sufficient for assurance
SGUH Complaints Acknowledgement within 3 working days	In September 2025, the complaints team experienced significant staffing issues which adversely impacted performance. The percentage of complaints acknowledged within 3 working days fell to 37% in September 2025 when previously it has met the target of 100%.	• Mitigation is in place to support the team and ensure cover for complaints whilst the sickness issues are worked through – which has had a positive impact with marked improvement in recent response rates. • SGUH Senior Nursing Team meeting with Group Complaints team weekly to ensure oversight and support for the team • An action plan is in place to support staffing shortfalls and ensure acknowledgement and response rates return to target.	October 2025	sufficient for assurance

Safe, High-Quality Care

Exception Report | ESTH - Patient Experience (Satisfaction)



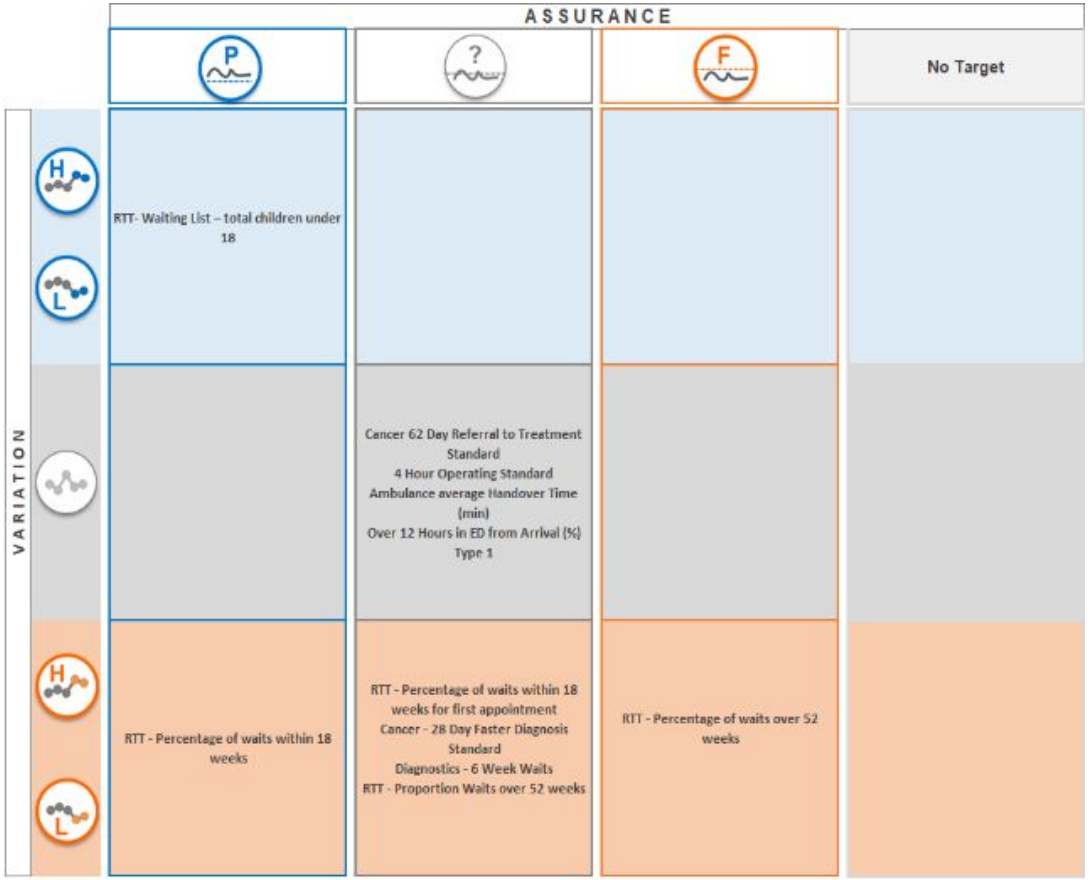
Site & Metric	Cause of variance/ non-compliance	Actions: Completed since last update, New, and Ongoing	Recovery Date	Data Quality
ESTH FFT ED Score Special cause variation of a concerning nature Consistently failing target	The FFT contract at ESTH has concluded and transitioned to Gather, where the survey is accessible via posters, reaching a limited audience. Information governance approval has now been received to send the survey to patients through text messaging, securing access to a text messaging service via procurement is now in progress. External data reporting continues but is not directly comparable to previous months and shows some variations, particularly in services where surveys are conducted via text.	• Improve Response rates across both hospital sites • Data Protection Impact Assessment (DPIA) approval received- progress to seeking suitable text messaging services via procurement has progressed and the BI team at ESTH are supporting re-developing this function to support the reinstatement of this function. • Analyse the themes and trends of patients who provide negative feedback. • Proposals to involve volunteers in the Emergency Department for feedback collection, including FFT, have been put forward; however, recruitment has not yielded results to date. • The Medicine Division is committed to enhancing patient experience during periods of heightened emergency care demand by increasing staffing levels and optimising patient flow to expand inpatient capacity.	Dec 2025 (response rate). Recovery date for scores under review.	Not sufficient for assurance

Section 2.1:
Operational Performance

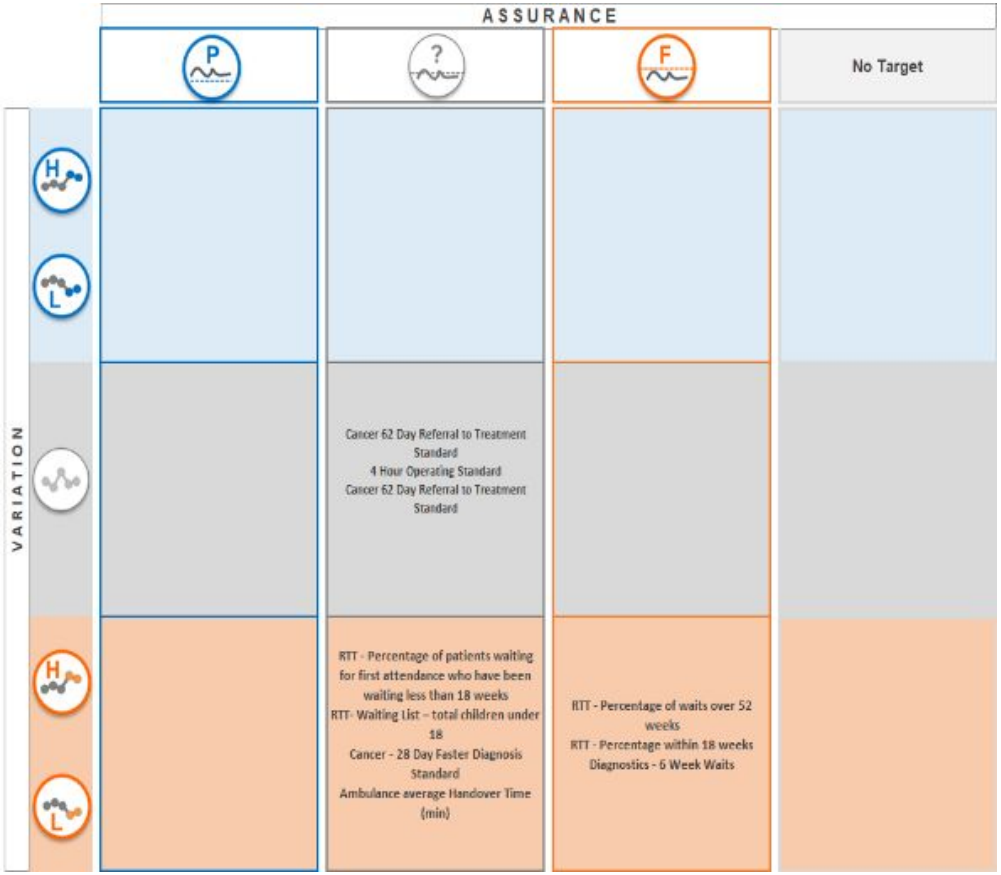
Section 2.1 Operational Performance

Matrix Summary

SGUH Operational Performance



ESTH Operational Performance



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Operational Performance

Overview Dashboard

KPI	St George's Latest month	St George's Previous Month Measure	St George's Latest Month Measure	St George's Target	St George's Variation	St George's Assurance	St George's Benchmark	Epsom & St Helier Latest month	Epsom & St Helier Previous Month Measure	Epsom & St Helier Latest Month Measure	Epsom & St Helier Target	Epsom & St Helier Variation	Epsom & St Helier Assurance	Epsom & St Helier Benchmark
RTT - Percentage of waits over 52 weeks	Aug 25	2.47%	2.54%	1.60%			3rd Quartile	Aug 25	1.8%	1.8%	1.0%			2nd Quartile
RTT - Percentage of waits within 18 weeks	Aug 25	61.2%	60.5%	60.0%			2nd Quartile	Aug 25	64.6%	63.7%	70.4%			2nd Quartile
RTT - Percentage of waits within 18 weeks for first appointment	Aug 25	65.2%	64.7%	66.6%			3rd Quartile	Aug 25	78.2%	77.0%	81.3%			2nd Quartile
RTT- Waiting List – total children under 18	Aug 25	6679	6562	7715			-	Aug 25	7175	7239	6449			-
Cancer - 28 Day Faster Diagnosis Standard	Aug 25	70.8%	64.4%	82.7%			2nd Quartile	Aug 25	77.5%	62.3%	86.8%			2nd Quartile
Cancer 62 Day Referral to Treatment Standard	Aug 25	77.3%	69.8%	85.0%			Top Quartile	Aug 25	83.3%	81.8%	86.6%			Top Quartile
Diagnostics - 6 Week Waits	Aug 25	4.3%	10.6%	5.0%			2nd Quartile	Aug 25	14.7%	14.4%	5.0%			2nd Quartile
4 Hour Operating Standard	Sep 25	78.3%	78.1%	78.0%			Top Quartile	Sep 25	75.9%	74.1%	78.0%			3rd Quartile
Over 12 Hours in ED from Arrival (%) Type 1	Sep 25	12.6%	10.4%	13.0%			3rd Quartile	Sep 25	11.9%	12.9%	13.5%			3rd Quartile
Ambulance average Handover Time (min)	Sep 25	00:24:52	00:22:46	00:24:00			TBC	Sep 25	00:24:02	00:24:31	00:22:00			TBC

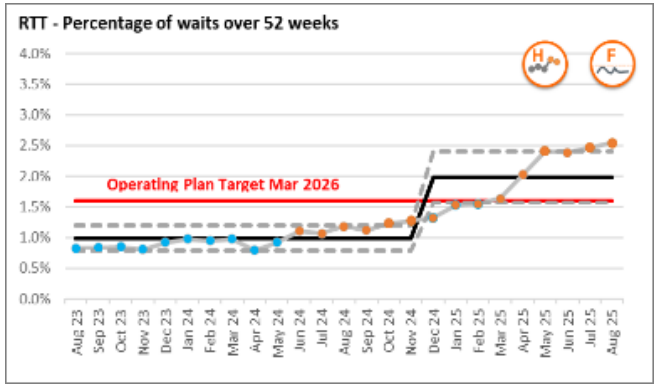
Targets based on Operating Plan end of year March 2026 position (trajectories in place)

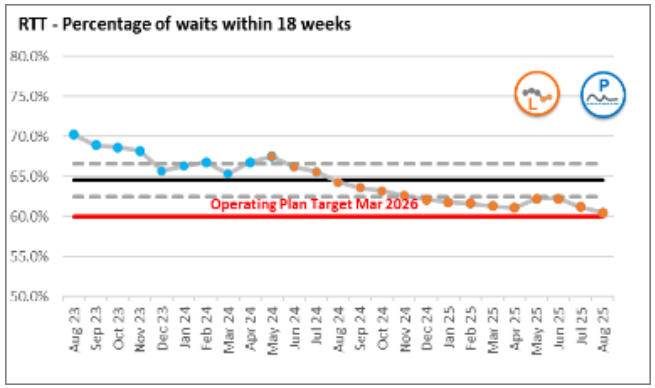
Operational Performance

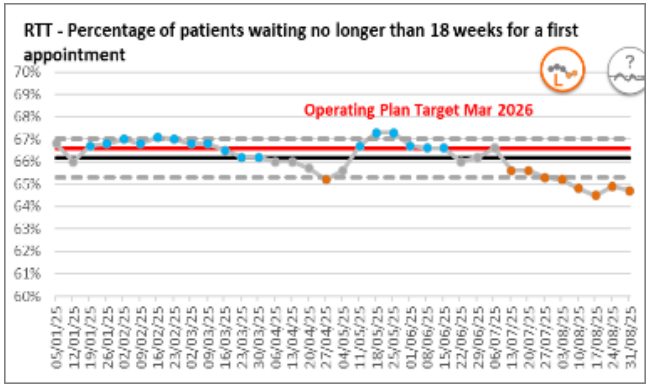
Overview Dashboard

KPI	Sutton Healthcare						Surrey Downs					
	Latest month	Previous month measure	Latest month measure	Target	Variation	Assurance	Latest month	Previous month measure	Latest month measure	Target	Variation	Assurance
Two hour UCR performance	Sep 25	68.7%	72.8%	70.0%			Sep 25	85.0%	88.1%	70.0%		
Virtual ward - Bed Occupancy	Sep 25	89.4%	88.2%	85.0%			Sep 25	96.2%	90.6%	80.0%		
Total Waiting List Size Adult	Sep 25	2110	2137	-			Sep 25	5568	5545	-		
Total Waiting List Size Adult >52wks	Sep 25	0	4	-			Sep 25	0	0	-		
Percentage of waits Adults >52wks	Sep 25	0.0%	0.2%	-			Sep 25	0.0%	0.0%	-		
Total Waiting List Size Children	Sep 25	1006	1064	-								
Total Waiting List Size Children >52wks	Sep 25	7	0	-								
Percentage of waits Children >52wks	Sep 25	0.7%	0.0%	-								

Operational Performance
Exception Report| SGUH Referral to Treatment RTT (Page 1 of 2)







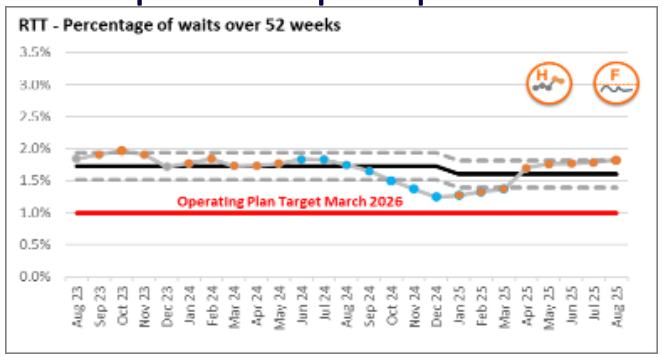
Site & Metric	Cause of variance/ non-compliance	Actions: Completed since last update, New, and Ongoing	Recovery Date	Data Quality
SGUH % waits over 52 weeks – Not meeting plan % within 18 weeks – meeting plan decreasing trend % wait for first attendance – below plan	At the end of August 2025; Proportion of 52-week waits – Of the total PTL size, 2.54% of patients have been waiting over 52 weeks, 1,812 patients. Compared to the previous month, the PTL size has decreased by 0.7%. Long waits are primarily driven by Neurosurgery (outpatients), General Surgery (bariatrics and upper GI) and Gynaecology. A high volume of out-of-area referrals have contributed to the long wait position. As well as referrals for specialist weight management. For which, we are not currently commissioned to provide	**"Super September"** – introduced to target long waiting patients on the PTL through an enhanced clinical and administrative validation (including text comms to all patients), review of current booking profile to ensure the right patients are booked into the right clinics at the right time and finally, ensuring that all patients waiting over weeks for a first appointment are all booked, in chronological order Neurosurgery have been tasked with ensuring all outpatients are booked chronologically. This being the main cause for long waits in the specialty. General Surgery – booking all outpatient bariatric patients for their first appointment. Refining DoS criteria so that demand is managed appropriately moving forward. Also, looking to stand up more lists at acute site to support upper GI demand. Gynae – Daily PTL meetings being held by DDO to support rapid recovery of wait times. Additional cases being put on theatre lists where appropriate and a review of the DoS to ensure service has consistent acceptance criteria when triaging elective referrals. As a way of managing demand.	Oct 2025 Oct 2025 Dec 2025 Dec-2025	sufficient for assurance

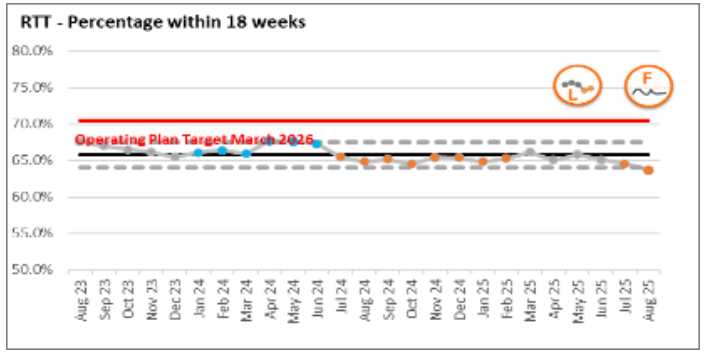
Operational Performance
Exception Report| SGUH Referral to Treatment RTT (Page 2 of 2)

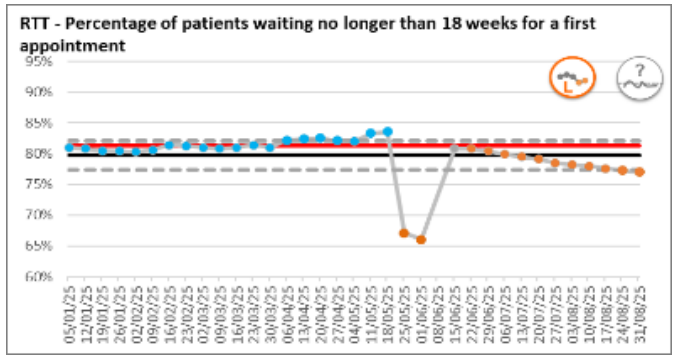
Site & Metric	Cause of variance/ non-compliance	Actions: Completed since last update, New, and Ongoing	Recovery Date	Data Quality
SGUH % waits over 52 weeks – Not meeting plan % within 18 weeks – meeting plan decreasing trend % wait for first attendance – below plan	Performance against the 18-week standard was 60.05% in August 2025, patients waiting >18 weeks has increased by 1% however seeing a slower growth rate compared to previous month. 60% is in line with the board signed off plan for 2025 / 26.	RTT Performance will be compromised by a reduction in overall PTL size. As the denominator reduces, the performance percentage will also drop. The key areas impacting overall RTT performance are our highest volume specialties (Neurosurgery - 48%, Gynaecology - 51%, ENT - 63%, Cardiology - 63% and Dermatology - 66%). Neurosurgery: Plan in place to reschedule patients in clinical and chronological order to reduce long waits. Additional clinics being put on in October to support long wait reduction and RTT performance improvement Gynae: DDO oversight of long wait patient management and review of service provision to ensure capacity is aligned with demand. Dermatology: Highest volume specialty impacted by an increase in cancer and urgent demand. Exploring AI service model options to help with RTT performance	Nov-2025	sufficient for assurance

Operational Performance

Exception Report| ESTH Referral to Treatment RTT





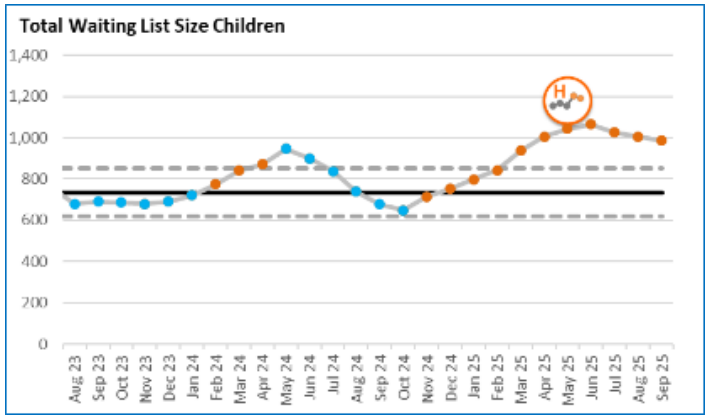


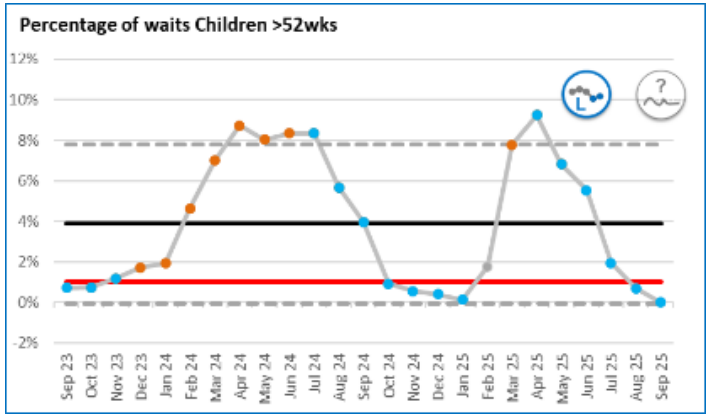
Site & Metric	Cause of variance/ non-compliance	Actions: Completed since last update, New, and Ongoing	Recovery Date	Data Quality
ESTH Proportion of waits over 52 weeks – above monthly trajectory of 1.31% Percentage within 18 weeks – below monthly trajectory of 65.43% Percentage waits for first appointment under 18 weeks – below monthly trajectory of 81.30%	• 52WW did not achieve the ambition of being below 1.31% in August 2025, with a performance of 1.83%. 52WW increased from 1039 (July 2025) to 1091 (August 2025). The highest volumes were in Dermatology (365), Gynaecology (122), T&O (98). • 65WW reduced slightly from 133 in July 2025 to 124 in August 2025. • The RTT PTL increased again from 58191 in July 2025 to 59726 in August 2025. • Percentage waits for first appointment under 18 weeks was below plan in August 2025 with a performance of 77.0%.	Total PTL -ESTH's PTL increased slightly in August, mainly due to the Electronic Patient Record (EPR) implementation. Reduced activity was needed to safely introduce the new system, and as with any major change, task times increased temporarily. Urgent and cancer pathways were prioritised to protect patient safety. Delays in outcome data recording and ongoing training issues, common in EPR rollouts, also contributed. Some patients remain on the PTL despite completed pathways, teams are working to resolve on iCLIP. However, the PTL is showing signs of stabilising in September 2025. Long Waiters -52WW - Recovery plans remain in place and ongoing for the most challenged specialties. • Dermatology: Long waits in this service stem from reduced activity following EPR implementation, cancer demand pressures, and delays from the Virtual Lucy platform. Team is developing a recovery plan for RTT and cancer, with additional capacity secured via Medinet until the end of November. While focused on cancer waits, this will also support RTT. A teledermatology pilot is planned to start in November to improve TWR and expand routine capacity. Exploring skin analytics and another Virtual Lucy exercise to further support. • Gynaecology: Extended waiting times are mainly due to limited theatre and clinic capacity for joint cases, fertility, and endometriosis patients. From 1 October 2025, a dedicated Endometriosis Consultant has joined the team, which will help increase capacity. In addition, plans are underway to triple the number of joint case lists with Colorectal between July 2025 and January 2026, further improving access for these patients. • T&O: Late referrals remain a challenge. Consultants agreed one outpatient overbooking to reduce waits. Flexi theatre lists supported with partners; SWLEOC starting five straightforward cases, with plans to expand. Most 52-week waits are Hands (ESTH) under one consultant. Their new appointments will pause from November for three months to reduce the admitted backlog. ESTH also faces theatre pressures due to loss of QMH capacity.	25/26 trajectories expected to be achieved by March 2026	August 2025 data sufficient for assurance

Operational Performance

Exception Report| **Community Services Waiting Times (Children)**

Sutton Healthcare

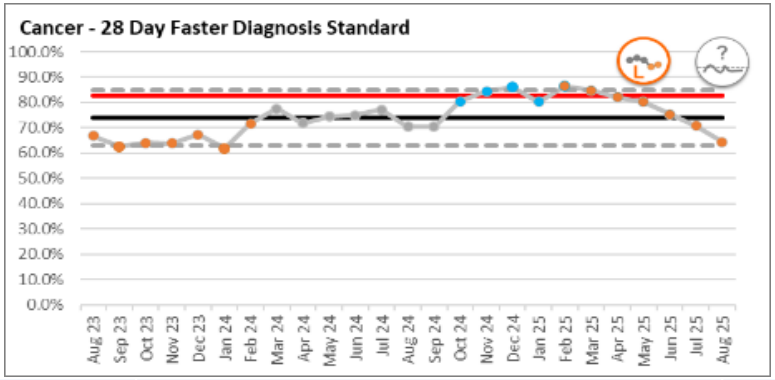


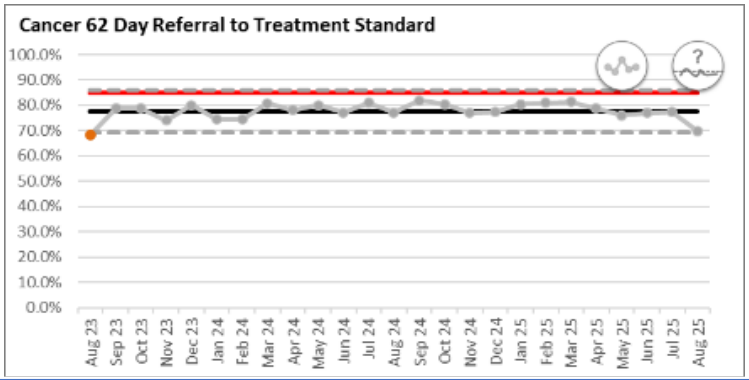


Site & Metric	Cause of variance/ non-compliance	Actions: Completed since last update, New, and Ongoing	Recovery Date	Data Quality
Sutton Health & Care % of waits over 52 weeks	Continued progress has been achieved in addressing long waits for the Children's Speech and Language Therapy (SALT) Service, with the number of patients waiting over 52 weeks successfully reduced to zero as of the end of September 2025. Overall waiting list size for children's services remains high with a consolidated action plan is in development across SWL, in conjunction with ICB commissioners.	• In April 2025, PLACE via Sutton Alliance endorsed actions to strengthen external oversight of children's therapy services, aiming to maximise efficiency, productivity, and embed best practice. SHC has since engaged with Cognus and other children's community providers across SWL to enhance collaboration and share learning. A consolidated action plan is in development in conjunction with ICB commissioners. • SHC undertake continued review of harms with Integrated Care Chief Nursing Officer. • Education, Health and Care Plans (EHCP) targets remain on track.	TBC	Sufficient for assurance

Operational Performance

Exception Report| SGUH 28 day and 62 day Cancer Performance

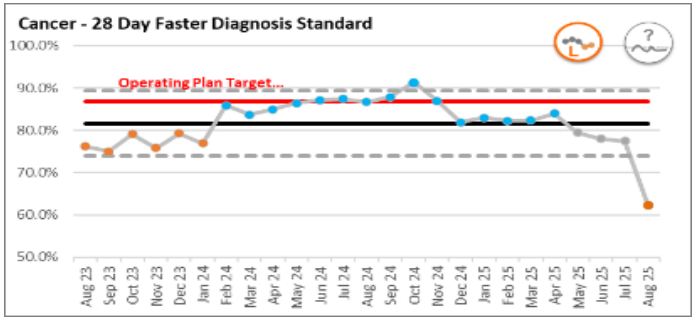




Site & Metric	Cause of variance/ non-compliance	Actions: Completed since last update, New, and Ongoing	Recovery Date	Data Quality
SGUH 28 Day – below target of 77% trajectory of 80.88% 62 Day Normal variation below trajectory of 80.11%	**28-Day Standard:** **Overall: 64.5% (vs target 77%) – August 25** **Key Drivers:** •**Skin: 39.6% –** Seasonal referrals up 30% compared to Aug 2024, peaking at 800 referrals; 31% booked past day 21. •**Gynae: 58.3% –** Limited access to one-stop hysteroscopy/scan; 29% waiting >21 days. •**Lower GI: 76.1% –** Improved from previous months. **62-Day Standard:** **Overall: 69.8% (vs plan 80.0%) – Decline in performance from the previous month.** **Theatre Access:** Lung 57.6, Urology 76.1%, Head & Neck 48.6%. **Diagnostics & Complex Pathways:** LGI 73.1%, UGI 72.2%. **Breast: 58.5% –** Workforce gaps and front-end delays. **Thoracic:** Ongoing capacity issues with robotics lists; next availability Jan 2026 for some clinicians.	**Dermatology** •**Short-Term:** Additional 32 slots identified each week. •Monitoring of clinic letters to ensure benign FDS diagnoses communicated within 5 working days. Recovery expected by Jan 2026, contingent on seasonal reduction in referrals and clearing backlog of c. 400 patients. •**Long-Term:** Locum consultant starts Jan 2026 (1 PA clinic in revised job plan); 12-month locum business case in progress. •**Innovation:** 2-month pilot removing age 70 cap to maximize Telederm capacity. •Trial NICE-approved Skin Analytics AI tool for 6 months (projected 30% referral reduction). **Gynaecology** •Implement cervicovaginal swab for abnormal bleeding triage (pre/post-menopausal) under Alliance-led project by **Nov 2025**; expected to reduce hysteroscopies by >90% while maintaining cancer detection rates. This should liberate 20 hysteroscopy slots each week. **Governance & Oversight** •Weekly Tier 1 meetings for cross-divisional assurance and management of diagnostics and treatments pathways. •PTL management: •Daily review of all patients on FDS pathway at day 21 to ensure actions in place to achieve clock stop by day 28. •Weekly review of all patients with a DTT and a breach date within the next 14 days •Weekly review of >104-day patients to expedite diagnostics/treatment.	Jan 2026	Sufficient for assurance

Operational Performance

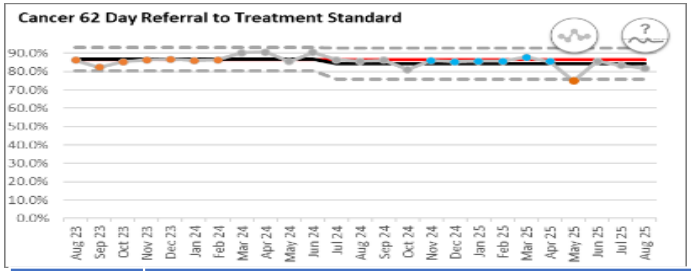
Exception Report| ESTH 28 day Cancer Performance



Site & Metric	Cause of variance/ non-compliance	Actions: Completed since last update, New, and Ongoing	Next steps/Actions	Recovery Date	Data Quality
28 Day Faster Diagnosis – Below trajectory of 86.9%	**FDS 28-day Standard performance was 62.3 % in August 2025, below the 77% national target.** Driven by challenges in three main specialties: **Dermatology (2.3%):** • Limited 1st outpatient capacity. • Long-term consultant sickness and unfilled vacancy. • Increased GP and Consultant Upgrade referral volumes. **Gynaecology (49.8%):** • Restricted outpatient and general anaesthetic (GA) diagnostic capacity. • Impact significantly worsened by Clinical staff annual leave. **Lower GI (60.9%):** • Complex caseload (elderly/incapacitated patients) requiring F2F review and radiological triage before Endoscopy. • Endoscopy bottlenecks due to deep sedation requirements and dependence on consultant-led lists.	**Dermatology:** • All routine OPA capacity converted to cancer OPA. • One long-term sickness returned; another due back mid-January. • Vacancy recruited, start in January. • Insourcing company managing routine patients. • RMP funding offered to support ad hoc capacity. • Daily huddles with Dermatology Management, Recovery Director and Cancer GM. **Gynaecology** Significant reduction in ASIs and escalation numbers. • Increased 1st OPA capacity via ad hoc clinics. • MDTM patient stratification reduced joint clinic pressure. • Deep sedation hysteroscopy lists created. **Lower GI:** • Planned Care F2F and virtual OPA capacity review for cancer recovery. • Endoscopy Deep Sedation Anaesthesia Lists mitigated via Saturday lists using RMP funding. • Endoscopy booking turnaround times are gradually improving.	• Teledermatology rollout in progress. • Continue escalation and monitoring at senior level. • Maintain improved performance. • Ongoing monitoring to ensure sustainability of new model. • Continue monitoring Endoscopy performance over coming weeks. • Assess sustainability of current improvement.	December 2025 as Derm team are balancing cancer recovery and 65 wk+ RTT recovery.	Sufficient for assurance .

Operational Performance

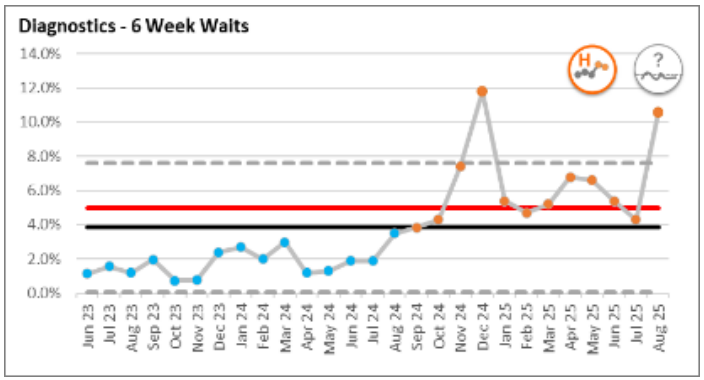
Exception Report| ESTH 62 day Cancer Performance



Site & Metric	Cause of variance/ non-compliance	Actions: Completed since last update, New, and Ongoing	Recovery Date/Status	Data Quality
62 Day Standard - Below trajectory of 86.21%	**Cancer 62-day Standard performance was 81.8% in August 2025, below the 85% national target** Low performing tumour sites were : **Lower GI (83.3%)** • Delays linked to vulnerable patients (age, co-morbidities). • Need for face-to-face OPAs, carer support, and best interest meetings. • Preference for radiological diagnostics (CT Colon) over Endoscopy creating pathway delays. • Theatre capacity issues for complex patients requiring two surgeons. **Lung (42.9%)** • Only one SWL hospital provides Navigational Bronchoscopy (3–4 week wait). • PET scan booking and reporting delays also contributing to poor performance. **Upper GI (61.5%)** • Persistent Endoscopic Ultrasound (EUS) delays impacting overall pathway timelines. **Gynaecology (84.6%)** • Theatre capacity limitations adding to pathway delays, in addition to previously noted outpatient and diagnostic challenges. **Head & Neck (60.0%)** • Complex pathways despite good performance on TAC and FNA OPA turnaround. • Treatment capacity concerns at St George's raised by H&N Cancer Lead.	**Lower GI:** •Additional AMP position recruited and undergoing training to assist with elderly and vulnerable patients. •Highlight patients for clinical review during PTL meetings to speed the pathway up. •Planned Care team to review colorectal surgical capacity. **Lung:** • Diagnostic delays persist (navigational bronchoscopy). • RMP exploring private sector support for above. • RMH PET scan delays improved (new scanner, additional radiologists). • Some capacity issues in F2F OPA, bronchoscopy, and lung function tests. **Upper GI:** • 6-week wait for EUS at Royal Marsden. • Business Case (BC) submitted to SWL to bring EUS in-house. • BC Proposal would enable ESTH to support sister hospitals and accelerate diagnosis of complex cancers (e.g. pancreatic, hepatobiliary). • Working group formed to review breach reports and streamline pathways. **Gynaecology:** • High-level meetings between senior managers & clinical leads yielded strong results. • 50% of endometriosis consultant operating capacity ring-fenced for cancer patients. **Head & Neck:** St George's Theatre Robot issue affecting capacity for shared treatments between ESTH & St George's.	• Training finish date TBC. • Continue collaboration with RMP on diagnostic pathway support. • Monitor improvement following bronchoscopy capacity expansion. • Service to review capacity issues. • Await decision on business case (update expected in next IQPR). • Continue engagement with Planned Care GM to model impact. • Maintain improved performance. • Ongoing monitoring to ensure sustainability of new model. • Escalated through joint patient PTL weekly call to St George's.	Sufficient for assurance

Operational Performance

Exception Report| SGH Diagnostic Performance

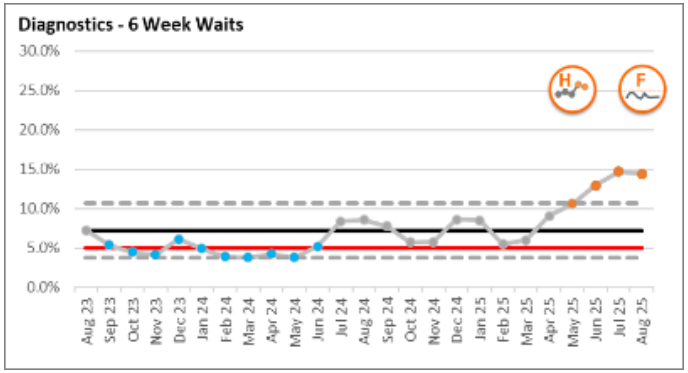


Modality	6 Week Breach	>6 Week Performance
Non-obstetric ultrasound	651	10.0%
Gastroscopy	226	34.5%
Magnetic Resonance Imaging	205	12.3%
Colonoscopy	128	38.0%
Flexi Sigmoidoscopy	60	35.7%
Cystoscopy	19	22.1%
Urodynamics - pressures & flows	16	17.4%
Cardiology - echocardiography	14	1.2%
Computed Tomography	0	0.0%
DEXA Scan	0	0.0%
Neurophysiology - peripheral neurophysiology	0	0.0%
Respiratory physiology - sleep studies	0	0.0%

Site & Metric	Cause of variance/ non-compliance	Actions: Completed since last update, New, and Ongoing	Recovery Date	Data Quality
SGH 6Wk waits 10.6% not meeting national interim target of 5%	At the end of August 2025, 10.6% of the diagnostic waiting list were waiting over six weeks for tests compared to 4.3% at the end of July 2025. The increase was significantly impacted by unplanned long and short-term sickness within Imaging (admin and sonographers) . A high number of Cardiac MRI appointments have been cancelled due to breakdown of machine due to ongoing works around it and ability to re-book has been challenging leading to longer waits Endoscopy waits continue to be challenged however continued focus on validation of waiting list and additional capacity coming on line, improvements have already been seen through September 2025.	Ultrasound • Opened additional radiologist lists (no uptake from sonographers) • Sent patient confirmation texts; very few cancellations received • Reallocated radiologist activity (reporting to scanning, paeds to adults) Cardiac MRI • Re-vetting all referrals to check that they are still required • Utilising weekend sessions on the 1.5T MRI scanner to support 3T backlog due to breakages • Planning to move to a 1.5T scanner permanently which should increase the reliability of scans and prevent cancellations and rescans Endoscopy • Optimize the referral process and maximizing efficiency. • Reminder calls - This proactive measure aims to decrease missed appointments. • Hybrid mail and SMS aiming to improve patient communication • Approval to open Room 6 for x 4 days per week, increasing points on all lists across 3 sites	TBC TBC TBC	Sufficient for assurance

Operational Performance

Exception Report| ESTH Diagnostic Performance

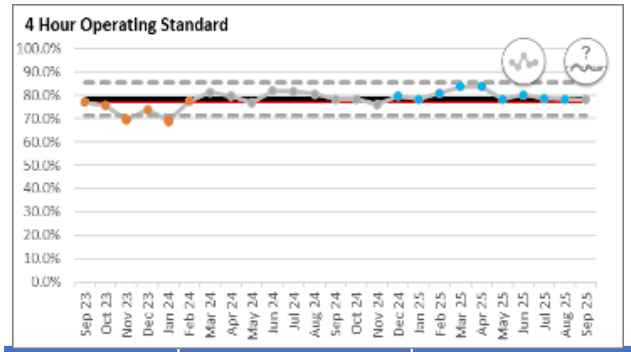


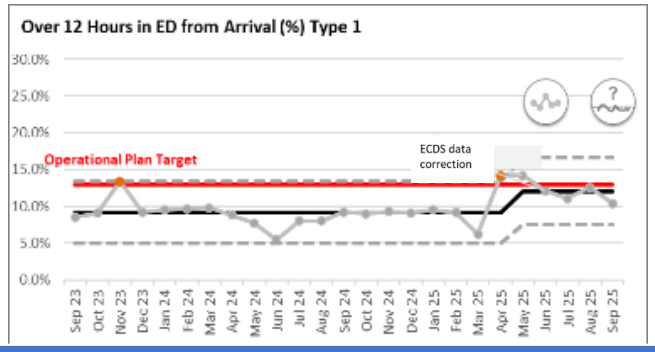
Modality	6 Week Breach	>6 Week Performan
Colonoscopy	474	55.2%
Cardiology - echocardiography	424	35.8%
Gastroscopy	318	46.1%
Audiology - Audiology Assessments	197	22.8%
Cystoscopy	132	29.1%
Non-obstetric ultrasound	129	2.0%
Flexi sigmoidoscopy	121	48.8%
Urodynamics - pressures & flows	88	61.1%
Computed Tomography	9	1.5%
Magnetic Resonance Imaging	7	0.7%
DEXA Scan	2	0.5%
Neurophysiology - peripheral neurophysiology	0	0.0%

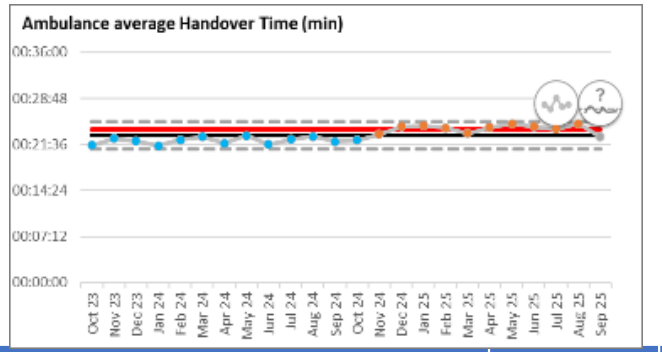
Site & Metric	Cause of variance/ non-compliance	Actions: Completed since last update, New, and Ongoing	Recovery Date	Data Quality
ESTH 6Wk waits 14.4% not meeting national interim target of 5%	At the end of August 2025 there were 1901 patients waiting more than 6 weeks for their diagnostic (DM01), down from 2152 in July 2025. As a result, the performance improved slightly from 85.32% in July 2025 to 85.58% in August 2025, still below the national interim target of 95%. The modalities with the highest volumes waiting >6 weeks at the end of August 2025 were Endoscopy (913), ECHO (424) & Audiology (197). Imaging modalities remain above 95%.	• **ENDOSCOPY:** An Endoscopy recovery plan aims to tackle the backlog caused by reduced activity during the iClip Pro launch and data issues from a new booking system. It proposes continuing Saturday Waiting List Initiative sessions at Epsom and St Helier by aligning nursing pay with St George's for 12 weeks. This is expected to deliver 270 extra procedures, cut the 6-week-plus backlog by 41%, and support cancer and RTT targets. This proposal is currently awaiting approval. • **ECHOs:** The number of breaches increased to 424 at the end of August 2025. Ongoing challenges include the new EPR system and reduced echocardiography capacity due to funding and recruitment constraints. Mitigation measures were presented to Exec Tri week commencing 6th October 2025 to improve the DM01 position, but outcomes are yet to be confirmed as of 8th October 2025. • **AUDIOLOGY:** The audiology service has faced challenges following the recent inclusion of paediatric audiology in the reporting matrix, combined with reduced activity after the iClip implementation. A recovery plan has been developed, though progress is limited as it does not rely on additional sessions. The department is also under staffing pressure due to recent long-term sickness and difficulties in recruiting experienced staff. However, three new appointments have been made. While it will take some time for them to start and become fully effective, the department anticipates seeing a positive impact within the next three months.	March 2026	August 2025 data still includes a degree of DQ following EPR implementation that continues to be worked through with BI and operational teams

Operational Performance

Exception Report| SGUH A&E Waits and Ambulance Handovers



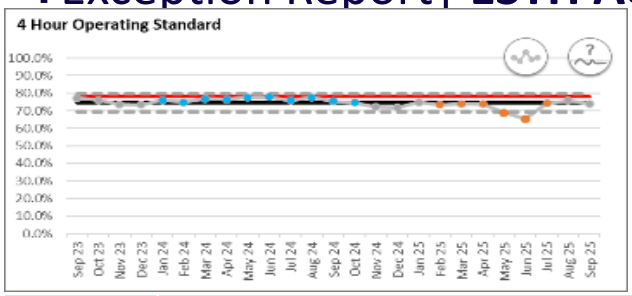


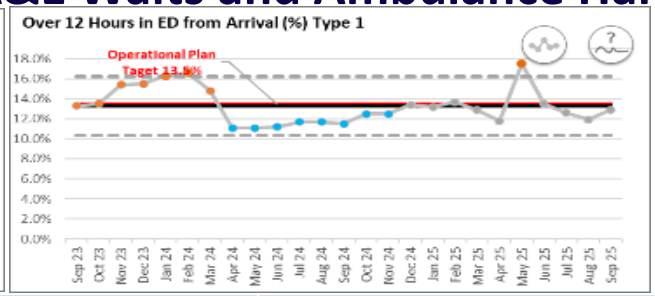


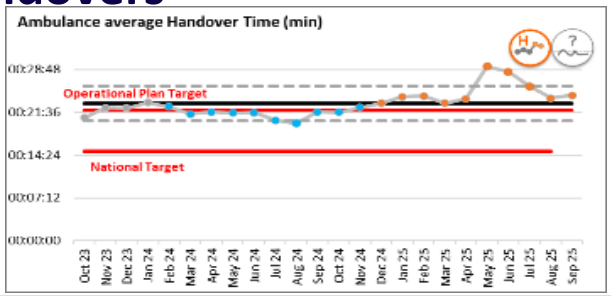
Site & Metric	Cause of variance/ non-compliance	Actions: Completed since last update, New, and Ongoing	Recovery Date	Data Quality
SGUH 4 Hour Target met in September 2025 12 Hour waits Type 1 – normal variance meeting plan Ambulance Handover – normal variation in line with plan	Achieved 78.1% 4hr performance in September 2025, meeting 78% national target. High volume of mental health patients attending ED, with long waits for mental health beds .	• Dedicated Treatment pod for faster delivery of IVs and dedicated investigation cubicle. • Maintaining in-and-out spaces to aid flow. • Further development of SDEC inclusion criteria, increase in surgical SDC capacity delivered with more planned. • Direct access to Paediatric clinics for UTC plastic patients. • Monthly meetings with London Ambulance Service (LAS) to resolve issues between both Trust and LAS. • Planned Frailty Same Day Emergency Care (SDEC) launched beginning of July – average 4 patients per day: 79% of patients discharged, 21% patients admitted with average LOS 2.5 days • Launch of Patient Check In has reduced average time in streaming queue from 28 mins to 8. • Long waiting patients in ED are continually monitored through their stay. Tests / diagnostics required for their onward treatment are requested while a ward-based bed is sought • Pharmacy first launched 14/07 – increased redirection x5 to local pharmacies. Next step: electronic referrals to allow additional 30 conditions to be managed in community – working with IT colleagues to implement via EMIS • Change of assessment / triage model to allow greater resources at the front door. This will give an additional streamer and have RAT consultant at ambulance triage to support timely handover and redirection – started 18/08 • Consultation of EP shift patterns / rota to allow additional streamer Mon-Wed – started 06/10 • Appointment bookings for local GPs from streaming – started 06/10 • Reviewing medical rota to allow ACPs and PAs to support streaming – started 13/10 • SWL ICC is going live in September 2025 with an aim to reduce the number of ambulances dispatched to Cat 2 patients, with advice and alternative pathways provided to crews to prevent conveyances • ‘Perfect Week’ medical SDEC w/c 20/10	4hr Performance currently being delivered 12hr performance meeting plan 15 min LAS handover by April 202	Sufficient for assurance Sufficient for assurance (data source NHSE ECDS Extract) Sufficient for assurance (NHSE Ambulance data)

Operational Performance

Exception Report| ESTH A&E Waits and Ambulance Handovers



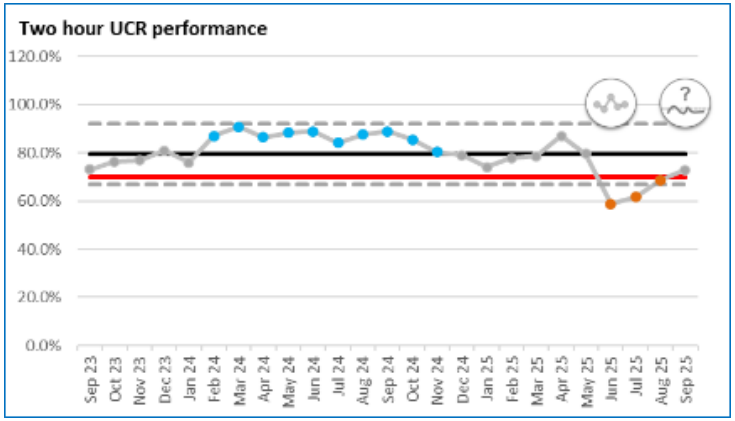


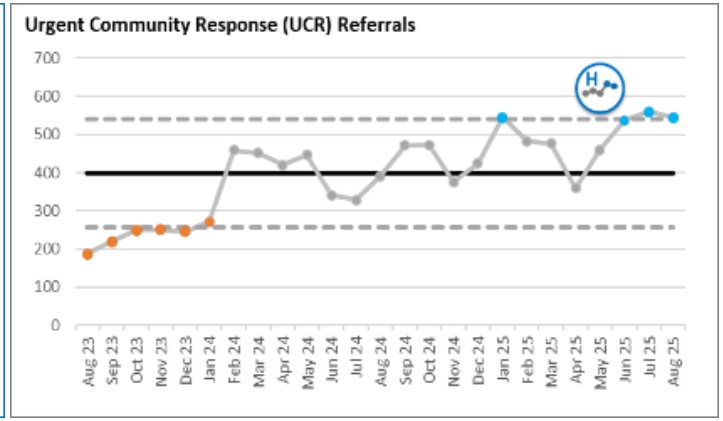


Site & Metric	Cause of variance/ non-compliance	Actions: Completed since last update, New, and Ongoing	Recovery Date	Data Quality
ESTH 4 Hr performance below trajectory of 76.5% ED Type 1 LOS>12 Hours - Meeting plan normal variation LAS Average Handover Time – Increasing Trend	ESTH delivered 74.1% 4-hour ED performance in September against an agreed trajectory of 76% performance. Failure to meet our ED performance trajectory is largely driven by adult attendances who require admission to an inpatient bed, with adult admitted ED performance of 27.7% compared to 81.2% for adult non-admitted patients. Paediatric ED performance is consistently meeting the monthly ED standard reporting 76.9% in September 2025. Our 4-hour ED trajectory for October 2025 is 75.5%, November 74%, and December 74%, increasing to 75.5% in January, 76% in February, and 78% in March. We are moving at pace to stabilise ED performance to support meeting performance outlined in the operating plan. 12 hour wait times increased in the month of September to 12.9% from 11.9% in August 2025, above the agreed trajectory of 10.8%. Bed availability and the ability to ensure timely admission to an inpatient bed is impacting 12-hour performance across both hospital sites High numbers of mental health patients requiring admission to an inpatient bed with many of these patients waiting a significant period in the department prior to transfer. Average ambulance handover times remained static in September 2025 at 24 mins.	As part of tier 2 interventions the trust has supported site visits from the NHSE London UEC team and ECIST during August and September 2025. Following these visits there are recommendations and associated actions in place to support improved patient flow, clinical safety, and operational efficiency across the UEC pathway. Areas of focus are: **Front Door UTC First Model , SDEC model, Acute Medical Unit, and Frailty Pathways**. Key actions implemented during the last month include: • Developed a revised ambulance handover SOP(Standard Operating procedure •Extending the front door frailty service from a 5-day to a 7-day service with additional consultant/SHO support on Saturday/Sunday •Ring-fencing 1 bed space in the frailty hub to accommodate chairs for ambulatory patients •Over the last two weeks we have undertaken a test of change for front door streaming processes in ED to support an increase in the number of patients seen in the UTC. This work is being supported by ECIST/NHSE. This also includes ring-fencing SDEC capacity to ensure that we have available space to assess patients. •We have agreed time to discharge KPIs with wider system partners for patients on pathways 1,2, and 3 with immediate implementation and mechanisms in place to monitor compliance against these metrics. The focus on our ED front door processes and UTC First model will support improvements in our non-admitted ED performance which will positively impact overall trust performance. Alongside this we are also focussed on improvements across the inpatient pathway, including admission avoidance to support an increase in bed availability. We are planning a reset week during week commencing 10th November which will focus on individual patient pathways to maximise discharge opportunities and create additional capacity for onward flow from ED	Nov 2025	4 Hour Sufficient for assurance (validated correct data) 12 Hours in ED – internal validated data (ECDS fix in place to correct) LAS Handover Sufficient for assurance (NHSE Reporting)

Operational Performance

Exception Report | Sutton Health Urgent Community Response Performance

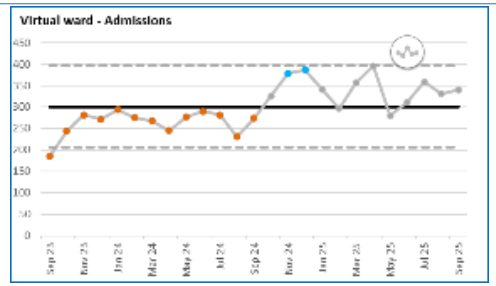
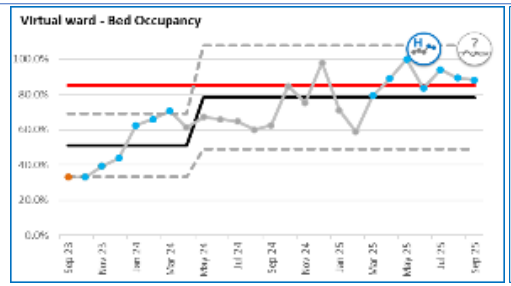
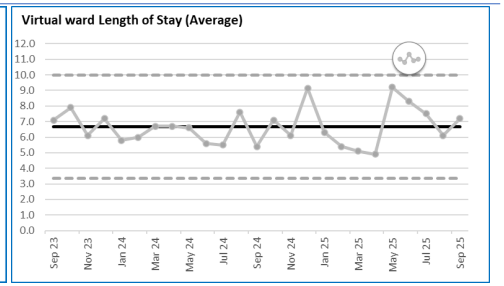
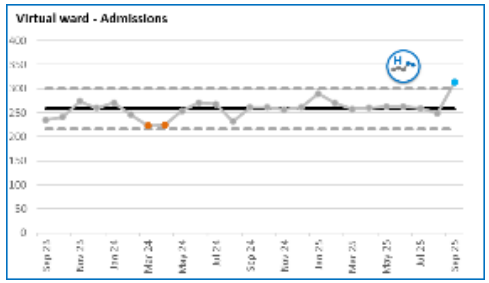
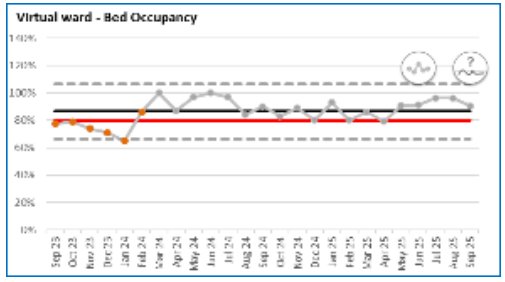
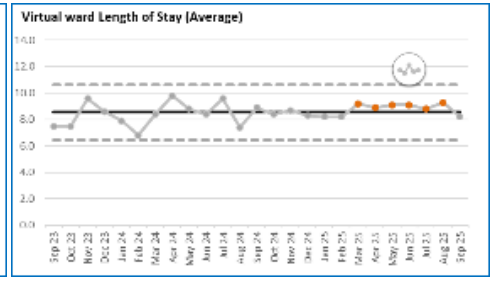




Site & Metric	Cause of variance/ non-compliance	Actions: Completed since last update, New, and Ongoing	Recovery Date	Data Quality
Sutton Health Urgent Community Response within 2-Hrs – Target rate of > 70% not met 3 of the last months, but improving.	• Technical data issues caused the 2 Hour UCR performance to reduce significantly in June 2025. This has now been resolved by EMIS and the 70% target was achieved in September 2025 with a performance of 72.8%. Increases in referral patterns are being reviewed.	• The increase in referrals (550 in the month compared with a usual trend of around 350), particularly during out-of-hours periods and at weekends, is being reviewed to identify the underlying causes and implement urgent mitigating actions to ensure the service continues to perform above target.	N/A (target met)	Sufficient for assurance

Operational Performance

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

Sutton Healthcare			
Surrey Downs			

Site & Metric	Cause of variance/ non-compliance	Actions: Completed since last update, New, and Ongoing	Recovery Date	Data Quality
Sutton Health & Care	Admissions to the virtual ward continue to exceed the average, and showing normal variation. Occupancy for September 2025 stood at 88.2%, exceeding target of 85% with reduced length of stay.	• LoS reduction programme with ESTH and Sutton Alliance is in progress to include virtual ward redevelopment. • Engagement work with relevant wards and clinicians continues.	N/A	Sufficient for assurance
Surrey Downs Health & Care	Admissions to virtual ward remain above the mean with bed occupancy rate above 80%	• On-going development of enhanced care and new pathways in Virtual Wards.	N/A	Sufficient for assurance

Section 2.2:
Operational Productivity

Operational Productivity

Overview Dashboard

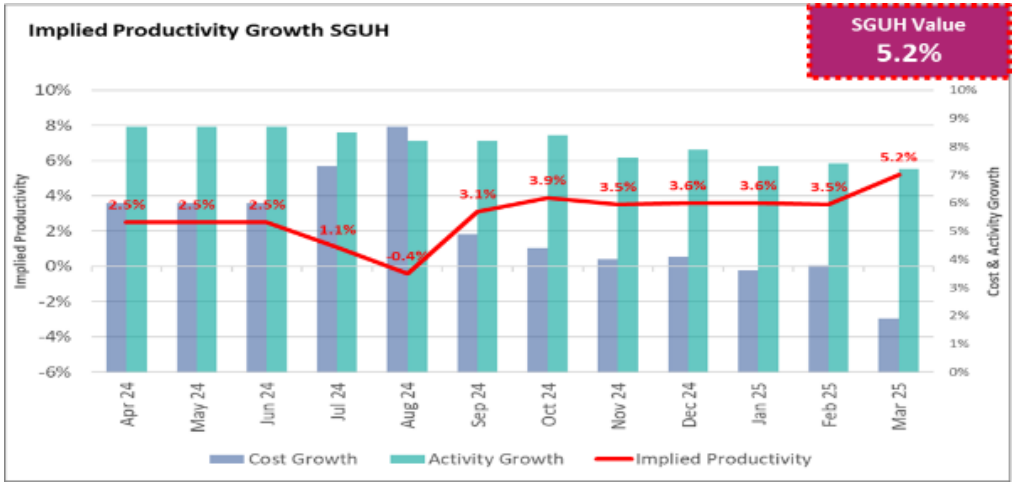
KPI	St George's Latest month	St George's Previous Month Measure	St George's Latest Month Measure	St George's Target	St George's Variation	St George's Assurance	St George's National Benchmark	Epsom & St Helier Latest month	Epsom & St Helier Previous Month Measure	Epsom & St Helier Latest Month Measure	Epsom & St Helier Target	Epsom & St Helier Variation	Epsom & St Helier Assurance	Epsom & St Helier National Benchmark
Implied Productivity Growth	Mar 25	3.1%	5.2%	-	N/A	N/A	Top Quartile	Mar 25	-0.8%	0.3%	-	N/A	N/A	Lowest Quartile
Non Elective Length of Stay (SWL Methodology exc 0 days, exc <18 years)	Sep 25	9.5	9.8	9.7			N/A	Sep 25	10.7	10.9	-			N/A
Average days from Discharge Ready Date to date of discharge (inc 0 day delays)	Aug 25	0.6	0.5	-			2nd Quartile	May 25	2.3	0.7	-			TBC
Theatre Utilisation (Capped)	Sep 25	82.9%	82.9%	85.0%			Top Quartile	Sep 25	74.8%	74.0%	85.0%			3rd Quartile
BADS All Daycase & Outpatient Procedures % of total procedures	Jun 25	82.0%	82.0%	83.6%			3rd Quartile	Jun 25	79.1%	74.6%	83.6%			Lowest Quartile
Outpatients Patient Initiatied Follow Up Rate (PIFU)	Sep 25	2.2%	2.3%	5.0%			Lowest Quartile	Sep 25	3.0%	3.4%	5.0%			2nd Quartile
Outpatients Missed Appointments (DNA Rate)	Sep 25	10.5%	10.2%	8.0%			Lowest Quartile	Sep 25	7.6%	7.4%	6.0%			3rd Quartile
First and Procedure Attendances as a proportion of Total Outpatients	Sep 25	53.5%	50.9%	49.0%			2nd Quartile	Sep 25	38.5%	40.3%	49.0%			Lowest Quartile

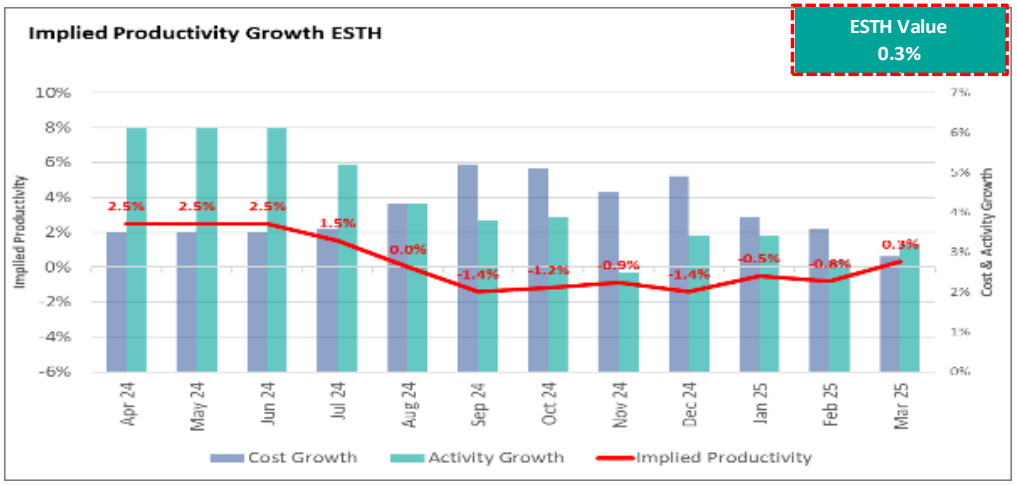
Operational Productivity

Implied Productivity – Headline NHSE Metric

Implied productivity for acute and specialist trusts is assessed by comparing the growth in outputs (cost-weighted activity) to the growth in inputs (operating expenditure), using a baseline period. This measure reflects year-to-date performance against the same period in the previous financial year. Data is drawn from the Model Health System, which reports with a four-month delay. A positive value indicates improved productivity; a negative value suggests a decline.

NHS England is expected to publish further detail on the methodology imminently, which will help identify key areas for improvement.





Summary and actions

- The *Implied Productivity* national metric shows a 5.2% improvement in productivity in 2024/25 YTD Month 12 compared to same period the previous year (2023/24). This is driven higher weighted activity growth of 7.2% compared to cost growth of 1.9%.

Summary and actions

- The *Implied Productivity* national metric shows a 0.3% increase in productivity in 2024/25 YTD Month 12 compared to same period the previous year (2023/24). This is driven by a cost growth of 2.9% compared to growth in weighted activity of 3.2%.
- Activity has increased across all points of delivery except maternity and critical care. However, the scale of growth remains below that of peer trusts. Further analysis of delivery-specific trends is underway, pending detailed data and metric methodology guidance from NHS England.

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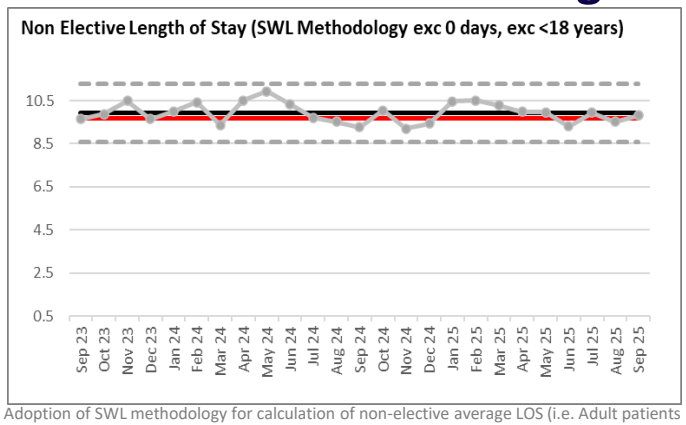
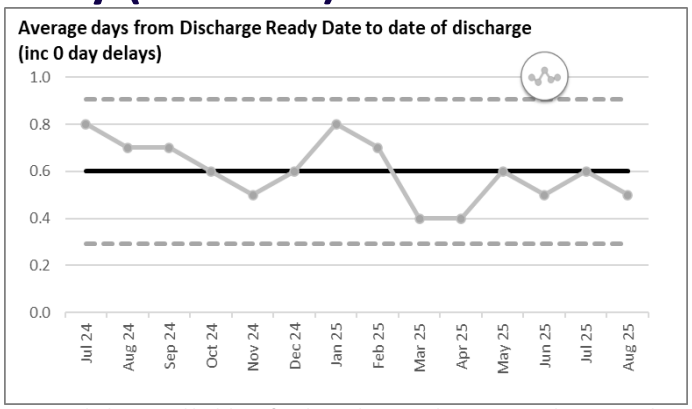
Model Hospital reporting YTD Month 12 2024/25, awaiting update

Operational Productivity

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



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



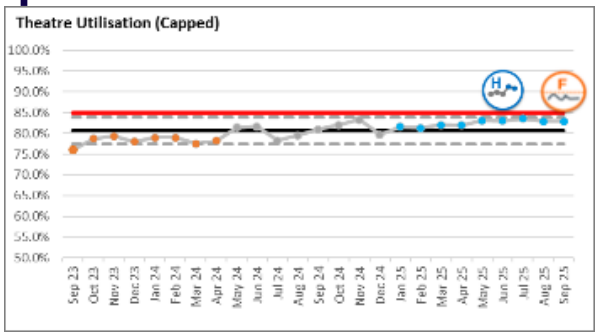
Acute discharges and bed days after the Discharge Ready Date averaged over a month.
Numerator: The total aggregate number of days from discharge ready date to date of discharge for all patients discharged in the period
Denominator: The total number of patients that have been discharged in the period

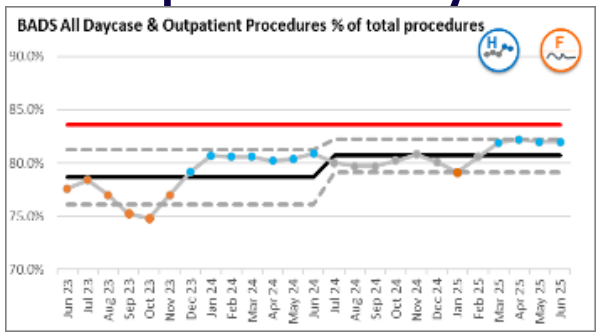
Metric	Reporting Month	Productivity Opportunity vs Target
NEL Length of Stay.	September-25	TBC

Site & Metric	Cause of variance/ non-compliance	Actions: Completed since last update, New, and Ongoing	Recovery Date	Data Quality
SGUH LOS - normal variation Average delay to discharge- normal variation	• Through September 2025, on average in-patients stayed in a hospital bed for 9.8 days, keeping in line with plan whilst delivering the ask of 83 beds being closed. • The number of NCTR patients has also seen a sustained improvement supporting length of stay reductions. • Largest number of NCTR patients are within pathway 0, which is an expected picture, and the site is now achieving the national expectation of 80%, however the length of stay post NCTR for this cohort remains too high with only 37% of pathway 0's being discharged within 24hrs, against a KPI of 80%. • Average delay to discharge remains consistent and below peer and national average	• >7 day LoS meetings embedding lead by all divisions with a 40+day panel established. • Care without corridor workshops being rolled out across all divisions, to nursing, medical and operational staff • IMS system continues to be embedded to ensure delivery of actions to improve flow • Complex case meetings in weekly with each local authority • Explore alternative methodologies for capturing NCTR data to improve accuracy and release nursing time • Winter Plan ask is to deliver average length of stay at 8.4 days. • Additional review of whole Non Elective pathway being undertaken and led by site transformation team to identify other opportunities • Weekly iQPR now established featuring UEC and LoS focused metrics		Sufficient for assurance Sufficient for assurance (published NHSE data on month in Arrears)

Operational Productivity

SGUH - Theatre Utilisation & Outpatient & Daycase Procedure Rates





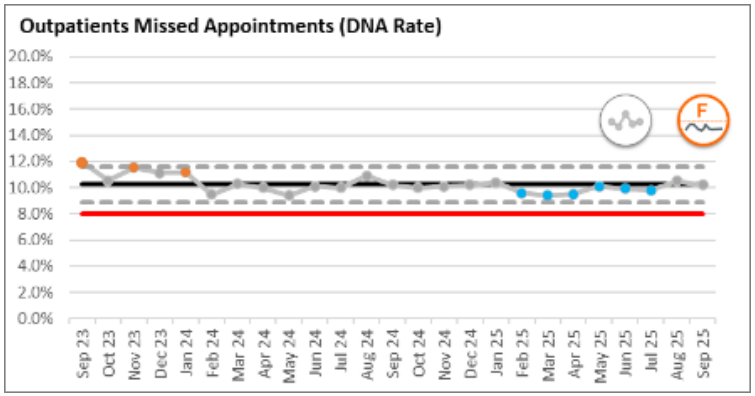
Metric	Reporting Month	Productivity Opportunity vs Top Quartile
Capped Theatre Utilisation	Sept-25	19 cases (based on an average case time of 124 min) to hit top quartile
Day cases and outpatient procedures (BADS)	Jun-25	149 cases opportunity to move to OP (3 month period)

Site & Metric	Cause of variance/ non-compliance	Actions: Completed since last update, New, and Ongoing	Recovery Date	Data Quality
SGUH - Capped Theatre Utilisation increasing trend	Theatre Utilisation – September 2025 Overview **Capped Theatre Utilisation:** Maintained at 83% throughout September 2025 (validated), placing performance in the top quartile compared with peers. **Same-Day Cancellations:** Fewer cases were cancelled on the day, demonstrating an improvement compared with the previous month. **Estates Issues:** Flooding across multiple theatres, particularly in all Lanesborough theatres, negatively impacted utilisation and contributed to late starts	**1. Theatre Scheduling Enhancements -** The Divisional Director of Operations now chairs the weekly 642 meeting to improve oversight of theatre allocation and dropped sessions. This process is supported by a bespoke, in-house digital tool designed to enhance productivity. Initial feedback has been positive, with early indications of increased ACPL. **2. On-the-Day Cancellation Policy -** A new OTDC cancellation policy is being implemented to standardise cancellation reasons in line with national frameworks. An IT change request to support this policy has been approved by the CICG; however, it will need to be prioritised alongside other IT demands. The IT team is currently undertaking a scoping exercise to allocate resources once the freeze is lifted. **3. Anaesthetic Quality Improvement Project -** The Anaesthetic team is leading a quality improvement initiative aimed at reducing avoidable cancellations in the Day Surgery Unit. This includes closer collaboration with the POA team to identify and optimise at-risk patients earlier. Findings and progress will be presented at the Theatre Transformation Board in November. **4. Day Surgery Unit Utilisation -** A detailed review of DSU utilisation, focusing on late starts and early finishes, will be conducted over the next four weeks. Results will be presented at the November Theatre Transformation Board.	TBC	sufficient for assurance
SGUH: normal variation, below top quartile peer	**Day Case Rate** Initiatives are underway to improve planning processes and transition more eligible procedures to DSU. SGUH continues to manage a higher volume of inpatient cases compared with peer organisations, largely due to greater patient complexity. This drives increased demand for inpatient beds for procedures that are typically performed as day cases elsewhere. Additionally, four DSU theatres at QMH were closed on 1st September, impacting overall day case capacity.	**BADS Compliance** Surgical teams are actively engaged through the Theatre Transformation Programme to enhance BADS compliance. This initiative is being driven via the “Right Procedure, Right Place” approach within local Theatre User Groups (TUGs) which will be reinstated in November. Targeted meetings have been set up with specialities with high volumes of identified DSU cases that could be done in OP settings. **Training and Job Aids** Trust-wide training on the use of management codes has improved data accuracy and reduced length of stay (LOS). Updated job aids now support more accurate coding for both administrative and clinical staff.	TBC	Sufficient for assurance

Operational Productivity

SGUH - Missed Appointments (DNA Rate)

St George's



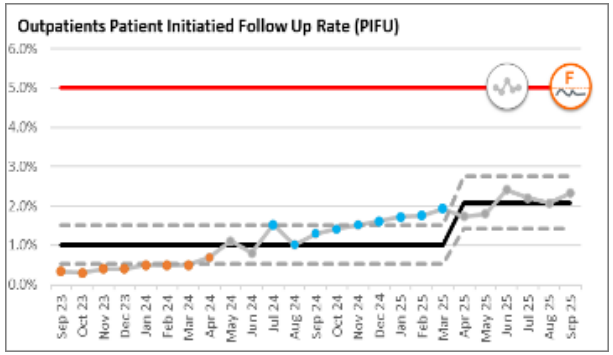
Metric	Reporting Month	Productivity Opportunity vs Top Quartile
Outpatients: DNA rates	Sept-25	1,217 appointments

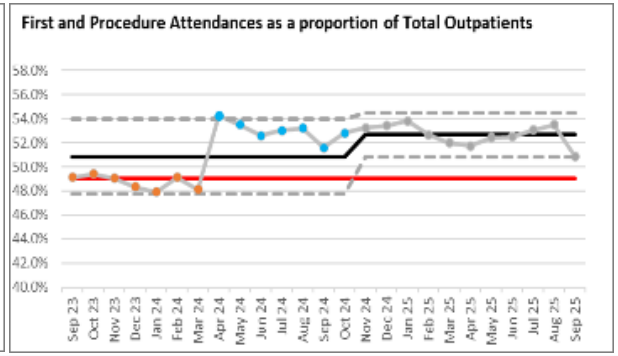
The methodology to calculate the opportunity to reduce the number of missed outpatient appointments is based on how your average missed outpatient appointments rate (from the last 6 months) compares to the national missed appointments profile for providers.

Site & Metric	Cause of variance/ non-compliance	Actions: Completed since last update, New, and Ongoing	Recovery Date	Data Quality
SGUH Normal variation however not meeting target of 8%	Current DNA rates of 10.2% against a peer average performance 8.7%. YTD **two thirds** of the Trusts DNAs have occurred in just 12 specialities. • Therapies • ENT & Audiology • Chest Medicine • Dermatology and Lymphoedema • Rheumatology • Neurology • T&O • Diabetes & Endocrinology • Obstetrics • Gastro and Endoscopy • Max Fax • Paediatric Medicine	- Automated call reminders pilot commenced to supplement sms reminders. - DNA Risk Model Pilot - A predictive model has been developed with the Trust Business Intelligence (BI) Team. An implementation plan is under way to launch the "bot" to identify patients that meet the algorithm of a high probability of not attending. Trauma & Orthopaedics have volunteered to trial. - GESH QIIA have agreed plan to supplement existing digital letters with sms based digital letters (via Netcall). - Expansion of Wait list validation underway. - Plan identified to protect vacated short notice slots for use with Long waiting patients. - Plan underway to expand Portal to encompass Paediatrics. - Partial Booking light to commence in October with first service to go live (Paediatric Respiratory)	Under review at Outpatient Transformation Board	sufficient for assurance

Operational Productivity

SGUH – Reduction in Outpatient Follow-Ups



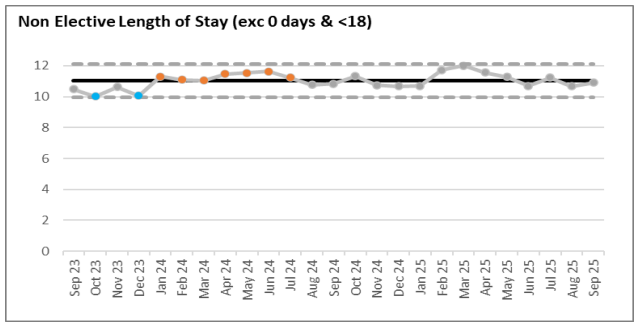


Metric	Reporting Month	Productivity Opportunity vs Top Quartile
1st + Proc as a % of Total OP	Sept-25	*0 (exceeding target)*
PIFU Rates	September -25	*Not quantified to avoid double-counting with New: FU Ratio opportunity*

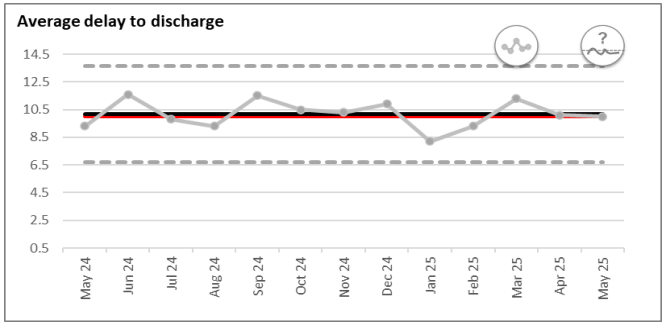
Site & Metric	Cause of variance/ non-compliance	Actions: Completed since last update, New, and Ongoing	Recovery Date	Data Quality
SGUH PIFU Rate: Consistently not meeting target, improving trend.	The operational plan signed off by the Board SGUH had a target of 3% due to the delay in starting PIFU. We are on the right plan to deliver this at year end. (National Target is 5%)	• All GIRFT specialties are now live with PIFU. Plans are in place to ensure more specialties are ready to go live -patient leaflets, clinician understand the process, and local SOP. • Specialties are being provided with evidence based data to review all patients who have been given a “non-value weighted” follow up appointment post clock stop. • GIRFT / Model Hospital documentation and literature being shared at specialty and pathway on established PIFU pathways set in similar organisations. • New PIFU and Follow up reduction workstream formed within OP Transformation Programme. PID has been agreed. • Work continues to develop PIFU by default pathways for post surgical cohorts. • Work continues to improve access process for PIFU patients requiring appointments. To improve patient experience and to provide assurance to clinicians that patients will be well supported, to increase the likelihood of them utilising the PIFU option for their pathways. • Work has begun to develop PIFU type process for post DNA rebooking. • Proposal made for addition of a PIFU Open access option for patient groups who will not be discharged eg, Sickle cell, Lymphoedema etc. • Patient Portal led Wait list validation programme underway. To date over 860 patients have been discharged for our care freeing up vital capacity. Plans being developed to automate this process to support expanded use.	3% target for end of 25/26	sufficient for assurance (Model Hospital Data based on Provider EROC)

Operational Productivity

ESTH – Non Elective Length of Stay



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



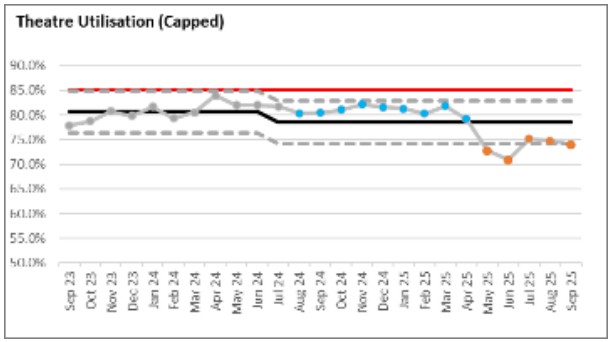
Acute discharges and bed days after the Discharge Ready Date averaged over a month.
Numerator: The total aggregate number of days from discharge ready date to date of discharge for all patients discharged in the period
Denominator: The total number of patients that have been discharged in the period

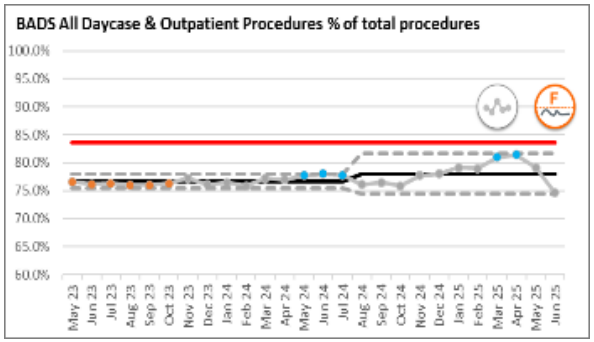
Metric	Reporting Month	Productivity Opportunity vs Target (annualised)
NEL Length of Stay.	Sept-2025	TBC

Site & Metric	Cause of variance/ non-compliance	Actions: Completed since last update, New, and Ongoing	Recovery Date	Data Quality
ESTH LOS Normal Variation Average delay to discharge normal variation	• Non-elective LOS for September 2025 is reported at **10.9 days**, reflecting a **0.2-day increase** compared to August 2025. However, this figure should be viewed positively, as it represents a **0.3-day reduction** from July 2025. This improvement was not acknowledged in the previous month's IQPR reporting. It is important to note that a **data quality refresh** was undertaken in September, which has **retrospectively altered baseline data** for the period **May to August 2025**. The September LOS figure, therefore, reflects updated and more accurate data, reinforcing the significance of the observed reduction from July. • There continues to be a month-on-month reduction for >7, >14 and > 21day LOS patients. • Work continues to ensure compliance and validation in NCTR position post EPR roll out. • A high number of patients are still awaiting complex pathway 3 placements or inpatient neuro-therapy providers.	**The ESTH Urgent Care Transformation programme has defined priorities for 2025/26, including:** • Board/Ward Rounds -Standardising ward processes and accelerating discharge pathways via structured board rounds and improvement huddles. • Therapies – Improving productivity and workforce deployment to deliver timely, needs-based care through targeted process enhancements, including daily validation of MFFD reports for therapy-led actions. • Bed Reduction Plans - agree and implement a redesign of the internal bed base trust wide optimising estate footprints and staffing ensuring improved efficiency and a reduction in overall capacity requirements. • Acute Medicine Workforce -Reviewing the acute medicine workforce to optimise available resources • Operational Flow Management -Strengthening patient flow through improved daily systems, escalation processes, and governance. • Reporting/KPIs –Developing a KPI dashboard to monitor progress across programme and workstreams • Daily discharge reports resumed post EPR cutover, aiding internal & external partners with tracking medically fit patients. • Daily CTR status reports and validation continues to support compliance and includes alerts by site, division, and ward. • Weekly reviews of 0–21-day LOS patients continue on a weekly basis, alongside complex discharge reviews involving external partners to ensure oversight of all acute inpatients. • Revised KPIs to support the 2025/26 UEC Transformation Programme have been developed	Target and recovery under review	Sufficient for assurance

Operational Productivity

ESTH - Theatre Utilisation & Outpatient & Daycase Procedure Rates (Pg 1 of 2)





Metric	Reporting Month	Productivity Opportunity vs Top Quartile
Capped Theatre Utilisation	Sept-25	490 cases (based on an average case time of 63 min) to hit top quartile
Day cases and outpatient procedures (BADS)	June-25	104 cases opportunity to move to OP (3 month period)

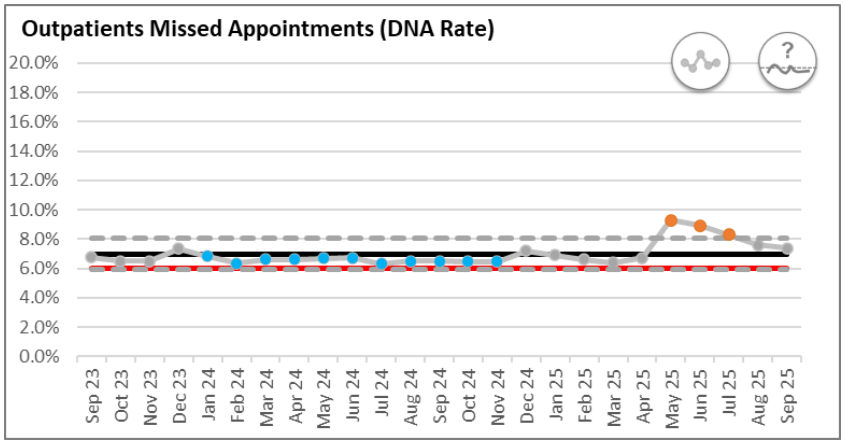
Site & Metric	Cause of variance/ non-compliance	Actions: Completed since last update, New, and Ongoing	Recovery Date	Data Quality
ESTH Theatre Utilisation Special cause variation of a CONCERNING nature. and failing target (85%) BADS performance Not meeting target, Variable trend	Theatre utilisation in September was 74%, a slight decrease from 74.8% in August, but up from 72.3% in July. The decline continues following the introduction of iClip as teams adapt to new systems. Pre-implementation performance was consistently above 80%, reaching 82.16% in April. There is a difference between Model Hospital and ESTHER figures due to some sessions being rejected because of data quality (DQ) issues, and these rejected sessions are not included in the Model Hospital calculation. The BI team continues to work weekly with operational teams to identify and resolve DQ issues. Operational Challenges Following iClip Implementation: Theatre performance reporting has been affected by data inconsistencies. A full dataset rebuild of the Dashboard has now resolved 95% of the issues, restoring reliable reporting across specialties. BI and the Theatre Ops team continue weekly reviews to complete and validate the remaining elements. Theatre Dashboard inconsistencies have currently limited monitoring and action on utilisation trends. The decline in the proportion of BADS procedures taking in place in daycase and outpatient settings since May 2025 is also attributable to iCLIP implementation.	Perioperative Care pathway and processes: • Epsom & St Helier and St George's have built the POA Patient Health Screening form into the patient portals, with go-live planned for December. Next phase is training the staff. • This mirrors the approach already taken by Kingston and Croydon, who have successfully integrated the form into their portals. Next steps: • Explore the longer-term IT support required to embed the Health Screening form into the GESH patient portal. • Work collaboratively across the network to ensure consistent systems and outcomes, avoiding siloed approaches Day Case Rates (Model Hospital – Quarter Ending June 2025): Overall ESTH day case rate was 74.5%, including 30.2% at SWLEOC, 82.4% at Epsom, and 93.0% at St Helier. Excluding SWLEOC, ESTH achieved 88.2%. BI and operational teams are working collaboratively to resolve the underlying reporting issues.	March 2026	May and June 2025 not sufficient for assurance due to large volumes of unoutcomed activity – this is improving

Operational Productivity

ESTH - Theatre Utilisation & Outpatient & Daycase Procedure Rates (Pg of 2)

Site & Metric	Cause of variance/ non-compliance	Actions: Completed since last update, New, and Ongoing	Recovery Date	Data Quality
ESTH Theatre Utilisation Special cause variation of a CONCERNING nature. and failing target (85%) BADS performance Not meeting target, Variable trend	• On-the-Day Cancellations (OTDC): Currently being collected manually by the Theatre Ops Team and passed to BI. This ensures data is cross-checked and correctly flows into the rebuilt Dashboard. • The Theatre Ops team are keeping a tracker of patients that have not been cancelled using the correct iClip process so that targeted training can be delivered to the scheduling teams. • OTDC National Standards: The new national theatre codes have been written into the revised Dashboard so that reporting is fully aligned with NHSE requirements.	Collaborative work is underway across the Group to improve how we capture actual SWLEOC activity — patients admitted and discharged — compared with the intended management recorded at the point of scheduling for hip and knee cases **Starting on Time: Late starts audit of Epsom Theatres: 6–20 October** to evaluate whether new consenting space has had a positive impact on session start times, better flow and reduced delays. The audit will include all theatres to record start times (AM, PM, all-day sessions). One theatre per day (deep dive) – detailed review of flow. **Stand-by patient activity** is now included in the **NHSE cancellations dataset**, as NHS England intends to monitor how effectively trusts are using stand-by lists to reduce lost theatre time. Through Theatre Performance meetings we will work with specialties to develop **processes for maintaining stand-by lists**, enabling patients to be brought in at short notice when cancellations occur. **Civility and Well Being:** The Civility and Wellbeing Task and Finish Group is driving initiatives to improve workplace culture and staff support, including simulation training, Health and Wellbeing Champions, visible wellbeing boards, and staff surveys to guide future priorities **Specialty Deep Dives:** Theatre Dashboard inconsistencies have limited the ability to monitor and act on utilisation trends. BI expect these issues to be resolved by the end of October, allowing related workstreams to resume.	March 2026	May and June 2025 not sufficient for assurance due to large volumes of unoutcomed activity – this is improving

Operational Productivity
ESTH Missed Appointments (DNA Rate)



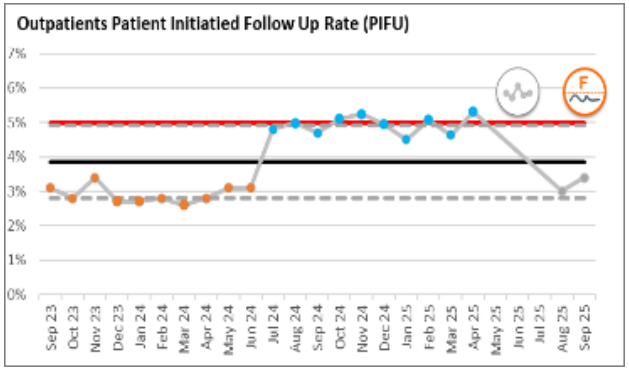
Metric	Reporting Month	Productivity Opportunity vs Top Quartile
Outpatients: DNA rates	Sep-25	782 Appointments

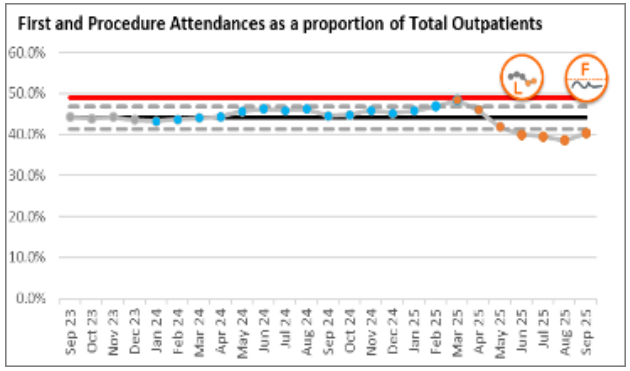
The methodology to calculate the opportunity to reduce the number of missed outpatient appointments is based on how your average missed outpatient appointments rate (from the last 6 months) compares to the national missed appointments profile for providers.

Site & Metric	Cause of variance/ non-compliance	Actions: Completed since last update, New, and Ongoing	Recovery Date	Data Quality
ESTH Failing target of 6%, decrease through July	Text reminder issues – now updated.	Continued reduction in DNA rates from peak in May. **Text reminders:** Centralised spreadsheet completed and additional clinic sessions now added to the text reminder. Expected to see impact in October DNA rate. **Dashboard reliability:** Progress made with DNA tab of Outpatient Dashboard, resource list updated. Patient Portal: The introduction of the patient portal in mid-December will support increased visibility of appointments for patients to further support DNA reduction. **Gynaecology:** High DNA rates identified in recurrent miscarriage clinics. Transformation is supporting the service to consider how PIFU could be used to support patients and reduce DNAs for these clinics.	March 2026	May and June 2025 not sufficient for assurance due to large volumes of unoutcomed activity – this is improving

Operational Productivity

ESTH – Reduction in Outpatient Follow-Ups





Metric	Reporting Month	Productivity Opportunity vs Target (annualised)
Outpatients: [1st + Proc] as a % of Total OP	Sep-25	£600k based on adhoc clinic spend and out of hours clinics
Outpatients: PIFU Rates	Sep -25	*Not quantified to avoid double-counting with New: FU Ratio opportunity*

Site & Metric	Cause of variance/ non-compliance	Actions: Completed since last update, New, and Ongoing	Recovery Date	Data Quality
PIFU – increased activity First & Procedure attendances – below target	Able to report on PIFU again. Drop in performance likely due to new iClip process steps and limited visibility before reports were reinstated.	**Patient Initiated Follow Up:** ***Gynaecology:*** Scenario guidance approved by clinical lead. Poster in development to share key information with clinicians. Peer comparison identified clinician outliers in discharge and PIFU rates; clinical lead arranging discussions to explore hesitancy. ***Cardiology:*** Outliers in discharge and PIFU rates identified. Clinical lead and service manager reviewing data ahead of targeted engagement with relevant clinicians. ***Paediatrics:*** PIFU and discharge guidance for 6 common conditions signed off and shared to clinicians. ***Governance:*** PIFU SOP updates ongoing to align with new iClip process to support Long-Term Condition PIFU use. Updates also being made to the PIFU Clinical Briefing pack to be shared via Transformation attendance at key specialty meetings, and wider via Service Managers. **Follow-up reduction:** Transformation attending key specialty meetings to increase KPI visibility, celebrate progress, and share peer variation to support opportunities. **Gastroenterology:** Funding secured for Enhanced Triage pathway. Project team setting up additional triage time and linking with Endoscopy to enable November launch. **ENT:** SWL-wide collaboration underway to develop a technical solution for post-diagnostic note reviews as first OPA. **Respiratory and Cardiology:** Cough pathway drafted as part of Integrated Medicine work.	March 2026	Not sufficient for assurance post go live - **Expected to be resolved by end of October 2025**

Section 3 - Our People

Overview Dashboard | People Metrics

St George's

KPI	Latest month	Previous Month Measure	Latest Month Measure	Target	Variation	Assurance	Benchmark
Staff Sickness Absence rate	Sep 25	4.5%	4.7%	4.0%			2nd Quartile
Agency rates	Sep 25	0.4%	0.6%	-			
MAST	Sep 25	91.0%	91.1%	85.0%			Top Quartile
Vacancy Rate	Sep 25	4.8%	4.5%	10.0%			
Appraisal Rate Medical	Sep 25	81.5%	82.5%	90.0%			
Appraisal Rate Non Medical	Sep 25	80.3%	80.1%	90.0%			Top Quartile
Turnover	Sep 25	9.9%	9.4%	13.0%			4th Quartile
Workforce WTE	Sep 25	10856	10785	10325			
Percentage BAME staff band 8 and above	Jul 25	32.9%	32.9%	-			

Epsom & St Helier

Latest month	Previous Month Measure	Latest Month Measure	Target	Variation	Assurance	Benchmark
Sep 25	5.1%	5.2%	4.0%			3rd Quartile
Sep 25	1.0%	1.0%	-			
Sep 25	88.5%	76.8%	85.0%			Quartile
Sep 25	11.3%	10.8%	10.0%			
Sep 25	99.5%	99.6%	90.0%			
Sep 25	78.0%	76.8%	90.0%			Top Quartile
Sep 25	9.9%	9.6%	12.0%			4th Quartile
Sep 25	7399.00	7367.00	7468.50			
Sep 25	30.8%	30.6%	-			

Sutton Healthcare

KPI	Latest month	Previous Month Measure	Latest Month Measure	Target	Variation	Assurance
Sickness Rate	Sep 25	7.2%	5.9%	4.0%		
Agency rates	Sep 25	1.0%	1.0%	-		
MAST	Sep 25	92.5%	92.5%	85.0%		
Vacancy Rate	Sep 25	14.5%	13.3%	10.0%		
Appraisal Rate Medical	Sep 25	100.0%	100.0%	90.0%		
Appraisal Rate Non Medical	Sep 25	72.1%	71.0%	90.0%		
Turnover (12-Month)	Sep 25	10.6%	10.2%	12.0%		
Percentage BAME staff band 8a and above	Sep 25	25.0%	25.5%	-		

Surrey Downs

Latest month	Previous Month Measure	Latest Month Measure	Target	Variation	Assurance
Sep 25	5.1%	5.6%	4.0%		
Aug 25	1.5%	1.6%	-		
Sep 25	94.5%	94.1%	85.0%		
Sep 25	13.1%	12.9%	10.0%		
Sep 25	100.0%	100.0%	90.0%		
Sep 25	88.5%	91.0%	90.0%		
Sep 25	12.2%	12.2%	12.0%		
Sep 25	11.7%	11.3%	-		

gesh

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

Appendices

Appendix 1 - Statistical Process Control (SPC)

Interpreting Charts and Icons

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

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

Appendix 2 - Watch List Metrics

Overview Dashboard

St George's

KPI	Latest month	Previous Month Measure	Latest Month Measure	Target	Variation	Assurance	Benchmark
Mixed Sex Accommodation Breaches	Sep 25	122	145	0			Highest Quartile
Number of Complaints Received	Sep 25	84	64	-			N/A
Number of re-opened complaints in month	Sep 25	4	1	-			N/A
Parliamentary and Health Service Ombudsman (PHSO) Received	Sep 25	0	1	-			N/A
Parliamentary and Health Service Ombudsman (PHSO) Closed	Sep 25	0	3	-			N/A
RTT - Total Size Incomplete Waiting List	Aug 25	71716	71215	74003			3rd Quartile
Cancer 31 Day Decision To Treat to Treatment Standard	Aug 25	96.0%	96.3%	96.0%			2nd Quartile
On the Day Cancellations not re-booked within 28 days	Sep 25	5	1	0			2nd Quartile
Outpatient Advice & Guidance Rate per 100 First OPA	Jul 25	25.1	26.1	16.0			2nd Quartile
Emergency Department Attendances per day	Sep 25	399	430	-			N/A
Mental health delays 4 Hour Breaches	Sep 25	139	161	-			N/A
Length of stay > 21 days (super stranded)	Sep 25	156	180	-			3rd Quartile
Overnight G&A beds occupancy - Adults	Sep 25	95.7%	96.0%	96.0%			3rd Quartile
Number of patients not meeting criteria to reside (Daily Avg)	Sep 25	113	117	-			2nd Quartile

Epsom & St Helier

Latest month	Previous Month Measure	Latest Month Measure	Target	Variation	Assurance	Benchmark
Sep 25	34	34	0			Highest Quartile
Sep 25	41	49	-			N/A
Sep 25	1	2	-			N/A
Sep 25	2	1	-			N/A
Sep 25	1	0	-			N/A
Aug 25	58191	59726	50386			3rd Quartile
Aug 25	99.1%	100.0%	96.0%			Top Quartile
Jun 25	3	4	0			Top Quartile
Jul 25	57.0	53.8	16.0			Top Quartile
Sep 25	413	450	-			N/A
Sep 25	207	211	-			N/A
Sep 25	165	164	-			Lowest Quartile
Sep 25	92.7%	94.6%	96.0%			2nd Quartile
Sep 25	153	159	-			3rd Quartile

Sutton Healthcare

KPI	Latest month	Previous Month Measure	Latest Month Measure	Target	Variation	Assurance
Urgent Community Response (UCR) Referrals	Sep 25	545	508	-		
Virtual ward - Admissions	Sep 25	328	340	-		
Virtual ward Length of Stay (Average)	Sep 25	6.1	7.2	-		
Discharge to Assess- Pathway 0-3 Delays (Median Days)	Sep 25	4	3	-		

Surrey Downs

Latest month	Previous month measure	Latest month measure	Target	Variation	Assurance
Sep 25	453	538	-		
Sep 25	249	313	-		
Sep 25	9.3	8.2	-		
Sep 25	2	1	-		

Appendix 3 - Cancer Performance by Tumour Type

Overview Dashboard

St George's

Cancer - 28 Day Faster Diagnosis Standard

KPI	Latest month	Previous Month Measure	Latest Month Measure	National Averages	Variation	Assurance
Brain/Central Nervous System	Aug 25	0.0%	N/A	90.6%		
Breast	Aug 25	75.0%	72.2%	89.6%		
Breast Symptomatic	Aug 25	80.3%	74.9%	93.0%		
Children's Cancer	Aug 25	71.4%	25.0%	93.8%		
Gynaecological	Aug 25	50.3%	58.2%	62.7%		
Haematological	Aug 25	63.2%	66.7%	61.3%		
Head & Neck	Aug 25	91.1%	86.9%	75.9%		
Lower Gastrointestinal	Aug 25	71.4%	76.1%	63.7%		
Lung	Aug 25	72.0%	76.3%	79.7%		
RDC	Aug 25	83.9%	64.3%	-		
Skin	Aug 25	59.3%	39.3%	90.6%		
Upper Gastrointestinal	Aug 25	81.7%	73.6%	76.3%		
Testicular	Aug 25	N/A	N/A	100.0%		
Urological	Aug 25	74.6%	72.7%	57.5%		

Cancer - 62 Day Referral to Treatment Standard

KPI	Latest month	Previous Month Measure	Latest Month Measure	National Averages	Variation	Assurance
Brain/Central Nervous System	Aug 25	100.0%	88.2%	-		
Breast	Aug 25	77.5%	57.5%	71.2%		
Gynaecological	Aug 25	45.5%	60.0%	65.2%		
Haematological	Aug 25	100.0%	91.7%	71.4%		
Head & Neck	Aug 25	75.0%	47.1%	58.5%		
Lower Gastrointestinal	Aug 25	64.7%	64.0%	60.0%		
Lung	Aug 25	60.5%	57.6%	63.6%		
Other	Aug 25	71.4%	100.0%	80.0%		
Skin	Aug 25	92.3%	87.5%	91.6%		
Upper Gastrointestinal	Aug 25	66.7%	75.0%	76.2%		
Urological	Aug 25	79.5%	76.1%	62.4%		

Target and Assurance based on national averages

Epsom & St Helier

Cancer - 28 Day Faster Diagnosis Standard

KPI	Latest month	Previous Month Measure	Latest Month Measure	National Averages	Variation	Assurance
Brain/Central Nervous System	Aug 25	100.0%	100.0%	90.6%		
Gynaecology	Aug 25	48.7%	37.2%	62.7%		
Haematological	Aug 25	100.0%	92.3%	61.3%		
Head & Neck	Aug 25	93.5%	89.9%	75.9%		
Lower Gastrointestinal	Aug 25	73.0%	64.9%	63.7%		
Lung	Aug 25	84.6%	90.0%	79.7%		
Skin	Aug 25	52.6%	18.8%	90.6%		
Upper Gastrointestinal	Aug 25	90.9%	83.5%	76.3%		
Urological	Aug 25	79.5%	83.8%	57.5%		
RDC	Aug 25	85.1%	72.3%	-		
Prostate	Aug 25	96.2%	87.1%	-		
Testicular	Aug 25	100.0%	100.0%	100.0%		

Cancer - 62 Day Referral to Treatment Standard

KPI	Latest month	Previous Month Measure	Latest Month Measure	National Averages	Variation	Assurance
Gynaecological	Aug 25	45.5%	84.6%	65.2%		
Haematological	Aug 25	77.8%	100.0%	71.4%		
Head & Neck	Aug 25	80.0%	60.0%	58.5%		
Lower Gastrointestinal	Aug 25	84.2%	83.3%	60.0%		
Lung	Aug 25	53.1%	42.9%	63.6%		
Skin	Aug 25	97.7%	100.0%	91.6%		
Upper Gastrointestinal	Aug 25	52.4%	61.5%	76.2%		
Urological	Aug 25	96.6%	85.5%	62.4%		
Other	Aug 25	100.0%	100.0%	80.0%		

Appendix 4

Metric Technical Definitions and Data Sources

Metric	Definition	Strategy Drivers	Data Source
Never Events	Serious incidents that are entirely preventable because guidance or safety recommendations providing strong systemic protective barriers	National Framework for Reporting and Learning from Serious Incidents	Local Data
Patient Safety Incidents Investigated	Any unintended or unexpected incident which could have, or did, lead to harm for one or more patient's receiving healthcare	National Framework for Reporting and Learning from Serious Incidents	Local Data
Venous thromboembolism VTE Risk Assessment	Percentage of patients aged 16 and over admitted in the month who have been risk assessed for VTE on admission to hospital using the criteria in a National VTE Risk Assessment Tool.	NHS Standard Contract & Constitutional Standard	Local Data
Pressure Ulcers	Number of patients with pressure ulcer (Category/Stage 3 & 4) in the Trust over a specific period of time.	gesh Priority - Fundamentals of Care/ National Patient Safety Incidents	Local Data
SHMI	Rolling 12 months ratio between the actual number of patients who die following hospitalisation at a trust and the number that would be expected to die on the basis of average England figures, given the characteristics of the patients treated there.	NHS National Oversight Framework	NHS Digital
Referral to Treatment Waiting Times (RTT)	Monitors the waiting time between when the hospital or service receives your referral letter, or when you book your first appointment through the NHS e-Referral Service for a routine or non-urgent consultant led referral to treatment date.	NHS National Oversight Framework, Constitution, and Priorities & Operational Planning Guidance	NHS England
Cancer 28 Day Faster Diagnosis Standard	The proportion of patients that received a diagnosis (or confirmation of no cancer) within 28 days of referral received date.	NHS National Oversight Framework, Constitution, and Priorities & Operational Planning Guidance	NHS England
Cancer 62 Day Standard	The proportion of patients beginning cancer treatment that do so within 62 days of referral received date. This applies to by a GP for suspected cancer, following an abnormal cancer screening result, or by a consultant who suspects cancer following other investigations (also known as 'upgrades')	NHS National Oversight Framework, Constitution, and Priorities & Operational Planning Guidance	NHS England
Diagnostic Waits > 6 Weeks	Percentage of patients waiting for more than 6 weeks (42 days) for one of the 15 diagnostic tests from referral / request date.	NHS Oversight Framework, Constitution, and Priorities & Operational Planning Guidance	NHS England
4 Hour Operating Standard	Percentage of emergency department attendances admitted, transferred or discharged within four hours of arrival	NHS National Oversight Framework, Constitution, and Priorities & Operational Planning Guidance	NHS England
Over 12 Hours in ED from arrival	Percentage of patients attending A&E who are not admitted, discharged or transferred within 12 hours of arrival, limited to department type 1 and 2.	NHS National Oversight Framework, Constitution, and Priorities & Operational Planning Guidance	NHS England
Ambulance Average Handover Times	Data definition numerator: Total time in seconds of patient handover or transfer to a cohort that took place from the time of hospital arrival to handover time at ED and non ED sites. NB: This does not exclude the first 30 mins. Data definition denominator: This is a count of all arrivals at ED and non-ED sites over the period.	NHS Priorities & Operational Planning Guidance	NHSE England
Non Elective Length of Stay	Adoption of SWL methodology for calculation of non-elective average LOS (i.e. Adult patients discharged from the hospital in month that had a method of admission of emergency, but excluding patients that did not have an overnight stay in hospital and excluding maternity, paediatric and A&E specialties).	NHS Priorities & Operational Planning Guidance	Local Data
Average days from Discharge Ready Date to date of discharge (inc zero delays)	The total aggregate number of days from discharge ready date to date of discharge for all patients discharged in the period / The total number of patients that have been discharged in the period	NHS National Oversight Framework, Constitution, and Priorities & Operational Planning Guidance	NHSE England
Length of Stay>21 Days (Stranded patients)	Based on NHSI Sitrep data. The guidance / methodology includes non-elective and elective patients as per operational planning technical guidance. Most of these patients will be non-elective, but to understand the overall impact it is important to include the number of elective patients.	NHS Priorities & Operational Planning Guidance	NHSI
PIFU Rate	Numerator: The number of episodes moved or discharged to a Patient Initiated Follow Up (PIFU) pathway. Denominator: Total outpatient activity	NHS Priorities & Operational Planning Guidance	Model Hospital
Capped Theatre Utilisation Rate	The capped utilisation of an individual theatre list is calculated by taking the total needle to skin time of all patients within the planned session time and dividing it by the session planned time	NHS Priorities & Operational Planning Guidance	Model Hospital
BADS	Day case and outpatient % of total procedures (inpatient, day case and outpatient)		Model Hospital
Implied Productivity	Inclusions: Outpatients, outpatient procedures, elective (IP & DC), Non elective, A&E Methodology: Activity weighted by national average costs by HRG and POD so that e.g. overnight elective activity is more highly weighted than A&E attendances. Cost: total operating expenditure, excluding impairments, includes PDC dividends, adjusted for inflation Compares YTD position with same YTD from previous year. Updated monthly and shown on Model Hospital under Productivity & Efficiency section Published productivity metrics not broken down by POD or specialty	Performance Assessment Framework, NHSE National Oversight Framework	SUS & national cost collection (for weighting) Provider Finance Return

Appendix 5
Glossary of Terms

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

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

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

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

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

NHS England

To: James Blythe
Chief Executive Officer
Epsom & St Helier University Hospital NHS Trust

Cc: Michael Pantlin
Deputy Chief Executive Officer
Caroline Clarke
Regional Director (London)
Helen Pettersen
Regional Chief Operating Officer (London)

NHS England
Wellington House
133-155 Waterloo Road
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23 October 2025

Dear James

Sir Jim Mackey's letter of 18 September 2025 set a clear expectation that all providers are to see and treat any remaining patients who have been waiting longer than 65 weeks by 21 December 2025. While we continue to make year on year progress to reduce waiting times, this is an important milestone for patients who have been waiting the longest.

To ensure providers are taking necessary steps to eliminate 65 week waits between now and 21 December, we are moving organisations who are expected to have more than 100 65 week waits at the end of October, into Tier 1. This means **Epsom & St Helier University Hospital NHS Trust** will move into **Tier 1 for Elective** and this will be aligned to any existing tiering arrangements (e.g. if your trust is in Tier 2 for Cancer), as appropriate.

Being in Tier 1 will involve appropriately regular meetings (the frequency of which will be agreed with your Region) with Regional and National colleagues to discuss delivery progress and track immediate actions required to deliver the required long waits reductions. This may include short term improvement support via the GIRFT team and the leadership of Professor Tim Briggs.

These arrangements will remain in place until all remaining 65 week waits have been cleared and we will review the tiering status at that time. Where this is in addition to existing tiering arrangements, we will formally review progress via the quarterly tiering review cycle between National and Regional NHS England teams. Tiering status changes will be ratified through the NHS England Executive. Given the critical importance of elective delivery, we will be regularly reporting progress on tiered organisations, as well as national performance against plans, to government in weekly meetings with the Secretary of State and regular meetings with the Prime Minister.

The first meetings will be arranged as quickly as possible where we can discuss any support you may need from our teams, over the weeks ahead. Please share this email with your

Trust Board and relevant committees and do email england.electivepmo@nhs.net should you have any questions.

Yours sincerely,

Mark Cubbon,
National Director for Elective, Cancer and Diagnostics
NHS England

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

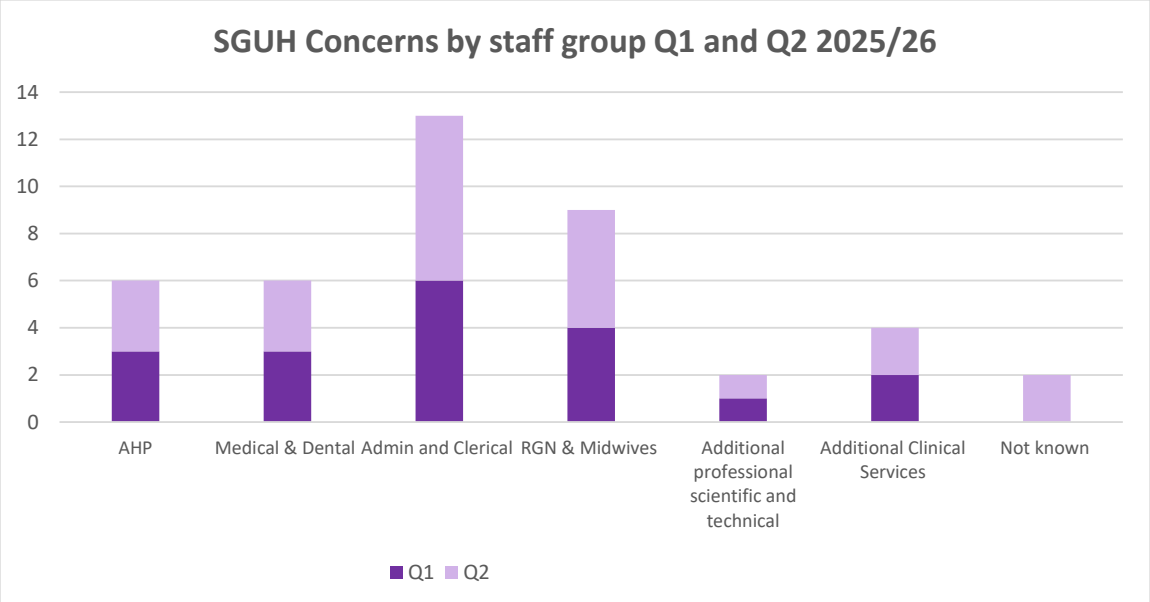
(a) Total number of concerns raised via Freedom to Speak Up in Q1 & Q2 2025/26

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.

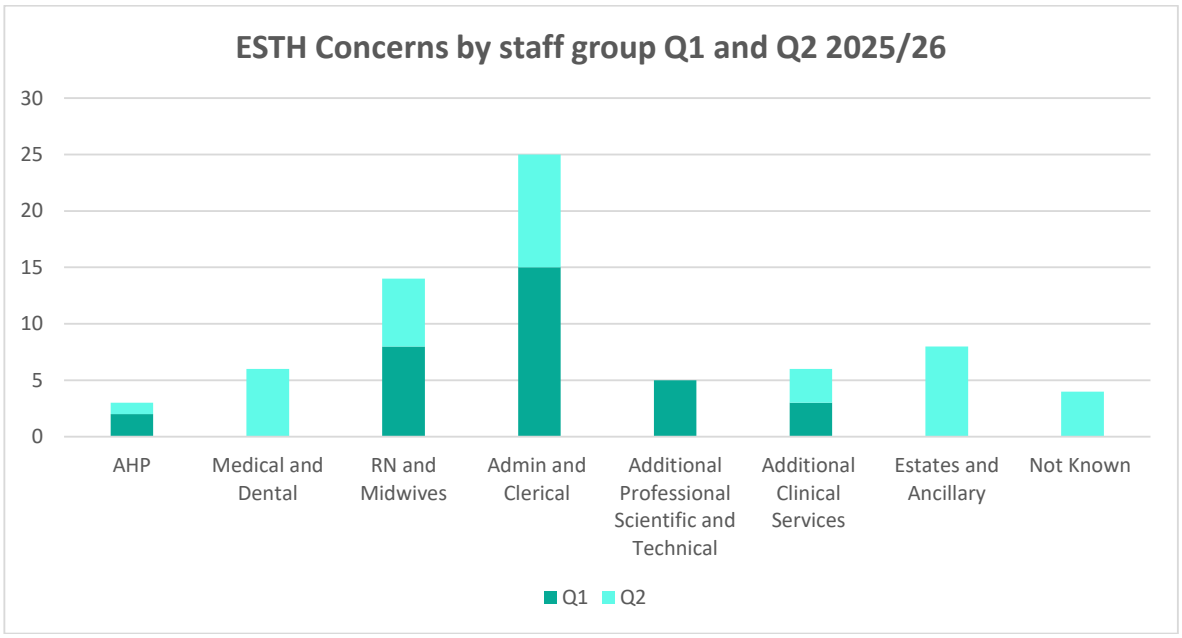


3.4 Staff groups at SGUH who have raised concerns with the FTSU Guardian over Q1 & Q2:

- **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:



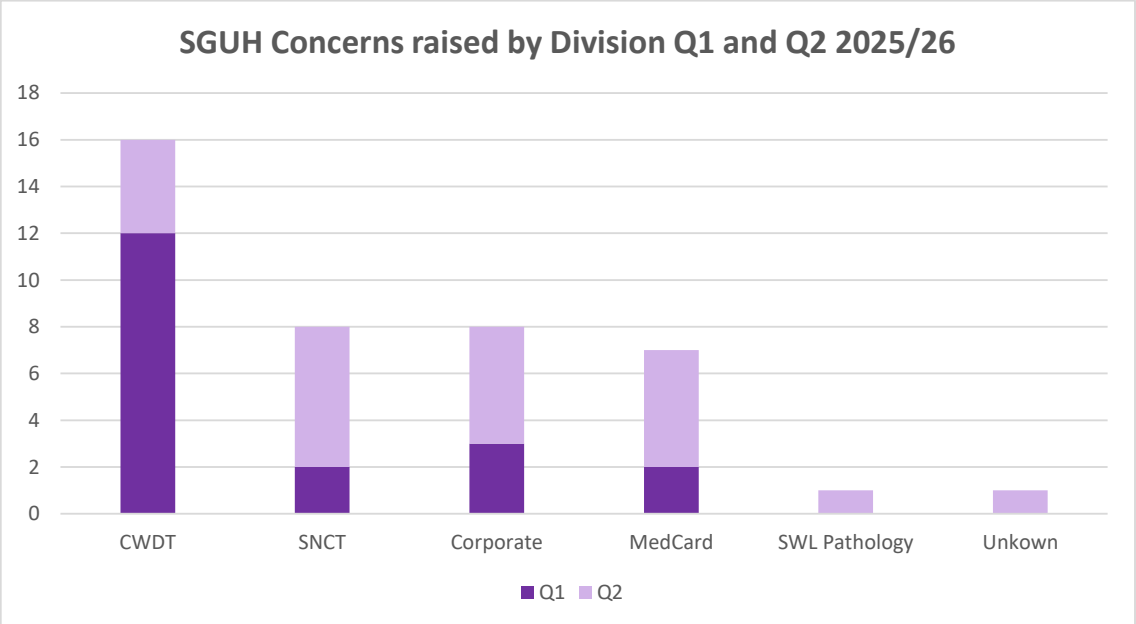
3.6 Staff groups which have raised concerns with the FTSU Guardian at ESTH over the past year shows that:

- **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:



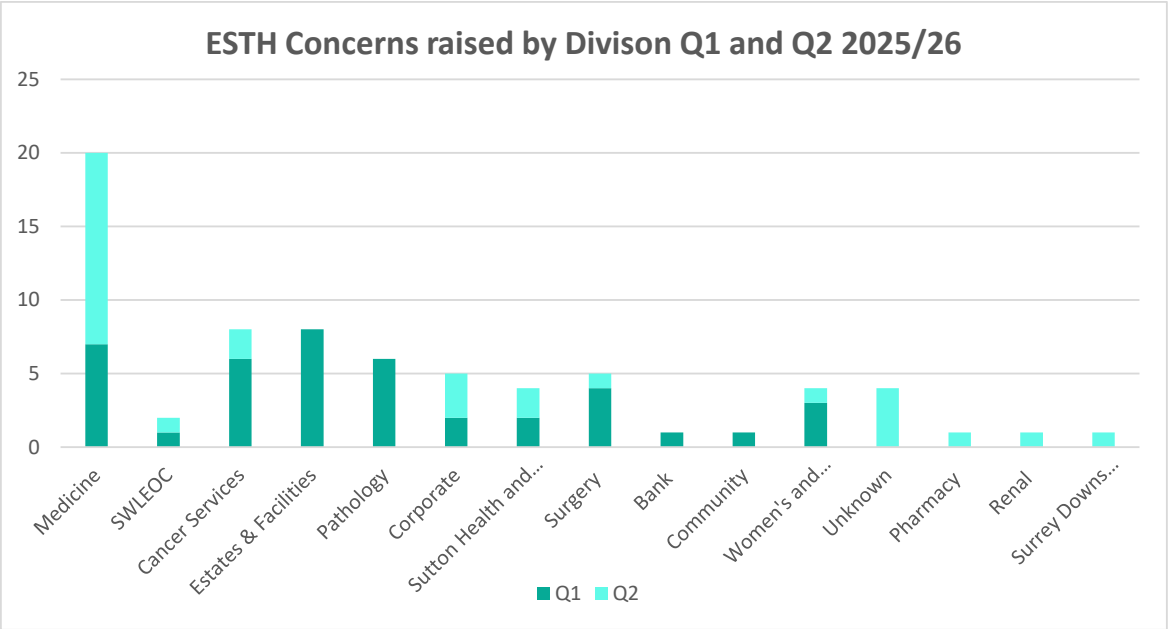
3.8 An analysis of the concerns raised by Division with the FTSU Guardian over the 2 quarters at SGUH shows that:

- 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%)

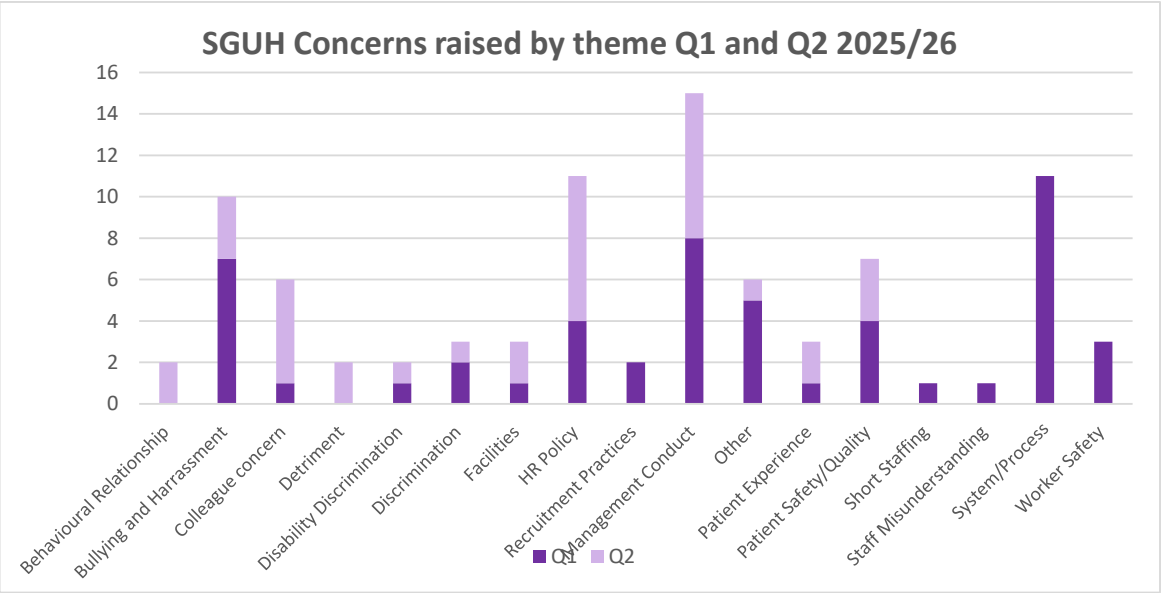
(f) **Themes in concerns raised with the Group FTSU Guardians in Q1 and Q2 2025/26**

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.

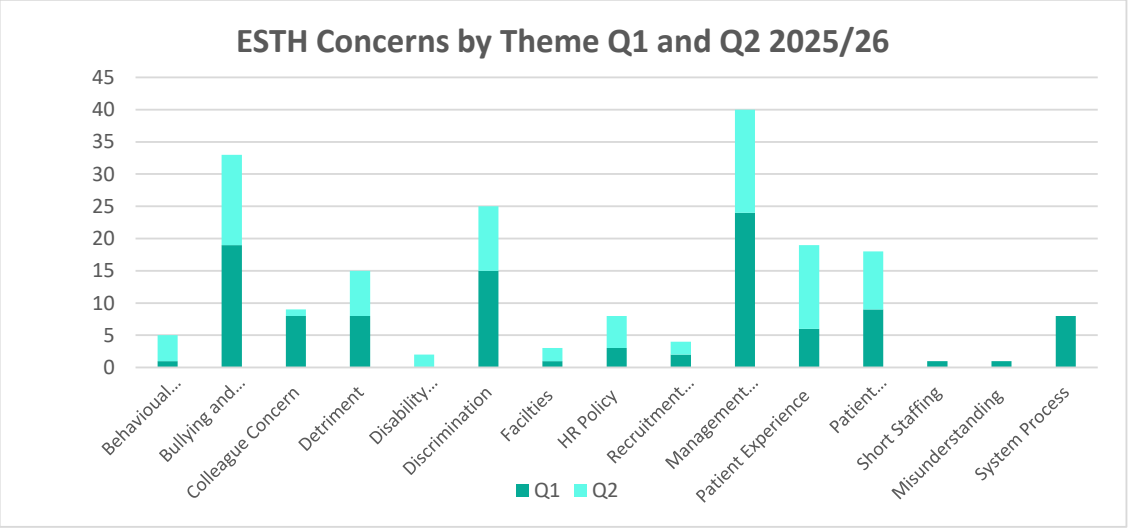
e) Historical Grievances and Outstanding Outcomes:

- 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.

Group Board

Meeting in Public on Thursday, 06 November 2025

Agenda Item	7.1	
Report Title	**CQC Well Led Report (St George's)**	
Executive Lead(s)	James Blythe, Interim Group Chief Executive Officer	
Report Author(s)	Stephen Jones, Group Chief Corporate Affairs Officer	
Previously considered by	-	-
Purpose	**For Review**	

Executive Summary

The Care Quality Commission (CQC) undertook a Well Led inspection at St George's University Hospitals NHS Foundation Trust (SGUH) between 25 and 27 February 2025, utilising its new Well Led assessment framework which was introduced in April 2024. The Trust received the report on 27 October 2025 ahead of publication on 31 October 2025, having previously reviewed a draft for factual accuracy checking in August 2025. This report provides an overview of the findings of the CQC Well Led report, a summary of key actions taken to take to respond to the initial feedback received from the CQC, planned actions, and next steps in relation to co-producing with the St George's Site Leadership team, divisional teams, and staff across the organisation a comprehensive action plan to respond to the CQC's detailed findings. That detailed action plan will be presented to the Board at its meeting in January 2026.

The CQC's overall assessment rates the Trust as "Requires Improvement", the same rating as the Trust received from the CQC in its previous CQC Trust-wide inspection report in December 2019. Although the areas of improvement highlighted by the CQC had been previously recognised by the Trust as needing further work, the CQC report has brought into sharp focus the scale of the change that it needed across the Trust, and the pace of change that it required to deliver the required change. The Group Executive Committee and the St George's Site Leadership Team have reviewed the CQC report and, while disappointed, are committed to taking the actions necessary to improve the culture of the organisation and to engage staff in the improvement work. The report highlights the improvement actions already taken on in train, alongside planned areas of further work, in particular in relation to improving culture. The Trust recognises that to make progress in all of the areas highlighted by the CQC a more comprehensive action plan needs to be developed and, importantly, needs to be co-produced not only by the Board, Executive and Site Leadership Team, but also by engaging with staff across the organisation. We plan to use a series of regular engagement events with staff, starting this month, as well as feedback from staff through the NHS Staff Survey and engagement with our strengthened Staff Networks, to help develop the programme of actions needed to respond to the CQC's feedback. The intention is to co-produce that wider action plan with staff and bring this to the Board in public in January 2026, setting out key milestones and success measures.

Action required by Group Board

The Group Board is asked to:

a) Receive and Note the CQC's Well Led inspection report on St George's University Hospitals NHS Foundation Trust, published on 31 October 2025, and note the overall Well Led rating for the Trust of "Requires Improvement".

b) Note the key findings from the CQC's Well Led inspection at St George's University Hospitals NHS Foundation Trust;

c) Note the actions taken since the CQC's inspection in February 2025 to address areas requiring improvement, and the proposed next steps in relation to both planned actions and co-producing with the St George's Site Leadership Team, divisional teams, and staff across the Trust a comprehensive action plan to respond to the CQC's detailed findings.

Appendices	
Appendix No.	**Appendix Name**
Appendix 1	CQC Well Led Report: St George's University Hospitals NHS Foundation Trust (31 October 2025)
Appendix 2	Summary of actions in response to CQC findings

Implications

Group Strategic Objectives

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

Risks

As set out in paper.

CQC Theme

☐ Safe	☐ Effective	☐ Caring	☐ Responsive	☒ Well Led

NHS system oversight framework

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

Financial implications

N/A

Legal and / or Regulatory implications

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

Equality, diversity and inclusion implications

EDI is embedded within Quality Statement 4 of the 2024 Well Led framework, and the CQC's Report provides detailed comments on the Trust's position in relation to the Workforce EDI quality statement.

Environmental sustainability implications

Environmental sustainability is embedded within Quality Statement 8 of the 2024 Well Led framework, and the CQC's Report provides detailed comments on the Trust's position in relation to environmental sustainability.

CQC Well Led Report (St George's)

Group Board, 06 November 2025

1.0 Purpose of paper

1.1 This report provides an overview of the findings of the CQC Well Led inspection, a summary of key actions taken to take to respond to the initial feedback received from the CQC, planned actions, and next steps in relation to co-producing with the St George's Site Leadership team, divisional teams, and staff across the organisation a comprehensive action plan to respond to the CQC's detailed findings. That detailed action plan will be presented to the Board at its meeting in January 2026.

2.0 Background

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

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

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

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

longer-term actions to strengthen the Trust's position in relation to the requirements of the new framework.

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

2.5 The Well Led inspection followed assessments of the Trust's frontline services: Urgent and Emergency Care; Maternity; and Surgery at both St George's Hospital in Tooting and Queen Mary's Hospital in Roehampton. The CQC's reports on the service level CQC inspections was published on 28 August 2025 and the outcomes of these inspections were reported to the Group Board at its meeting on 5 September 2025.

2.6 The Trust received high level feedback from the CQC following the inspection in March 2025. This feedback letter and a high level set of actions to respond to the initial feedback was reported to the Group Board in public at its meeting on 1 May 2025.

2.7 The Trust received the Well Led inspection report from the CQC on 27 October 2025 and the report was published on 31 October 2025. Prior to this, the Trust had reviewed a draft of the report for factual accuracy checking.

3.0 Findings and key themes

Overall rating

3.1 The CQC's Well Led inspection report for St George's University Hospitals NHS Foundation Trust rated the Trust as "Requires Improvement" overall, the same rating as the Trust's previous Trust-wide CQC rating in December 2019.

3.2 For each of the eight quality statements that comprise the Well Led framework and which inform the overall score, the CQC provided the following ratings:

Quality Statement	CQC rating	
	Rating	Rating Definition
Shared Direction and Culture	2	Some shortfalls; Requires Improvement
Capable, Compassionate and Inclusive Leaders	2	Some shortfalls; Requires Improvement
Freedom to Speak Up	2	Some shortfalls; Requires Improvement
Workforce Equality, Diversity and Inclusion	1	Significant shortfalls; Inadequate
Governance, Management and Sustainability	1	Significant shortfalls; Inadequate
Partnerships and Communities	3	Good standard; Good
Learning, Improvement and Innovation	3	Good standard; Good
Environmental Sustainability	3	Good standard; Good

Key themes

3.3 The CQC Well Led inspection for St George's recognised a number of areas where the Trust was performing well including:

- the Trust had a clear, Board-approved strategy in place which had been developed with the input of patients, staff and stakeholders and which was aligned to local plans;
- the Trust had a well established set of values; most leaders had the skills and experience, knowledge and capacity to fulfil their roles and understood the challenges to sustainability;
- robust systems were in place to manage the Fit and Proper Persons Regulation;
- the Trust had strengthened its Freedom to Speak Up Guardian Service and had strengthened Board and Executive oversight of Freedom to Speak Up;
- there was a genuine desire to improve culture;
- there had been some improvements in the Trust's position in relation to the Workforce Race Equality Standard and Workforce Disability Equality Standard;
- leaders had taken action to address bullying and harassment and were committed to working towards a culture to promote equality and equity for staff;
- the Trust had in place an Accountability Framework, governance structures for the Group, assurance systems, systems and processes to identify and manage risk, processes and systems to monitor current and future performance;
- senior leaders understood their duty to collaborate and work in partnership and the Trust worked well with system partners;
- there was a focus on continuous learning, improvement and innovation and a strong focus on research; and
- senior leaders understood the impact of the organisation's activities on the environment.

3.4 However, the CQC also identified a number of areas where improvements were required. These included:

- the Trust's strategy was not fully embedded across the organisation and staff did not always understand their role in delivering the strategy;
- progress in implementing the strategy had been slower than planned;
- there had been a lack of pace in embedding the Group model with Epsom and St Helier NHS Trust and of realising the benefits of working as a Group;
- while values were in place, they were not well embedded in the Trust's culture, which was described by some staff as a blame culture, toxic, unprofessional and lacking in accountability;
- behaviours were not always inclusive and some managers lacked capacity for strategic delivery;
- leadership development, talent management and succession planning needed to be strengthened across the Trust;
- despite improvements to the Freedom to Speak Up Guardian Service and to Board and Executive oversight of speaking up, staff found it hard to speak up and organisational culture did not always encourage staff in raising concerns;
- leaders were not always viewed as acting with openness, honesty and transparency;
- the genuine commitment to improving culture was not reflected in staff experience;
- there was a need to improve the experience of staff across the protected characteristics and to promote an inclusive culture;
- despite some improvements, there was little evidence to support an overall improvement in equality, diversity and inclusion;
- systems of governance and management were not ways effective and service inspections in maternity, surgery and urgent and emergency care meant there was a lack of governance and accountability in specific areas.

Regulation 17 Notices

3.5 For the two quality statements where the CQC rated the Trust with a score of "1", the CQC issued Regulation 17 notices as follows:

- *The trust must ensure that they use feedback from staff to improve the culture of the organisation and measure the impact of actions taken.*

- *The trust must ensure that they improve governance and management functionality to keep people safe from avoidable harm.*

3.6 Regulation 17 notices are notices issued under Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The purpose of this regulation is to ensure that providers have systems and processes to ensure that they are able to meet other requirements of the 2014 Regulations, specifically in relation to governance, assurance, and monitoring and driving improvements in quality and safety, including the quality of the experience for people using the service. A key part of this regulation is the expectation that providers seek and act on feedback from people using the service, those acting on their behalf, staff and other stakeholders, so that they can continually evaluate the service and drive improvement.

4.0 Trust response and co-producing with staff a comprehensive action plan

4.1 Although the areas of improvement highlighted by the CQC, including in its Regulation 17 Notices, had been previously recognised by the Trust as needing further work, the CQC report has brought into sharp focus the scale of the change that it needed across the Trust, and the pace of change that it required to deliver the required change. The Group Executive Committee and the St George's Site Leadership Team have reviewed the CQC report and, while disappointed, are committed to taking the actions necessary to improve the culture of the organisation and to engage staff in the improvement work.

4.2 As some of the areas for improvement were understood by the Trust ahead of the inspection through the self-assessment undertaken by the Board, the Trust had already put in place a number of improvement actions. Appendix 1 sets out the actions already taken and the workstreams already in place to help drive improvement. It also sets out a number of further actions currently being planned or developed to deliver further progress. As the CQC report was received only last week, these actions require further development before they are consolidated into a single action plan.

4.3 The Trust recognises that to make progress in all of the areas highlighted by the CQC a more comprehensive action plan needs to be developed and, importantly, needs to be co-produced not only by the Board, Executive and Site Leadership Team, but also by engaging with staff across the organisation. That wider engagement with our staff will help ensure that the action plan we co-design is collectively owned and embedded, and is one which leaders at al levels of the organisation recognise and feel empowered to deliver. We plan to use a series of regular engagement events with staff, starting this month, as well as feedback from staff through the NHS Staff Survey and engagement with our strengthened Staff Networks, to help develop the programme of actions needed to respond to the CQC's feedback, in particular in relation to improving the culture of the organisation. We also plan to use the current NHS Staff Survey to help the Site Leadership Team target organisational development, management capability and leadership interventions based on either a low feedback rating or specific poor ratings from staff, and to ensure effective Executive and Board level assurance in relation to focused follow-up in response to departmental-level negative outliers in the Staff Survey.

4.4 At the same time, the development of our response to the CQC Well Led inspection at St George's coincides with the development of our Medium Term Plan. We have integrated into our transformation programme key programmes of work that respond to the CQC's feedback. For example, one of the transformation programme workstreams focuses on organisational

culture and developing quality improvement and a second transformation workstream is focused on developing the Group-model, strengthening our organisational form, and developing a new Target Operating Model for the Group, which aims to clarify how the Group should operate in future to deliver the Group strategy.

4.5 A progress report will be presented to the Group Board at its meeting in public in January 2026, setting out an integrated action plan, key milestones, and success measures.

5.0 Learning from the inspection for Epsom and St Helier

5.1 A CQC Well Led inspection will likely take place at Epsom and St Helier at some point in the coming months and it is important that we learn from the experience of the Well Led inspection at St George's as we prepare for the inspection at Epsom and St Helier.

5.2 Some of the CQC's observations about St George's have resonance at Epsom and St Helier, and the areas of improvement that have been highlighted by the CQC are areas which we need to focus at Epsom and St Helier. The actions being taken, or developed, to respond to the Well Led inspection at St George's are either Group-wide in nature or are applicable on a Group-wide basis. So progress in taking the actions needed to improve at St George's will help in strengthening the preparations for a Well Led inspection at Epsom and St Helier.

6.0 Recommendations

6.1 The Group Board is asked to:

a) Receive and Note the CQC's Well Led inspection report on St George's University Hospitals NHS Foundation Trust, published on 31 October 2025, and note the overall Well Led rating for the Trust of "Requires Improvement".

b) Note the key findings from the CQC's Well Led inspection at St George's University Hospitals NHS Foundation Trust;

c) Note the actions taken since the CQC's inspection in February 2025 to address areas requiring improvement, and the proposed next steps in relation to both planned actions and co-producing with the St George's Site Leadership Team, divisional teams, and staff across the Trust a comprehensive action plan to respond to the CQC's detailed findings.

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

APPENDIX 2: Summary of actions and future plans to response to CQC findings

AREA FOR IMPROVEMENT	CQC DOMAIN	CURRENT WORKSTREAMS	FUTURE PLANS / ACTIVITY TO DESIGN NEXT STEPS
The Trust must ensure that they use feedback from staff to improve the culture of the organisation and measure the impact of actions taken	Regulation 17	• New Equality, Diversity and Inclusion Plan, approved by the Board in February 2025. • An inclusive board programme to mirror the work of the Group Board, with the aim of readying senior leaders from under-represented backgrounds for executive roles has been approved. • What Matters to You programme being piloted in 10 clinical and non-clinical teams across gesh with a view to rolling it out wider – *Included, Safe* and *Supported* are the three core pillars. • Reinvigorated Executive sponsorship of our 4 staff networks. • Quarterly in person roadshows with all divisions and services across the organisation to update on trust priorities and create a forum for questions and discussion. • Launch a number of listening events to compliment roadshows to enhance our ability as an organisation to discuss issues relating to race and discrimination. These aim to further unpack and understand our colleagues' experiences, listen to hard truths and ensure all voices are being heard. It will also give us an opportunity to create solutions that drive meaningful and sustained change on the ground for all of our colleagues.	• Introducing quarterly pulse surveys to get more regular feedback and use these to target management interventions either at Trust/site or unit level. • Inclusive Board programme to be launched • Run staff survey engagement sessions to support and empower managers to interpret results and create impactful action plans. • People Strategy Implementation and Equality, Diversity and Inclusion Action Plan to be monitored by People Committee and other key governance forums to drive improvements. • Embed on-going engagement between Group CEO, Chair and Network Chairs to understand lived experience, to share concerns and ensure issues are addressed.
The Trust must ensure they improve governance and management	Regulation 17	• Trust Quality and Safety Governance Improvement Plan approved by the Quality Committee in July 2025.	• Embed the Trust Quality and Safety Governance Improvement Plan through agreed changes to structures, processes and ways of working.

AREA FOR IMPROVEMENT	CQC DOMAIN	CURRENT WORKSTREAMS	FUTURE PLANS / ACTIVITY TO DESIGN NEXT STEPS
functionality to keep people safe from avoidable harm		• Raising Concerns Oversight and Triangulation Group in place to enable Executive-led oversight of areas where concerns are being raised through multiple routes. • Executive-level Risk and Assurance Group has been established and risk reporting to the Audit & Risk Committee has been reviewed and strengthened in line with the new Risk Framework. • Sexual Safety Charter launched in November 2024 and a new Sexual Misconduct Policy in September 2025.	• Continue to drive and communicate the groupwide quality priorities across all sites. • Design and launch a strategic approach to identifying, disseminating and embedding learning from concerns raised by staff across the Trust and the wider Group. • Make groupwide working easier through a new Target Operating Model for the Group to support the delivery of the Medium-Term Plan and consider the case for a potential merger of ESTH and SGUH. • Launch Violence Prevention and Reduction policy.
The group strategy, launched in May 2023 is not yet fully embedded and the pace has been slower than planned. Not all staff understand their role in the strategy to improve services.	Shared Direction and Culture	• Launched a structured approach to reviewing the local delivery of improvements to support the embedding and implementation of the Group strategy using CARE Boards at Executive, Site, Divisional and increasingly departmental levels. • Have commenced Quarterly roadshows to help share/explore Trust development and future • Development of 13 transformation programmes and 4 CSSG to help involve more of our talent in the required changes to deliver strategy	• Embed the CARE framework into staff objectives and Performance and Development Reviews so that staff are supported to understand how their role supports the delivery of the strategy, alongside a more structured career conversation and an ongoing focus on wellbeing. • CARE Objectives to be incorporated into all departments and the Ward Accreditation Programme.
Progress in realising the benefits of working as a Group with Epsom and St Helier has been slower than planned.	Shared Direction and Culture	• Supporting the implementation and embedding of the new Clinical Strategy and Standards Groups to drive forward clinical collaboration and integration across the Group to support improved care for patients, address unwarranted variation, and deliver sustainability.	• Engaging staff and stakeholders on the future of the group

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

AREA FOR IMPROVEMENT	CQC DOMAIN	CURRENT WORKSTREAMS	FUTURE PLANS / ACTIVITY TO DESIGN NEXT STEPS
The CQC found that some leaders displayed behaviours that were not inclusive and some lacked capacity for strategic delivery. There is a need to strengthen leadership development, talent management and succession planning across the Trust and Group.	Capable, Compassionate and Inclusive Leadership	• An inclusive board programme to mirror the work of the Group Board, with the aim of readying senior leaders from under-represented backgrounds for executive roles has been approved. • A new talent management and succession strategy agreed by the Board. This will provide a framework for identifying and nurturing talent and career development across the organisation, supporting greater diversity in more senior leadership positions, and promoting a more inclusive culture. • Relaunched the Leadership and Management Development offer – aimed at equipping managers through focussed and inclusive leadership development, with the skills needed to tackle poor behaviours where they occur.	• Inclusive Board programme to be launched • Recruitment inclusion representatives to be included on interview panels for all band 7 roles and above (currently band 8 and above) and ensure feedback is more systematic. • We will use the current staff survey to help the Site Leadership team and divisional teams target OD, management capability and leadership interventions based on either a low feedback rate or specific poor ratings from staff. • For all sites in the group, the group executive and People Committee will receive assurance that negative outlier staff survey results at departmental level are investigated with follow up discussions with staff in those areas. • We will recognise and gain insight from positive outliers on the staff survey to inform our wider approach. • Launch Talent Management Programme (including inclusive recruitment and career conversations). • Clearly defined expectations for leaders and managers are set and held to account. • Board Development to include inclusive leadership and supporting accountability.
Some staff do not always feel they can speak up,	Freedom to Speak Up	• New Group-wide Freedom to Speak Up Policy, incorporating the new national model and new	• Co-design a new Group-wide Freedom to Speak Up Vision and Strategy drawing on feedback from

AREA FOR IMPROVEMENT	CQC DOMAIN	CURRENT WORKSTREAMS	FUTURE PLANS / ACTIVITY TO DESIGN NEXT STEPS
and that leaders were not always viewed as acting with openness, honesty and transparency. Some staff found it hard to speak up and the organisational culture did not ways encourage staff in raising concerns.		Group-wide protocol for managing concerns from staff encountering detriment for speaking up implemented. • Developed a new Insights Dashboard to support triangulation of concerns raised by staff • Sexual Safety Charter launched in November 2024 and a new Sexual Misconduct Policy in September 2025.	the NHS Staff Survey and through a series of focus groups with staff across the Group. • Consider intervention in specific teams as above. • Toolkits and training for staff on sexual safety and misconduct to be developed. • Findings of review will inform areas to invest in building capability and greater accountability.
The CQC highlighted that a number of staff had raised concerns to them following the Well Led inspection raising concerns about racial discrimination, bullying and harassment, and organisational culture. The Trust's commitment to improving the organisation's culture is not reflected in staff experience across the protected characteristics and more needs to be done to promote an inclusive culture.	Workforce Equality, Diversity and Inclusion	• New Equality, Diversity and Inclusion Plan, approved by the Board in February 2025. • Strengthened and refreshed Executive and Site level sponsorship of Staff Networks. • Bitesize microaggression training delivered. • Group wide bullying and harassment awareness sessions held. • All Board members have an EDI objective.	• Review current data and cases to understand specific nature of issues raised (i.e. grievances) with a focus on learning to inform future case management.

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.

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.

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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.

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.

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

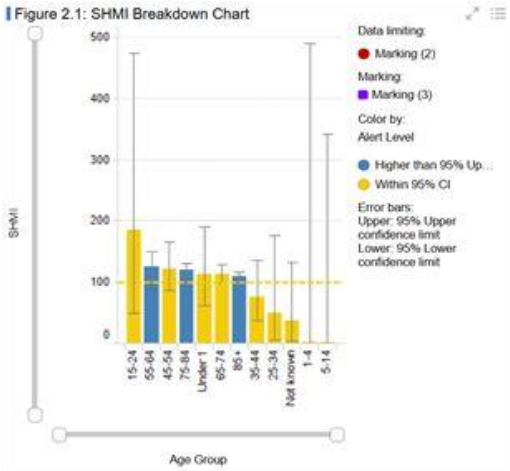
APPENDIX 4: ANALYSIS OF SHMI BY AGE, SEX AND DEPRIVATION

Source: Healthcare Evaluation Data (HED)

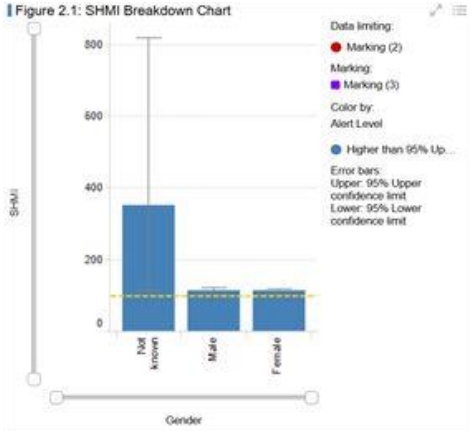
ESTH:

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

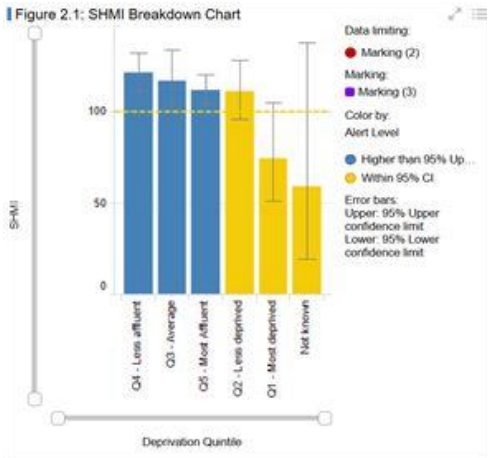
SHMI by age



SHMI by sex



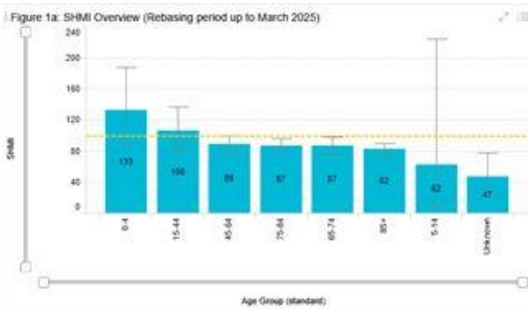
SHMI by deprivation



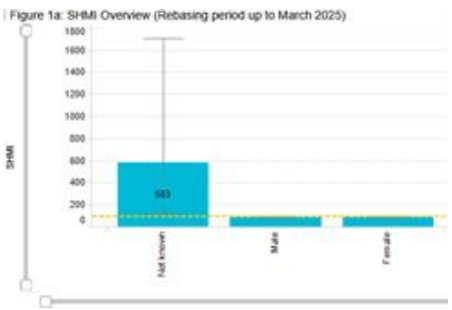
SGH:

Mortality is either as expected, or lower than expected

SHMI by age



SHMI by sex



SHMI by deprivation