Group Board

Agenda

Meeting in Public on Thursday, 08 January 2026, 09:15 – 11:45

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

Introductory items					
Time	**Item**	**Title**	**Presenter**	**Purpose**	**Format**
09:15	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
09:20	1.5	Group Chief Executive Officer's Report	IGCEO	Review	Report

Quality and Safety– Items for Review and Assurance					
Time	**Item**	**Title**	**Presenter**	**Purpose**	**Format**
09:30	2.1	Quality Committees Report	Committee Chair	Assure	Report

Finance, Performance, Audit and Risk – Items for Review and Assurance					
Time	**Item**	**Title**	**Presenter**	**Purpose**	**Format**
09:40	3.1	Finance and Performance Committees Report	Committee Chair	Assure	Report
	3.2	Finance Report – Month 8	GCFO	Review	Report
09:50	3.3	Integrated Quality and Performance Report	GDCEO	Review	Report
10:10	3.4	Audit and Risk Committees Report	Committee Chair	Assure	Report

People – Items for Review and Assurance					
Time	**Item**	**Title**	**Presenter**	**Purpose**	**Format**
10:20	4.1	People Committees Report	Committee Chair	Assure	Report

Infrastructure – Items for Review and Assurance					
Time	**Item**	**Title**	**Presenter**	**Purpose**	**Format**
10:30	5.1	Infrastructure Committees Report	Committee Chair	Assure	Report

Strategy and Governance – Items for Review and Assurance					
Time	**Item**	**Title**	**Presenter**	**Purpose**	**Format**
10:40	6.1	SGUH CQC Well Led Report Response Update	GCEO	Review	Report
10:55	6.2	Board Assurance Framework	GCCAO	Review	Report

Items for Noting					
Time	**Item**	**Title**	**Presenter**	**Purpose**	**Format**
-	7.1	Healthcare Associated Infection Report	GCNO	Note	Report

Closing items					
Time	**Item**	**Title**	**Presenter**	**Purpose**	**Format**
11:10	8.1	New Risks and Issues Identified	Chair	Note	Verbal
	8.2	Reflections on the Meeting	Chair	Note	Verbal
	8.3	Questions from members of the public and Governors of St George's*	Chair		Verbal
	8.4	Any Other Business	All	Note	Verbal
11:25	8.5	Patient / Staff Story	GCNO	Review	Verbal
11:45	-	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
Lizzie Alabaster	Interim Group Chief Finance Officer	IGCFO
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
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
Anna Macarthur	Group Chief Communications Officer	GCCO
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 Thursday, 06 November 2025, 12:00-16:30

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

PRESENT		
Mark Lowcock	Group Chair	Chair
James Blythe	Interim Group Chief Executive Officer	IGCEO
Natalie Armstrong	Non-Executive Director	NA
Mark Bagnall*^	Group Chief Facilities, Infrastructure and Environment Officer	GCFIEO
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^	Associate 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 & ESTH (Associate)	LP
Bidesh Sarkar	Non-Executive Director ESTH & 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		
Elizabeth Dawson	Group Deputy Director of Corporate Affairs	GDCCA
APOLOGIES		
OBSERVERS		
Sarah Dixon	NHS England	
John Hallmark	SGUH Governor	
Karyn Richards-Wright	Freedom to Speak Up Guardian (item 5.2)	FTSUG
Daniel Pople	Group Deputy Chief Communications Officer	GDCCO
Katie Vaughan	CEO, St George's Hospital Charity (item 7.2)	KV
Anna Walker	Chair, St George's Hospital Charity (item 7.2)	AW

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

		Action
	Feedback from Board Visits	
	Mortuary: JY, PW, GCNO and GCOFIE had visited the mortuary which had been clean, calm and well organised. The GCOFIE highlighted the robust security measures in place. The care given to the bereaved was evident, as was the strength of the team who had been asked to support with repatriations following the Air India air disaster. The team had been nominated for a gesh CARE ward. Pharmacy: CSH, PD, GCPO and MD-ESTH had visited the Pharmacy with Audrey Khoo who had led the visit and was noted as a credit to the service with her positivity and enthusiasm. It was hoped that eventually pharmacy and the EPR could be integrated to further improve the service but it was appreciated that this would require significant investment. The long waits experienced by patients on occasion was a concern particularly when there was felt to be insufficient seating and issues with temperature control in the area. The GCOFIE would look into this. Cath Lab: AM, BS, GCCAO and MD-IC had visited the Cath Labs which carried out a mix of elective, non-elective and emergency care. The area had been clean but it was noted that the corridors were crowded which could be as a result of the Vascular Team using one of the labs while their space was being refurbished. The MD-SGUH acknowledged the flexibility that the service had shown in making space for the vascular team, particularly given the knock-on effect on cardiology waits, with the refurbishment set to be completed in February 2026. AM noted the rigorous use of checklists was now a culture within the team, following on from this being highlighted in Never Event reporting, which gave confidence. It was highlighted that 3 of the consultants would be receiving an international award for their cutting edge work. Industry funding and working in partnership with the university had also been discussed during the visit. Fracture Clinic: NA, KM, IGCEO, GCMO and Sarah Dixon (NHSE) visited the Fracture Clinic. It was reported that this was a well kept, pleasant environment with high levels of activity. Areas raised for improvement were the overlap between a planned MDT meeting and bookings, long waits and the quality of pre-appointment patient information. A high turnover of staff was noted, with it suggested that burnout was a possible cause with the use of AI to make the role more attractive offered a potential solution to this. The flu vaccination programme and staff survey were promoted and a fire warden for the area had been appointed. Staff had reported feeling well supported and that the security team had been responsive to any incidents of violence or aggression. Thomas Young Stroke Unit: The Chair, LP, GDCEO and GCFO had visited the Thomas Young Unit which had 15 acute and 10 rehabilitation beds. The unit had been clean and calm but corridors were cluttered with computer equipment. Faulty lifts were raised as an issue as the unit was on the 3rd floor and there were also leaky pipes, with it felt that the estates and facilities team could be more responsive. More positively, the facilities were good with a gym to support rehabilitation. Ward staff would like to develop their dining area, which would further support patient rehabilitation, and it was suggested that the charity may be able to help with this. The Chair noted that a lot of patients stayed on the unit for some time and the staff continuity seen on the unit was important. The Chair thanked Board members for their feedback and the good mix of positive feedback and learning.	

1.0	**INTRODUCTORY ITEMS**
1.1	**Welcome, introductions and apologies**
	The Chair welcomed everyone to the meeting. Particular welcome was made to James Blythe, Interim GCEO, Elaine Clancy, Interim GCNO and Alex Shaw, Interim Managing Director of Epsom & St Helier who were all attending their first Group Board (public) meetings. Leonie Penna and Bidesh Sarkar were also welcomed at their first meeting Group Board (public) meetings as Non-Executive Directors. The Chair also noted that this was Pankaj Davé's first public Board meeting as a NED at Epsom & St Helier, having been a NED at St George's since February 2025. Sarah Dixon from NHS England and John Hallmark, a St George's Governor, who were observing the meeting were welcomed. The Chair gave thanks to Andrew Grimshaw, Group Chief Finance Officer, who was leaving the Group at the end of November to take up a role at Mid and South Essex NHS Foundation Trust. Andrew had been a Board member at SGUH since June 2017 and joined the ESTH Board when the Group was formed in 2022. During his time, Andrew had overseen significant improvements in the robustness of the Trust's financial governance and oversaw St George's move out of financial special measures in December 2019. He had also served as Deputy Chief Executive of St George's under Jacqueline Totterdell, stepping up to be Acting Chief Executive for several months during the Covid-19 pandemic when the CEO was hospitalised. The Chair noted the huge service Andrew had given for which all were fantastically grateful. There were no apologies for absence.
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, Pankaj Davé, Yin Jones, Andrew Murray, Leonie Penna and Bidesh Sarkar as Non-Executive Directors; • James Blythe, Mark Bagnall, Elaine Clancy, Andrew Grimshaw, Richard Jennings, Stephen Jones, Michael Pantlin and Victoria Smith as Executive Directors. There were no other declarations other than those previously reported.
1.3	**Minutes of the Previous Meeting**
	The minutes of the Group Board meeting on 5 September 2025 were approved as a true and accurate record.
1.4	**Action Log and Matters Arising**
	<u>The Group Board reviewed the action log and noted the following updates:</u>

	• PUBLIC20250901.1: The Group Chief People Officer proposed a revised date of Spring 2026 for reviewing MAST training requirements across the Group to ensure a consistent approach to Freedom to Speak Up training. This was on the basis that proposals were currently being drafted and would be considered by the Group Executive and People Committee Committee early in the new year. • PUBLIC20241107.2: The CQC Well Led report was not received until the end of October and included a number of comments about culture and raising concerns by staff. As the CQC item later in the agenda suggested, work was planned to develop a set of actions to support speaking up. To allow time for engagement with staff and a co-ordinated approach a revised date of Spring 2026 was proposed. **The Board approved the revised dates.**	
1.5	**Group Chief Executive's Officer (GCEO) Report**	
	The IGCEO began by echoing the thanks of the Chair to the GCFO for his service to the group. He took his report, which included a range of updates and assurance matters, as read with the following highlighted: • **Medium Term Planning:** The NHS England Framework had been issued, and the Group was developing ambitious plans in line with the NHS 10 Year Plan. With a submission date of 17th December there was a huge amount to be done, with a draft to be shared with the Board at the beginning of December. • **SGUH CQC Well Led:** This would be discussed in detail later in the agenda but the Group Executive and SGUH Site Leadership Team had taken on board the findings in the report and would be seeking to address them, with learning to be taken across the whole group. • **gesh Care Awards:** This would be the second year for the awards which would be held on 9 December at the Oval Cricket Ground. Over 900 nominations had been received across all functions across the Group, of a very high standard. The IGCEO recorded thanks to all those that were involved. In relation to the Medium-Term Plan, PD said that he hoped that there were sufficient discussions taking place with partners as the shift from hospital to community was extremely complex. With Surrey Downs we had experience of community work and the positive impact it could have for patients. He looked forward to future discussions on how the group would balance what was needed now, whilst also preparing for the future. **The Group Board noted the GCEO report.**	
2.0	**ESTH Soft Facilities Management**	
2.1	**ESTH Soft Facilities Management Staff Terms and Conditions**	

	The GDCEO reminded the Board that the issue had been shared in public at a previous meeting, and he was now able to provide an update and set out the recommendations. The Soft Facilities Management (FM) team were hugely important to the running of ESTH and without them, hospital operations could not function effectively. Over the past decade, Soft FM provision had undergone several structural changes, with services outsourced in 2018 to address pay inequalities and cost pressures, then brought back in-house in 2021 too strengthen equity, quality and local control. The Board at the time had agreed that this was would not be under Agenda for Change (AfC) and a new local pay model had been implemented in 2023 to formalise pay structures and ensure compliance with the London Living Wage. However, this was not a situation anyone was now comfortable with; inequalities persisted and industrial relations challenges had grown. Colleagues in the Soft FM team at ESTH felt undervalued and that they were being treated less favourably than colleagues working elsewhere in the Trust under AfC terms and conditions. The situation had been compounded by a pension enrolment error confirmed in July 2025, where staff who had transferred in 2018 and 2021 had been enrolled on the National Employers' Savings Trust (NEST) scheme rather than the NHS Pensions Scheme. This was wrong and was being corrected, and from January 2026 all staff would now be offered the NHS scheme. To address Agenda for Change, four strategic options have been evaluated: 1. Do Nothing - retain current local contracts. 2. Outsource - retender to private providers (TUPE applies). 3. Immediate AfC Alignment - implement AfC terms in full immediately, with no backdating. 4. Phased migration to AfC, with no backdating The GDCEO said that as current contracts were legally compliant and the financial implications were unaffordable, backdating was not recommended. Option 4: Phased AfC Alignment was the preferred approach as it balanced fairness and affordability and would recognise NHS service. In discussion, the Board commented on the letter that had been received from staff member Farrokh Hormoz and how helpful it had been to hear so clearly from the staff perspective. They recorded their thanks for the ideas that had been put forward. AM expressed his support for Option 4, but asked whether this would result in financial implications in other areas, and whether NHSE were supportive of the approach being taken. The IGCEO confirmed that NHSE had been briefed as the matter progressed and had said that the understood the position. Once the Board had made their decision he would update NHSE and did not expect an adverse reaction. He acknowledged that there were a number of different contracts for Estates and Facilities staff and the Group would be bringing these into line with NHS expected practice. **Following discussion, the Board agreed that there should be a phased migration of the ESTH Soft FM staff to Agenda for Change Contracts, without any backdating, to the timescales set out in the paper.**	

	Thanks were recorded to everyone who had been involved in the discussions to find the right balance of fairness and affordability to resolve this issue for a crucial group of colleagues.	
3.0	**Quality and Safety - Items for Review and Assurance**	
3.1	**Quality Committees Report**	
	AM, Committee Chair, took the report as read and highlighted that the key areas discussed by the Committee had been falls, where they had assurance that the right actions were in place but this assurance remained limited as completion of the actions was not on track. There had also been a deep dive into the Emergency Departments and wider ED pressures at Epsom and St Helier including the unavoidable use of corridor care. The Committee were assured that the risks and response to those risks were clearly understood. Issues in Acute Medicine at St Helier had been reported to the Committee, the difficult context was noted as were the actions in train to address them. The Committee had also considered the Winter Plan. AM explained that approval of the plan rested with the Finance and Performance Committee but it should also be reviewed by the Quality Committee with the quality impact assessment that had been carried out coming to the November meeting. Reports had also been received on maternity (which was later on the agenda), learning from deaths and PSIRF. PW asked whether the new Patient Safety Incident Response Framework (PSRIF) was achieving its stated aims. The IGCNO responded that it was too early to say as trusts across the country had implemented the Framework at different times. The GCMO agreed, adding that there were no simple metrics to evaluate it, but some benefit was being seen as the new Framework was less repetitive and more agile. However, the discipline of Serious Incident reporting had been lost and would need to be kept under review. The GCMO added that the new system was one way in which a blame culture could be avoided but the CQC report showed that there was still more to be done. NA informed the Board that she was a member of the steering group developing a national evaluation of PSIRF and that she would like to involve the GCMO and GCNO with its work. **The report from the Quality Committees was noted.**	
3.2	**Group Maternity Services Quality Report**	
	The IGNO introduced the report, noting the significant work that had been done to address comments on the quality and length of information being shared. The team was now more stable, although a few vacancies meant that interim arrangements were in place, with the Group Chief Midwifery Officer joining in the spring. The GCMO said that the medical leadership were very engaged but there was more to be done to ensure this was replicated in their approach to maternity governance. In response to a query from the IGCEO, AM said that there were still inconsistencies in reporting and better triangulation was needed with reports that	

	were submitted to the Quality Committees. AM noted that under Safety Action 1, Perinatal Mortality Review Tool (PMRT) timeliness, two late reports would mean fill compliance would not be achieved. The same issue had arisen the previous year so it was disappointing that this had occurred again. Although the quality issues were being addressed, there was a financial implication. PD queried the equality, diversity and inclusion data in ESTH reporting. AM agreed that there was not enough information and the Quality Committee had asked to review maternal outcomes for BAME women as it was well known that this group had worse outcomes. A report would come back to the to the Committee in due course, which would be reported to the Board. CSH asked whether there had been improvements in the culture in maternity which had been previously flagged as an ongoing issue. The IGCNO said that concerns over the culture in maternity were being addressed but would make better progress once these the new Group Midwifery Officer was in post. AM added that despite the turnover in maternity leadership, which had not helped, he was confident that there was work taking place at each site with the embedding of positive behaviours which gave assurance. AM noted the that the oversight of MD-SGUH and the leadership team was making a difference. **The Board noted the report.**	
4.0	**Finance and Performance - Items for Review and Assurance**	
4.1	**Finance and Performance Committees Report**	
	BS, as Committee Chair, took the report as read, highlighting that for Month 6, the forecast had been maintained at both Trusts but the material risks remained as some identified savings were behind plan. Additional savings and external support were being sought but there was limited assurance that the forecast would be achieved at year end. **The Board noted the report, the scale of the task and the limited assurance on delivery of the plan.**	
4.2	**Finance Report – Month 6**	
	The GCFO informed the Board that both Trusts were reporting being on plan in M6 but delivery of Cost Improvement Plans (CIPs) remained a key risk. Cash releasing savings, over and above what had already been done, had to be found including a decrease in workforce numbers was part of the planned CIP. The Chair concluded that the Group was committed to coming in on plan for both Trusts but recognised the risks as highlighted. **The Board noted the report.**	
4.3	**Integrated Quality and Performance Report (IQPR)**	
	The GDCEO referred the meeting to the report, explaining the challenges with winter and financial pressures that would impact performance. Appendix 2 of the	

	report shared a letter from NHSE putting both trusts in Tier 1, and ESTH in Tier 2, due to the risk of not meeting the targets for reducing waiting lists by the end of the calendar year. A meeting with NHSE to discuss the actions needed in the second half of the year had been helpful. The MD-SGUH, MD-IC and MD-ESTH highlighted key performance areas from their sites, acknowledging the impact of the pressures that the GDCEO had raised. For SGUH, the challenge to clear those waiting more than 65 weeks was being felt, and dermatology and breast services were a focus. Theatre performance was going well and the removal of surgery at QMH was being managed but diagnostic waits were increasing but would be addressed. At ESTH, as had been expected, the implementation of the Electronic Patient Record (EPR) had impacted on performance but there were signs that this was improving. A total of 124 patients were on the 65 week waits with dermatology making up the majority of these due to the rise in two week referrals which took priority. A plan was in place to try and address this without increasing capacity. In response to a question from PW, the IMD-ESTH said that the benefits of the EPR were being seen in in the Emergency Departments, Same Day Emergency Care (SDEC) and on the wards but outpatient workflow less so. The use of ambient artificial intelligence (AI) would help. The MD-IC reported that there were more limited metrics for integrated care but good progress was being made and we would be well placed to make the changes from hospital to community set out in the NHS 10 Year plan. In response to a question from PW, it was agreed that a discussion should take place in the future on the benefits of integrated care and how this supported the left shift. The MD-IC noted that an example of this would be how a frailty study showed that community care reduced the need for visits to EDs. **It was agreed that to ensure oversight a report on the Tier 1 and 2 status and quality and performance metrics would be shared with the Board at their private meeting in December.** **The Board noted the report and the challenges of trying to sustain high performance in the context of the winter pressures and financial constraints, and the strain that this put on staff.**	
4.4	**Audit and Risk Committee Report**	
	PD, Chair of the Committee, referred the meeting to the report, highlighting that the external audits had gone well with the team working well with Grant Thornton. The Committee had received internal audit reports on a number of areas including cyber security. The impact of a cyber security incident would be high and there were a number of actions to be completed by December with some scenario testing to take place. A residual risk would remain which would be monitored by the Committee.	

	The GCCAO had identified a number of actions to improve the quality of internal audit reporting and management responses. These included asking the auditors to suggest more substantive actions and to distinguish between strategic and operational issues, and ensuring that each final internal audit report and actions were approved by the relevant Executive. The new Group Risk Management Framework that had been agreed in February 2025 would take time to embed with more work needed to refresh the risks on the corporate risk registers. The GGCAO added that this needed to be done systematically; work was progressing on refreshing risks and the intention was to ensure that, following the refresh, the relevant risks on the corporate risk registers were regularly reviewed by the relevant Committees of the Board and the corporate risk register as a whole reviewed alongside the Group Board Assurance Framework on a quarterly basis in 2026/27. The Board Assurance Framework (BAF) would also be shared with Committees for review in December ahead of the January Board meeting. In discussion it was noted that a review of the Board's risk appetite would be beneficial as part of this work, and that the intention was that this would be reviewed alongside a possible refresh of the BAF. **The Board noted the report.**	
5.0	**People - Items for Review and Assurance**	
5.1	**People Committees Report**	
	YJ, the Committees Chair, took her report as read. At their last meeting, the GCPO had provided an update on 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. The Committees had also endorsed the Designated Body Annual Report and Statement of Compliance that each Designated Body is required to submit to NHS England. The Committee welcomed the work being done to align the People policies across the Group. The IGCEO said that the Resident Doctors 10 Point Plan was key and that the actions required would be rigorously monitored by NHSE so strong assurance processes would be needed. The GCMO added that the ongoing dialogue that resident doctors had requested take place on quarterly was a positive step. **The Group Board noted the report.**	
5.2	**Group Freedom To Speak Up Report**	
	The GGCAO referred the meeting to the report and invited Karyn Richards-Right, Group Freedom to Speak Up (FTSU) Guardian to highlight key themes. The FTSUG said that the issues raised with the team highlighted the uncertainty that the financial position was creating. At SGUH, there had been an improvement in the last year on the timeliness of concerns being addressed, with key themes for concerns being a perceived lack of communication and inconsistency in the application of staff policies. At ESTH cultural issues with staff feeling psychologically unsafe were noted. There was a continuing need for the team to be	

	transparent on the role of FTSU and for managers to be clear on how long it might take them to respond to concerns. Providing support for managers was an area that needed addressing as many felt out of their depth and some saying they also felt psychologically unsafe when responding. The GCCAO said that the Raising Concerns Triangulation Group was beginning to find its feet and have an impact on how quickly concerns could be addressed. He thanked FTSUG for the infrastructure that had been put in place for the service but noted the challenge for the organisation on responding appropriately and without undue delay to concerns, as well as the broader need for the Group to create an effective culture of speaking up more generally which required engagement from managers at all levels. LP queried how patient safety concerns were escalated. The FTSUG responded that in the vast majority of cases the concern was not directly related to patient safety and were to do with culture. However, if it was identified that there was a risk of harm this would be immediately shared with the appropriate member of the site team. In response to a question from YJ, the GCPO said that there was not yet a decision on whether FTSU would become mandatory at ESTH as it was at SGUH. An NHS wide review of mandatory training was currently underway which would inform the decision as would the cost, both financial and in time, of mandating this group wide. A report would come to the People Committee and then on to the Board as soon as possible. The Chair thanked FTSUG for the report and the work of her team. **The Board noted the report.**	
6.0	**Infrastructure - Items for Review and Assurance**	
6.1	**Infrastructure Committees Report**	
	PW, Committee Co-Chair, referred the meeting to the report highlighting that the Estates Safety Fund, which was nationwide, should bring some additional capital funding. The London Fire Brigade had written to ESTH with an enforcement notice requiring actions at St Helier to be completed by September 2026. The Committee had also been updated on the progress of the digital strategy and the progress with PACS project. In response to a question from BS, the GDCEO said that digital was being considered as part of the Medium-Term Plan with the detailed digital strategy to be discussed at the Board Strategy and Development session in December. **The Board noted the report.**	
7.0	**Strategy and Governance – Items for Review and Assurance**	
7.1	**CQC Well Led Inspection Report**	

	The IGCEO reminded the Board that the Care Quality Commission (CQC) undertook a Well Led inspection at SGUH between 25 and 27 February 2025. The report was published on 31 October 2025 and rated the Trust as 'Requires Improvement' overall, which was unchanged from the December 2019 inspection. Although all were disappointed in the outcome the findings were fully accepted. The negative experience of working at SGUH as reported by some staff to the CQC not acceptable – no staff members should encounter racism in the workplace and all staff should feel safe, respected and able to speak up all of the time. The findings in the report built on the areas that were already been worked on, as set out in the workstreams that were attached to his report, but it was clear that faster progress was needed. The next step was to co-produce 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 MD-SGUH said that the report was a sobering read. As well as the cultural elements that the IGCEO had referred to, issues such as silo working, learning across the organisation not always being systematic and the Accountability Framework not being embedded were recognised. Most concerning was the number of staff saying that they had encountered racism and that they did not feel safe to speak up, and in depth work was needed to understand the reasons for this so it could be addressed. Other members of the Executive endorsed the views of the IGCEO and MD-SGUH with the GCPO adding that the organisation needed to listen differently to what staff were saying and to work closely with the staff networks to understand, and progress at pace, the improvements that were needed with EDI. PD said that he had tried to look at the report objectively and to understand how we had got to the point where it was felt the leadership were not seen as responsive and where there could be a high level of trust and respect in many areas but not universally. Staff concerns around the lack of diversity and transparency in recruitment had to be addressed. Increasing diversity at a senior leadership level was key to this. YJ highlighted the Inclusion Board which was due to be introduced in the new year which would bring a wider range of voices and views to decision making at a senior level. The Board agreed with this, with AM adding that a Talent Management strategy, including inclusive recruitment, had been in development and queried when it would be available for review. The Board agreed with the comment from BS, that the overarching objective had to be clear – how do we recruit and retain the best talent so that we can serve our community. That talent may, or may not, be representative of the community but we did not currently have the right processes and plans in place to say that we could identify and attract the very best people from the widest and most inclusive field. **It was agreed that a timeline for finalising the talent management strategy should be submitted to the People Committee as soon as possible.** The Board noted the actions and workstreams that were already underway and that more detailed plans would come to the Board in January 2026. It was queried how the Board would have oversight of progress. The GGCAO explained that once the	

	plans had been co-designed and agreed by the Board, it would be possible to allocate elements to the relevant Board Committees so that they could review and seek assurance on progress in addressing the issues and implementing actions in response. Clearly, a large number of the actions related to equality, diversity and inclusion, speaking up and leadership would be overseen by the People Committee and the assurance levels then reviewed by the Board. The IGCEO acknowledged the appropriately high level of challenge from the Board and the views that had been expressed. The executive team and site leadership team would be moving forward with co-designing the action plan with staff, ensuring that there was quality in the listening that would take place. **The Board agreed 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;** **d) Receive at the January Board a comprehensive action plan to address the findings including key milestones and success measures.**	
7.2	**St George's Hospital Charity Update**	
	Anna Walker, Chair (AW) and Katy Vaughan, CEO (KV) provided an update on the work of the charity over the last year. The Board were reminded by KV that the charity launched a new strategy in 2024 after consultation with the Trust, called Healthier Together, which had four priorities which aligned with the trust vision: 1. Staff and patient wellbeing 2. Research and Innovation 3. Health Equity 4. Improving the Hospital Environment The goal was to raise £5 million per year by 2029/30 - the end of the current strategic period, and they were firmly on track to achieve it. Forecast income for 2024–25 was £3.8 million, a 42% increase on the previous year, reflecting both the loyalty of supporters and the effectiveness of the new fundraising strategy.	

	Last year the Board had rightly challenged the high cost of fundraising and KV was pleased to report that this had reduced from 27% to 16%. AW added that more was needed on describing the impact of the work of the charity, of which the community were hugely supportive. Donations in the form of legacies were an important source of funding but were often restricted to specific areas or projects so increasing unrestricted funding was an area of focus. Four keys asks were made of the Trust: 1. **Champion and advocate for the completion of the Children's Appeal** 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** Board support for 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** 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 together to agree annual priorities and involve the Charity early in project design so funding is focused where it adds the greatest value. In discussion, the Board commended KV on the work done to reduce costs and thanked the Charity for all that they did. NA recognised the value of the co-location with the University, adding that they were reviewing their approach to philanthropy, the Board supported joint working on funding for research between the University and the Charity. In response to a question from AM, KV said that the Charity would be establishing an advisory steering group to support decision making around grant funding for research. The MD-SGUH thanked KV and AW for all that the charity did and the enormous difference their funding made to staff, patients and their families. The GCMO recorded particular thanks for the funding of a member of staff to lead on Health Inequalities which had been mirrored at ESTH. The Board noted the report and gave their support for the asks that had been made.	
8.0	**Items for noting**	
8.1	**Learning From Deaths Report**	
	The Board noted the report.	

9.0	**CLOSING ITEMS**	
9.1	**New Risks and Issues Identified**	
	The findings of the CQC Well Led Inspection were noted as a new issue, albeit that some of the areas highlighted were captured on the Board Assurance Framework and corporate risk registers.	
9.2	**Questions from members of the public and Governors of St George's**	
	Questions in advance had been received from two members of the public. *Barry Tebb had asked:* *I have been informed (in writing) that the Botox Clinic, a part of the Headache Unit to treat migraine, has closed due to cost cutting. Copy of letter enclosed. By what authority has the statement been made and have the clinical considerations been given due weight by the Medical Directorate? Limiting a service to existing patients but barring it to other patients surely has implications under the Equalities Act.* The MD-SGUH responded that there was a new form of chronic migraine treatment, the anti-CGRP medications, which had been introduced and formed part of our regional headache management pathway. We had therefore been asking patients whether they would consider switching from Botox to an anti-CGRP medication over the last year. Botox was still an option for refractory migraine – but we were trying to reduce its use by the trialling of other interventions first – ie it is becoming the treatment of last resort. A written response would be sent to Mr Tebb. *Marion Parkes, who was present at the meeting, had submitted questions on the Picture Archiving and Communication System contract between Optum to which the GCFO responded as follows:* • Q1.*Before he leaves GESH, and as a member SWL APC Senior Management team and procurement lead for the below two systems, please could the Director Finance /IT give an update regarding the SWL PACS Contract with Optum aka Change Healthcare aka United Healthcare.* *Having already spent the £4million allocated by NHS England to implement this PACS (it was tested extensively demonstrated to be not fit for purpose) will GESH be recovering these costs from Optum to fund any future possible implementation?* A1: Further to our previous correspondence, I can confirm that all four Trusts within South West London (SWL) continue to work collaboratively with Optum to address the issues raised following Trust Board approvals to proceed with the programme. We are actively engaging with Optum on additional aspects that require joint development and implementation to ensure successful delivery.	

	Q2: Clinical Decision support system contract between MyOrb and GESH signed end 2021. Please could the Director of Finance/IT give an update on the above contract. In excess of £400K was paid on Contract signature to myOrb with no system being demonstrated. A Companies House search shows that MyOrb went into liquidation on July 2nd 2024. Has the system as contracted with MyOrb been supplied and in Live use? If not, has the contract been notated to another company? If not, what steps are being taken to recover the funds? A2: MyOrb and SWL completed a pilot at Kingston and Richmond Hospital Trust. Following its conclusion, the initiative was not progressed further. There are no funds to recover as the pilot was completed. *Q3: Is this an example of fraudulent misappropriation of public funds? If so, what steps are GESH taking to rectify this?* A3: The GCFO was not that aware of fraudulent misappropriation of public fund until this question was raised and so had referred the matter to the Counter fraud team. *Q4: What is the status of live patient data sent to MyOrb, this includes demographic data and radiology data including reports.* A4: No live data is being sent, only test data was sent. *Q5: Has a Lessons Learned Report been undertake to specifically identify the Procurement process for these IT system?* A5: Not at this time. As Ms Parkes had been previously informed, a review would be carried out at the end of the project so that any lessons could be learnt. Ms Parkes was invited to speak and expressed her disappointment with the responses. She did not believe that the system was fit for purpose, that the project could not be terminated, or that the procurement rules had been followed appropriately. The GCFO said that Ms Parkes had been provided with a number of responses to the queries she had raised but it was not possible to share information that was legally privileged. The IGCEO added that the Board had received an assurance report from South West London Procurement at a previous meeting, which had also set out the options for the project and it had been agreed that it should continue. The IGCEO offered to follow up with Ms Parkes directly.	
9.3	**Reflections on meeting**	
	The GCFO gave his reflections on what was his 85th Board meeting since joining SGUH. Although the faces around the table may have changed, what had remained constant was the dedication and application of the Board and his other	

	colleagues. During today's meeting there had been some good discussion, particularly on the CQC Report which had been useful. The challenge from CQC and the Board on how we respond to some of our issues had been a good debate.	
9.4	**Patient Story**	
	Amir Hassan, Clinical Director for Urgent Care at ESTH, presented a patient story explaining how the team had learnt from the death of a patient with a learning disability. Unfortunately, the family were unable to be present at the meeting but supported their experience being shared. Chris was an 80 year old gentleman with learning difficulties who was managing at home with support from family and carers. He presented to the ED at Epsom Hospital with increasing confusion and was seen in ED, before transferring to the Acute Medical Unit (AMU) and then to Croft Ward. Chris unfortunately died from a bowel perforation several days later. Chris's family felt that nurses failed to make reasonable adjustments, did not treat him with kindness and compassion and that he therefore, received sub-standard care. A comprehensive Nursing Review was undertaken and shared with Chris's family which covered the following identified issues for both medical care and in caring for those with a learning disability: 1. Limited availability of learning disability liaison nurse input 2. Treatment and management of faecal loading and constipation 3. Understanding of learning disabilities 4. Ward transfer without rationale 5. Consideration of reasonable adjustments 6. Delayed or inadequate complaint response 7. Pain monitoring for individuals with learning disabilities. A number of actions were carried out in response: • Feedback from Chris's family was shared with ESTH Senior Leadership Team, Patient Safety & Quality Group and gesh Quality Group for awareness and learning. • The Divisional Medical Director met with Chris's family to discuss their experience, Chris's chronology of care during his time at ESTH and learning for the Division and wider Trust. • A Family meeting to review learning with Divisional, Trust and gesh Senior Leaders. • Care of the Learning Disability patient is the key focus of the Division's Safety Improvement plan which has been presented at Divisional Governance meetings and at the Trust's Patient Safety Incident Response panel. • The formal complaint response shared with the family following a thorough investigation. AM thanked AH for his powerful presentation and the learning that had been taken, he asked how it was being shared. AH responded that there was a tiered approach which had had been discussed at Grand Round, the Care of the Learning Disability Patient approach was first being shared with medical teams and would then be rolled out.	

	The IGCNO recorded condolences to the family, noting that nursing also needed to learn from what had happened and take a holistic approach to take onboard the views of the patient. The IGCNO asked that the learnings be shared with the SGUH team to increase awareness and so that training needs could be identified. In response to a question from PW, AH responded that the challenges with ensuring that the form that had been developed to share information about a person with learning disabilities was used were recognised but noted that it should not be task oriented but holistic. The Board thanked AH for his contribution and the reflections that it had provoked on the care and support that was needed when treating patients with learning disabilities.	
CLOSE		
The meeting closed at 4.15pm		

Group Board (Public) - Updated January 2026

Action Log

ACTION REFERENCE	MEETING DATE	ITEM NO.	ITEM	ACTION	WHEN	WHO	UPDATE	STATUS
PUBLIC20251104.01	04-Nov-25	4.3	IQPR Report	It was agreed that to ensure oversight a report on the Tier 1 status and quality and performance metrics would be shared with the Board at their private meeting in December.	04/12/2025	GDCEO	Presented at December meeting.	PROPOSED FOR CLOSURE
PUBLIC20251104.02	04-Nov-25	7.1	SGUH CQC Well Led Report	Receive at the January Board a comprehensive action plan to address the findings including key milestones and success measures	08/12/2026	IGCEO	On agenda for January meeting.	PROPOSED FOR CLOSURE
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.	NOT YET DUE
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 originally 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 feedback 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 received until the end of October. To allow time for engagement with staff and a co-ordinated approach a revised date of Spring 2026 is proposed.	NOT YET DUE

Group Board

Meeting in Public on Thursday, 08 January 2026

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, 08 January 2026

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 As reported at the last meeting, in support of the delivery of the NHS 10 Year plan, NHS England issued new guidance entitled 'Medium Term Planning Framework – delivering change together 2026/27 to 2028/29'. As a reminder, the 3-year roadmap set 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 also 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.

As required and following discussion with the Board, the first draft of our Medium-Term Plan was submitted to NHSE on 17 December 2025 with the final version due in February.

3.0 Our Group

3.1 CQC Inspections at Epsom and St Helier

The Care Quality Commission (CQC) carried out planned service inspections of Maternity, Emergency Services and Surgery at Epsom and St Helier Hospitals in the first week of December. Whilst we await publication of the reports, I would like to record my thanks to the staff who supported the inspections.

The CQC have also given notice of a 'Well Led' Inspection at Epsom and St Helier on 10-12 March. As set out in the Board item on developing a well-led group, we have begun our preparations to ensure that the inspection goes smoothly and are building on the learning from the February 2025 inspection at St George's.

3.2 Maternity services Survey

The annual national CQC maternity services survey has been published with both St George's and Epsom and St Helier receiving results in line with national averages, with several standout strengths highlighted.

The annual survey captures the experiences of women who gave birth in February 2025, asking them to rate the quality of their care from pregnancy through to the postnatal period. Participants were randomly selected and services were assessed across antenatal care, labour and birth, postnatal support and interactions with staff.

At Epsom and St Helier, women reported higher than average levels of kindness and understanding after birth, strong mental health support during pregnancy, and good involvement of partners during labour and birth. The Trust also scored much better than others for the support provided at the start of labour.

St George's achieved above average scores for staff introducing themselves before examinations and for providing clear information about physical recovery after birth. The Trust also performed better than most in supporting new mothers during the first four weeks postnatally.

One area identified for improvement at St George's was staff awareness of women's medical histories during antenatal checks, which saw a decline and will require further review.

3.3 Robotic Surgery

At the private part of the December Group Board, approval was given to purchase a new surgical robot at a capital cost of £2.4m, to be located at Epsom hospital, and used by surgeons across gesh. This is aligned with the Group surgical strategy and supports a group-wide approach to surgical services as well as growing Epsom hospital's existing role as an elective hub, building on the strength of the SWLEOC model.

I would like to record our thanks to the ESTH Charity for their significant donation which allowed us to take this forward in the current financial year.

3.4 Winter Pressures

As reported in the national media, an early flu season and industrial action by resident doctors in December impacted on NHS services. This was no different at gesh and will be reflected in our performance data, but overall we were able to minimise the impact and sustained around 98% of planned activity. We continue to identity ways to increase support for staff wellbeing during the most challenging periods and are grateful for the support that our two charities offer such as providing free staff meals on Christmas Day.

The new year has started with high levels of operational pressure which will be evident to Board members during today's Board visits to clinical areas.

4.0 Events, Appointments and Our Staff

Gesh CARE Awards 2025

4.1 The gesh CARE Awards 2025 were held on 9 December at the Kia Oval Cricket Ground and attended by over 400 colleagues. We recognised clinical and non-clinical staff who make a

difference to patients, colleagues, and the wider community and over 900 nominations were received this year, almost double that from the previous year. 13 awards were presented to a wide range of individuals and teams across both trusts celebrating the very best of gesh and the NHS.

The gesh CARE awards are generously sponsored by our hospital charities and local businesses to thank our teams for the care their provide every day.

NHS Staff Survey

4.2 The 2025 staff survey is now complete. Results are under embargo until the Spring whilst the detailed national analysis takes place but we are grateful to all who staff who shared their views. We will bring a full report to the Board on the results as soon as the embargo is lifted including plans for how we will respond, building on the intention set out in the well-led paper to focus much more closely on variation in staff survey scores between teams.

Recent leadership changes

4.3 Following the departure of Andrew Grimshaw, Group Chief Finance Officer, in November, Lizzie Alabaster (Site CFO at ESTH) was appointed into the interim role after a competitive process. Recruitment for the substantive role will begin shortly.

5.0 Recommendations

5.1 The Group Board is asked to note the report.

Group Board Meeting (Public)

Meeting on Thursday, 08 January 2026

Agenda Item	2.1	
Report Title	**Quality Committees Report**	
Executive Lead(s)	Richard Jennings, Group Chief Medical Officer	
Report Author(s)	Andrew Murray	
Previously considered by	n/a	Click or tap to enter a date.
Purpose	**For Assurance**	

Executive Summary

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

1. Quality Priorities Quarterly Update: The Committee welcomed the report, noting that overall, Q2 performance demonstrates continued progress in several domains, balanced against ongoing operational pressures and variation between sites. A discussion was held on Falls within the organisation, particularly at ESTH, the Site Chief Nurse advised the Committees that a Falls Group has been set up with a view to understand and prevent what is causing falls in the organisation. Audits are also taking place in wards to ensure that improvement is being made.
2. Group Patient Safety Incident Report: It was noted that the PSII report for ESTH has been completed, with the Committees Chair requesting that this be shared with members for their information. The Committees Chair also requested that the emerging themes from the never event action plans be presented to the Committees. During a conversation on PSIRF training, Committees members agreed with the principle of tailoring the training package in a focused way to enable staff to undertake the essential training efficiently.

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 November and December 2025.

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

Appendices	
Appendix No.	**Appendix Name**
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, 08 January 2026

1.0 Purpose of paper

1.1 This report sets out the key issues considered by the Quality Committees at its meetings in November and December 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 27 November 2025 and the 18 December 2025 the Committees considered the following items of business:

27 November 2025	18 December 2025 – Focus Session
• Group Key Issues Report • Quality Priorities Quarterly Update • Infection Prevention and Control Report • SWL Pathology Report • Integrated Quality Performance Report • Safeguarding Update • Health Inequality Update	• Patient Safety Incident Report • Dementia and Delirium • Winter Plan Quality Impact Assessment • Interstitial Lung Disease at ESTH -RCP Invited Review update. • Group Board Assurance Framework

2.2 The Committees was quorate at both meetings.

3.0 27 November – Key Issues for Escalation to Group Board

3.1 <u>Group Key Issues Report</u>

3.1.1 Committees members had a discussion on pressure ulcers, noting that whilst there will be incidents when pressure ulcers are unavoidable, avoiding these occurring where possible remains the aspiration of the organisation. Therefore the committee did not support relaxing the target for category 4 pressure ulcers. It was agreed that investigations into each pressure ulcer occurrence would help develop learning which could be implemented into the organisation going forward.

3.1.2 When discussing VTE, Committees members noted that the group has made the decision to report VTE compliance from time of admission to an inpatient ward, rather than from time that Decision to Admit (DTA) is recorded on Cerner for patients admitted from the Emergency Department. Members noted that whilst this approach may be needed for data quality, they expressed concern with regards to the risk that patients may be waiting over 12 hours for a risk assessment from the point of being admitting to ED. LP requested that to mitigate this risk, safeguards are put in place, such as data being presented to the Committees which details the time from arrival at ED to the point of receiving the assessment so that there is an understanding of how many patients are waiting over 12 hours. It was also requested that VTE occurrence within 72 hours of admission are monitored, with a view to ensure that those

occurrences were not directly caused by the organisation's policy. The Committees noted that VTE is a quality priority and will receive an update on this in three months' time.

3.1.3 Continuing the discussion on VTE, Committees members also noted that the paper advised that the approach being taken is to ensure the national target is met, however this is not a good enough reason to change the way of measuring performance. It should be noted that the more compelling reason to take this approach is because of concerns about bleeding, as there are potentially patient risks of doing a risk assessment too early.

3.1.4 Committees members **endorsed** the decision taken by gesh Quality Group with regards to VTE compliance, with the caveat that the reporting safeguards detailed in point 3.1.2 are presented to the Committees in order provide assurance that the policy is not causing patient harm.

3.2 Quality Priorities Quarterly Update

3.2.1 The Committees received the report, noting that overall, Q2 performance demonstrates some progress in several domains, balanced against ongoing operational pressures and variation between sites. The Quality Priorities are:

- Fundamentals of Care
  - Pressure ulcer prevention
  - Venous Thromboembolism (VTE) risk assessment
  - Falls prevention
  - Delirium assessment
- Improve flow in the Emergency Department to reduce overcrowding and long waits for treatment
- Safe maternity services

3.2.2 The Committees Chair advised that for ESTH, there is an annual threshold of 16 against the priority for Falls with moderate and above harm, but noted that the Trust is now on 14 and so is close to the threshold; he asked if there are mitigations in place to prevent more falls occurring. CNO-ESTH advised that a Falls Group has been set up with a view to understand and prevent what is causing falls in the organisation. Audits are also taking place in wards to ensure that improvement is being made. The Committees will continue to carefully monitor this through the quarterly updates.

3.3 Health Inequality Update

3.3.1 The report presented the Quality Committees with an overview of the gesh Group's progress in advancing the programme to tackle health inequalities over the past six months. GCMO introduced both TLHE-SGUH and TLHE-ESTH to Committees members, noting that they are both newly appointed to the roles.

3.3.2 Committees members noted that they would welcome a focus on what the difference in patient experience is based on ethnicity, along with what the difference in outcomes is based on this. Committees Chair asked how the team will identify the areas in the organisation where health inequalities are a real concern. TLHE-SGUH advised that the data on health inequalities is currently being analysed and once the position is established, the focus will be on enabling the teams at a local level to address issues, and empower them to work with the patients for directly, for example, to hold listening events with the patients. Workshops will also be held with the view to embed culture change within teams to better ensure patient experience is improved for those of ethnicities which currently experience their care in a negative way.

4.0 27 November 2025 – Key issues to which the Committees received assurance

4.1 Integrated Quality and Performance Report

4.1.1 The Committees noted that both ESTH and SGUH were placed in Segment 3 of the NHS Oversight Framework for Q1 2025/26, reflecting ongoing operational and financial pressures. SGUH would otherwise have achieved Segment 1 were it not for the finance override, while ESTH's position is driven by UEC, productivity and financial challenges.

4.1.2 Committees members welcomed the inclusion of over 65-week wait data. LP noted that at ESTH there has been an increase in 52-week waits, asking for assurance that 65-week waits are not being prioritised at the expense of 52-week waits. MD-ESTH advised that the focus is on trying to clear the 65-week waits by the end of December, and to bring 52-week waits down to 1% of the total waiting list by the end of March.

4.2 Safeguarding Update

4.2.1 The Committees noted that adult and child safeguarding training compliance at ESTH has been static over the past 18 months and so welcomed the news that training material is to be relaunched to make it less time-consuming and hence easier to schedule and complete. Members asked how soon the safeguarding team expect to see the impact of this new material. The Director of Safeguarding advised that currently two or three trainings sessions per week are taking place but she does not yet have a trajectory for this, but will present it to the Committees once available.

4.2.2 The Committees agreed that **limited assurance** could be taken that the mitigations are in place with regards to safeguarding, noting that once the trajectory is in place for improving the training compliance at ESTH, reasonable assurance will be able to be given.

5.0 18 December 2025 – Key Issues for Escalation to the Group Board

5.1 Patient Safety Incident Report

5.1.1 The Committees discussed that each site continues to embed and strengthen use of PSIRF, through governance forums and staff engagement. The journey to fully embed and realise the benefits of the new way to respond to incidents is long (early adopters are starting to really see the benefits after about 5 years), however gesh is making good progress. There are some difficulties with overall capacity for learning responses and the shift to improvement. This is to be expected as PSIRF is such a significant shift in mindset and methodology from the previous framework.

5.1.2 Committees members welcomed the news that the PSII report for ESTH has been completed, requesting that this be shared with members for their information. The Committees Chair also requested that the emerging themes from the never event action plans be presented to the Committees.

5.1.3 Committees members noted that there is an ongoing PSII for a maternity related never event which took place in August, asking what learning has been identified. It was advised that whilst the process is ongoing, there has been an emerging theme relating to how the medical workforce work together. The team are subsequently developing practices that lead to clear ownership, accountability and decision making within the workforce.

5.1.4 The Committees discussed the complexity of arranging PSIRF training for medical staff, particularly as doctors only receive 10 study leave days per year. To mitigate this, the team are determining ways to deliver bite-size PSIRF training to staff which focuses on the essential practice of PSIRF. Committees members agreed with the principle of tailoring the PSIRF training in a focused way to ensure that 100% of people have the essential PSIRF training.

5.1.5 Committees members agreed that **reasonable** assurance could be taken with regards to the organisations response to patient safety, however, the assurance on never-events specifically remains **limited**. Members felt that this assurance might be increased once the report into the patient safety investigations has been considered.

5.2 Dementia and Delirium

5.2.1 The Committees discussed the report, noting there are key challenges in this area, such as:

- High Prevalence and Burden: Dementia and Delirium affect a large portion of the aging population in the UK. The number of people affected by Dementia is expected to grow from 982,000 in 2024 to over 1.6 million by 2050, while Delirium impacts up to 50% of hospitalised older adults. These conditions contribute to longer hospital stays, increased morbidity, and mortality.
- Inconsistent Screening and Diagnosis: While screening tools like the 4AT Delirium assessment are in place, the use of these tools is inconsistent across both Trusts, leading to gaps in timely diagnosis and care.
- Data Quality and Performance: Issues related to data quality, benchmarking, and adherence to National Institute for Clinical Excellence (NICE) guidelines are noted. Audits show a lack of standardisation in assessment methods across both Trusts.

5.2.2 Committees members agreed that they **could not take assurance** from the report in its current form. There were concerns with the quality of data provided in the report and lack of a clear narrative about challenges and progress. There appeared to be a lack of progress on this Quality Priority without clear mitigations. It was agreed that the executives would review the data offline and present an updated report to the Committees before the end of the financial year. Members agreed that an assurance rating will be provided on dementia and delirium at the time that the updated report is presented.

5.3 Group Board Assurance Framework

5.3.1 Committees member noted that there are no proposed changes to the risk scores or assurance ratings for any of the four strategic risks overseen by the Quality Committee. Committees members recommended the proposal of no changes to the scores is presented to the Group Board on 8th January 2026.

5.4 Interstitial Lung Disease at ESTH -RCP Invited Review update.

5.4.1 GCMO advised the Committees that the Trust does not yet have the final RCP Report, but a draft is being checked for factual accuracy, and the RCP has invited the consultant concerned to contribute to this factual accuracy check. In its review of case notes, the RCP panel of experts found that there were cases in which inappropriate clinical management did lead to harm – it is not anticipated that factual accuracy checking will alter these findings.

5.4.2 The GCMO will be writing to those patients, or the families of those deceased patients, whose care was reviewed by the RCP, to let them know what the RCP found with regard to the individual's care. In some cases, this letter will be a necessary discharging of Statutory Duty of Candour, and in other cases it will simply be an appropriate exercise in being open and transparent.

5.4.3 The draft RCP recommendations, which have already been considered at the Group Executive Committee, do not contain anything in support of patient safety that is not already being acted upon or already done.

5.4.4 When the final version of the RCP Report is received, it will be presented to the Quality Committee with a paper describing the Trusts' response, it will then subsequently be presented to the Group Public Board.

6.0 18 December 2025– Key issues to which the Committees received assurance

6.1 Winter Plan Quality Impact Assessment

6.1.1 The Committees were advised that although the winter plans had been signed off, the process of completing the quality impact assessment for those plans was ongoing. An update on the status of the QIA would be presented at the next meeting. If the ESTH QIA is still not approved then the SGH QIA, which has been approved, will be presented regardless.

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 November and December 2025.

Group Board

Meeting on Thursday, 08 January 2026

Agenda Item	3.1	
Report Title	**Report from Finance and Performance Committee**	
Executive Lead(s)	Lizzie Alabaster, IGCFO	
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 November and December 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, the current financial deficit plan is deliverable without significant improvements.

Appendices	
Appendix No.	**Appendix Name**
Appendix 1	[Add name or delete if not required]

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

Finance and Performance Committee Report
Group Board, 08 January 2026

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 November and December 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 28th November and 19th December 2025, the Committee considered the following items of business:

28th November 2025	19th December 2025
PUBLIC MEETING • GCFO briefing • Integrated Finance report M7 • Forecast update • 2026/27 Financial and MTP • Business Case update • IQPR	**PUBLIC MEETING** • GCFO briefing • Integrated Finance report M8* • Forecast update* • Finance BAF risk update * • 2026/27 Financial plan and MTFP • Productivity update • Ambient Voice Technology • Procurement contract planner • IQPR

**items marked with an asterisk are on the Group Board agenda as stand alone items in January 2026*

2.2 The Committee was quorate for both meetings.

4.0 Sources of Assurance

4.1

a) Financial Performance M8/Forecast update

Both trusts have reported being on plan at month 8. As in previous months, additional non-recurrent CIPs have been required but positions are tracking broadly in line with the recovery action plan overall. Some slippage on delivery of CIP recovery actions requires mitigation in future months but actions are in place to address this. The Group Executive remains committed to work to deliver the net financial plan for both trusts as agreed but recognises there are challenges in achieving that. A route to delivery of the net financial plan has been identified and work continues to implement actions and identify ways to mitigate risks.

b) Productivity update

The Committee noted the two new national publications: the annual National Cost Collection Index and the productivity opportunity packs. The former shows costs increasing against benchmarks compared to previous years, and the latter indicates significant opportunity in productivity. Whilst noting caveats related to potential double counts, it was observed that non-elective pathways and length of stay metrics were not surprising areas for opportunity. The elective and outpatient position at SGH was socialised at SGH SLT with an action plan in place.

The GCEO observed the two emergency departments at ESTH which will impact the figures and caveats around data quality which required triangulation.

The GCMO noted the keenness of clinicians outside leadership roles to be involved in clinical transformation, which is brought together through the Clinical Strategy and Standards groups that have expanded in their ambition, especially in Surgery and Paediatrics.

c) Business Planning/MTFP 2026/27

The committee noted the paper following the review and plan approval at the Extraordinary Board on the 15th December and submission to NHSE on the 17th December. The Committee noted further assurance on CIP would be produced ahead of the final plan submission on 12th February.

d) Business Case update

It was noted that NHP funding is now being made available if the group could demonstrate that it could reduce the requirements for funding in future years, focussed on the Renal Development in particular.

It was also noted second addendum to the EPR business case had been confirmed. He confirmed that the original case had all the funding drawn down in advance of approval, and that there is a requirement to track EPR benefits which is suggested addressed by outlining which CIP plans are related to EPR and that this is brought through committee for review.

e) Operational Performance

The Committee discussed Dermatology demand with increased cancer referrals and the good progress against the 65 week wait target for the end of the calendar year. SGH emergency care performance was praised as regularly in the top London performers in recent weeks.

f) Procurement contract planner

The Committee welcomed the horizon scanning of procurement contracts and asked for a more graphical presentation as well as any early warning signs of delays to tendering processes.

g) Ambient Voice Technology

The Committee noted the progression of a business case to procure Ambient VT with colleagues from Kingston and Richmond FT and Croydon NHS Trust which would be presented to committee in January

5.0 Risk Implications

5.1 The Committee did not have time to give a recommendation to Group Board on the BAF operational-related risk SR 8 – Reducing Waiting Times paper. The paper had no suggested changes to the score of '20' and limited assurance. The forecast for the year end in the paper is '20' 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 forecast for the year end is '25' and Limited assurance. A discussion was had on whether the rating was too high before the decision was made to leave it as it is for now.

6.0 Recommendations

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

Group Board

Meeting on Thursday, 08 January 2026

Agenda Item	3.2	
Report Title	**Integrated Finance Report M8**	
Executive Lead(s)	Lizzie Alabaster, Interim Group Chief Finance Officer	
Report Author(s)	GCFO, SCFOs	
Previously considered by	Finance and Performance Committee	19 December 2025
Purpose	**For Review**	

Executive Summary

- Both organisations remain on plan at M8.
- 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. A route to delivery of the financial plan has been identified and work continues to implement actions and identify ways to mitigate risks.
- At M8 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	M8 Finance Report

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	
See appendix A	
Legal and / or Regulatory implications	
Equality, diversity and inclusion implications	
n/a	
Environmental sustainability implications	
n/a	

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Group Board-in-Common – Public

8th January 2026

Integrated Finance Report M8

GCFO/Site CFOs

NHS
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 M8.
- In line with the recovery plan the Trust has recognised £1.2m of confirmed SWL income for the industrial action costs incurred to date.

Performance £'000	YTD Plan	Actual	Variance
Income	485,583	491,342	-5,758 F
Total Pay	**-329,783**	**-333,978**	**4,194 A**
Non-Pay	-167,769	-169,363	1,594 A
Non Operating Items	-4,151	-4,121	-29 F
Performance Target	**-16,120**	**-16,120**	**0 A**

Performance £'000	Annual Plan	Forecast	Variance
Income	733,033	746,492	13,459
Total Pay	**-493,469**	**-502,738**	**-9,269**
Non-Pay	-238,420	-243,184	-4,764
Non Operating Items	-6,845	-6,270	575
Performance Target	**-5,700**	**-5,700**	**0**

Performance £'000	YTD Plan	Actual	Variance
Substantive	-292,200	-288,329	-3,871 F
Bank	-31,487	-40,618	9,131 A
Agency	-4,665	-3,711	-954 F
All Other pay	-1,431	-1,320	-111 F
Total Pay	**-329,783**	**-333,978**	**4,195 A**

Workforce	YTD Plan WTE	Actual WTE	Variance WTE	Move from M07 WTE
Substantive	6,377	6,430	-53 A	-6 A
Bank	730	931	-200 A	-14 A
Agency	66	65	1 F	5 F
Total	**7,173**	**7,425**	**-252 A**	**-15 A**

Key Metrics		Plan	Actual	Variance	M7 actual	Movement
Bed Number	**No**	**577**	**591**	**-14 A**	**593**	**-2**

Income

- Income YTD is £5.7m favourable due income from NHS England is £0.5m favourable due to prior year income received and £0.1m for Martha's rule . ICB income is above plan by £4.1m due to the release of a £1.5m provision for prior year ERF clawback, an accrual of £1.1m to reflect income to offset incurred costs from industrial action in July and November plus £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 Clockstop Validation Sprints ,24-25 true up by South East London ICB and income in respect of Martha's Rule.
- Income is being accrued to plan despite the shortfall in reported activity due to EPR implementation.

Non pay

- Non pay overall is £1.6m adverse to plan YTD but with an overspend of £2.4m in non pay relating to EPR offset by underspend in clinical supplies.

Pay and workforce

- Trust is 252 WTE adverse to plan, 15 adverse to M6, the increase is all related to cover for the industrial action in month.
- Substantive Pay overall is reported £3.9m favourable to plan YTD which does not triangulate to the adverse position on WTE due to use of £4.3m of non recurrent pay technical actions reported in substantive pay position. The underlying pay position is closer to £8.2m adverse.
- £9.1m adverse position on bank £ largely triangulates with the WTE variance The in month adverse position on bank was industrial action cover.

Other key metrics

- G&A beds M8 are 591 compared to 577 plan and a favourable movement of 2 since M7. 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

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M8 Commentary

Trust is on plan in M8 but with an underlying position that is £2.6m off plan in month. This has been mitigated using the following non-recurrent items:

- £0.3m of recovery actions not delivering mitigated with phasing of NR actions.
- £0.3m of baseline pressures from non pay pressure in clinical consumables and drugs & ward pressures, this pressure has been mitigated with a pull forward of NR actions.
- £2.0m of additional income from SWL to support and has been phased over M6-9.

Performance	Plan £'000s	Actual £'000s	Variance £'000s
Income	867,954	869,161	1,207
Total Pay	-552,604	-555,152	-2,548
Non-Pay	-316,142	-315,535	607
Non Operating Items	-13,858	-13,124	734
Performance Target	**-14,650**	**-14,650**	**0**

Performance	Annual Plan £'000s	Forecast £'000s	Variance £'000s
Income	1,298,910	1,298,910	0
Total Pay	-821,654	-821,654	0
Non-Pay	-456,542	-457,676	-1,134
Non Operating Items	-20,714	-19,580	1,134
Performance Target	**0**	**0**	**0**

Workforce YTD	Plan £'000s	Actual £'000s	Variance £'000s
Substantive	-504,926	-513,918	-8,992
Bank	-37,296	-35,185	2,111
Agency	-8,246	-3,911	4,335
Other Pay	-2,136	-2,138	-2
Total	**-552,604**	**-555,152**	**-2,548**

Workforce	Plan WTE	Actual WTE	Variance WTE	Move from M07 WTE
Substantive	9,622	9,975	-352	23
Bank	645	773	-129	-53
Agency	58	86	-27	-12
Total	**10,325**	**10,834**	**-508**	**-42**

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

YTD Commentary

Income

- Income is £1.2m favourable YTD, with patient care income £2.2m favourable and other operating income £1.0m adverse.
- Patient Care income is driven by £1.4m industrial action income and £0.8m of service specific funding, both offset by expenditure.
- Other Operating Income is driven by Pharmacy (£0.9m adverse) which is mostly offset by savings in pay and non pay expenditure.

Non pay & Non Operating Items

- Non-Pay & Non Operating items are £1.3m favourable YTD. This is driven by a £1.4m overdelivered CIP and other non-pay reserve releases which are offsetting consumables pressures.

Pay and workforce

- Pay is £2.5m adverse to plan YTD where underspends in bank and agency are offset by under- delivery of pay CIPs.
- Bank and Agency both remain below plan with CIPs focussed on temporary staff reduction.
- Trust is 508 WTE adverse to plan in M8 due to decrease in WTE plan from M4 onwards of 425 WTE linked to stepped increase in CIP target.
- The movement from M7 shows an increase in temporary staffing offset by decrease in substantive which is primarily driven IA and ward temporary staffing.

Other key metrics

- G&A beds M8 are 797 which is in line with the plan.

Group Board

Meeting on Thursday, 08 January 2026

Agenda Item	3.3	
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	Finance and Performance Committees	19 December 2025
Purpose	**For Review**	

Executive Summary

This report summarises key operational and quality performance, alongside ongoing improvement actions, across St George's University Hospitals (SGUH), Epsom and St Helier Hospitals (ESTH) and Integrated Care (IC) sites. It draws on the latest available data, presented using statistical process control charts with benchmarking included where available.

The executive summaries in the report highlight successes achieved throughout the month and challenges affecting quality, safety, and operational performance for each Trust. Additionally, an overview of the current assurance process and key messages across quality and performance are highlighted below.

NHSE Assurance & Oversight Update

In Q1 2025/26, both ESTH and SGUH were placed in Segment 3 of the NHS Oversight Framework, reflecting ongoing operational and financial pressures. SGUH would otherwise have been in Segment 1 were it not for the finance override, while ESTH's position was driven by challenges in urgent and emergency care (UEC), productivity, and financial performance.

The NHS Oversight Framework incorporating Quarter 2 data was refreshed and published on 11 December 2025. Both SGUH and ESTH have experienced a deterioration in their relative national positions among acute trusts, reflecting worsening performance across several metrics during Quarter 2.
SGUH's unadjusted segment moved from Segment 1 in Quarter 1 to Segment 2 in Quarter 2, with its national ranking declining from 37th to 61st out of 134 acute trusts. This deterioration has been driven primarily by operational performance metrics. It is noted that the Patient Safety domain remains in Segment 4, indicating an ongoing area of significant concern requiring sustained focus and improvement.
ESTH's unadjusted segment moved from Segment 2 in Quarter 1 to Segment 3 in Quarter 2, with its national ranking declining from 61st to 101st out of 134 acute trusts. This reflects broader performance challenges across Quarter 2, with deterioration across multiple domains contributing to the overall position.

Both Trusts continue to be designated Tier 1 for elective recovery, with a specific requirement to eliminate 65-week waits by the end of December 2025. Tier 1 status brings national oversight,

including fortnightly NHSE meetings requiring Group CEO attendance. In addition, ESTH has been placed in Tier 2 (regional oversight with monthly meetings) due to continued pressures on ED four-hour and 12-hour performance.

Both Trusts have made strong progress towards eliminating 65-week waiters by the end of December through securing additional capacity and proactive patient engagement. The 65-week breach cohort continues to fall, supported by rigorous waiting list management and financial support from NHSE. Key risks—including patient choice and potential further industrial action—remain under close review.

To support sustained improvement in UEC performance at ESTH, the team has focused on rolling out MDT huddles across the emergency floor, ring-fencing SDEC capacity, and implementing boarding during weekends and evenings. Early data indicates these actions are helping to improve flow and discharge performance.

Other Key updates

Cancer performance remains below target at both SGUH and ESTH, with neither meeting the 28-Day Faster Diagnosis Standard or the 62-day treatment standard. At ESTH, FDS fell to 61% in October (from 69.1% in September), driven by dermatology capacity pressures and persistent GI delays. SGUH improved to 71.7% (from 65.1%), though still under target, affected by seasonal dermatology demand and limited one-stop hysteroscopy and gynaecology imaging capacity. SGUH's 62-day performance declined to 68.3%, with constraints in Lung Thoracic linked to robotics theatre time and ongoing pressures in Urology due to theatre access and Uro-Renal capacity. Both Trusts are progressing recovery actions, including expanded outpatient and diagnostic capacity, targeted recruitment, additional clinics and WLI sessions, and continued support from Royal Marsden Partners.

Waiting times in Children's Services at Sutton Health and Care remain under strain, with only 47.4% of children treated within 18 weeks against a 78% ambition. Rising caseloads and increasing complexity continue to drive the pressure, and 37 children are currently waiting over 52 weeks against an ambition of zero. A consolidated SWL-wide action plan is being developed with the ICB to support recovery.

UEC performance remains mixed: SGUH delivered 80.3% against the 4-hour standard, while ESTH delivered 71.8%. Sutton Health and Care's 2-Hour Urgent Community Response (UCR) performance improved to 69.1%, continuing to be challenged by increased out-of-hours demand. Surrey Downs Health and Care maintained strong performance at 87.8%. Virtual ward occupancy remains consistently above the 80% target and continues to support timely interventions and admission avoidance. The Group continues to focus on reducing average of length of stay to improve flow, reduce cost, and improve patient experience and outcomes.

Mortality indicators remain favourable. SGUH continues to perform in the 'better than expected' SHMI range, while ESTH remains 'as expected' with further improvements noted. VTE risk assessment remains a priority, and updated reporting logic has increased reported performance to 84% at SGUH and 79% at ESTH. Both, however, remain below the 95% target. A joint VTE workshop has outlined plans to strengthen reporting, standardise assessments, and enhance clinical leadership across both trusts.

Outpatient satisfaction remains above 90% across the Group, with further productivity gains expected through reduced follow-up rates, expanded PIFU, lower DNAs and improved theatre utilisation.

Workforce retention remains strong, though sickness absence persists as a challenge, with renewed focus on prevention and attendance improvement measures.

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

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	Full IQPR

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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Group Integrated Quality & Performance Report

November 2025

Outstanding Care, Together: Our strategy 2023 to 2028

Publication Date: 12th December 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

Reduce average non-elective LOS (days): Oct 25

	Actual	Plan	Trend
SGUH	10.2	8.4	normal variation
ESTH	10.9	TBC	normal variation

Reduce delays between planned & actual discharge (inc 0 delays) Sep 25

	Actual	Trend
SGUH	0.7 days	no significant change
ESTH	1.6 days	no significant change

Enable increase in referrals to Urgent Community Response Team: Nov 25

	Actual	Trend
Sutton	395	normal variation
Surrey	576	normal variation

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

Deliver Financial Plan (month 8)

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

Improve (Implied) Productivity (YTD Jul 25)

	YoY Change	National Benchmark
SGUH	-0.1%	3rd quartile
ESTH	-0.5%	Lowest Quartile

Deliver CIP Target (month 8)

	YTD Delivery	Note
SGUH	£48.9m to date	In line with plan. Includes £1.9m of nr b/f and £2.8m of nr additional to support
ESTH	£32.1m to date	Includes £5.2m of nr balance sheet to support the non-delivery of planned CIP

Improve Cash Position (month 8)

	Current balance and Cash stress expected based on current cash flow		
SGUH	£48.7m	£9.7m favourable	Q1
ESTH	£55.7m	£44.7m favourable	Q1

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

Improve VTE Performance: Nov 25

	Actual	Plan	Trend
SGUH	84%	95%	no significant change
ESTH	79%	95%	no significant change

Reduce RTT 52week waiters: Oct 25

	Actual	Plan	Trend
SGUH	2.23%	1.0%	improved
ESTH	2.26%	1.0%	deteriorating

Maintain 12-hour waits in ED at or below 24/25 levels: Oct 25

	Actual	Plan	Trend
SGUH	11.7%	13.5%	no significant change
ESTH	16%	11%	no significant change

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

Staff recommending gesh as an employer

	Actual 2023	Actual 2024	Trend
SGUH	59.5%	63.2%	improved
ESTH	59.3%	61.46%	improved

Reduce Staff sickness absence rates: Oct 25

	Actual	Plan	Trend
SGUH	4.82% (Nov-25)	4%	deteriorating
ESTH	6.08%	4%	deteriorating
Sutton	6.39%	4%	no significant change
Surrey	6.03%	4%	deteriorating

2

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
Effectiveness & experience of care	9	Summary Hospital Level Mortality Indicator	R12 - Mar-25	2.00	2.00
	10	Average number of days between planned and actual discharge d	Jun-25	1.74	Not Reported (DQ)
	11	CQC inpatient survey satisfaction rate	2023	2.00	2.00
	12	Urgent community response 2-hour performance	Q1-25/26	N/A	2.24
Patient Safety	13	NHS Staff Survey -raising concerns sub-score	2024	3.12	2.78
	14	CQC safe inspection score (if awarded within the preceding 2 yea	N/A	N/A	N/A
	15	Rates of MRSA infections	R12 -Jun-25	2.37	2.63
	16	Rates of C-Difficile infections	R12 -Jun-25	3.62	2.62
	17	Rates of E-Coli infections	R12 -Jun-25	3.39	2.05
People and workforce	18	Sickness absence rate	R12 -Mar-25	1.72	2.44
	19	NHS Staff Survey engagement theme score	2024	2.38	2.20
Finance and productivity	20	Planned surplus/deficit	Apr-25	4.00	4.00
	21	Variance year-to-date to financial plan	YTD Jun-25	1.00	1.00
	22	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:** No Never Events were reported in November 2025. A PSII was initiated for a missed diagnosis in the Delivery Suite. A wrong-site surgery in Neurosciences, identified as a Never Event, was reviewed by Central Incident Review Group (CIRG) ; the incident occurring in November 2025 but is pending official declaration following Care Quality Commission (CQC) notification.
- **VTE Risk Assessments:** Compliance improved to 84% following a revision to the reporting logic to use admission time (bed placement) instead of time of Decision to Admit. Chief Medical Offices across gesh are leading on improvement work to deliver the 95% national target.
- **Falls Prevention and Management:** In November 2025 there was two higher harm falls, one moderate fall on Gunning ward from a hip fracture and one extreme where the patient died. From the SWARM it has been concluded that the patient collapsed rather than fell so will be downgraded.
- **Pressure Ulcers:** There was one category 4 and seven category 3 pressure ulcers reported in November 2025. The Trust has breached the category 3 & 4 pressure ulcer targets for the second consecutive month. The causes for these increases are multifactorial, with winter pressures likely having an impact. The category 4 pressure ulcer was acquired on a medical ward; this is the first pressure ulcer incident to be investigated using a SWARM as part of the on-going work to align this process with the PSIRF principles.
- **Infection Prevention and Control (IPC):** Four new C diff cases in November 2025, YTD 43 against a trajectory of 43. Continuous reviews are addressing identified lapses in care.
- **Flu:** Increase in flu cases, resulting in bay/partial ward closures. Guidance on safe opening of a flu cohort ward has been circulated.
- **Respiratory infections**: Group IPC flu guidance shared in response to the increase in respiratory infections seen both locally and nationally.
- **Complaints:** Staffing shortages led to a recent decline in performance. By November 2025, performance improved to 76%, though it remained below target. An action plan is in place to address staffing gaps and meet required acknowledgment and response rates.
- **Mortality:** Mortality rate, as measured by the Summary Hospital-level Mortality Indicator (SHMI), performance is better than expected. The change to Same Day Emergency Care (SDEC) data reporting which went live on the 29th October 2025 may negatively affect future SHMI results. This continues to be monitored closely.
- **Family and Friends Tests:** FFT scores remain strong across Inpatient, Outpatient, Maternity, and Community Services. However, the Emergency Department continues to perform below the 90% target.

Epsom & St Helier

Key Messages

- **Patient Safety Incident Investigations (PSII) and Never Events:** No new Never Events were reported in November 2025. No new Patient Safety Incident Investigation (PSII) initiated in November 2025.
- **VTE Risk Assessments:** As per the groupwide change to now using admission time (bed placement) instead of Decision to Admit, compliance has seen an increase through quarter 2. Compliance for October 2025 was 79%. Work will commence in the new year to recruit medical VTE champions.
- **Falls Prevention and Management**: In November 2025 there was one moderate harm fall. The patient fell on Oaks wards where they sustained a greater tuberosity periprosthetic fracture. The incident underwent a SWARM review and key learning was discussed at the relevant Divisional Incident Response Group (DIRG) meeting.
- **Pressure Ulcers:** There were zero hospital-acquired category 3 or 4 pressure ulcers in November 2025 and performance remains within normal limits.
- **Infection Prevention and Control:** Two C diff cases in November, YTD 37 against a trajectory of 63, showing common cause variation. Bay and ward closures due to Norovirus and flu/COVID.
- **Respiratory infections**: Group Infection Prevention Control (IPC) flu guidance shared in response to the increase in respiratory infections seen both locally and nationally.
- **Water Safety: -** Water safety issues continue to be monitored via the Water Safety Group and the Water Safety action plan with additional meetings to be set up with SLT to provide assurance and make decisions about long term solution. Integrated Care: lack of assurance with water safety in Dorking and Molesey hospitals. External Authorising Engineer commissioned to review current NHS Property Services water safety plan.
- **Complaints:** In November 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% showing a continued drive to maintain this level of performance.
- **Mortality:** The latest SHMI for the 12-month period from July 2024 to June 2025 is as expected level at 1.12 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%.

Executive Summary

Operational Performance & Productivity

St George's Hospital

Successes

- Capped theatre utilisation continues to see sustained improvement, placing it in the top quartile of the national rankings and seeing an increase in the average cases per session.
- RTT 65-week and 52-week waits have shown positive weekly reductions since mid-September 2025. RTT performance in October was 60.5%, ahead of the submitted plan and we have also seen a reduction in overall waiting list size.
- Diagnostic performance improved significantly in September and October 2025, with recovery plans reducing long waits, particularly in Ultrasound and Cardiac MR
- The 4-hour emergency department standard continues to be maintained achieving 80.3% in November 2025. This is supported by reduced times for ambulance handover and improved performance within the admitted pathway.

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 revised RTT plan and trajectory. Targeted actions are underway and overseen by the Chief Operating Officer (COO). The summary of key actions are set out in the report.
- Anaesthetic pay issues are impacting on capacity.
- Cancer 28 day FDS performance improved through October 2025, however remains below target with performance at 71.7%. Key drivers include seasonal referral surges in Dermatology impacting capacity; backlog clearance underway: accelerated Notes Review, RMP-Funded Mutual Aid, and locum consultant secured for Jan 2026. This is being overseen in line with Tier 1 actions.
- 62-day standard performance was 68.3%, impacted by theatre capacity constraints: Lung impacted by robotics availability; Urology limited by theatre access and Uro-Renal capacity. RMP-funded mutual aid is being utilised to increase surgical capacity.
- Winter Resilience Funding: £60K RMP funding has been released to support recovery of FDS and 62-day pathways
- Patient-Initiated Follow-Up (PIFU) rates remain below our end of year target of 3%. Whilst PIFU rates for the Trust are lower than peers, discharge rates are significantly higher.
- Further requirement to reduce length of stay to meet winter plan of 8.4 days.

Epsom & St Helier

Successes

- Cancer performance standards achieved in October 2025: 31-day (99%)
- The Theatres team is enhancing the perioperative pathway through digital triage and pilot programs to improve start times, while also promoting staff wellbeing and civility
- RTT Patient Tracking List reduced again in October 2025 for the second consecutive month since EPR go live, following four months of increases, achieved by continuing to run focused validation events.
- Diagnostic performance has improved again, for the third consecutive month. Recovery plans remain in place supporting increasing activity and working through on-going workflow issues. Echo and Endoscopy remain the most challenged modalities.
- Ambulance handover delays reduced, with 72% completed within 30 minutes, 94% within 45 minutes, and 98% within 60 minutes.
- Non-elective LOS for November 2025 is reported at 10.9 days, a 0.4-day reduction from October 2025.
- There was a reduction in the percentage of patients waiting over 12 overs in our A&E department from 13.6% in October 2025 to 12.6% in November 2025.

Challenges

- iClip Pro implementation, supported by a six-week activity reduction, has impacted recent performance. Our teams are actively resolving workflow and data challenges and we are starting to see improvement.
- Increasing >52-week and >65-week waits again in October, mainly driven by challenges within Dermatology. Mitigations have been implemented with the aim of achieving close to zero 65 week waits by the end of December 2025. Total PTL size and the numbers of >52-week and >65-week waiters are all expected to improve in November 2025 compared with October.
- Cancer 62-day Standard performance was 80.3%, below the 85% national target and 28-day Faster Diagnosis was 61% below 77% national target , primarily due to capacity constraints .
- Capacity pressures in Dermatology continue to impact all the cancer targets. Endoscopy delays and anaesthetic staffing shortages are affecting GI pathways, while the lung cancer diagnostics remain constrained by external wait times for navigational bronchoscopy and endobronchial Ultrasound (US).
- 4-hour performance remains off-trajectory. Data quality improvements are ongoing, and the 2025/26 Urgent Emergency Care (UEC) programme is advancing to support recovery.
- Following visits from NHSE London Region team and GIFRT UEC to the St Helier site in August and September 2025, GIRFT UEC has committed to support ESTH with the following improvement priorities: developing a UTC first mindset and model, ED front door processes, acute medicine peer support, advice and guidance, UEC therapies, peer support, advice and guidance, and decompressing the ED.

Executive Summary
Integrated Care

Community Wide Messages

- Efforts continue to reduce pressure ulcers, with a specific emphasis on prevention strategies
- Embedding Simulation Exercises into PSIRF methodology to enhance our learning response.
- Discharge flow remains challenged by complexity and funding constraints. Both sites have development plans underway to strengthen the discharge model
- Recovery@Home: integrated reablement and home-based care assessment to improve discharge flow and reduce delays
- Inreach Developments Early, community-led assessment and support planning on the ward.
- Surry Downs and Sutton are driving innovation to improve productivity and tackle waiting list pressures; Musculoskeletal (MSK) Transformation - A full redesign of the MSK pathway has integrated GP First Contact Practitioners, MSK Clinical Assessment and Triage Service (CATs) and Community MSK services, creating a more streamlined and accessible model of care

Safe, High-Quality Care Key Messages

Sutton Health & Care (SHC)

- Safety and infection control indicators remained robust in November 2025, with zero reported cases of MRSA, C. difficile, E. coli, and falls with harm.
- Community FFT results are positive, and complaints remain low showing a steady performance
- Special school governance-reviewing Safeguarding supervision structures and leadership structure
- Developed pathway for missed dose insulin-improving management of avoidable acidosis.

Surrey Downs Health & Care(SDHC)

- Safety and control indicators (MRSA, Cdiff, Ecoli and Falls are stable), with no significant issues reported in November 2025.
- Surrey Downs Health and Care has won the HSJ Award for Transforming Care for Older People! We entered this category to showcase the amazing neighbourhood model of care we've cocreated over the last seven years - from developing seven INTs delivering coordinated, integrated care in partnership with primary care to our HomeFirst service providing acute level support for people at home.
- Care home colleagues from across Surrey Downs came together for SDHC Care Homes Conference In November, creating a fantastic opportunity to connect, learn, and share ideas.

Operational Performance Key Messages

Sutton Health & Care (SHC)

- November 2025 2-hour response performance was 69.1%, against a 70% target. Increased referrals, especially out of hours and weekends, have impacted capacity.
- Virtual ward sustained high demand with 96.5% occupancy (target: 85%). Therapy-led recovery and reablement unit, with ESTH, delivered significant impact—reducing care package needs by 44%.
- Children's services waiting list remains high, with an action plan in development across SWL. Long waits for Children's SALT improved earlier in the year; For November, 37 patients are waiting over 52 weeks, mainly in SALT services and overall 47.4% of children were waiting less than 18 weeks.

Surrey Downs Health & Care(SDHC)

- Service Continues to achieve the 2 –hour Urgent Community Response (UCR) target.
- Virtual ward occupancy rates exceeded target at 96.8% in November with high demand.
- Surrey Downs community beds have maintained significantly shorter patient stays than regional and national averages.
- Surrey Downs' Proactive Frailty Care model, delivered through Integrated Neighbourhood Teams, is demonstrating measurable population-level impact: 35% fewer ED attendances, 31% reduction in hospital admissions, and 11% fewer GP contacts.
- Work continues to expand Virtual Ward provision and ensure it remains a viable alternative to acute care. A recent audit found 76% of patients met criteria to reside—an improvement from 2024
- Waiting list performance remains strong however increasing demand for services and staffing challenges to some specialist posts e.g. Neuro Occupational Therapy

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	FFT - Outpatients Score			Moderate and Severe Harm from Falls Mortality - SHMI
L				
H		Never Events Patient Safety Incident Investigations Pressure Ulcers Acquired Category 3&4 Infection Control - Number of MRSA Infection Control - Number of Cdiff Infection Control - Number of E-Coli Complaints - Responded to within 35 working days Complaints - Acknowledgement within 3 working days FFT - Maternity Score	VTE Risk Assessment Number of complaints not completed within 6 months from date of receipt FFT - Emergency Department Score	30-Day Emergency Readmission Rate % Births with 3rd or 4th degree tear % Births PPH >1.5 L Stillbirths per 1,000 births Neonatal deaths per 1,000 births HIE per 1,000 births
L				
H	FFT - Inpatients Score			
L				

ESTH Safe, High-Quality Care & Patient Experience

VARIATION	ASSURANCE: P	ASSURANCE: ?	ASSURANCE: F	No Target
H		Never Events Complaints - Responded to within 35 working days Number of complaints not completed within 6 months from date of receipt		Mortality - SHMI
L				
H	Pressure Ulcers Acquired Category 3&4 FFT - Inpatients Score FFT - Outpatients Score	Patient Safety Incident Investigations Infection Control - Number of MRSA Infection Control - Number of Cdiff Infection Control - Number of E-Coli Complaints - Acknowledgement within 3 working days FFT - Maternity Score	VTE Risk Assessment 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 Neonatal deaths per 1,000 births HIE per 1,000 births
L				

Safe, High-Quality Care

Overview Dashboard

St George's

KPI	Latest month	Previous Month Measure	Latest Month Measure	Target	Variation	Assurance	Benchmark
Never Events	Nov 25	0	0	0			N/A
Patient Safety Incident Investigations	Nov 25	1	1	0			N/A
Moderate and Severe Harm from Falls	Nov 25	0	2	-			N/A
Pressure Ulcers - Acquired Category 3&4	Nov 25	13	8	7			N/A
Infection Control - Number of MRSA	Nov 25	0.0	0.0	0.0			3rd Quartile
Infection Control - Number of Cdiff - Hospital & Community	Nov 25	7	4	5			2nd Quartile
Infection Control - Number of E-Coli	Nov 25	3	8	9			Lowest Quartile
30-Day Emergency Readmission Rate	Oct 25	12.9%	12.5%	-			TBC
VTE Risk Assessment	Nov 25	84.9%	84.0%	95.0%			N/A
Mortality - SHMI	Jun 25	0.85	0.86	-			Better than Expected
% Births with 3rd or 4th degree tear	Nov 25	1.1%	1.1%	-			3.0%
% Births Post Partum Haemorrhage >1.5 L	Nov 25	2.4%	1.8%	-			3.0%
Stillbirths per 1,000 births	Nov 25	2.7	6.3	-			3.3
Neonatal deaths per 1,000 births	Nov 25	0.0	6.3	-			1.6
HIE (Hypoxic ischaemic encephalopathy) per 1,000 births	Nov 25	5.4	0.0	-			N/A

Epsom & St Helier

Latest month	Previous Month Measure	Latest Month Measure	Target	Variation	Assurance	Benchmark
Nov 25	0	0	0			N/A
Nov 25	1	0	0			N/A
Nov 25	3	1	-			N/A
Nov 25	0	0	7			N/A
Nov 25	0	0	0			3rd Quartile
Nov 25	1	2	6			2nd Quartile
Nov 25	5	7	5			2nd Quartile
Apr 25	5.3%	5.7%	-			TBC
Oct 25	79.0%	79.0%	95.0%			N/A
Jun 25	1.12	1.12	-			As expected
Nov 25	2.68%	3.11%	-			2.7%
Nov 25	2.9%	4.8%	-			3.2%
Nov 25	3.6	3.4	-			3.30
Nov 25	3.6	0.0	-			1.60
Nov 25	0.0	0.0	-			N/A

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	Nov 25	92.0%	86.0%	85.0%			N/A
Complaints - Acknowledgement within 3 working days	Nov 25	66.0%	76.0%	100.0%			N/A
Number of complaints not completed within 6 months from date of receipt	Nov 25	1	1	0			N/A
Friends and Family Test - Inpatients Score	Nov 25	98.6%	96.1%	90.0%			Top Quartile
Friends and Family Test - Emergency Department Score	Nov 25	76.2%	75.6%	90.0%			3rd Quartile
Friends and Family Test - Outpatients Score	Nov 25	94.8%	95.2%	90.0%			3rd Quartile
Friends and Family Test - Maternity Score	Nov 25	83.9%	100.0%	90.0%			3rd Quartile

Epsom & St Helier

Latest month	Previous Month Measure	Latest Month Measure	Target	Variation	Assurance	Benchmark
Nov 25	86.0%	80.0%	85.0%			N/A
Nov 25	100%	100%	100%			N/A
Nov 25	10	11	0			N/A
Nov 25	91%	96%	90%			3rd Quartile
Nov 25	38.5%	73.6%	90.0%			Lowest Quartile
Nov 25	95.4%	93.5%	90.0%			Top Quartile
Nov 25	100.0%	95.5%	90.0%			3rd Quartile

Sutton Healthcare

KPI	Latest month	Previous Month Measure	Latest Month Measure	Target	Variation	Assurance
Patient Safety Incidents Investigated	Nov 25	0	0	0		
Number of Falls with Harm (Moderate and Above)	Nov 25	0	0	-		
Pressure Ulcers Category 3&4	Nov 25	2	1	-		
Infection Control - Number of MRSA	Nov 25	0	0	0		
Infection Control - Number of Cdiff	Nov 25	0	0	-		
Infection Control - Number of Ecoli	Nov 25	0	0	-		
Community FFT	Nov 25	94%	97%	90%		

Surrey Downs

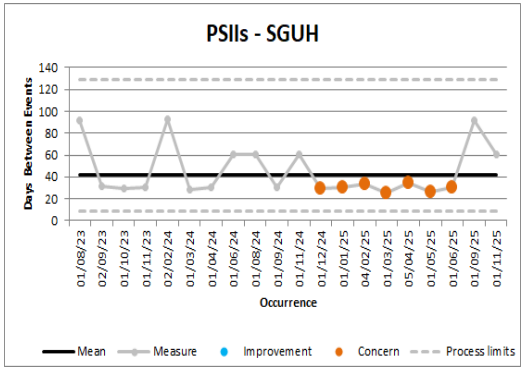
Latest month	Previous Month Measure	Latest Month Measure	Target	Variation	Assurance
Nov 25	0	0	0		
Nov 25	0	0	-		
Nov 25	9	6	-		
Nov 25	0	0	0		
Nov 25	0	0	-		
Nov 25	0	0	-		
Nov 25	96.7%	96.3%	90.0%		

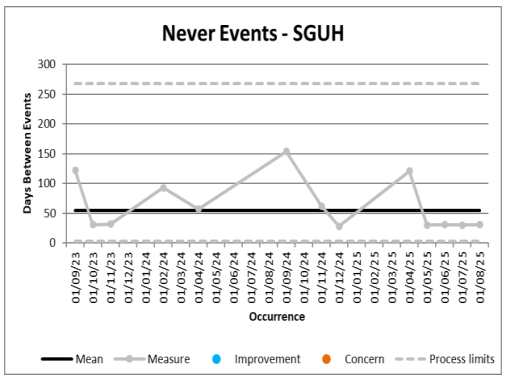
- Community FFT is a subset of Epsom and St Heliers FFT data.
- IC (Dorking and Molesey Hospitals – community do not have set national trajectories for HCAIs although all cases are reviewed and investigated)

Safe, High-Quality Care

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

St George's





Summary & Actions

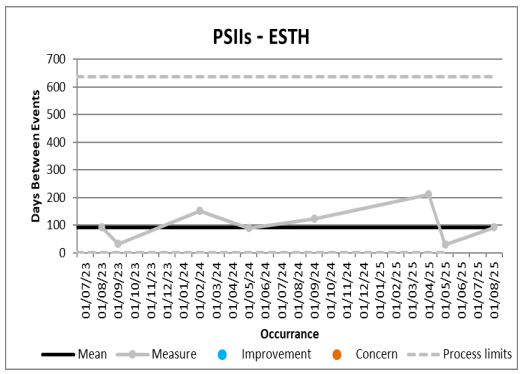
One Patient Safety Incident Investigations (PSII) was declared at SGUH in November 2025.

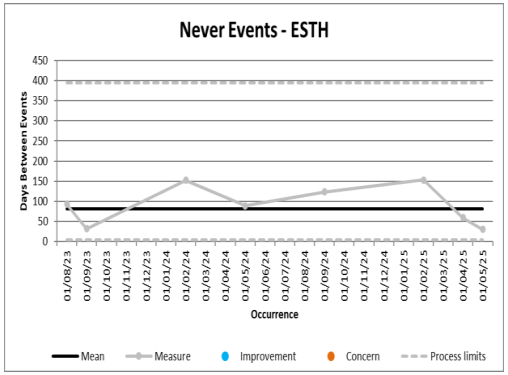
- A missed diagnosis / failure to recognise complication incident for Delivery Suite.

Summary & Actions

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

Epsom & St Helier





Summary & Actions

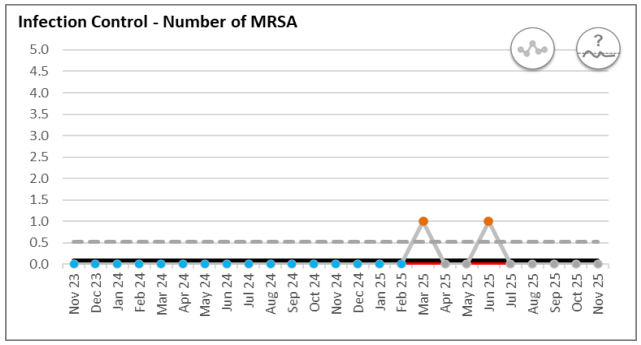
No new Patient Safety Incident Investigations were initiated at ESTH in November 2025.

Summary & Actions

No Never Events were reported at ESTH in November 2025.

Safe, High-Quality Care

Exception Report | SGUH - Infection Prevention and Control

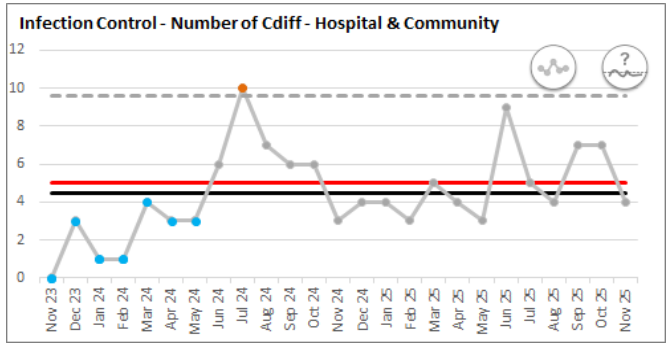


SGUH - Summary & Actions

Healthcare Associated MRSA Bacteraemia:

Trust	Nov-25	MRSA Cases YTD (M8)	Annual Threshold
SGUH	0	1	0

No MRSA bacteraemia reported in November 2025



SGUH - Summary & Actions

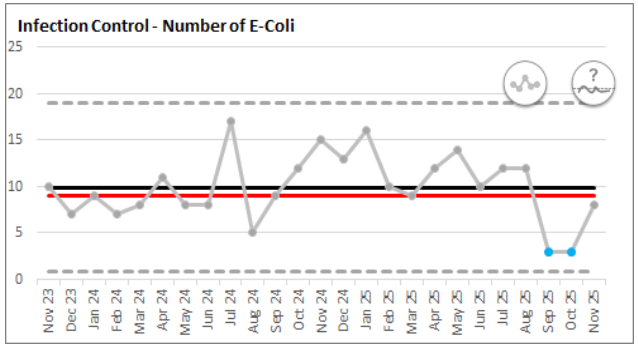
Healthcare Associated CDIs– Hospital & Community

Trust	Nov-25	CDI Cases YTD (M8)	Annual Threshold
SGUH	4	43	43

The trust reached it annual threshold (43) in November signalling a high likelihood of surpassing the annual limit by year-end.

Actions in place include:

- An overarching group C difficile action plan shared with divisional leads
- Multi-disciplinary C difficile ward rounds and continuous reviews to identify themes for learning. New review template being trialled and shared with governance leads.
- Use of high level of decontamination for the environment. HPV machines available via Mitie contract..
- Additional C. difficile education delivered across key forums and training groups.



SGUH - Summary & Actions

Healthcare Associated E-coli Cases

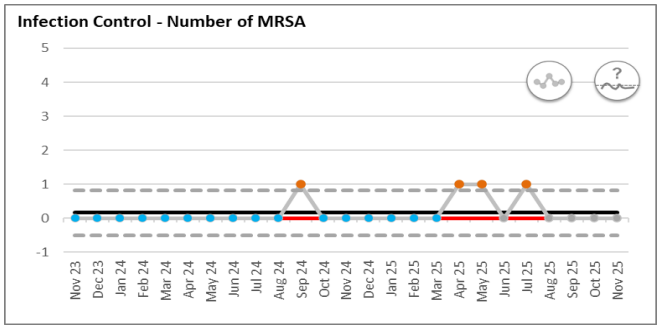
Trust	Nov-25	E.coli Cases YTD (M8)	Annual Threshold
SGUH	8	85	109

Actions in place:

- Working with iClip documentation team to upload/have a digital urinary catheter passport to help with management/reviews for both hospital and community staff.

Safe, High-Quality Care

Exception Report | ESTH - Infection Prevention and Control

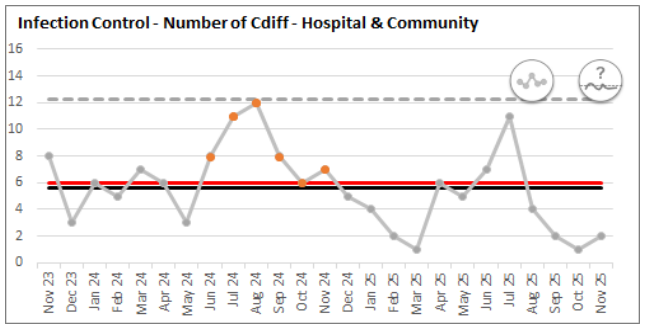


ESTH - Summary & Actions

Healthcare Associated MRSA Bacteraemia

Trust	Nov 25	MRSA Cases YTD (M8)	Annual Threshold
ESTH	0	3	0 (zero avoidable cases)

MRSA: No MRSA bacteraemia reported in November 2025.



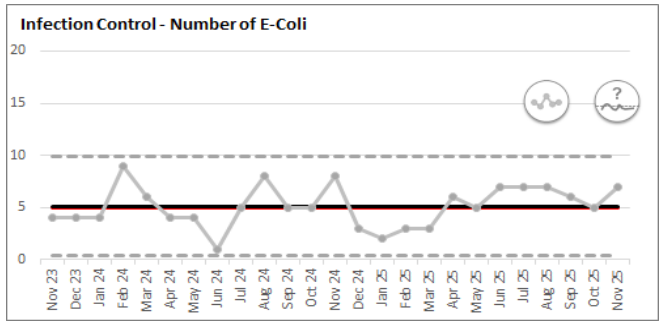
ESTH - Summary & Actions

Healthcare Associated CDIs:

Trust	Nov 25	CDI Cases YTD (M8)	Annual Threshold
ESTH	2	37	63
IC	0	0	0

Actions:
An overarching group C. difficile action plan shared with divisional leads

- **Water safety:** issues continue to be monitored via the Water Safety Group and the Water Safety action plan. Recurring update meetings with SLT representation to be set up to gain assurance/monitor progress of actions in place/to be into place to ensure Unit remains safe to be operational. Ward closures due to Norovirus and COVID for both Sutton Health Care (SHC) and Surrey Downs Health Care (SHDC).



ESTH - Summary & Actions

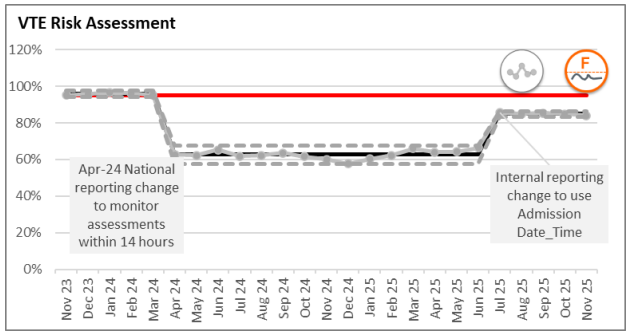
Healthcare Associated E. coli

Trust	Nov 25	E.coli Cases YTD (M8)	Annual Threshold
ESTH	7	49	57
IC	1	2	0

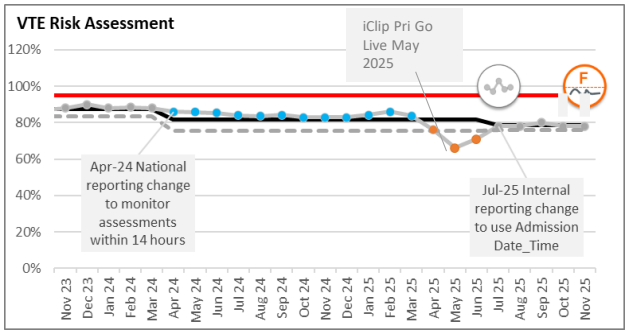
Actions:
Working with iClip documentation team to upload/have a digital urinary catheter passport to help with management/reviews for both hospital and community staff.

Safe, High-Quality Care
Exception Report | SGUH & ESTH VTE Risk Assessment

St George's



Epsom & St Helier

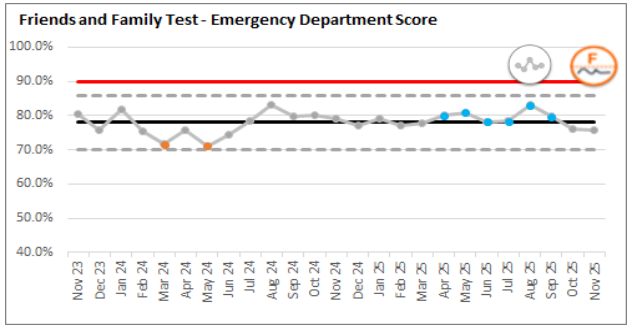


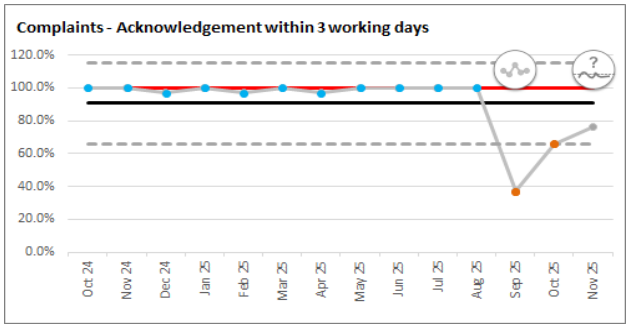
Site & Metric	Cause of variance/ non-compliance	Group Actions: Completed since last update, New, and Ongoing	Recovery Date	Data Quality

SGUH: VTE 84%. Not meeting target of 95%,
 	
ESTH: VTE 79% Not meeting target of 95%
	• The Chief Medical Officers at gesh have reviewed the reporting logic for VTE assessments. The Trusts now records the *admission time* (when the patient is placed in a bed) instead of the Decision to Admit time. Reported VTE risk assessments rates have consequently improved to 84% and 79% at SGUH and ESTH respectively.
	
	• Reporting at ESTH has been adversely affected by the implementation of the new EPR:
	  ○ Maternity risk assessments are not aligned with national guidance. Badgernet is being used for post-pregnancy and birthing people, and this data has not flowed into PBI for August to November. The BI team is aware and working on a solution.
	  ○ Incorrect coding of low-risk cohorts remains an issue, with ongoing meetings with the BI team to address this.
	  ○ Patient tracker boards, including VTE risk-assessment completion, are not easily accessible on iClip Pro. VTE nurses are working with services to support re-embedding this.
		Other Actions include:
		• VTE champions form a multiprofessional group to boost assessment compliance, aiming for a 5% increase by December 2025.
		• A joint workshop with thrombosis leads and VTE champions from both trusts was held on the 21st November with plans for task groups to review reporting accuracy, align assessments, develop education and training and drive clinical leadership culture.
		• 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..
			Trajectories under review for 2025/26
			
			Trajectories under review for 2025/26
				Sufficient for assurance
				
				Not sufficient for assurance until Maternity resolved (mid Jan-26)

Safe, High-Quality Care

Exception Report | SGUH Patient Experience (Satisfaction & Complaints)

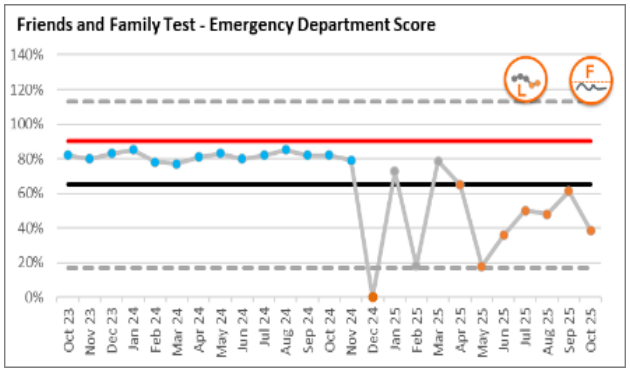




Site & Metric	Cause of variance/ non-compliance	Actions: Completed since last update, New, and Ongoing	Recovery Date	Data Quality
SGUH FFT ED Score was 76%	In November 2025, 76% of patients said they would recommend the department to friends and family. This is comparable to the most recent national data, which shows a national average of 79% (September 2025, shown in graph above). This is the same % as October and represents the lowest percentage year to date and highlights the significant challenges the department is facing, including prolonged waiting times and patients receiving care in corridors The ED FFT survey response rate has dropped significantly this month, with only 702 responses (600 fewer than the 12-month average) equating to 6%. The IT team is investigating the issue and has raised a call with Netcall. We are awaiting their findings and assurance that the issue will be resolved, with the expectation that response rates will return to normal levels in December 2025.	1. Review of patient feedback with the relevant leads to identify areas where improvement is required Corridor care checklist and intentional rounding – ongoing 2. Standardised documentation template for corridor care by Registered Nurses to ensure consistent records and risk assessments. All patients offered a comfort pack 3. ED matron checklist completed daily with focus on safety; RAT rota now Mon–Fri, 11:00–19:00, for earlier senior review and patient redirection 4. Patient Check-In (a digital check in tool) launched in January 2025 to make the checking in process more efficient 5. 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 Acknowledged within 3 working days.	In September 2025, the complaints team experienced significant staffing issues which adversely impacted the Acknowledgement metric. The action plans put in place to support staffing shortfalls to ensure acknowledgement and response rates return to target have resulted in the percentage of complaints acknowledged within 3 working increasing in October to 66% and even further in November 76%. In the last 2 weeks, performance has hit 100% and 94%, now showing common cause variation.	• 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. • Approval received to recruit permanently which should help stabilise the position	March 2026	sufficient for assurance

Safe, High-Quality Care

Exception Report | ESTH - Patient Experience (Satisfaction)



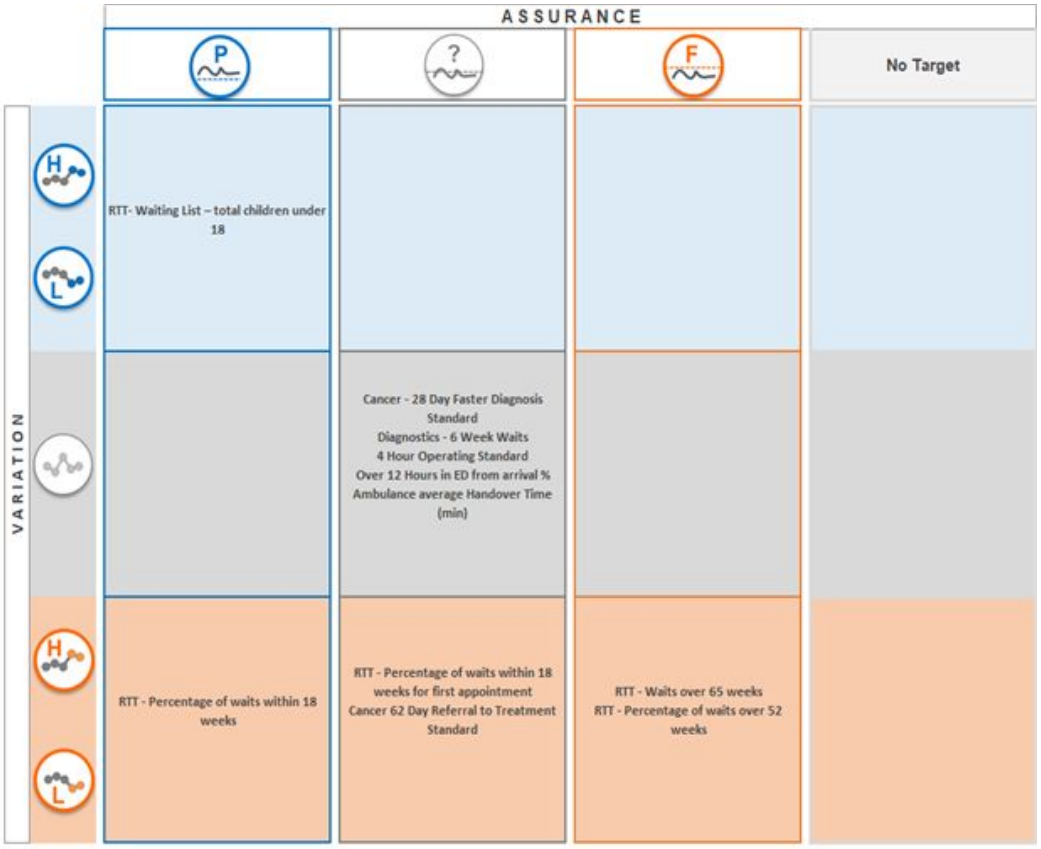
Site & Metric	Cause of variance/ non-compliance	Actions: Completed since last update, New, and Ongoing	Recovery Date	Data Quality
ESTH FFT ED Score Special cause variation of a concerning nature Consistently failing target	The FFT contract at ESTH has concluded and transitioned to Gather, where the survey is accessible via posters, reaching a limited audience. Information governance approval has now been received to send the survey to patients through text messaging and this commenced in October 2025. 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 • Text messaging re-commenced from October 2025. • Planned review of messaging within ED re: Survey • 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 and will be reviewed in the New year. • The Medicine Division is committed to enhancing patient experience during periods of heightened emergency care demand by increasing staffing levels, putting actions into place to support patients in escalation areas within the department and optimising patient flow to expand inpatient capacity.	March 2026 (response rate). Recovery date for scores under review.	Not sufficient for assurance

Section 2.1:
Operational Performance

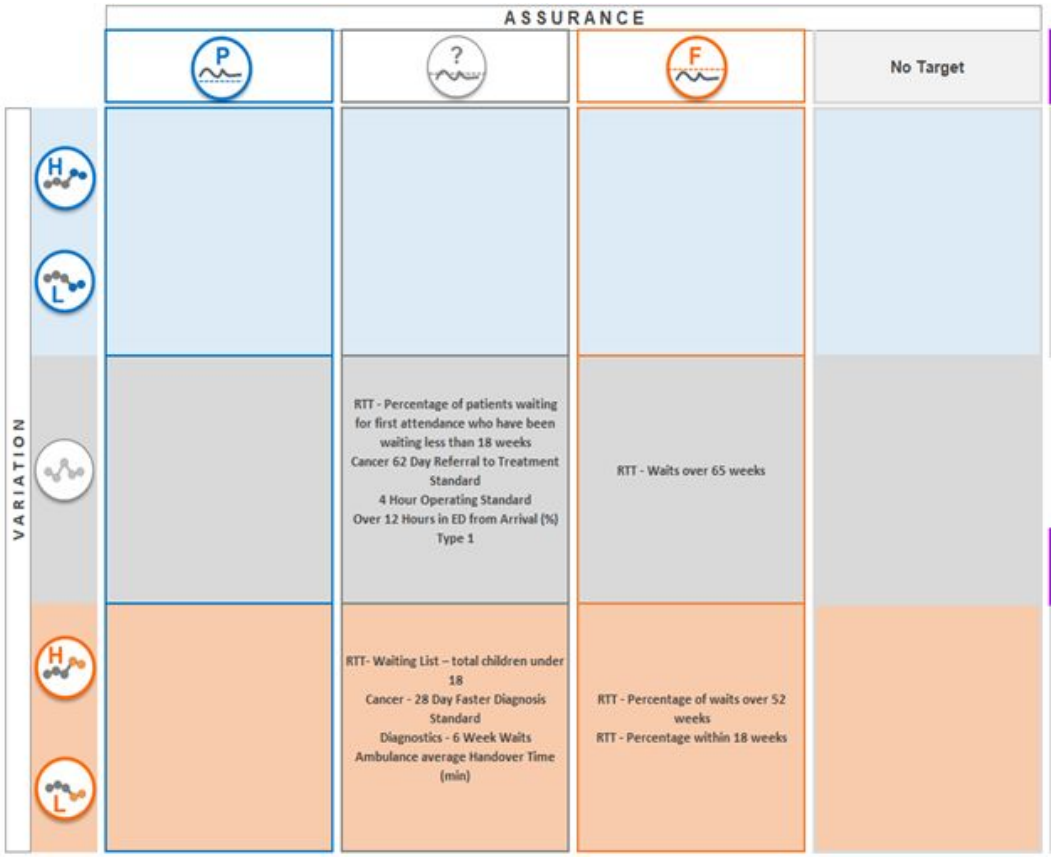
Section 2.1 Operational Performance

Matrix Summary

SGUH Operational Performance



ESTH Operational Performance



Operational Performance

Overview Dashboard

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KPI	Latest month	Previous Month Measure	Latest Month Measure	Target	Variation	Assurance	Benchmark
St George's							
RTT - Waits over 65 weeks	Oct 25	297	226	0			Lowest Quartile
RTT - Percentage of waits over 52 weeks	Oct 25	2.52%	2.23%	1.00%			2nd Quartile
RTT - Percentage of waits within 18 weeks	Oct 25	60.8%	60.5%	60.0%			3rd Quartile
RTT - Percentage of waits within 18 weeks for first appointment	Oct 25	64.1%	64.1%	66.6%			3rd Quartile
RTT- Waiting List – total children under 18	Oct 25	6294	6323	7715			-
Cancer - 28 Day Faster Diagnosis Standard	Oct 25	65.1%	71.7%	82.7%			Lowest Quartile
Cancer 62 Day Referral to Treatment Standard	Oct 25	71.3%	68.3%	85.0%			2nd Quartile
Diagnostics - 6 Week Waits	Oct 25	9.6%	6.8%	5.0%			2nd Quartile
4 Hour Operating Standard	Nov 25	79.1%	80.3%	78.0%			2nd Quartile
Over 12 Hours in ED from Arrival (%) Type 1	Oct 25	11.4%	11.7%	13.0%			3rd Quartile
Ambulance average Handover Time (min)	Oct 25	00:22:46	00:24:26	00:24:00			TBC

Latest month	Previous Month Measure	Latest Month Measure	Target	Variation	Assurance	Benchmark
Epsom & St Helier						
Oct 25	165	171	0			Lowest Quartile
Oct 25	2.10%	2.26%	1.00%			2nd Quartile
Oct 25	63.10%	61.75%	70.43%			2nd Quartile
Oct 25	76.50%	75.40%	81.30%			2nd Quartile
Sep 25	7239	6839	6449			-
Oct 25	69.1%	61.0%	86.8%			Lowest Quartile
Oct 25	81.5%	80.3%	86.6%			Top Quartile
Oct 25	13.6%	11.6%	5.0%			2nd Quartile
Nov 25	73.4%	71.8%	78.0%			3rd Quartile
Oct 25	12.9%	13.6%	13.5%			Lowest Quartile
Oct 25	00:24:31	00:27:23	00:22:00			TBC

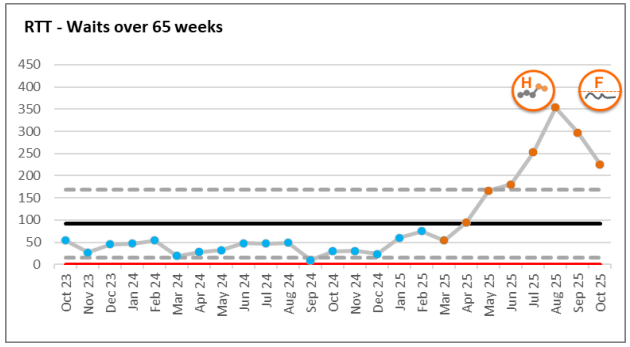
Targets based on Operating Plan end of year March 2026 position (trajectories in place)
Benchmark Position in arrears in line with model hospital publication dates

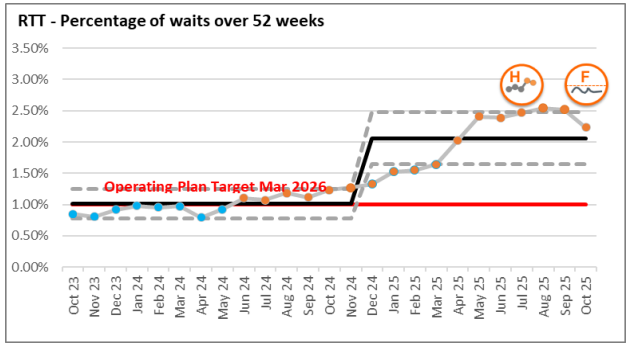
Operational Performance

Overview Dashboard

KPI	Sutton Healthcare Latest month	Previous Month Measure	Latest Month Measure	Target	Variation	Assurance	Surrey Downs Latest month	Previous month measure	Lastest month measure	Target	Variation	Assurance
Two hour UCR performance	Nov 25	67.4%	69.1%	70.0%			Nov 25	86.4%	87.8%	70.0%		
Virtual ward - Bed Occupancy	Nov 25	95.3%	96.5%	85.0%			Nov 25	96.8%	100.0%	80.0%		
Number of waits Adults >52wks	Nov 25	0	1	0			Nov 25	0	0	0		
Percentage of waits Adults <18wks	Nov 25	99.2%	99.2%	78.0%			Nov 25	97.7%	97.1%	78.0%		
Number of waits Children >52wks	Nov 25	8	37	0								
Percentage of waits Children <18wks	Nov 25	47.3%	47.4%	78.0%								

Operational Performance
Exception Report | SGUH Referral to Treatment RTT

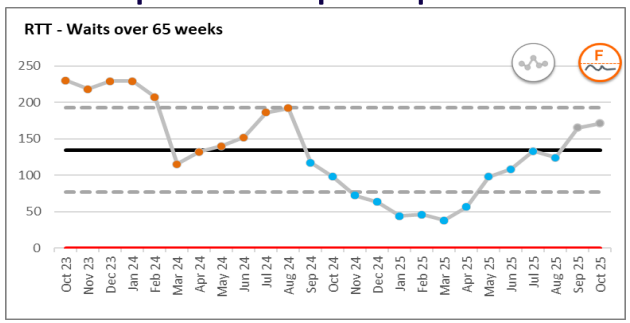


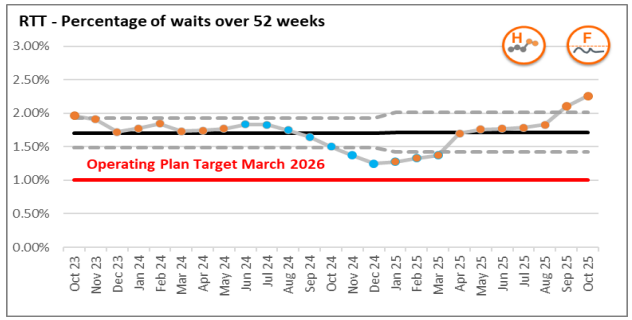


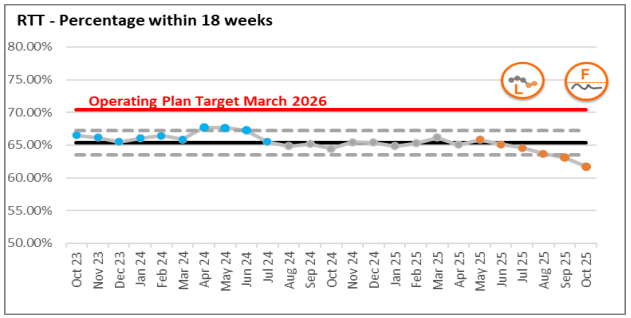
Site & Metric	Cause of variance/ non-compliance	Actions: Completed since last update, New, and Ongoing	Recovery Date	Data Quality
SGUH Waits over 65 weeks - reduction Waits over 52 weeks - reduction	52 and 65 weeks waits – both showing weekly reductions since 15th September. Slippage is due to the late start of specialist weight management clinics – which commenced on 31st October 2025 Bariatric Surgery remains the risk within General Surgery. The increase in demand from out of area referrals has outweighed capacity – this impacts our >65 week position The number of patients on the PTL has reduced steadily since August 2025, which is negatively impacting 18- and 52-week wait performance due to the smaller denominator.	**Ongoing:** Specialist Weight Management patients. Agreement was reached with the ICB on funding for this pathway. The team is now working at pace to stand up a number of OP clinics to address the backlog. With fewer than 15 waiting over 65 weeks compared to >300 previous month. Funding secured from NHSE to support reduction of long waiting patients as follows: • General Surgery – Working with Spire to take 62 patients for surgery over November and December • Gynae – Sending 6 patients for surgery at St Anthony's, standing up 8 additional outpatient clinics and looking to do additional robotic surgery through evenings and weekends to address long waits. Subject to anaesthetic availability • Vascular – Working with locum consultant and Xyla to put on additional clinics and procedural capacity to see and treat long waits. Tier one operational performance committee meeting now stood up on a weekly basis, chaired by Chief Operating Officer, to look at Cancer, and RTT performance, reduction of long waits, Diagnostic (DM01) performance and Urgent Emergency Care. **New:** Specialties now focusing on forward view for January to ensure all patients over 40 weeks are booked for their first appointment	52 week waits – Mar 2026 65 week waits – Dec 2025 Multiple metrics - Jan 2026	sufficient for assurance

Operational Performance

Exception Report| ESTH Referral to Treatment RTT





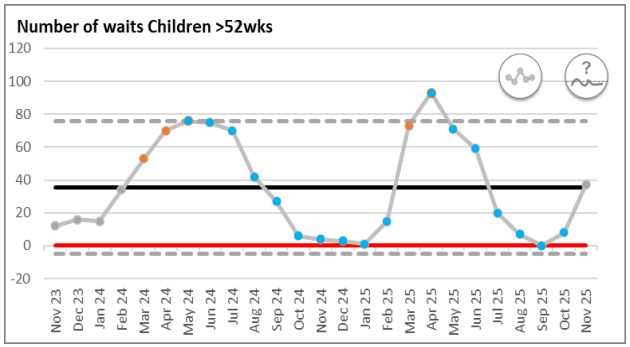


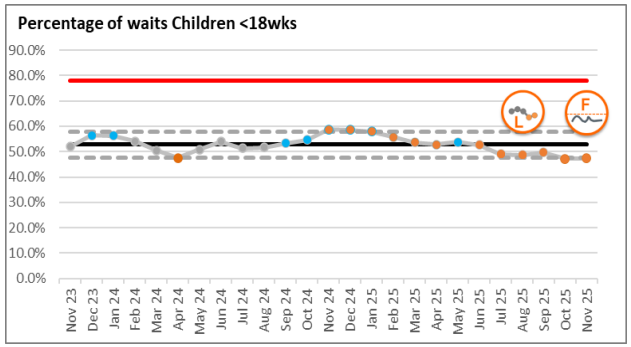
Site & Metric	Cause of variance/ non-compliance	Actions: Completed since last update, New, and Ongoing	Recovery Date	Data Quality
ESTH Proportion of waits over 52 weeks – above monthly trajectory of 1.18% Percentage within 18 weeks – below monthly trajectory of 65.43% Percentage waits for first appointment under 18 weeks –below monthly trajectory of 81.30%	• 52WW did not achieve the ambition of being below 1.18% in October 2025, with a performance of 2.26%. 52WW increased again from 1241 (September 2025) to 1307 (October 2025). The highest volumes were in Dermatology (465), T&O (129) and Gastroenterology (118). • 65WW increased again from 165 in in September 2025 to 171 in October 2025, the majority of which were in Dermatology. • The RTT PTL reduced again for the second consecutive month since EPR go live, from 58667 in September 2025 to 57913 in October 2025. • Percentage waits for first appointment under 18 weeks was below plan in October 2025 with a performance of 75.4%.	**Total PTL** -ESTH's PTL fell again in October 2025, marking a second consecutive monthly drop since EPR go-live after four months of growth. Processes are stabilising as teams adapt, with improving task times. Urgent and cancer pathways remain prioritised, and data quality issues are gradually being resolved, leading to fewer patients remaining on the PTL unnecessarily. Overall, the PTL continues to show clear signs of recovery. **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 has developed a recovery plan for RTT and cancer, with additional capacity secured via Medinet until the end of December. External funding received from RMP & NHSE to support Dermatology's recovery. Teledermatology pilot is planned to start in December (delayed from November due to equipment delivery & training requirements) to improve TWR and expand routine capacity. Exploring skin analytics and another Virtual Lucy exercise to further support the service. • T&O: Late referrals remain a challenge. Consultants have agreed one outpatient overbooking and introduced post-diagnostic phone appointments to reduce follow-ups and increase new capacity. First outpatient waits are steady at around 12wks for Hip & Knee. Flexi theatre lists with partners continue; SWLEOC has started five cases with plans to expand. Most 52WWs are within Hands (ESTH), where new appointments have paused since November to reduce the admitted backlog. Extra Saturday lists have been arranged to support high waits. • Gastroenterology: Key challenges relate to reduced clinical capacity due to consultant long-term sickness and specialist nursing gaps, with short-term locum support being recruited. Patient engagement with bloods and diagnostics remains difficult, and a text-reminder service is being explored. A PTL coding change at iCLIP splitting TFC 301 into two local treatment functions (Gastroenterology-301 and Endoscopy-30101) caused some pathway delays which the team are now reviewing and aligning to the correct service.	25/26 trajectories expected to be achieved by March 2026	October 2025 data sufficient for assurance

Operational Performance

Exception Report | Community Services Waiting Times (Children)

Sutton Healthcare

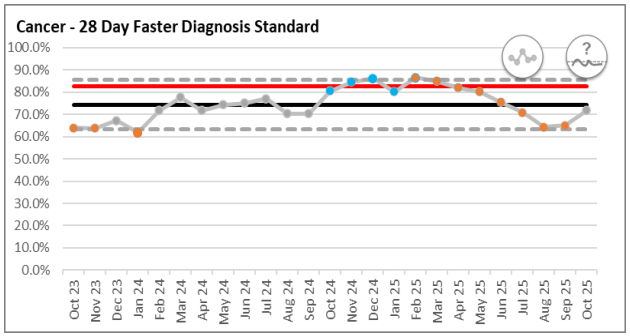


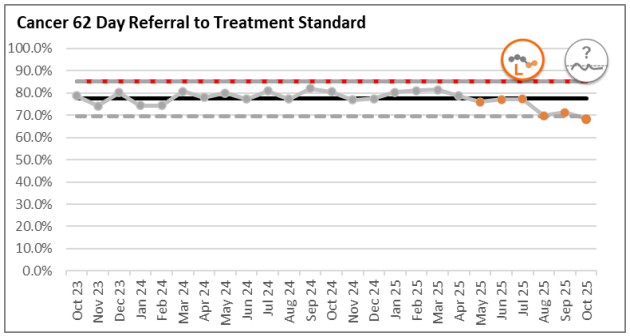


Site & Metric	Cause of variance/ non-compliance	Actions: Completed since last update, New, and Ongoing	Recovery Date	Data Quality
Sutton Health & Care % of waits over 52 weeks % of waits within 18 weeks	Overall waiting list size for children's services remains high with a consolidated action plan in development across South West London. Waiting lists are stretched due to capacity versus demand with referrals continuing to increase year on year. This is also a national issue and has been highlighted on the risk register. Progress was 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, however at the end of November 2025 this increased to 37 (3.7% of the children's waiting list), predominantly within Children's SALT services. At the end of November 2025, 47.4% of children were waiting less than 18 weeks for treatment. Overall waiting list size for children's services remains high with an action plan in place. Performance against the 78% Standard remains a challenge and likely to remain a challenge for the foreseeable future, due to capacity, which ICB and partners are aware of.	• 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. Further work is ongoing with an action plan in place to reduce waits and improve productivity • Harm reviews are taking place with our chief nurse to ensure there is no harm to these children who wait. There have been no concerns raised • 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

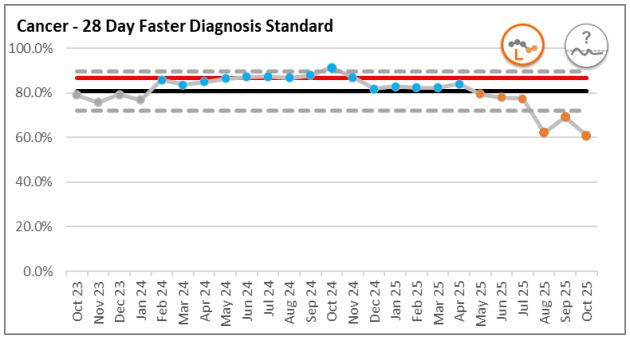




Site & Metric	Cause of variance/ non-compliance	Actions: Completed since last update, New, and Ongoing	Recovery Date	Data Quality
SGUH 28 Day – below target of 75% 62 Day Below target of 85%	**28-Day Standard: Oct-25 Improvement to 71.7%, achieving 66.6% in Q2** Key Drivers: • Skin: 37.7% – Seasonal referrals up 32% compared to 2024, this has begun to reduce; Gynae: 58.9% – Limited access to one-stop hysteroscopy/scan; **62-Day Standard: Oct-25 68.3%, reporting 73% in Q2.** Key Drivers • Lung (26.3%) Thoracic: Ongoing capacity issues with robotics theatre lists • Urology (45.2%) due to access to theatre and Uro-Renal capacity.	**Dermatology** Backlog Progress: Priority is being given to scheduling follow-on Notes Review clinics within 48 hours of tele-dermatology appointments to address a backlog of 119 patients awaiting review. Results Follow-Up: A new template letter has been implemented to expedite communication of results. RMP-Funded Mutual Aid: Over 100 referrals have been transferred to KUH through four all-day, one-stop clinics scheduled for November and December 2025. Long-Term Capacity: A locum consultant is scheduled to commence in January 2026, with a 12-month locum business case currently in progress. **Gynaecology Pilot Launch:** A 12-month pilot for cervicovaginal swab testing for abnormal bleeding commenced on 24 November 2025, providing 24 slots per week. **Lung/Thoracic Mutual Aid:** RMP-funded mutual aid is being utilised to increase surgical capacity and release slots at Imperial. Eight patients have been transferred under this arrangement. **GI services discharge from endoscopy** is now live from the 8th of December 25, for patients on the Faster Diagnosis Standard (FDS) pathway following a normal colonoscopy (no malignancy detected). **Support & Oversight** **Winter Resilience Funding: £60K** RMP funding has been released to support recovery of FDS and 62-day pathways across Skin, Breast, Histopathology, Thoracic, and Urology. **Off-Pathway Management:** A Tableau dashboard with live updates of patients awaiting off-pathway letters is now operational, enabling daily management of FDS communications.	Full recovery is anticipated by January 2026, subject to a continuation of a reduction in referrals and clearance of the remaining backlog for skin.	Sufficient for assurance

Operational Performance

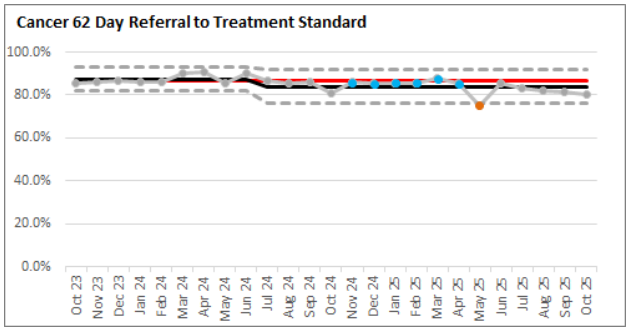
Exception Report | ESTH 28-Day Cancer Faster Diagnosis Performance



Site & Metric	Cause of variance/ non-compliance	Actions: Completed since last update, New, and Ongoing	Recovery Date	Data Quality
28 Day Faster Diagnosis decreasing trend 61% – Below trajectory of 86.9% and national target of 77%	**Dermatology (22.8%):** **FDS performance for dermatology have improved slightly compared 2.6 % from last month.** • Limited 1st outpatient capacity with first appointment after 28 days. • Long-term consultant sickness and unfilled vacancy. • Increased GP and Consultant Upgrade referral volumes.	• All routine OPA capacity converted to cancer OPA. • Vacancy recruited, start date in January 2026. • RMP provided additional funding to clear the backlog. • Regular weekly huddles have been established with Dermatology Management, the Recovery Director, and the Cancer General Manager to support pathway oversight.	February 2026	Sufficient for assurance
	Gynaecology (62.4%): **FDS performance for Gynaecology have improved slightly compared to 48.7 % from last Month.** • Restricted outpatient and general anaesthetic (GA) diagnostic capacity.	• Significant reduction in ASIs and escalation numbers with increased 1st OPA capacity via ad hoc clinics. • MDTM patient stratification reduced joint clinic pressure. • Deep sedation hysteroscopy lists created. **Next Steps - Maintain improved performance and ongoing monitoring to ensure sustainability of new model.**		
	Upper GI (73.3%): • Complex caseload (elderly/incapacitated patients) requiring F2F review and multiple investigations • Endoscopy bottlenecks due to deep sedation requirements and dependence on consultant-led lists.	• 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. **Next Steps –** Cancer Services are working with the service team and setting up regular meetings to improve patient pathways at various levels. A post-MDT clinic is being introduced to enable the nursing team to proactively request diagnostics and provide patients with feedback on their upcoming investigations which will support in improving the FDS.		

Operational Performance

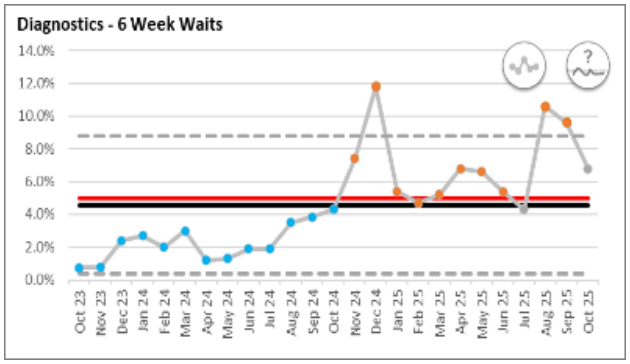
Exception Report | ESTH 62-Day Cancer Waits Performance



Site & Metric	Cause of variance/ non-compliance	Actions: Completed since last update, New, and Ongoing	Recovery Date/Status	Data Quality
62 Day Standard Normal variation 80.3% Below trajectory of 86.21% and national target of 85%	**Gynaecology (56.3%)** Delays in arranging first appointments and limited JCC clinic capacity were key contributors to breach values for Gynaecology. These bottlenecks impacted timely access to diagnostics and pathway progression. Escalations are proactively managed daily to maintain efficiency.	• The service team has streamlined booking to ensure first appointments occur within 14 days. A new clinician joined in mid-September, enabling two extra cancer clinics weekly. JCC capacity is regularly reviewed so patients are scheduled per MDT outcomes, with non-priority cases redirected to suitable clinics. POA capacity at St Helier has also increased, supporting timely bookings • Recruitment is underway for a one-stop nurse-led hysteroscopy clinic to boost diagnostic capacity. Extra TWR slots support hysteroscopies, and Penthrox (introduced in October) improves pain management, reducing need for general anaesthesia helping patients tolerate procedure	Cancer Recovery Plans under review by service team. This will be discussed in Cancer Performance Steering Group on 18th December	Sufficient for assurance
	Lung (44.4%) • Delays to CT-guided biopsies and Navigational Bronchoscopy at Royal Brompton causing delays	• Diagnostic delays persist (navigational bronchoscopy), RMP exploring private sector support • Some capacity issues in face to face out patients, bronchoscopy, and lung function tests • Continue collaboration with RMP on diagnostic pathway support.		
	Skin(80.4%) • Limited 1st outpatient capacity. • Long-term consultant sickness and vacancy. • Delay in introducing tele-dermatology project due iClip implementation.	• All routine OPA capacity has been converted to cancer OPA. • Vacancy filled; start date Jan 2026. Extra RMP funding allocated for ad hoc capacity via GPSIs • Weekly PTL review to identify high-risk patients for the clinical lead and expedite pathways		
	Head & Neck (77.8%)(Low numbers) • Complex pathways despite good performance on TAC and FNA OPA turnaround.	A complex pathway contributed to a patient breach due to a slight delay in reporting an MRI scan. This issue has been raised with the radiology team to implement measures that mitigate such delays in the future.		

Operational Performance

Exception Report| SGH Diagnostic Performance

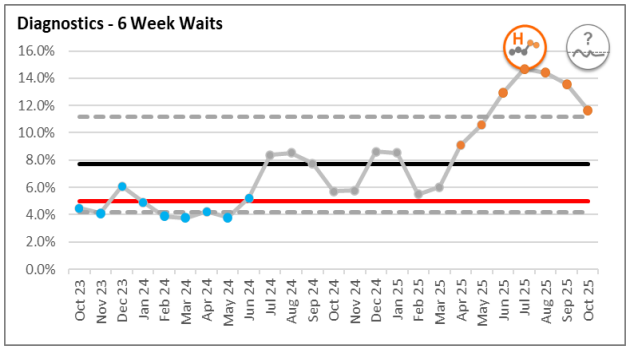


Modality	6 Week Breach	>6 Week Performance
Magnetic Resonance Imaging	383	14.6%
Non Obstetric Ultrasound	338	5.3%
Gastroscopy	69	17.9%
Colonoscopy	45	17.9%
Cardiology - echocradiography	24	2.0%
Urodynamics - pressures & flows	19	18.6%
Flexi Sigmoidoscopy	18	15.3%
Cystoscopy	6	4.7%
Neurophysiology - peripheral neurophysiology	3	1.2%
Computed Tomography	0	0.0%
DEXA Scan	0	0.0%
Respiratory physiology - sleep studies (Pulse Ox)	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 – normal variation 6.8% not meeting national interim target of 5%	At the end of October 2025, 6.8% of the diagnostic waiting list were waiting over six weeks for tests compared to 9.6% at the end of September 2025, seeing for a consecutive month a reduction in six week waits. The increase in August 2025 was significantly impacted by unplanned long and short-term sickness within Imaging (admin and sonographers) which created a backlog impacting overall Trust performance. A high number of Cardiac MRI appointments have been cancelled due to breakdown of machine due to ongoing works and not having the capacity to re-booked within target leading to longer waits. Endoscopy has not achieved the 5% target since March 2024. This is primarily due to sustained growth in the waiting list, capacity pressures from bowel screening activity, and the transfer of patients from the planned list to the active PTL when not seen within scheduled timeframes. Activity and capacity have remained static, resulting in a widening gap over time and longer patient waits.	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 • Recent performance continues to show an improving trend	Under Review	Sufficient for assurance

Operational Performance

Exception Report | ESTH Diagnostic Performance

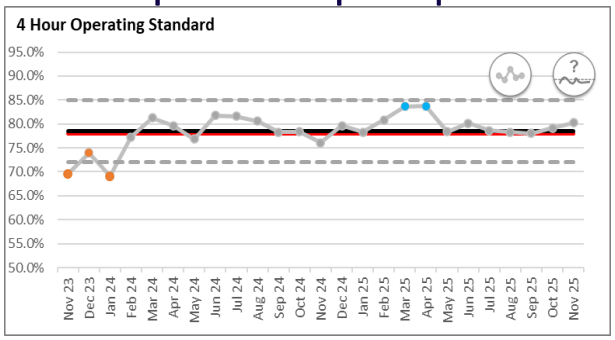


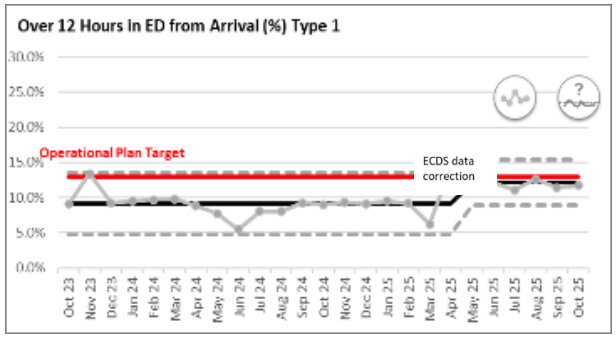
Modality	6 Week Breaches	>6 Week Performance
Cardiology - echocardiography	501	33.1%
Colonoscopy	490	55.1%
Gastroscopy	334	47.0%
Audiology - Audiology Assessments	150	17.4%
Flexi sigmoidoscopy	130	53.5%
Non-obstetric ultrasound	87	1.2%
Urodynamics - pressures & flows	54	30.7%
Cystoscopy	42	15.3%
Computed Tomography	19	1.9%
Magnetic Resonance Imaging	11	0.6%
DEXA Scan	9	2.0%
Neurophysiology - peripheral neurophysiology	0	0.0%

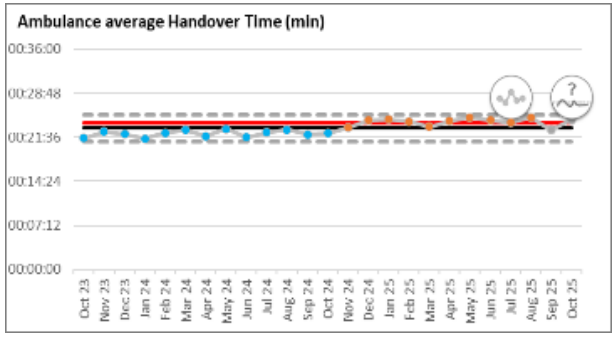
Site & Metric	Cause of variance/ non-compliance	Actions: Completed since last update, New, and Ongoing	Recovery Date	Data Quality
ESTH 6Wk waits 11.6% not meeting national interim target of 5%	At the end of October 2025, there were 1,827 patients waiting more than six weeks for their diagnostic (DM01), a reduction from 1,970 in September 2025. Performance also improved from 86.42% in September to 88.36% in October, although it remains below the national interim target of 95%. The modalities with the highest volumes waiting >6 weeks at the end of October 2025 were Endoscopy (954), ECHO (501) & Audiology (150). Imaging modalities remain above 95%.	• **ENDOSCOPY:** An ongoing 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. Further Saturday Waiting List Initiative sessions have been approved at Epsom and St Helier (for 12 weeks from December to February). This is expected to deliver 270 extra procedures, cutting the 6-week-plus backlog by 41%, and supporting cancer and RTT targets. • **ECHOs:** The number of breaches reduced to 501 at the end of October 2025. Weekly waiting list validation is in place to prevent DQ challenges due to new EPR system. There's been an increase in capacity for additional clinics in November and the number of breaches is expected to be below 400 at the end of November. Recruitment for new substantive band 7 is ongoing, whilst approval for agency staff as interim measure has been sourced via triple lock process- pending approval. • **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, but recently there has been a slight improvement in performance. A recovery plan has been developed, though progress is limited as it does not rely on additional sessions. The department is also under pressure due to recent long term sickness, recruitment challenges, and additional demand after neighbouring Trusts, including Dorking, Royal Surrey, and other SWL Trusts, began rejecting referrals. Three new appointments have also been made, and 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. A short business case will be submitted seeking support for additional capacity to achieve the DM01 target by March 2026.	March 2026	October 2025 data still includes a degree of DQ following EPR implementation that continues to be worked through with BI and operational teams. This DQ is mainly within OP modalities Neuro-Phys, Urodynamics and Cystoscopy.

Operational Performance

Exception Report | SGUH A&E Waits and Ambulance Handovers



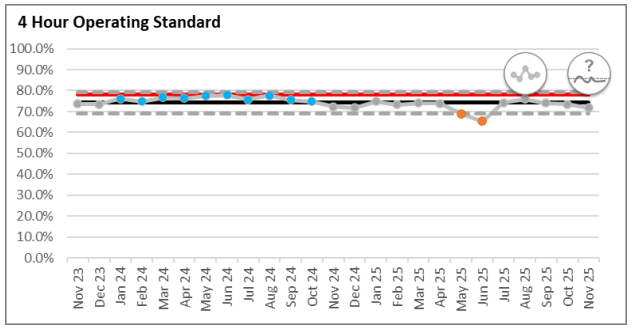


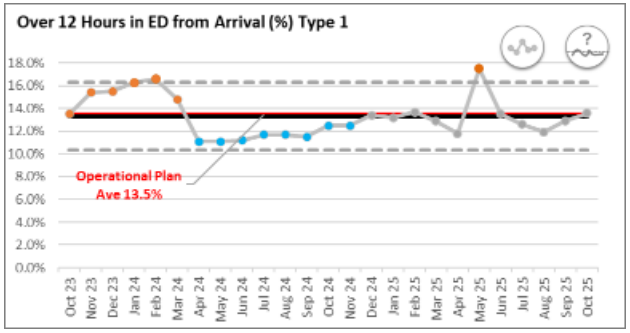


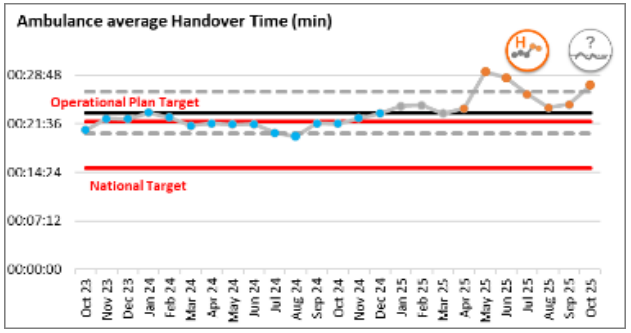
Site & Metric	Cause of variance/ non-compliance	Actions: Completed since last update, New, and Ongoing	Recovery Date	Data Quality
SGUH 4 Hour Target met in November 2025 12 Hour waits Type 1 – normal variance meeting plan Ambulance Handover – normal variation in line with plan	Achieved 80.26% 4hr performance in Oct-25, meeting 78% national target. High volume of mental health patients attending ED, with long waits for mental health beds. Decrease in the number of admitted patient breaches	• 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. • Frailty SDEC launched in July, averaging 4 patients daily: 79% discharged, 21% admitted (average LOS 2.5 days) • Launch of Patient Check In has reduced average time in streaming queue from 28 mins to 8. • 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, due to start in Dec-25 • Access to book GP slots via EMIS beyond M&W to be launched in December (delay from 25/11 start date) • Operations/management lead will be based in ED to oversee performance, wait times, and escalations, supporting Matron of the Day • Assessment/triage model updated to add resources at the front door, including an extra streamer and a RAT consultant at ambulance triage for timely handovers and redirection; in addition to: • 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 Advanced Clinical Practitioners and Physician Associates to support streaming –13/10 • 55% increase in number of patients streamed to primary care from Sept to Oct • SWL Integrated Care Co-ordination Hub (ICC) launched in Sep-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 • From 13 November 2025, the Emergency Care Data Set (ECDS) NHSE publication introduced several improvements including reporting on 4 hour performance, working with BI and ED admin team to review and establish ways of working to ensure correct and timely validation and reporting first time in line with ECDS submissions	Meeting targets	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



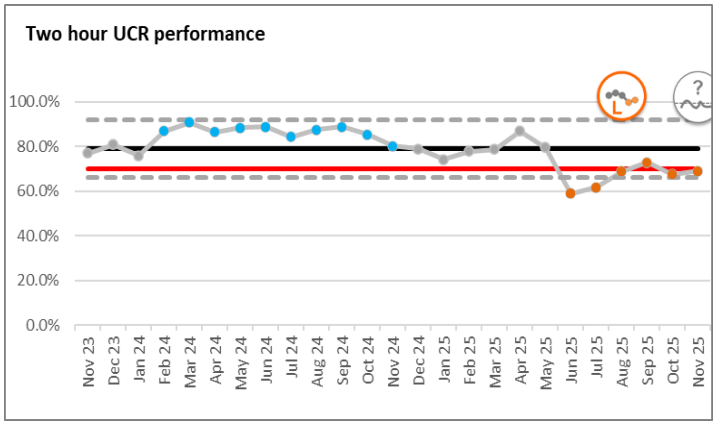


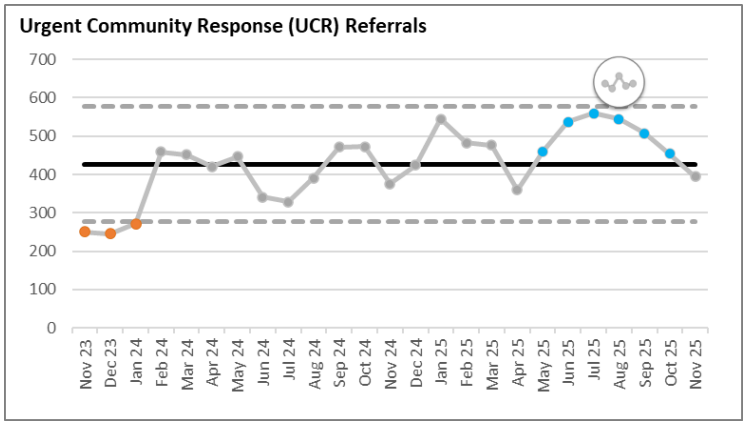


Site & Metric	Cause of variance/ non-compliance	Actions: Completed since last update, New, and Ongoing	Recovery Date	Data Quality
ESTH 4 Hr performance below trajectory of 76.5% ED Type 1 LOS>12 Hours - Meeting plan normal variation LAS Average Handover Time – Increasing Trend	• ESTH delivered 71.8% 4-hour emergency department (ED) performance in November 2025 against an agreed trajectory of 74% 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 28.4% compared to 78.6% for adult non-admitted patients in the month of November 2025. • 12 hour wait times decreased in the month of November to 12.6% from 13.6% in October 2025, noting an improvement above the agreed trajectory of 11.0%. Bed availability and the ability to ensure timely admission to an inpatient bed is impacting 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.	Tier 2 interventions: GIRFT Urgent Emergency Care (UEC) site visits (Aug–Oct 2025) led to recommendations and actions to support improved patient flow, safety, and efficiency across pathway. Focus areas: Front Door Urgent Treatment Centre (UTC) First Model , Same Day Emergency Care (SDEC) model, Acute Medical Unit, and Frailty Pathways. We are moving at pace to stabilise performance to support meeting operating plan. Key actions implemented during the last month include: • Developed and implement revised ambulance handover Standard Operating Procedure (SOP). • Streaming SOP approved, Test of change in ED streaming to increase UTC patients, supported by GIRFT UEC; includes ring-fencing SDEC capacity for patient assessment. • Extending front door frailty service to 7 days with added weekend consultant/SHO support. • Ring-fencing 1 bed space in the frailty hub to accommodate chairs for ambulatory patients • Test of change in ED streaming to increase UTC patients, supported by GIRFT UEC; includes ring-fencing SDEC capacity for patient assessment • Focus on ED front door and UTC First model to improve non-admitted ED performance. • Decision to Admit (DTA) huddles introduced in Emergency Departments on both sites to include dedicated Emergency Care Intensive Support Team (ECISIT) support week commenced 10th November. • 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. • Trustwide RESET week too place week commencing 10th November focusing on individual patient pathways, engaging system partners to maximise discharge opportunities and utilise community pathways to support ED flow.	Dec 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



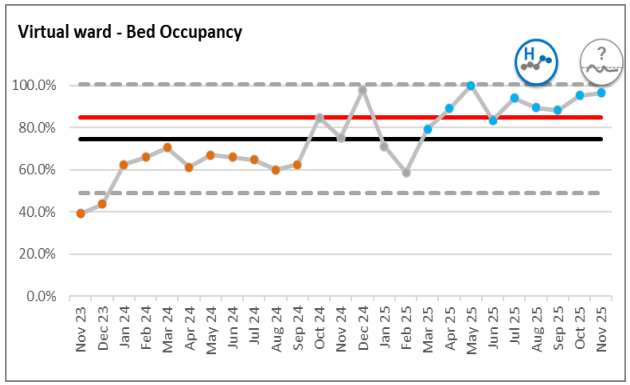


Site & Metric	Cause of variance/ non-compliance	Actions: Completed since last update, New, and Ongoing	Recovery Date	Data Quality
Sutton Health Urgent Community Response within 2-Hrs – Target rate of > 70% not met	• 2 Hour Response time performance November 2025 was 69.1%, an increase compared to 67.4% reported in October 2025 against 70% target. There has been a recent increase in referrals, particularly in the out of hours periods and at weekends. There is a continued focus to ensuring the service meets targets vis a vis its capacity to deliver. Demand has fallen through November 2025.	• The increase in referrals (550 in the month compared with a usual trend of around 350), is being reviewed to identify the underlying causes and implement urgent mitigating actions to ensure the service continues to perform above target.	TBC after detailed analysis which is in progress	Sufficient for assurance

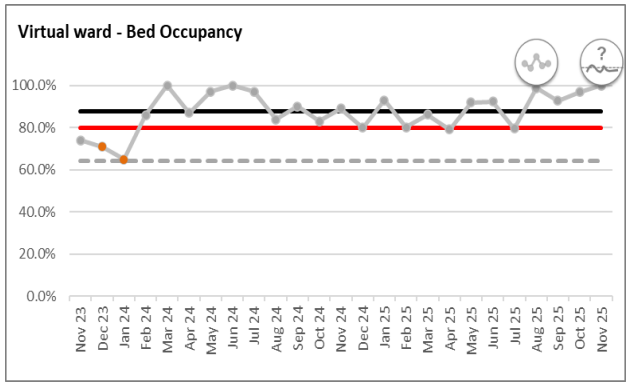
Operational Performance

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 have seen a significant increase performing above the upper control limit through October and November 2025 (412 admissions) Occupancy for November 2025 stood at 96.5%, exceeding target of 85%.	• LoS reduction programme with ESTH and Sutton Alliance is in progress to include virtual ward redevelopment. • Continue to expand the scope and capability of our Virtual Ward offer, including benchmarking acuity to ensure safe and appropriate care at home • On-going development of enhanced care and new pathways in Virtual Wards. • On-going transformational development to strengthen the discharge model via the TOCH.	N/A	Sufficient for assurance
Surrey Downs Health & Care	Admissions to virtual ward remain above the mean with bed occupancy rate at 100% through November 2025. Admissions remain higher than average.	• Site has a clear development plan underway to strengthen the discharge model • Short-term reablement and rehabilitation to support safe discharge. • Home-based assessment of care needs rather than waiting in hospital. • Integrated working between rehab support workers and the wider @home team. • Early, community-led assessment and support planning on the ward. • Minimal handover required, with direct verbal handovers to ensure smooth transition home. • Ability to follow patients home to maintain continuity of care and reduce risk of delays or re-admission	N/A	Sufficient for assurance

Section 2.2:
Operational Productivity

Operational Productivity

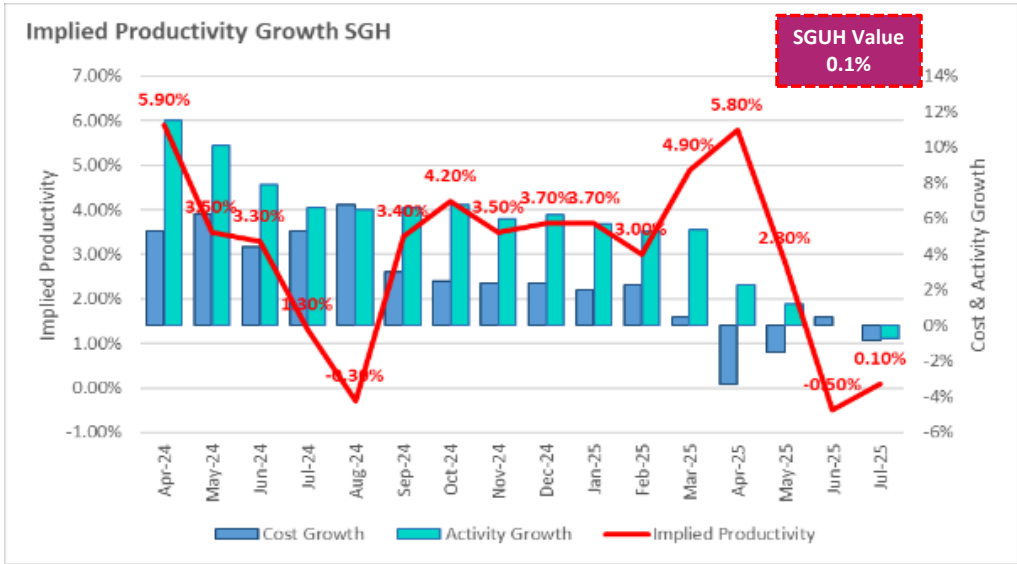
Overview Dashboard

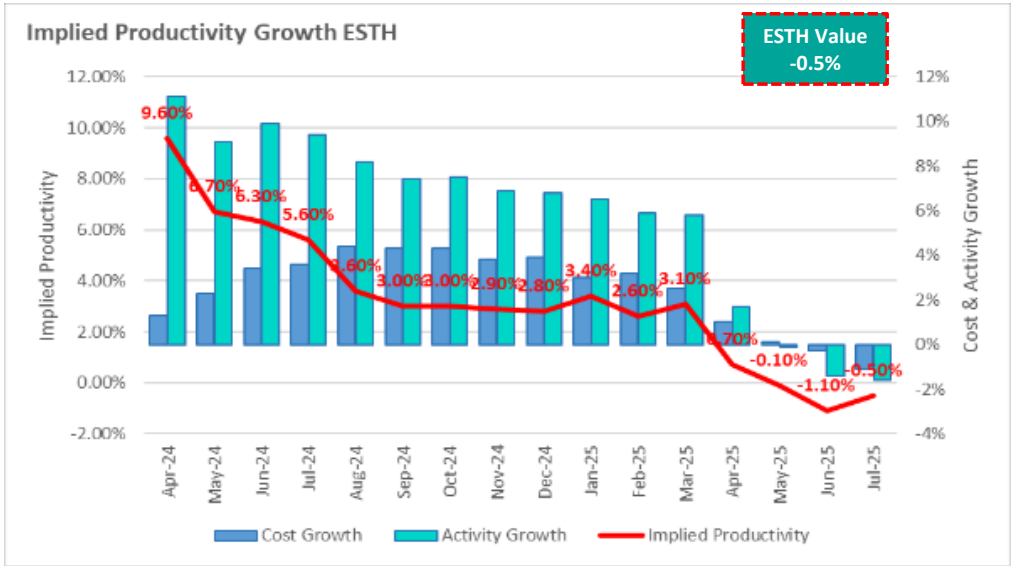
KPI	St George's Latest month	St George's Previous Month Measure	St George's Latest Month Measure	St George's Target	St George's Variation	St George's Assurance	St George's National Benchmark	Epsom & St Helier Latest month	Epsom & St Helier Previous Month Measure	Epsom & St Helier Latest Month Measure	Epsom & St Helier Target	Epsom & St Helier Variation	Epsom & St Helier Assurance	Epsom & St Helier National Benchmark
Implied Productivity Growth	Jul 25	-0.5%	0.1%	-	N/A	N/A	3rd Quartile	Jul 25	-1.1%	-0.5%	-	N/A	N/A	Lowest Quartile
Non Elective Length of Stay (SWL Methodology exc 0 days, exc <18 years)	Nov 25	10.0	10.2	8.4			N/A	Nov 25	11.3	10.9	-			N/A
Average days from Discharge Ready Date to date of discharge (inc 0 day delays)	Sep 25	0.5	0.7	-			2nd Quartile	Sep 25	0.7	1.6	-			TBC
Theatre Utilisation (Capped)	Oct 25	82.9%	82.4%	85.0%			Top Quartile	Oct 25	74.8%	76.8%	85.0%			3rd Quartile
BADS All Daycase & Outpatient Procedures % of total procedures	Jul 25	82.0%	83.3%	83.6%			3rd Quartile	Jul 25	67.0%	62.4%	83.6%			Lowest Quartile
Outpatients Patient Initiatied Follow Up Rate (PIFU)	Oct 25	2.3%	2.2%	5.0%			Lowest Quartile	Oct 25	3.1%	3.5%	5.0%			2nd Quartile
Outpatients Missed Appointments (DNA Rate)	Oct 25	10.2%	10.0%	8.0%			Lowest Quartile	Oct 25	7.4%	7.5%	6.0%			3rd Quartile
First and Procedure Attendances as a proportion of Total Outpatients	Oct 25	51.4%	51.6%	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 three-month delay. A positive value indicates improved productivity; a negative value suggests a decline.





Summary

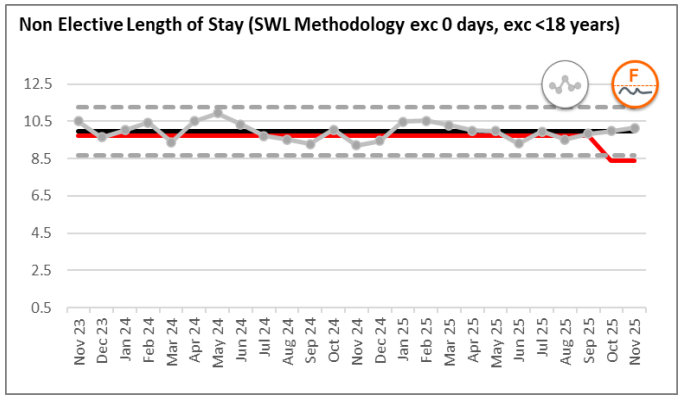
- The *Implied Productivity* national metric shows a 0.1% increase in 2025/26 Month 4 compared to same period the previous year (2024/25) driven by a decline in cost weighted activity.

Summary

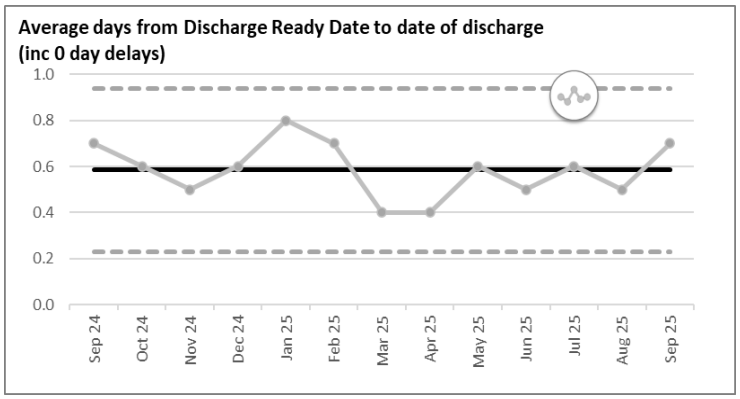
- The *Implied Productivity* national metric shows a -0.5% decrease in 2025/26 Month 4 compared to same period the previous year (2024/25). This has been driven by EPR implementation and the impact of reduced activity represented by the declining cost weighted activity

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).

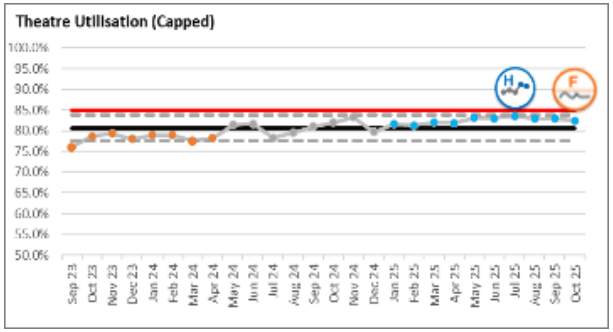


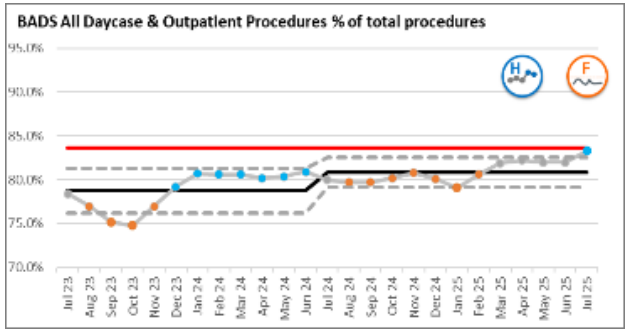
Acute discharges and bed days after the Discharge Ready Date averaged over a month.
Numerator: The total aggregate number of days from discharge ready date to date of discharge for all patients discharged in the period
Denominator: The total number of patients that have been discharged in the period

Metric	Reporting Month	Productivity Opportunity vs Target
NEL Length of Stay.	Nov-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 below winter plan of 8.4 days Average delay to discharge- normal variation	• Through November 2025, on average in-patients stayed in a hospital bed for 10 days showing normal variation, whilst delivering the ask of 83 beds being closed. Winter plan to reduce length of stay target to 8.4 days. • The number of NCTR patients has also seen a sustained improvement supporting length of stay. • 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	• Review of discharge functions being undertaken to see if further efficiencies can be gained on reducing internal delays • NEL LoS transformation programme has been revised and will be presented to the Senior Leadership Team (SLT) for approval ahead of implementation in winter, which builds on previous successes and focuses on reducing delays without increasing workforce or capacity • Full capacity protocol will be revised through multi division and multi profession workshops aimed at embedding lessons learnt from previous versions but also reflecting national ask with regards to handover times, corridor care and 12hr ED delays.		Sufficient for assurance Sufficient for assurance (published NHSE data on month in Arrears)

Operational Productivity
SGUH - Theatre Utilisation & Outpatient & Daycase Procedure Rates





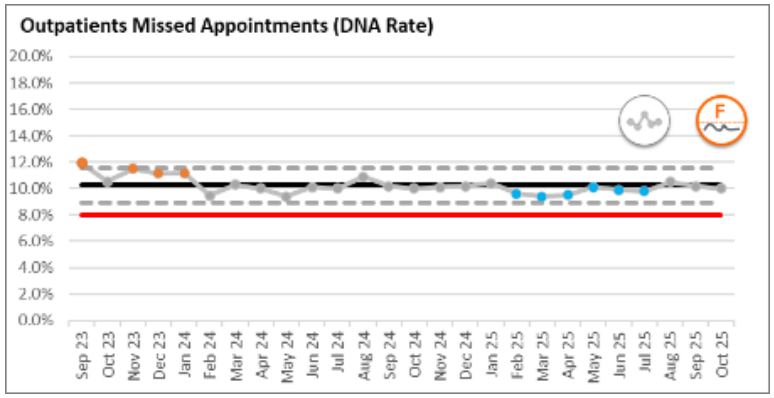
Metric	Reporting Month	Productivity Opportunity vs Top Quartile
Capped Theatre Utilisation	Oct-25	46 cases (based on an average case time of 124 min) to hit 85%
Day cases and outpatient procedures (BADS)	Jul-25	138 cases opportunity to move to OP (3 month period)

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 – October 2025 Overview **Capped Theatre Utilisation:** Maintained level throughout Oct-25 at 82.4% (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.	**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 average case per list (ACPL). **2. On-the-Day Cancellation Policy -** A new same-day cancellation policy is being introduced to align reasons with national standards. The CICG has approved an IT change request to support this, but it must be prioritized with other IT demands. The IT team is currently scoping resources **3. 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: Increasing trend, below top quartile peer	**Day Case Rate** 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. Data for July from Model shows a significant improvement.	**BADS Compliance** Initiatives underway to improve planning processes and transition more eligible procedures to DSU. 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 that could be done in an outpatient setting. **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.	TBC	Sufficient for assurance

Operational Productivity

SGUH - Missed Appointments (DNA Rate)

St George's



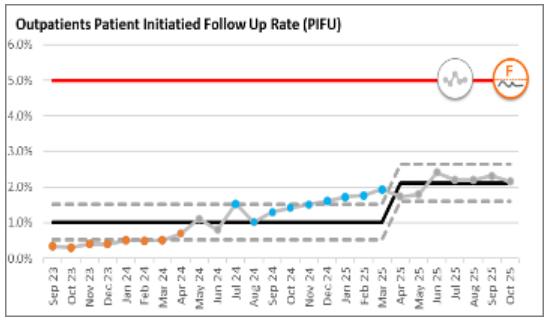
Metric	Reporting Month	Productivity Opportunity vs Top Quartile
Outpatients: DNA rates	Sep-25	1,356 appointments

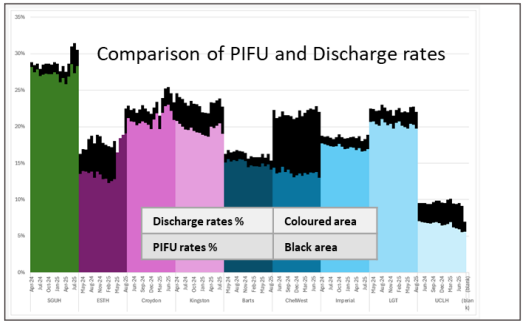
The methodology to calculate the opportunity to reduce the number of missed outpatient appointments is based on how your average missed outpatient appointments rate (from the last 6 months) compares to the national missed appointments profile for providers for the previous month.

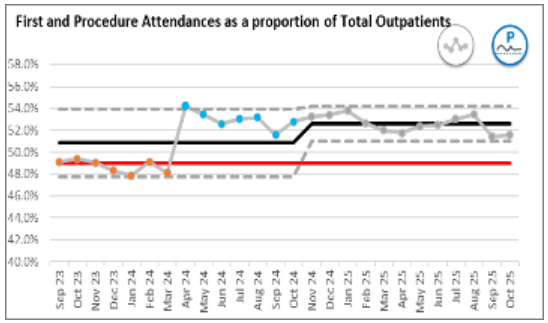
Site & Metric	Cause of variance/ non-compliance	Actions: Completed since last update, New, and Ongoing	Recovery Date	Data Quality
SGUH Normal variation however not meeting target of 8%	Current DNA rates of 10% against a peer average performance 8.7%. YTD **two thirds** of the Trusts DNAs have occurred in the following specialties all with rates higher than peers • Therapies • ENT & Audiology • Chest Medicine • Dermatology and Lymphoedema • Rheumatology • Neurology • T&O • Obstetrics • Max Fax	- 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. Pilot underway to use automated calling and the DNA risk model, with Rheumatology, Physiotherapy and Dermatology. Initial results extremely positive. Currently expansion is limited by Call capacity of 200 calls per day. Plan to submit Charity bid to their Health Inequalities fund to allow for expansion of trial. - Improvements to Zesty Patient Portal planned to show appointment location more clearly in the Portal. - 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 commenced in November with first service to go live (Paediatric Respiratory) Work commenced to implement with Dermatology. - Trial planned to improve DNA rebooking management within T&O.	Under review at Outpatient Transformation Board	sufficient for assurance

Operational Productivity

SGUH – Reduction in Outpatient Follow-Ups





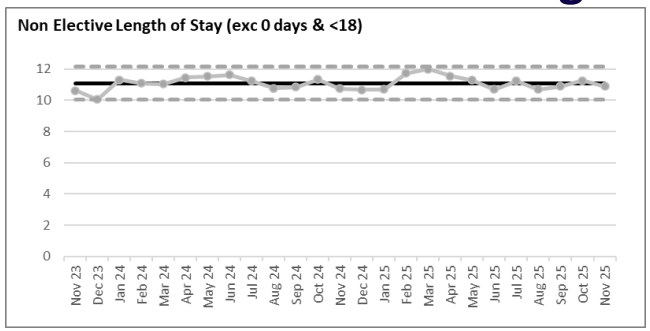


Metric	Reporting Month	Productivity Opportunity vs Top Quartile
1st + Proc as a % of Total OP	Oct-25	*0 (exceeding target)*
PIFU Rates	Oct-25	*Not quantified to avoid double-counting with New: FU Ratio opportunity*

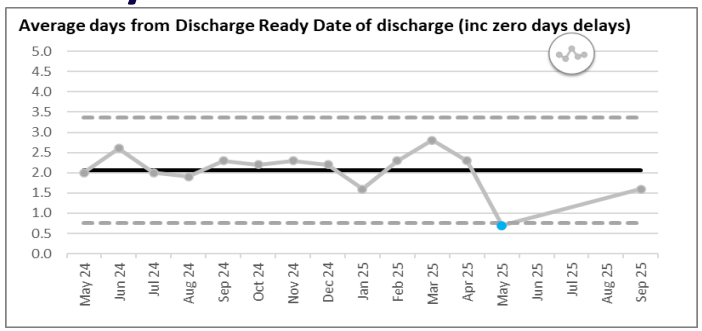
Site & Metric	Cause of variance/ non-compliance	Actions: Completed since last update, New, and Ongoing	Recovery Date	Data Quality
SGUH PIFU Rate: Consistently not meeting target, improving trend.	The operational plan signed off by the Board SGUH had a target of 3% due to the delay in starting PIFU. We are on the right plan to deliver this at year end. (National Target is 5%) Whilst PIFU rates for the Trust are lower than peers, discharge rates are significantly higher as shown in the chart above. The Trusts overall performance with respect to reducing unnecessary follow ups is better than its peers.	• 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, PIFU remote monitoring and PIFU to Follow Up option to supplement PIFU to Discharge process.	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).



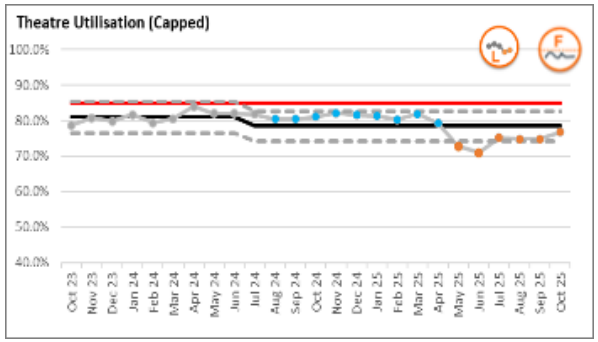
Acute discharges and bed days after the Discharge Ready Date averaged over a month.
Numerator: The total aggregate number of days from discharge ready date to date of discharge for all patients discharged in the period
Denominator: The total number of patients that have been discharged in the period

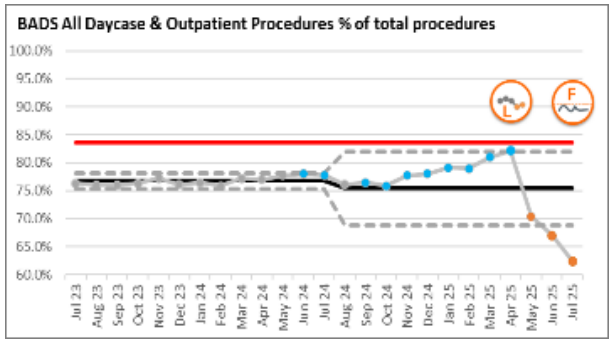
Metric	Reporting Month	Productivity Opportunity vs Target (annualised)
NEL Length of Stay.	Nov-2025	TBC

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 November 2025 averaged 10.9 days, a reduction of 0.4 days from October. • Marginal increases are noted across >14 and >21 day stranded cohorts >14 and > 21day LOS patients in the month of November however a reduction in > 7 days should be noted. • Work continues to ensure compliance and validation in Not meeting Criteria to Reside (NCTR) position post EPR roll out.	**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. • Trustwide RESET week took place week commencing 10th November 2025 to include system partners.	Target and recovery under review	Sufficient for assurance

Operational Productivity

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

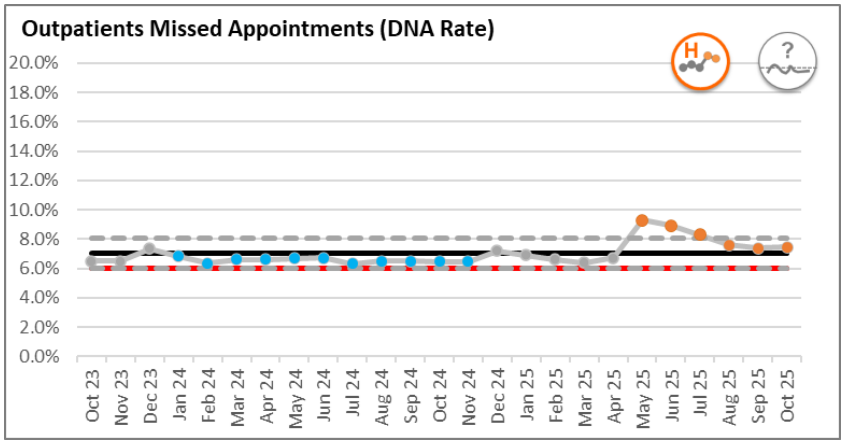




Metric	Reporting Month	Productivity Opportunity vs Top Quartile
Capped Theatre Utilisation	Oct-25	490 cases (based on an average case time of 63 min) to hit top quartile
Day cases and outpatient procedures (BADS)	Jul-25	104 cases opportunity to move to OP (3 month period)

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	Theatre utilisation in October 2025 increased to 76.8%, showing steady improvement as teams adapt to the iClip system. Although still below the pre-implementation level of 82% (January 2025), this upward trend demonstrates continued progress. A review of time recording identified that post-iClip, utilisation was measured from when the patient entered theatre rather than the anaesthetic room. Reporting has now been corrected to capture activity accurately from Anaesthetic Room to Recovery, which will provide a more accurate measure of utilisation and likely contributed to lower reported performance post-implementation. 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. We are working with teams to ensure the procedures undertaken in an outpatient setting are being recorded correctly.	**Perioperative Care & Screening** Implement Pre-Operative Assessment (POA) health screening across Epsom & St Helier sites. Training underway; go-live planned for December. Long-term IT solution required to embed screening into E5 pathway. **Process Standardisation** Collaborative work across theatres to ensure consistent systems, acceptance criteria, and clinical outcomes. Address data quality issues impacting theatre reporting and dashboard accuracy. **Day Case & Theatre Efficiency** Investigate root causes of low day case rates and implement corrective actions. Increase elective activity and reduce cancellations through better scheduling. Additional theatre sessions added (Epsom: 6–20 Oct) to recover lost capacity. **Staffing & Workforce** Recruitment of additional theatre staff and targeted training to support new processes. Address workforce constraints impacting list utilisation and reduce late changes. **Data Quality & Operational Improvements** 100% of the dataset re-written to capture all scheduled procedures in dashboards and Model Hospital. New test dashboard developed showing **Planned vs Actual** (scheduled vs processed) procedures. **Data Quality pages** added to support ongoing validation and improvement of dashboard inputs through weekly review meetings with BI Team.	March 2026	not sufficient for assurance due to large volumes of un-outcomed activity – this is improving and DQ actions in place

Operational Productivity
ESTH Missed Appointments (DNA Rate)



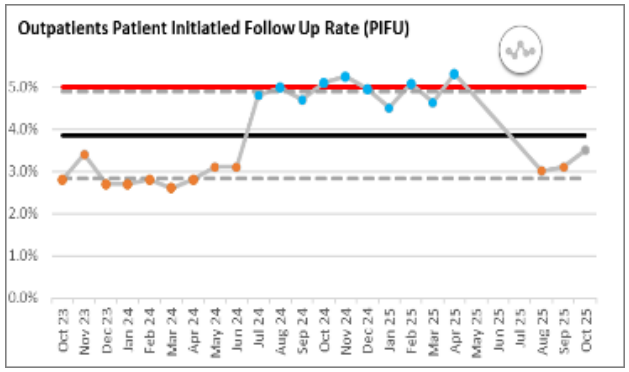
Metric	Reporting Month	Productivity Opportunity vs Top Quartile
Outpatients: DNA rates	Sep-25	805 Appointments

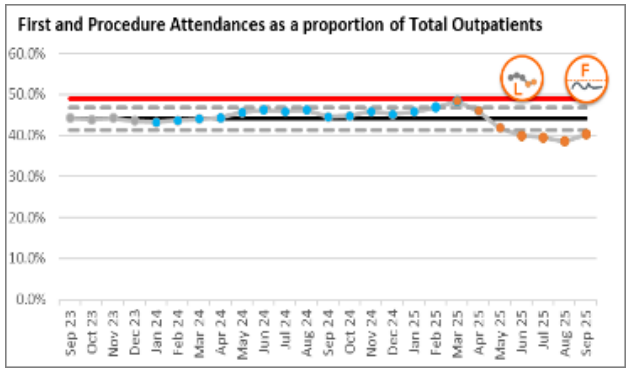
The methodology to calculate the opportunity to reduce the number of missed outpatient appointments is based on how your average missed outpatient appointments rate (from the last 6 months) compares to the national missed appointments profile for providers for the previous month.

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 since iClip Go Live	New Text reminder extract issue identified November 2025 – now mitigated. Model Hospital August 2025 Peer Average 8.7%; Lowest in SWL 7.3% Kingston Example high areas (Oct 2025) Diabetes 12.6%, Neurology 11.6%, Paediatric Audiology 17.2% Respiratory 10.8%	**Text reminders:** Additional new text reminder issue identified in early November in the extract used for the reminder upload. This was identified swiftly and a fix put in place. **Dashboard reliability:** The Outpatient Dashboard is now functioning well for DNA monitoring. Minor DQ issues persist due to iClip user errors but are being worked through as identified. **Patient Portal:** The introduction of the patient portal in mid-December will support increased visibility of appointments for patients to further support DNA reduction. The portal is on track to go live Dec 8.	March 2026	May and June 2025 not sufficient for assurance due to large volumes of un-outcomed 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	Oct -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	Drop in performance likely due to new iClip process steps and limited visibility before reports were reinstated. PIFU is now growing again. Model Hospital August 2025 – Peer av. 2.5%. SWL Highest peer – Kingston 3.7%	**Patient Initiated Follow Up:** ***Gynaecology:*** PIFU Poster with suggested scenarios to share best practice now drafted. ***Paediatrics:*** PIFU sustained growth – over 4% for 5 months now June to October. ***Governance:*** PIFU SOP updates ongoing to align with new iClip process to support Long-Term Condition PIFU use. Working to develop an aligned approach with SGH. PIFU clinical briefing pack circulation has begun. **Follow-up reduction:** Transformation continue to attend key specialty meetings to increase KPI visibility, celebrate progress, and share peer variation to support opportunities. ***Gastroenterology:*** Enhanced triage project has begun. This is expected to deliver a reduction in follow ups by ensuring patients have all anticipated diagnostics ahead of their 1st OPA. PIFU in Endoscopy is also due to start in November. ***ENT:*** GESH meeting 18 Nov to identify a technical solution for post-diagnostic note reviews as first OPA to reduce follow ups for up to 25% of ENT adult patients. ***Respiratory:*** Consistent discharge for stable COPD and Bronchiectasis cohorts due to begin in November.	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	Nov 25	4.8%	4.8%	4.0%			2nd Quartile
Agency rates	Nov 25	0.8%	0.7%	-			
MAST	Nov 25	91.1%	90.9%	85.0%			Top Quartile
Vacancy Rate	Nov 25	5.1%	5.0%	10.0%			
Appraisal Rate Medical	Nov 25	79.3%	84.7%	90.0%			
Appraisal Rate Non Medical	Nov 25	78.5%	80.0%	90.0%			Top Quartile
Turnover	Nov 25	9.9%	9.8%	13.0%			4th Quartile
Workforce WTE	Nov 25	10792	10834	10325			
Percentage BAME staff band 8 and above	Nov 25	33.3%	33.5%	-			

Epsom & St Helier

Latest month	Previous Month Measure	Latest Month Measure	Target	Variation	Assurance	Benchmark
Nov 25	6.1%	5.9%	4.0%			3rd Quartile
Oct 25	0.2%	1.0%	-			
Nov 25	88.4%	89.4%	85.0%			Top Quartile
Nov 25	10.8%	10.6%	10.0%			
Nov 25	95.6%	96.4%	90.0%			
Nov 25	78.0%	82.6%	90.0%			Top Quartile
Nov 25	9.2%	9.1%	12.0%			4th Quartile
Oct 25	7410.00	7425.00	7468.50			
Nov 25	30.6%	30.6%	-			

Sutton Healthcare

KPI	Latest month	Previous Month Measure	Latest Month Measure	Target	Variation	Assurance
Sickness Rate	Nov 25	6.4%	5.9%	4.0%		
Agency rates	Nov 25	1.6%	2.1%	-		
MAST	Nov 25	92.8%	93.0%	85.0%		
Vacancy Rate	Nov 25	13.7%	13.7%	10.0%		
Appraisal Rate Medical	Nov 25	100.0%	100.0%	90.0%		
Appraisal Rate Non Medical	Nov 25	73.2%	76.0%	90.0%		
Turnover (12-Month)	Nov 25	10.2%	8.9%	12.0%		
Percentage BAME staff band 8a and above	Nov 25	25.0%	25.0%	-		

Surrey Downs

Latest month	Previous Month Measure	Latest Month Measure	Target	Variation	Assurance
Nov 25	6.0%	5.2%	4.0%		
Nov 25	1.3%	1.3%	-		
Nov 25	94.8%	95.3%	85.0%		
Nov 25	13.2%	11.6%	10.0%		
Nov 25	100.0%	100.0%	90.0%		
Nov 25	87.6%	89.4%	90.0%		
Nov 25	12.1%	11.4%	12.0%		
Nov 25	11.3%	11.3%	-		

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

Appendices

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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	Oct 25	145	140	0			Highest Quartile
Number of Complaints Received	Nov 25	95	67	-			N/A
Number of re-opened complaints in month	Nov 25	2	5	-			N/A
Parliamentary and Health Service Ombudsman (PHSO) Received	Nov 25	5	1	-			N/A
Parliamentary and Health Service Ombudsman (PHSO) Closed	Nov 25	1	0	-			N/A
RTT - Total Size Incomplete Waiting List	Oct 25	70397	69123	74003			3rd Quartile
Cancer 31 Day Decision To Treat to Treatment Standard	Oct 25	96.0%	92.4%	96.0%			2nd Quartile
On the Day Cancellations not re-booked within 28 days	Oct 25	1	2	0			2nd Quartile
Outpatient Advice & Guidance Rate per 100 First OPA	Aug 25	26.1	22.2	16.0			2nd Quartile
Emergency Department Attendances per day	Nov 25	429	440	-			N/A
Mental health delays 4 Hour Breaches	Nov 25	137	164	-			N/A
Length of stay > 21 days (super stranded)	Nov 25	167	171	-			3rd Quartile
Overnight G&A beds occupancy - Adults	Oct 25	96.0%	96.7%	96.0%			3rd Quartile
Number of patients not meeting criteria to reside (Daily Avg)	Oct 25	117	121	-			2nd Quartile

Epsom & St Helier

Latest month	Previous Month Measure	Latest Month Measure	Target	Variation	Assurance	Benchmark
Oct 25	34	53	0			Highest Quartile
Nov 25	64	59	-			N/A
Nov 25	2	1	-			N/A
Nov 25	2	0	-			N/A
Nov 25	2	0	-			N/A
Oct 25	58667	57913	50386			3rd Quartile
Oct 25	97.1%	99.0%	96.0%			Top Quartile
Sep 25	1	1	0			Top Quartile
Aug 25	53.8	66.3	16.0			Top Quartile
Nov 25	434	451	-			N/A
Oct 25	211	230	-			N/A
Oct 25	164	167	-			Lowest Quartile
Oct 25	94.6%	92.1%	96.0%			2nd Quartile
Oct 25	159	169	-			3rd Quartile

Sutton Healthcare

KPI	Latest month	Previous Month Measure	Latest Month Measure	Target	Variation	Assurance
Urgent Community Response (UCR) Referrals	Nov 25	454	395	-		
Virtual ward - Admissions	Nov 25	396	409	-		
Virtual ward Length of Stay (Average)	Nov 25	6.3	5.8	-		
Discharge to Assess- Pathway 0-3 Delays (Median Days)	Nov 25	4	4	-		
Total number of adult patients on the waiting list	Nov 25	2096	2092	-		
Total number of children patients on the waiting list	Nov 25	1005	1000	-		

Surrey Downs

Latest month	Previous month measure	Latest month measure	Target	Variation	Assurance
Nov 25	560	576	-		
Nov 25	307	288	-		
Nov 25	9.6	8.1	-		
Nov 25	1	2	-		
Nov 25	5479	5275			

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 Average	Variation
Brain/Central Nervous System	Sep 25	N/A	N/A	-	
Breast	Sep 25	72.2%	79.0%	87.3%	
Breast Symptomatic	Sep 25	74.9%	88.4%	82.6%	
Children's Cancer	Sep 25	25.0%	80.0%	90.9%	
Gynaecological	Sep 25	58.2%	65.2%	70.1%	
Haematological	Sep 25	66.7%	88.9%	71.4%	
Head & Neck	Sep 25	86.9%	87.4%	73.4%	
Lower Gastrointestinal	Sep 25	76.1%	70.2%	73.1%	
Lung	Sep 25	76.3%	73.0%	85.7%	
RDC	Sep 25	64.3%	63.6%	-	
Skin	Sep 25	39.3%	35.6%	89.6%	
Upper Gastrointestinal	Sep 25	73.6%	72.4%	75.0%	
Testicular	Sep 25	N/A	N/A	87.5%	
Urological	Sep 25	72.7%	74.1%	72.7%	

Cancer - 62 Day Referral to Treatment Standard

KPI	Latest month	Previous Month Measure	Latest Month Measure	National Average	Variation
Brain/Central Nervous System	Sep 25	88.2%	100.0%	-	
Breast	Sep 25	57.5%	63.2%	68.6%	
Gynaecological	Sep 25	60.0%	50.0%	78.6%	
Haematological	Sep 25	91.7%	71.4%	91.3%	
Head & Neck	Sep 25	47.1%	57.9%	61.3%	
Lower Gastrointestinal	Sep 25	64.0%	70.0%	75.8%	
Lung	Sep 25	57.6%	63.6%	62.5%	
Other	Sep 25	100.0%	N/A	83.3%	
Skin	Sep 25	87.5%	81.5%	93.9%	
Upper Gastrointestinal	Sep 25	75.0%	100.0%	75.0%	
Urological	Sep 25	76.1%	76.8%	74.7%	

Epsom & St Helier

Cancer - 28 Day Faster Diagnosis Standard

KPI	Latest month	Previous Month Measure	Latest Month Measure	National Average	Variation
Brain/Central Nervous System	Sep 25	100.0%	85.7%	-	
Gynaecology	Sep 25	37.2%	48.7%	70.1%	
Haematological	Sep 25	92.3%	60.0%	71.4%	
Head & Neck	Sep 25	89.9%	90.8%	73.4%	
Lower Gastrointestinal	Sep 25	64.9%	65.9%	73.1%	
Lung	Sep 25	90.0%	84.2%	85.7%	
Skin	Sep 25	18.8%	2.6%	89.6%	
Upper Gastrointestinal	Sep 25	83.5%	82.5%	75.0%	
Urological	Sep 25	83.8%	86.5%	72.7%	
RDC	Sep 25	72.3%	80.0%	-	
Prostate	Sep 25	87.1%	91.2%	-	
Testicular	Sep 25	100.0%	100.0%	87.5%	

Cancer - 62 Day Referral to Treatment Standard

KPI	Latest month	Previous Month Measure	Latest Month Measure	National Average	Variation
Gynaecological	Sep 25	84.6%	50.0%	78.6%	
Haematological	Sep 25	100.0%	100.0%	91.3%	
Head & Neck	Sep 25	60.0%	66.7%	61.3%	
Lower Gastrointestinal	Sep 25	83.3%	87.2%	75.8%	
Lung	Sep 25	42.9%	60.5%	62.5%	
Skin	Sep 25	100.0%	82.8%	93.9%	
Upper Gastrointestinal	Sep 25	61.5%	88.2%	75.0%	
Urological	Sep 25	85.5%	87.0%	74.7%	
Other	Sep 25	100.0%	N/A	83.3%	

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
ASI	Appointment Slot Issues
CATS	Clinical Assessment and Triage Service
CNS	Clinical Nurse Specialist
CQC	Care Quality Commission
CT	Computerised tomography
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
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

Terms	Description
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
ICB	Integrated Care Board
IPC	Infection Prevention and Control
IPS	Internal Professional Standards
IR	Interventional Radiology
KPI	Key Performance Indicator
LA	Local anaesthetics
LAS	London Ambulance Service
LBS	London Borough of Sutton

Terms	Description
LGI	Lower Gastrointestinal
LOS	Length of Stay
N&M	Nursing and Midwifery
MADE	Multi Agency Discharge Event
MAST	Mandatory and Statutory Training
MDRPU	Medical Device Related Pressure Ulcers
MDT	Multidisciplinary Team
MRSA	Methicillin-resistant Staphylococcus aureus
MSSA	Methicillin-resistant Staphylococcus aureus
MSK	Musculoskeletal
NCTR	Not meeting the Criteria To Reside
NHSE	NHS England
NMC	Nursing and Midwifery Council
NNU	Neonatal Unit
NOUS	Non-Obstetric Ultrasound
OT	Occupational Therapy
PIFU	Patient Initiated Follow Up
PPH	postpartum haemorrhage
PSIRF	Patient Safety Incident Response Framework
PTL	Patient Tracking List
QMH	Queen Mary Hospital
QMH STC	QMH- Surgical Treatment Centre
RCA	Root Cause Analyses
RMH	Royal Marsden Hospital
RTT	Referral to Treatment

Terms	Description
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
SNTC	Surgery Neurosciences, Theatres and Cancer
SOP	Standard Operating Procedure
TCI	To Come In
ToC	Transfer of Care
TWW	Two-Week Wait
UCR	Urgent Community Response
VTE	Venous Thromboembolism
VW	Virtual Wards
WTE	Whole Time Equivalent

Group Board Meeting (Public)

Meeting on Thursday, 08 January 2026

Agenda Item	3.4	
Report Title	**Audit and Risk Committees 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 Lizzie Alabaster, Interim 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 10 December 2025. The key issues the Committee wishes to highlight to the Board are:

- **Internal Audit:** The Committee was encouraged by stronger delivery of the 2025/26 internal audit plan, which was significantly ahead of progress achieved at the same point in the previous two years. Internal audit reports reviewed were predominantly “reasonable assurance”, with strengths identified in financial controls, emergency preparedness, and NICE guideline compliance. However, recurring themes emerged around inconsistent compliance with policies. Areas receiving partial assurance, notably Discharge Management and Patient Safety Incident Response Framework at ESTH, included high-priority actions. The Committee noted the number of internal audit actions with revised completion dates, particularly within digital and data-related audits and in relation to patient complaints, and will review the position at its next meeting.

- **Cybersecurity:** This remained a significant area of risk, with progress against Data Security and Protection Toolkit requirements ongoing but impacted by delivery delays and capacity constraints. Plans to establish a single Group-wide digital and cyber function were welcomed.

- **Risk:** The Committee welcomed improvements in risk reporting and oversight, noting substantial work underway to refresh and align corporate risks across both Trusts. It supported plans to refresh the Board Assurance Framework in line with the new Medium-Term Plan to ensure strategic risks remain current and robustly assured.

Action required by Group Board

The Board is asked to note the report of the Audit and Risk Committee and the issues highlighted to the Board by the Committee.

Committee Assurance	
Committee	Audit and Risk Committees
Level of Assurance	N/A

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

As set out in substantive reports presented to the Board.

Legal and / or Regulatory implications

N/A

Equality, diversity and inclusion implications

N/A

Environmental sustainability implications

N/A

Audit and Risk Committee Report to Group Board

Group Board, 08 January 2026

1.0 Purpose of paper

1.1 The gesh Audit and Risk Committee met on 10 December 2025. The Committees agreed to bring the following matters to the attention of the Group Board.

2.0 External Audit

2.1 **External Audit**

2.1.1 The Committee received an update on the plans on the preparation for the 2025/26 External Audit of the two trusts Annual Accounts. These plans would be prepared collaboratively by the group's finance team and the gesh External Auditors, Grant Thornton, with the work on the audit by GT commencing during Q4 2025/26. A further update, including the timetable for the delivery of the audit, would be brought to the next meeting of the Committee due to take place in February 2026.

3.0 Internal Audit

3.1 The Committee received a regular report from the Group's internal auditors, RSM UK, and reviewing progress against the delivery of the in-year internal audit programme was a major area of focus for the Committee at its December 2025 meeting.

3.2 In terms of progress in delivery of the 2025/26 internal audit plan, the Committee was assured that good progress was being made in the completion of the programme, with progress in delivery significantly further ahead at this point in 2025/26 compared with the previous two years. Since the last meeting of the Committee in September 2025, a total of six internal audit reports had been completed:

- Three final Group-wide audits had been issued, with a further two finalised for ESTH and 1 for SGUH.
- Two further draft reports had been issued, and the auditors were working with management to finalise these.
- Four audits were currently in progress, and
- One final audit which was scheduled for Q4 2025/26 would commence shortly.

3.3 The Committee reviewed the six final internal audit reports, the outcomes of which are set out below.

In relation to Group-wide internal audits, the Committee received the following final reports:

- Key Financial Controls (Debtors) – Reasonable Assurance. The Committee noted that, overall, across both SGUH and ESTH, the Trusts demonstrated adequate debtor management practices. Monthly reconciliations were completed. Governance was robust and internal controls were operating reasonably, with financial decisions appropriately authorised. A number of good controls were identified in the audit, particularly related to control account reconciliations, the authorised signatory list, and sales invoices. One 'medium' and five 'low' priority actions had been identified. The

audit highlighted a number of aged debts dating back to 2011, and also noted that the Standing Financial Instructions and SBS Debt Management Policy needed to be updated.

- Emergency Preparedness Resilience and Response – Reasonable Assurance. The Committee noted that, overall, across both SGUH and ESTH, the Trusts demonstrated adequate EPRR arrangements, with established EPRR policies to support and provide a framework for the development and exercising of emergency plans, as well as governance oversight groups in place to appropriately scrutinise EPRR related activity. A number of good controls and areas of practice were identified by the auditors, including in relation to the assessment of plans against NHS England EPRR framework guidance, incident specific plans, and testing of plans. Three 'medium' and four 'low' priority actions had been identified for follow-up by management. These related to: providing evidence plans had been reviewed in line with the EPRR policy; reporting on EPRR matters to the Board to include training compliance and significant updates to plans in-year; updating the SGUH EPRR policy and updating the terms of reference for the ESTH Trust Resilience Group. The Committee also agreed that it was important EPRR plans were aligned appropriately with cybersecurity incident planning, and asked that the Executive provide assurance planning for cyber attack was appropriately integrated within wider EPRR plans.

- NICE Guidelines Compliance – Reasonable Assurance. Overall, both Trusts were found to employ adequate processes and procedures to ensure NICE guidelines were reviewed and complied with. A number of good controls were identified, which related to both Trusts having up-to-date accessible NICE policies that clearly outlined responsibilities, defined roles and responsibilities, good discussion of guidelines, positive monitoring of adherence to the guidelines, reporting of non-compliance, and good governance for reviewing NICE updates, audits and actions which provided structured oversight. Three 'medium' and two 'low' priority actions had been identified for follow-up by management. These related to: management circulating guidance to appropriate clinical leads within four weeks of issue; assessment forms being circulated and escalated within agreed timescales; establishing a process to share learning and best practice from NICE guidance across the Group.

In relation to internal audits related to SGUH only, the Committee received the following final report:

- Rostering and Agency (Non-Medical) – Reasonable Assurance. The Committee noted that the audit had identified some robust controls around governance and reporting arrangements and use of non-framework agencies. Good controls and practice were identified in relation to: work rostering processes; action plans to reduce reliance on agency staff and improve rostering; use of Trust and bank staff ahead of agency staff; use of non-framework agencies; Board and other governance committee reporting; and data analytics. One 'high' and two 'medium' priority actions had been identified for follow-up by management. The 'high' action related to developing and implementing a formal action plan for temporary staffing recommendations, but this had already been completed prior to the Committee's meeting. The remaining actions related to: management analysing trends in roster requests and updating the temporary staffing policy.

In relation to internal audits related to ESTH only, the Committee received the following final report:

- Discharges – Partial Assurance. The Committee noted that the audit had identified that, overall, the Trust had established an adequate framework for managing the discharge process, a key component of which was the Hospital Discharge and Criteria to Reside Policy which had been agreed in May 2024. The audit had noted positive progress overall, but also identified that further improvements were needed to enhance consistency and compliance across the organisation. Two 'high' and five 'medium' priority actions had been identified for follow-up by management. The 'high' priority actions related to: completion of No Criteria to Reside on iClip; and ensuring that all pathway 2 referrals to community hospitals were consistently documented within iClip, and ensuring that discharge referral forms were appropriately documented.

- Patient Safety Incident Response Framework – Partial Assurance. The Committee noted that the audit had identified a number of good controls in relation, including in relation to: the PSIRF Policy, which was appropriate and up-to-date; the Trust Patient Safety Incident Response Plan; the recording of incidents on Datix; and governance oversight of PSIRF. However, the auditors had identified two 'high', three 'medium' and two 'low' priority actions for follow-up by management. The 'high' actions related to: all incidents being managed and investigated in line with established processes and timescales; and enhancing the assurance process surrounding Never Events to ensure that categorisation decisions, documentation, reporting and learning responses will be escalated and followed-up where required.

3.4 The Committee reflected on the common themes across the internal audits reviewed at the meeting, and noted that compliance with existing policy and, in some cases, policies that had passed their review date were areas where the control environment could be strengthened, and the Committee will return to this at its next meeting.

3.5 Work had commenced on the preparation of the 2026/27 internal audit plan, with RSM having held members with members of the Executive team and designated audit leads. A longlist of proposed reviews had been collated. The internal auditors would work with the Executive team during January to finalise the proposed programme, which is scheduled to be presented to the Committee in February 2026.

3.6 The internal auditors reported that monthly progress meetings were being held with the GCCAO to review the delivery of the plan, and this had been positive. RSM also attended the Group Executive Committee to present the overall position.

3.7 The position regarding follow-up of internal audit actions previously agreed by management was a more mixed picture, and the Committee expressed concern at the number of internal audit actions where management had proposed revised completion dates. Among the extended ESTH internal audit actions, these principally related to Digital (Cyber Assessment Framework; Data Quality; and Data Security and Protection Toolkit) and Nursing (Complaints; Patient Experience; and Data Quality on Maternity). Among the extended SGUH internal audit actions, the area with the highest number of extended dates for completion were principally related to Digital (Cyber Assessment Framework; IT Assets and Maintenance; and Data Quality).

3.8 The Committee noted that considerable work had been undertaken both by the internal auditors and the governance team to follow-up on these actions, and that each audit was concluded with a debrief with management and management responses were only finalised with confirmation of the lead Executive's approval. Noting that internal audit was intended to be supportive of improvements, the Committee asked that Executive leads for internal audit reviews carefully scrutinised the final actions arising so that the actions were clear, deliverable and improvement-focused, with realistic timelines for completion. The Committee considered

that timely completion of management actions was a lead indicator of a healthy governance culture, and while recognising the pressure on the Executive and Site teams, it was important that agreed actions were delivered.

4.0 Counter Fraud

4.1 The Committee received the progress report from the Counter Fraud Service provided by RSM for both Trusts. This gave details of the proactive activities undertaken across both SGUH and ESTH since the last meeting of the Committee held on 11 September 2025. Details were shared of new fraud referrals received, cases closed since the previous Audit and Risk Committee as well as updates on the investigations that were currently ongoing at ESTH and SGUH. A total of eight referrals have been received since the last Audit and Risk Committee; 11 had been closed; and 17 remained ongoing across the two trusts.

4.2 Other work which had been undertaken place by the Counter Fraud team included:

- Meeting with the new Chair of the Audit and Risk Committee to discuss the Counter Fraud Plan for 2025/26 ongoing cases and general themes across both trusts.
- Delivery of a bespoke training session for Human Resource Business Partners. This session was attended by nine staff and covered relevant legislation, undertaking parallel investigations and emerging risks. A further session for the wider department had been scheduled for the new year.
- Producing a benchmarking exercise report on the use of single tender waivers. This report demonstrated that the number had decrease during 2024/25 and was below the average across the RSM sample of 60 Healthcare organisations.
- Raising awareness of fraud and bribery amongst staff continued to be a key part of creating a strong anti-fraud culture. RSM delivered a number of sessions during International Fraud Awareness Week. These included Money Laundering, Fraud Awareness and Procurement Fraud and Procurement Act 2023.

4.3 The Committee enquired whether there were any links between fraud referrals and concerns raised by staff through the Group's Freedom to Speak Up (FTSU) Guardian Service. The Committee heard that RSM had regular dialogue with the Group FTSU Guardian and concerns involving potential fraud were signposted to counter fraud by the Guardian. Discussion also took place relating to the importance of due diligence with new starters in helping to prevent fraud. It was also important for staff to be aware of how they can report instances of suspected fraud and that they should feel supported to do so. Therefore, there would always be the need for continuous education of staff around fraud.

5.0 Finance

5.1 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, the key points of which were:

- Debtors and bad debts ESTH shows a stable debt position. SGH had seen a £4m increase in debt since the last report to the audit Committee. There was ongoing management action and greater focus needed on timely debt repayment as pressure on cash increases.
- Better Payment Practice Code (BPPC) performance was within acceptable bounds, with performance at 92.5% (ESTH) and 92.6% (SGUH) year-to-date for payment of all

non-NHS invoices within required timescales. The Committee heard that there was a risk that these figures would decrease due to potential future cash pressures.

- Salary over-payments continued to be an area of challenge, with the main drivers being process issues within each Trust, notably late notification of termination and changes to contracts.
- Losses and compensations followed similar trends to previous periods, with the main areas of loss being in Pharmacy (ESTH) and Cardiology (SGUH)
- Waivers remained low in both Trusts, though there an uptick was expected in Q4 driven by late access to capital funds.
- Breaches were high in both Trusts but were mainly driven by a small number of high value “technical” breaches.
- In relation to ‘no purchase order no pay’, phase 2 of the rollout had been delayed due to resource constraints and additional demands on the operational procurement service. Action was needed to finalise the roll out across the remaining in-scope suppliers.

5.2 The Committee reviewed and approved a proposal to write off £2.33m debt for SGUH and £0.735m for ESTH. These write offs related to specific debts that were either over six years old, or debts where the Trusts had exhausted all reasonable recovery actions, including use of debt collection agencies. The debts were attributed to a number of reasons including salary overpayments and the emergency treatment of overseas visitors who were not entitled to free care within the UK. The Committee had a detailed conversation relating to Overseas Patient Debt and the steps in place to try and prevent in and to recover monies outstanding.

6.0 Cybersecurity

6.1 The Committee received an update on Cyber Security and Information Governance for both Trusts within gesh. The key points were that:

- Both Trusts published their 2024-25 (version 7) DSPT toolkits in June 2025 as “standards not met”. ESTH had submitted its September improvement plan update and NHSE changed the ESTH DSPT status to “Approaching standards met”. The final ESTH improvement plan update was submitted on 2 December 2025 and the NHSE response was awaited. SGUH had submitted its September improvement plan update and NHSE maintained the status of SGUH as “standards not met” due to the lack of a vulnerability management system, where implementation was in progress. The final SGUH improvement plan update was due by the end of December 2025.
- Work had started on completion of the 2025/26 DSPT by both trusts. The baseline submissions were due to be submitted by the deadline of the 31 December 2025. Audits of the toolkits by the auditors, RSM is planned for March 2026.
- A gesh Cyber Security Dashboard was being developed which will offer real-time threat detection and incident response prioritising centralised visibility, faster threat detection improved incident response and proactive risk management. It also translates risk into business language, enhances communication measures, security programme effectiveness ensures compliance and governance. It was hoped this would go live in Q4 2025/26.

- Windows 11 Update: Both Trust teams had migration plans which would be completed by April 2026.There was also a requirement for new hardware (PCs/laptops) to replace those which would not support Windows 11. In total across GESH there are 3000 PCs/laptops which will not support windows 11; which most of these are based at SGUH. Extended Support Updates have been procured across GESH and the technical teams are looking to deploy the licences to the Windows 10 device environment.

6.2 The Committee debated and challenged the fact that target dates for the completion of digital projects seemed to continue to be delayed. Concerns relating to the importance of having good cybersecurity and general IT systems in place had been discussed at the Group Board meeting in November 2025. The Group was about to start a consultation process to put in place a Group-wide digital team. Part of that restructure would involve creating a single cyber security team that would be responsible for looking after all aspects of this across gesh and ensure there was a single view and project plan for all projects. The Committee also heard that migration to NHS.net for SGUH staff was important in terms of meeting cybersecurity threats.

7.0 Risk

7.1 The Committee received a paper and a briefing which provided an overview of :

- the gesh Risk Management Framework
- Internal Audit Actions in relation to risk management and progress against these
- the key issues considered by the gesh Risk and Assurance Group at its meetings in September and November 2025
- the position of the two Trusts' Corporate Risk Registers as at 1 December 2025
- the workstreams identified to review, improve and align risks on both the Corporate Risk Registers at both Trusts
- the progress in addressing the legacy extreme risks at ESTH not on or aligned with risks on the Trust Corporate Risk Register
- Divisional risks at both Trusts, including the clinical and corporate divisions

7.2 The Committee welcomed the reporting on risk and noted that this was in line with the improvement plans for risk management which envisaged greater detailed oversight and scrutiny of risk by the Committee, as well as at management level. The Committee noted that a lot of work was underway to review the risks on both Trusts' Corporate Risk Registers to ensure these appropriately captured all of the principal risks facing the Group and its constituent Trusts. The Committee heard this work was progressing, and that the intention was to re-commence reporting of relevant Corporate Risk Register risks through all Board Committees from February 2026 once the risks had been refreshed and to the Board as a whole on a quarterly basis starting from the beginning of 2026/27. The Committee also heard that, as part of the refresh, work was being undertaken to seek to align risks on the two Trusts' Corporate Risk Registers, given that, in a number of areas, the underlying risks facing the two Trusts were broadly similar, even if specific controls and mitigating actions varied by Site.

7.3 The Committee heard that a key part of the approach to reviewing risks on the Corporate Risk Registers was ensuring that the refresh was being owned and overseen by the relevant leads so that risk was integrated into management practice rather than being undertaken 'on the side' by the risk team. The Committee welcomed this approach, which it endorsed, but noted that the scale of the task to review all risks across the Group was very considerable.

7.4 In respect of the Board Assurance Framework, the Committee noted the current position ahead of review of the strategic risks by the relevant Board Committees in December 2025. It

noted that the current strategic risks on the BAF had been agreed by the Board in March 2024 and these aligned with the Group Strategy. With the development of the new Medium-Term Plan and a new transformation programme to deliver the Medium-Term Plan, the BAF would need to be refreshed. The Committee noted that the Board had resolved to undertake this refresh at its development session in February 2026, with a view to agreeing a refreshed BAF for 2026/27.

8.0 Recommendations

8.1 The Board is asked to note the report of the Audit and Risk Committee and the issues highlighted to the Board by the Committee.

Pankaj Davé
Audit and Risk Committee Chair, NED

Group Board Meeting (Public)

Meeting on Thursday, 08 January 2026

Agenda Item	4.1	
Report Title	**People Committees Report to Group Board**	
Non-Executive Lead	Yin Jones, People Committees Chair, SGUH & ESTH NED	
Report Author(s)	Yin Jones, People Committees Chair, SGUH & ESTH NED	
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 December 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 national productivity benchmarking data, noting that SGUH was 6% and ESTH 10% lower than pre-pandemic levels. Locally, Phase 3 of the People Function integration was approved, and preparations were confirmed for resident doctors' industrial action starting 17 December 2025

Equality, Diversity and Inclusion (EDI) Action Plan
The Committees agreed with the suggested Limited level of assurance for the EDI Action Plan. This was necessitated by the number of overdue actions (6 remaining) and the regulatory context following CQC Well-Led findings.

Physician Associates (PA) Update
The Committees approved "Option 1" to maintain the current PA footprint but with significantly tightened clinical governance and standardised scopes of practice across the Group. Clinical safety variations between sites would be referred to the Quality Committees.

Nursing & Midwifery Job Evaluation
The GCPO briefed the Committees on a national mandate for job evaluations carrying high financial risk and potential banding upgrades. The Committees endorsed the GCPO as the SRO (senior responsible officer) for this initiative.

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 December 2025.

Committee Assurance

Committee	People Committees
Level of Assurance	Reasonable Assurance: The report and discussions assured the Committee that the system of internal control is generally adequate and operating

	effectively but some improvements are required, and the Committee identified and understood the gaps in assurance

Appendices	
Appendix No.	**Appendix Name**
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				
Three people-related strategic risks (Recruitment/Retention, Culture/EDI, and Engagement) remained scored at 20 (Extreme).				
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 was published on 31 October 2025.				
Equality, diversity and inclusion (EDI) implications				
CQC Well Led Inspection Report included findings about EDI.				
Environmental sustainability implications				
N/A				

People Committees Report
Group Board, 08 January 2026

1.0 Purpose of paper

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

11 December 2025
• Group Chief People Officer Report
• NHS Staff Survey Evaluation: Final Response Rate and Early Feedback
• Equality, Diversity and Inclusion Action Plan Update
• Inclusion Board Update
• Resident Doctors 10 Point Plan
• Nursing & Midwifery Job Evaluation Update
• Physician Associates Update
• Workforce KPI Performance Report
• Area of Focus: Employee Relations (ER)
• Sexual Safety at Work Update
• Medical Revalidation Responsible Officer Report Q2
• Board Assurance Framework (BAF) Report

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 11 December 2025 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 GCPO provided a verbal update covering national, SW London, and gesh-specific contexts. Nationally, the focus remained on winter pressures and productivity. Data indicated that SGUH productivity was 6% lower and ESTH 10% lower than pre-pandemic levels. Locally, Phase 3 of the People Function integration had been approved, and the flexible working policy was being rolled out with a focus on retention and cultural shift. Plans were in place for the resident doctors' strike that was due to start on 17 December 2025.

Workforce Performance

The Group deviated from its operational plan for month 7 2025/26, largely due to under-delivery of planned workforce WTE CIP (cost improvement programme). Sickness absence remained above the 4.1% target, driven by mental health and MSK conditions.

Board Assurance Framework (BAF)
Strategic risks related to Culture, Recruitment, and Engagement remained at extreme scores of 20. Assurance remained Limited pending the outcome of the Well-Led response. The Committees agreed with GCCAO's proposal that the BAF should come to the Committees quarterly in the 2026/27 cycle (rather than twice a year) to allow for more direct and frequent review alongside the corporate risk register.

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:

Equality, Diversity and Inclusion (EDI) Action Plan Update
The EDI plan had been streamlined to six priority areas. Currently, 37 actions were embedded, but 6 remained overdue. The focus was shifting toward measurable outcomes in inclusive recruitment and addressing bullying and harassment, particularly for staff from ethnic minority backgrounds. The Committees agreed a Limited level of assurance due to the number of overdue actions and regulatory context.

Medical Revalidation Responsible Officer Report Q2 2025/26
The Responsible Officers (RO) for SGUH and ESTH presented the Q2 data. Revalidation rates remained high, though a minor dip was noted due to administrative delays and clinicians failing to provide evidence in a timely manner. No clinical performance concerns were identified in the overdue cohort. The GCMO agreed to review whether this report could move to a six-monthly reporting cycle to allow for more strategic discussion.

Area of Focus: Employee Relations (ER)
The Committees received an update on the ER function and noted that, under Phase two of the HR group restructure, two distinct roles were created - the Group Head of ER and the Group Head of Employee Services, separating the ER team from the HR Services teams to allow the development and improvement of both functions at a group wide level.

Nursing & Midwifery Job Evaluation Update
The Committees noted that the national mandate for Nursing and Midwifery job evaluations carried a high financial risk as it may result in banding upgrades across several cohorts. The Trust must ensure a consistent approach across the Group to avoid industrial relations issues.

Resident Doctors 10-Point Plan
The Committees noted the progress of the 10-Point Plan submitted to NHSE, welcoming the fact that there had been positive movement in engagement forums and resident doctor feedback. Physical estate issues, such as high-quality rest and well-being spaces, remained a significant challenge at both Trust sites.

5.0 Other issues considered by the Committees

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

NHS Staff Survey Evaluation: Final Response Rate and Early Feedback
The Committees noted that the final response rates were 48.1% for ESTH and 42.4% for SGUH. While ESTH performed near the national average, SGUH lagged behind. Primary barriers identified included survey fatigue, lack of protected time for clinical staff, and technical

issues with accessing the survey on shared hardware. The Committees noted the contents of the report and requested a prompt “You Said, We Did" campaign in January 2026 to maintain trust.

Inclusion Board Update

The Committees received an update about the launch of a new Board-level shadowing and development programme for internal talent, with a target of at least 50% representation from ethnic minority backgrounds. The goal is to build a robust and diverse leadership pipeline. The Committees approved the programme design and requested an update about the overall development of the Inclusion Board and the suggested extension from 6 to 12 months (funding permitting) at a future meeting.

Sexual Safety at Work Update

The group started implementing the national "Sexual Safety in Healthcare" charter, focusing on creating a culture where staff feel safe to report incidents. A key development is the upcoming launch of a new, anonymous reporting tool in Q4 2025/26, designed to capture data on misconduct that often goes unreported through formal channels. The Committees emphasised that the success of the charter relied on a zero-tolerance, visible leadership stance which must be communicated across all Trust sites.

Physician Associates (PA) Update

The Committees noted the Group's response to the national Leng Review and RCEM (Royal College of Emergency Medicine) guidance and agreed with the recommendation to maintain the current PA footprint (Option 1) but with significantly tightened clinical governance, defined scopes of practice, and enhanced supervision to ensure patient safety and professional clarity.

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 11 December 2025.

Group Board Meeting (Public)

Meeting on Thursday, 08 January 2026

Agenda Item	5.1
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 21 November 2025 (Estates & Facilities focus) and 12 December 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 fire enforcement notice for Epsom Hospital, delays with the ITU build at St George's and the decision for a phased implementation of Agenda for Change for the soft ESTH FM team.
2. **ESTH Estate and Facilities Update (Water Safety)**
   The Committees reviewed the findings from the Dr. Surman-Lee's report which identified 41 issues with water safety at the Maternity Unit, including the need for an invasive risk assessment of pipework and improvements to the scheme of control. The Committees agreed to raise this issue to the Board on 8 January 2026 to ensure medium-term planning addressed the root causes.
3. **Board Assurance Framework (BAF)**
   The Committees reviewed the two of the 14 strategic risks on the BAF overseen by them - SR5: Modernising our Estate and SR6: Adopting Digital Technology and commended the risk scores (25 and 20 respectively) and assurance ratings (limited for both risks) for submission to the Group Board in January 2026.
4. **Deep Dive: Cyber Security**
   The Committees reviewed the report which provided a comprehensive deep dive into cybersecurity, focusing on technical vulnerabilities, organisational resilience, and emerging threats and welcomed the confirmation from NHSE that our Cyber Risk Reduction Funding FY2025/26 (the revenue funding) had been approved. The Committees emphasised the need for digital infrastructure investment to remain a focus given the fundamental requirements to run the hospital and to build the foundations that future innovations would require.

5. **Terms of Reference Update**
   The Committees reviewed the proposed updates to the Terms of Reference, including adding DGCEO as executive lead for Digital Services; GCTO as a regular attendee; updating the GCDIO title; and moving the GCFO to a regular attendee. The adjustments were approved for recommendation to the Board in January 2026.

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 November and December 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 4.5 - Digital Risk Management Update and 5.2 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				
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, 08 January 2026

1.0 Purpose of paper

1.1 This report sets out the key issues considered by the Infrastructure Committees' meetings on 21 November 2025 and 12 December 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 21 November 2025 and 12 December 2025, the Committees considered the following items of business:

21 November 2025 (Estates & Facilities focus)	12 December 2025 (IT focus)
• Group Chief Officer - Facilities, Infrastructure & Environment Update • ESTH Estate and Facilities Update • ESTH Water Safety and Fire Safety Update • Group Green Plan Update • Premises Assurance Model (PAM) • IT Updates (by exception) • PACS Update	• Digital Delivery Update • Deep Dive: Cyber Security • Digital Risk Management Update • PACS Project Review • Digital forward look • Board Assurance Framework (BAF)

2.2 The Committees were not quorate on 21 November and 12 December 2025. Any decisions made during inquorate meetings are ratified by email or at the next quorate meeting.

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 enforcement notice was received for Epsom Hospital, with an external project manager appointed to manage the remedial action plan.
- Proposals were being finalised for the Estates Safety Fund based on risk registers and the Board Assurance Framework aimed at addressing critical infrastructure risks.
- The GCOFIE provided an update on the ongoing delays with the ITU build at St George's, with completion now forecast for March 2026. Mitigation plans for clinical activity were in place with oversight from NHS England.
- A decision had been made to endorse the recommendation for a phased implementation for Agenda for Change for the soft ESTH FM team.

The Committees noted the report and requested an update on the Epsom Car Park at the next Estate focused meeting.

3.2 ESTH Estate and Facilities (E&F) Update

The Committees reviewed the report that and noted that a 20% review of the 6 Facet survey had been commissioned. This is a common rolling programme approach where a portion of the estate is surveyed each year (e.g., 20% per year over 5 years) to ensure the data remains current without the expense and disruption of a full annual survey. A thorough review of estate risks had been conducted, particularly focusing on long-standing risks. £14.8 million of capital funding had been allocated, with confidence expressed that this would be fully spent. Extensive work was underway to prepare for the upcoming CQC visit.

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

The Committees received both the fire safety and water safety updates and noted that an external project manager from Hanover Health had been appointed to manage the fire safety action plan. In relation to the new enforcement notice for Epsom General Hospital (EGH), the Trust intended to negotiate with Surrey Fire and Rescue (SFR) for extensions on longer-term structural works, similar to the approach taken with the London Fire Brigade. The Committees noted the report and agreed on a Limited assurance rating given the two active fire notices.

The Committees also reviewed the findings from the Dr. Surman-Lee's report which identified 41 issues with water safety at the Maternity Unit, including the need for an invasive risk assessment of pipework and improvements to the scheme of control. The Committees agreed to raise this issue to the Board to ensure medium-term planning addressed the root causes.

3.4 Digital Delivery Update

The Committees received and noted the key updates from the gesh Digital Governance Group (DGG) meeting held on the 27th November 2025, including ESTH Data Quality Policy, Federated Data Platform (FDP), Ambient AI, Enterprise Service Management and Oracle Innovation Release.

3.5 Deep Dive: Cyber Security

The Committees reviewed the report which provided a comprehensive deep dive into cybersecurity, focusing on technical vulnerabilities, organisational resilience, and emerging threats and welcomed the confirmation from NHSE that our Cyber Risk Reduction Funding FY2025/26 (the revenue funding) had been approved. St Georges & ESTH received £60.000 each which would be used for a GESH cyber strategy focusing on our biggest risks, gaps, prioritisation and technology. The Committees emphasised the need for digital infrastructure investment to remain a focus given the fundamental requirements to run the hospital and to build the foundations that future innovations would require.

3.6 Terms of Reference Update

The Committees reviewed the proposed updates to the Terms of Reference, including adding DGCEO as executive lead for Digital Services; GCTO as a regular attendee; updating the GCDIO title; and moving the GCFO to a regular attendee. The adjustments were approved for recommendation to the Board in January.

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 **Group Green Plan Update**

The Committees welcomed the key achievements which included the Board approval of the Green Plan refresh, the decommissioning of the nitrous manifold at Epsom and St Helier and meeting clinical waste targets ahead of schedule.

It was noted that the CQC Well-Led inspection at St George's rated the sustainability section as Good. The work was ongoing on LED lighting upgrades and solar panel installation at St George's.

4.3 **Premises Assurance Model (PAM) Update**

The Committees noted that NHS England was changing the PAM questions, leading to a pilot process with approximately 660 yes/no questions and welcomed the news that a new permanent compliance manager for estates at St George's had been appointed. The Committees requested prompt action on the key underlying drivers for inadequate ratings at ESTH as they were linked to governance gaps and documentation.

4.4 **PACS Project Update**

The Committees noted that the negotiations for the Contract Change Notice (CCN) had been delayed into January 2026 following the identification of gaps in clinical functionality and requested an update at the January 2026 meeting of the Infrastructure Committees.

4.5 **Digital Risk Management Update**

The Committees welcomed the update about the systematic review of current risks from a group perspective that took place between September and December 2025. Through this exercise, and following a number of mini workshops, 3 gesh IT 'extreme' risks were created to represent critical overarching IT Infrastructure challenges. These include Data Centre Failure, Core Network Infrastructure Failure and Cybersecurity Attack.

5.0 Other issues considered by the Committees

5.1 **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.

5.2 **Board Assurance Framework**

Two of the 14 strategic risks on the BAF overseen by the Infrastructure Committees were reviewed - SR5: Modernising our Estate and SR6: Adopting Digital Technology. For SR5 (Estates), there were no proposed changes to the current risk score (25) or assurance rating (limited) for this risk as at Q1 2025/26. This is largely on the basis of the continuing impact of the delays to the BYFH programme, the impact in terms of managing estates risks at St Helier on a longer-term basis, the delays to the renal build and ITU build at SGUH, and the significant constraints in capital availability.

For SR6 (Digital), despite the significant progress in implementing the EPR, developing the draft Group digital strategy, and integrating digital teams across the Group, it was proposed to hold the risk at the current risk score (20) and current assurance rating (limited) at December 2025 given the scale of the challenges faced by the Group in adopting digital technology more generally, the continuing cybersecurity threat, and the constrained capital position.

The Committees commended the risk scores and assurance ratings for submission to the Group Board in January 2026.

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 November and December 2025.

Group Board Meeting (Public)

Meeting on Thursday, 08 January 2026

Agenda Item	6.1	
Report Title	**Developing a Well-Led Group: Next steps**	
Executive Lead(s)	James Blythe, Interim Group Chief Executive Officer	
Report Author(s)	Group Executive Team	
Previously considered by	Group Executive Committee	06 January 2026
Purpose	**For Approval / Decision**	

Executive Summary

Four years after its inception, the gesh group has made significant progress on developing a model of leadership for its two constituent Trusts and hosted services. Notwithstanding this, significant further work on our leadership model is required. This paper summarises current progress and next steps in five key areas:

1) The development of a just, equitable, patient-focussed culture across the group, which is sufficiently consistent to enable the organisation to deliver its transformation goals, improve services, and spot and develop talented staff so that future leadership capacity is created and nurtured

2) The continued development of a quality governance framework for the group which is robust, proportionate, ensures safety and quality risks are managed appropriately and provides clear and timely assurance

3) Further iteration of a governance and accountability approach and underlying operating model which is reflective of the scale of the organisation and therefore balances expectations of grip and visibility by the Board and executive with the real need for subsidiarity and to balance the use of leaders' time

4) Communicating and embedding organisational strategy

5) How efforts in this area will be co-ordinated to address the CQC inspection at SGUH and ahead of the CQC well-led inspection at ESTH.

Action required by Group Board

The Board is asked to:

a. Note the above updates
b. Share any specific reflections or concerns it want the well-led working group to address
c. Agree to the commitment to develop an explicitly anti-racist organisation, as noted in section 3

Committee Assurance	
Committee	N/A
Level of Assurance	N/A

Appendices	
Appendix No.	**Appendix Name**
Appendix 1	Talent Pilot Projects: Overview of Work Programmes and Timescales

Implications

Group Strategic Objectives

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

Risks

Regulatory criticism or enforcement action

Ineffective organisational leadership

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 specifically

Legal and / or Regulatory implications

Risk of CQC criticism/enforcement action

Equality, diversity and inclusion implications

As outlined in the paper, improving our approach to EDI is critical to our successful leadership of the group

Environmental sustainability implications

N/A specifically

Developing a Well-Led Group: Next Steps
Group Board, 08 January 2026

1 Purpose of paper

Four years after its inception, the gesh group has made significant progress on developing a model of leadership for its two constituent Trusts and hosted services. This progress has been made in the context of significant operational and financial pressure and the cultural and operational legacy of the pandemic period.

Notwithstanding this, significant further work on our leadership model is required. This is illustrated by the findings of the St George's CQC well-led inspection in February 2025, with many of the critical findings being applicable across the group and of note given the imminent well-led inspection at Epsom and St Helier in March 2026. However, the imperative for undertaking this work should not be the timing of regulatory inspections; the reason for improving our leadership is to ensure that we are meeting our responsibilities to patients, public, staff, government and taxpayers, as well as we can within the resources provided.

This paper summarises current progress and next steps in five key areas:

1) The development of a just, equitable, patient-focussed culture across the group, which is sufficiently consistent to enable the organisation to deliver its transformation goals, improve services, and spot and develop talented staff so that future leadership capacity is created and nurtured
2) The continued development of a quality governance framework for the group which is robust, proportionate, ensures safety and quality risks are managed appropriately and provides clear and timely assurance
3) Further iteration of a governance and accountability approach and underlying operating model which is reflective of the scale of the organisation and therefore balances expectations of grip and visibility by the Board and executive with the real need for subsidiarity and to balance the use of leaders' time
4) Communicating and embedding organisational strategy
5) How efforts in this area will be co-ordinated ahead of the CQC well-led inspection at ESTH.

2 Developing our organisational culture

A culture which empowers our people to deliver effectively is central to our transformation programme and financial sustainability. The Board has discussed previously, some of the findings of the St George's CQC report, and how these triangulate with other sources of information about culture across the group. SGUH received a Regulation 17 notice from the CQC, that 'The Trust must use feedback from staff to improve the culture of the organisation and measure the impact of actions taken.'

The organisational culture across gesh is not homogenous and we know that there are different cultural norms within each trust and at divisional, departmental and team level. Looking critically at each trust, in St George's we know the culture at its worst is characterised by persistently poor experience of staff in some areas in relation to equality, diversity and inclusion (EDI), siloed working, ineffective corporate processes and systems and adversarial relationships. In Epsom and St Helier we also see EDI issues, examples of poor management, high profile disputes which are reputationally

damaging, and high levels of sickness absence. There are also, in parts, hugely positive aspects of our culture at both trusts which co-exist alongside the challenges and engagement with teams on this issue suggests that there are many colleagues whose experience would not be reflected in the characterisation above. We should be careful not to inadvertently create an overly negative and self-fulfilling narrative.

Adverse comment by the CQC has focussed in particular on the experience of global majority staff in terms of systemic discrimination, bias, and lack of support for progression and career development. The fact that the executive team is entirely white, in an organisation where only about half the staff are white, is a visible and pervasive cause of scepticism and challenge from staff when engaging on this issue.

The approach to driving improvement and systemic change is based on:

1) Wide and meaningful engagement at scale to build a shared understanding of how our people feel about working at gesh.
2) A continuous improvement approach to culture change that recognises the need for: active leadership role modelling; the development of clear and universally understood expectations and performance standards in all teams; and the consistent development of talent and skills – all backed by formal policies and processes which reinforce the correct approach.
3) Making gesh an explicitly anti-racist organisation

Engagement with staff at St George's on the CQC report continues. However the executive has already committed to the five areas of action outlined below. A timeline for delivery of these pieces of work is appended to this paper.

Inclusive Recruitment	Leadership & Management Development Programme	Inclusion Board	Succession Planning	Career Conversations & Appraisal
• **Purpose** – debias gesh recruitment process ensuring consistency, fairness and accessibility for both recruiting manager and candidate • **Outcomes** – higher employee trust in recruitment practices demonstrated through WRES, WDES and Engagement -Manager confidence and capability in recruiting fairly -Diverse pool of candidates applying and employed	• **Purpose** - To ensure our people managers have the skills and capabilities to adapt and thrive as high performing leaders • **Outcomes** - Culturally cognizant, strategic and competent leaders managing their teams, developing talent and recruiting fairly -Measured through anecdotal feedback, recruitment data, WRES, WDES, Engagement	• **Purpose** - to create development opportunities for a wider pool of gesh communities, and address the current underrepresentation of Black, Asian and Minority Ethnic colleagues at VSM and Board Level, creating diverse voices in decision making • **Outcomes** - Diverse talent prepared and able to move in Board Level and VSM roles	• **Purpose** – To develop internal talent and mitigate business risks through vacancies and low retention/high turnover, single points of failure • **Outcomes** – Business awareness of risks in employee turnover and retention with plans to mitigate and plan - Overall positive financial impact with reduced recruitment spends and turnover	• **Purpose** – To embed a culture of employee and manager career conversations as part of the appraisal process to enhance appraisal experience and develop internal Talent • **Outcomes** – All colleagues feel valued through the appraisal conversation with everyone having objectives set and at least one annual career conversation

Communication with staff on the Inclusion Board began in December 2025.

The executive has also committed to a systemic approach to supporting (and where necessary challenging) leaders in areas that are negative outliers on staff survey results, and highlighting and supporting leaders of teams who are positive outliers, or where there is notable progress on improving staff experience.

This approach must also be reflected in how the group's leadership responds to staff speaking up about concerns. Rather than rely on the FTSU Guardian to manage an increasing number of individual and collective staff concerns, it is vital that a non-defensive mindset that prioritises problem sensing, actively seeking feedback and visibly responding to concerns, is embedded in the

organisational culture, through the work highlighted above and in particular the leadership & management development programme.

The executive also wishes to secure the Board's support to gesh becoming an explicitly anti-racist organisation. Structural racism in parts of our organisation remains a material risk to leadership effectiveness, workforce retention and wellbeing, patient outcomes and organisational credibility. Incremental actions such as additional training or revised strategies will likely remain insufficient if our aspiration is to bring about a real step change. For that the organisation will need to explicitly commit to becoming an anti-racist organisation. This requires:

1) A shift from EDI being viewed as a compliance issue to anti-racism as core leadership practice
2) Board level ownership and personal accountability, which is replicated at all levels of leadership
3) Willingness to disrupt and replace norms in our systems, processes and leadership culture

The executive believes that some external expertise will be required to develop an effective approach to becoming anti-racist. We would like the Board's support to secure this expertise and co-develop a programme with full Board involvement over the next three months.

3 Quality governance

The principle to which the group works for the purposes of quality governance is that the majority of governance work should be performed as near to the clinical service as possible, but should be performed consistently so that it is possible to aggregate and compare, where appropriate, for the purposes of assurance across the group.

A two-part quality governance review was commissioned by the Group Board in June 2023, with the output of the first phase reported to the Group Board in July 2024 and the second phase in May 2025. A Quality and Safety Governance Action Plan was taken to Quality Committees in Common in July 2025. This focussed on the implementation of consistent standards of reporting, audit, use of data and application of the Patient Safety Incident Response Framework (PSIRF) across the Group.

The actions contained within this plan would go a considerable way to addressing the shortcomings in quality governance identified by the CQC during the SGH well-led inspection and in particular the Regulation 17 notice.

However, even with this plan, the lead executives (the Group CNO, Group CMO and Managing Directors) are not currently assured that there is a clear enough division of responsibility between group and site-based teams with regard to their respective roles and responsibilities for quality governance. We are also not yet assured that group-based quality teams have the right skills, experience and presence within the sites to support the site-led aspects of quality governance. This leads to gaps in effective assurance in some areas. It also leads to duplication of oversight which has a significant impact on the capacity of the site CMOs and CNOs and their teams, both to oversee an effective quality governance system but also provide wider professional leadership to both business as usual and transformation work.

The Group CNO and CMO, with the respective site leads, are therefore reviewing the organisational structures in place across their respective teams to ensure that site based quality governance functions have clear and deliverable expectations backed by appropriate professional support, and whether the overall action plan agreed in June 2025 may need some further revision. The Quality Committees in Common have requested an update on this plan which will be reviewed in February 2026.

4 Governance, accountability and operating model

The Board agreed a revised accountability framework in February 2025 which set out clearly the respective roles and responsibilities of the Board, group executive committee (GEC) and sub-groups, and site leadership teams. As with the specific approach to quality governance, the accountability framework is clear that decision-making should be delegated to the lowest appropriate level. This accountability framework is based on the Group Operating Model which was developed and agreed at the formation of the gesh Group in 2022.

This accountability framework remains largely what the group works to and is, in large parts, successful. Many decisions and judgements are made through effective matrix working between the sites and associated corporate services. Sub-groups to GEC oversee the frameworks under which these decisions occur. The GEC largely focusses on strategic direction, major risks and focus areas (such as the financial position, transformation plan and more latterly organisational culture), and significant/contentious decisions. The Group Board and Committees-in-Common are also well established and operate effectively.

However, the CQC's findings in its Well Led inspection at SGUH highlighted that the way in which the Group operates, and the interaction of group and site management and governance, in particular, did not always function effectively, with the benefits of operating as a Group not visible to staff. This interaction is most acutely felt in relation to the operational of quality governance structures and processes, as set out above. There are, however, a number of areas where the organisation's operating model needs to be further developed and embedded, supported by the further development of the accountability framework and associated governance structures:

1) The respective roles of the Group Executive and Site leadership teams need to be more fully defined and clarified to ensure greater clarity in roles and responsibilities, in order to address gaps in assurance and avoid unnecessary duplication while ensuring consistency in standards and avoiding unwarranted variation across the Group. Clarifying the relationship and interaction between the Group and Site will go a long way to addressing specific areas of challenge within the Group governance framework, which largely flow from this.

2) From this, some processes that necessarily require the involvement of site teams, groupwide corporate teams and GEC sub-groups do not work well consistently, especially where there is a lack of a common understanding about how the Group should operate. This is reflected in areas, including but not limited to risk management and policies, where previously agreed moves to a common Group-wide approach have proved difficult to navigate in practice.

3) We also need to review our wider meetings structures at both Group and Site levels to ensure that these are streamlined in a way that both reflects the principles of subsidiarity and provides effective assurance while ensuring that Executive and Site Directors are freed up to have greater capacity to lead transformational change across our Group. A subgroup of the Executive led by the GDCEO and GCCAO have started this work.

4) With the further refinement of our Group Operating Model to reflect the above and the parallel strengthening of our quality governance, we need to reflect these changes in our Group Accountability Framework as well as codify the changes in the way in which we operate in a new Scheme of Reservation and Delegation of Powers (SoRD). The SoRD was most recently updated in April 2023 to take account of the operation of the Group, in particular the operation of the Group Board, Committees-in-Common, as well as in relation to the financial limits within the SoRD and the latest changes to our ways of operating in practice need to be reflected in a more comprehensive refresh of the SoRD.

Our transformation programme incorporates a dedicated programme of work on developing the Group's operating model and ways of working to ensure that we operate effectively as a Group in the delivery of high quality and sustainable patient care. This work is being led by the Group Deputy Chief Executive Officer. In the shorter-term, a refreshed SoRD is being developed by the Executive team in January and February for consideration by the Group Board in March, led by the GCCAO to reflect the accountability framework and recent changes in how we operate as a Group. As part of wider work to prepare for the ESTH CQC Well Led inspection, the GCCAO is also working with colleagues at Executive and Site level to review the operation of the group approach to risk and policy management, as two key areas where Group and Site interact most closely, in order to consider how these can be strengthened and further refined.

5 Communicating and embedding organisational strategy

The SGUH CQC well-led inspection specifically referenced that the group's strategy was not embedded within the organisation and the lack of a clear narrative on the benefits of the group.

We have taken significant steps to address this with the development of the Clinical Strategy and Standards groups and the medium term transformation plan, including the appointment of chairs and SROs from across the group and widespread involvement in strategy development. With the approval of the surgical robot at Epsom, it has for the first time been possible to point to a new investment in a service in a part of the group, which would not have been possible without the existence of the group and the development of a groupwide surgical strategy. This has been discussed at the all-staff Executive Question Time and the opportunities to 'decompress' a very busy surgical workload at SGH have been highlighted. The resolution of the ESTH soft FM issue would also not have been possible without the groupwide restructure of the oversight of facilities management.

We have also, for the first time as a group, explicitly embedded anticipated financial benefits of groupwide transformation of both clinical and corporate services into business planning.

One of the Group-wide transformation programmes in our medium-term plan, led by the Deputy CEO, is to build the quality management system we need to deliver our long-term ambitions, i.e. clearly defined and continually monitored metrics at group, site/corporate service, divisional/team and service level which are aligned to the C/A/R/E strategic objectives. A key element of this programme will be to embed 'board to ward priorities', based on the CARE framework, against which local teams pursue improvement. Early work on embedding this work into a number of pilot 'high performing wards' has been successful.

The annual CARE awards also use award categories aligned to the strategic objectives to further assist with their reinforcement. The proliferation of CARE-based metric boards around the Trusts' corporate offices is testament to the increasing resonance of CARE and a linked continuous improvement approach.

We should therefore be confident that this issue has moved on significantly since February 2025. However culture and perception on the benefits of the group and the relevance of group strategy to individual services can take some time to influence effectively, and it is important to continue to strongly communicate our strategy and groupwide work throughout the group's leadership community.

6 Co-ordination of actions

Much of what this paper describes is a continued progression which started with the inception of the Group which has seen a groupwide way of working become more effective, embedded and mature. However as outlined above there are still significant challenges to be addressed.

In November, I committed to bring an action plan to this Board to address the CQC findings at St George's. We have subsequently been advised of the ESTH well-led inspection. So in effect the co-ordination of actions to address the findings of the SGUH well-led report has become the preparation phase for the ESTH inspection.

The GCCAO is co-ordinating a weekly well-led working group from early January up to and through the ESTH CQC well-led inspection. The group will include group executive, corporate team and site based representatives. This will:

1) Receive updates and provide direction on behalf of GEC and the SLTs, to work in the areas outlined above that both address the findings of the SGUH well-led and prepare for the ESTH inspection.

2) Ensure that work to strengthen our Quality and Safey Governance is progressed in a way that addresses the CQC's findings in relation to SGUH.

3) Ensure that our ways of working as a Group are reviewed and strengthened, particularly in relation to the interaction of the Group and Site, to ensure the principle of subsidiarity is embedded alongside delivering effective assurance, taking risk and policies as an initial focus in testing new ways of working that can become business as usual post inspection.

4) For ESTH specifically, identify and propose mitigations to any further gaps identified against the CQC's nine Key Lines of Enquiry for the well-led domain

5) Ensure the communications and logistics for the inspection are in hand.

The Board will receive an update on the working group's activities at the February development session, which will also involve a Board self-assessment of CQC Well Led readiness, and the March Board.

6.0 Recommendations

6.1 The Board is asked to:

a. Note the above updates
b. Share any specific reflections or concerns it want the well-led working group to address, or gaps it feels have not been addressed by this paper
c. Agree to the commitment to develop an explicitly anti-racist organisation, as noted in section 3

Appendix 1: Talent Pilot Projects

Overview of Work Programmes

Programmes	Dec 25	Jan 26	Feb 26	Mar 26	Apr 26	May 26	June 26	July 26	Aug 26	Sept 26	Oct 26	Nov 26
Inclusive Recruitment		ESTH RIS training roll out, JD and scoring criteria review and toolkit design	Standardise JD comms, launch gesh RIS process and golden ticket scheme	Launch gesh inclusive recruitment training	Deliver inclusive recruitment training	Deliver inclusive recruitment training	Deliver inclusive recruitment training	Review and evaluate training	Embed processes into BAU			
Leadership & Management Development Programme	Evaluation and adaption from Pilot	Launch Tier 1 and 2	Programme roll out	Programme roll out	Programme roll out, Tier 3 Development	Programme roll out, Tier 3 Development	Programme roll out, Tier 3 sign off	Six-month evaluation process	Tier 3 Pilot Promotion	Launch Tier 3 Pilot	Programme roll out	Programme roll out
Inclusion Board	Soft launch and promotion	Applications open	Applications close, shortlisting, selection	Selection, programme start date announced	Inclusion Board sessions	Inclusion Board sessions	Inclusion Board mid programme review	Inclusion Board sessions	Inclusion Board sessions	Inclusion Board sessions	Programme Graduation Event	Review and Evaluate (Inclusion Board continues)
Succession Planning	Research and data gathering	Options Appraisal and Design sign off	Deploy Pilot approach	Review and adapt	Second Pilot after feedback	Review and Adapt	Policy, guidance toolkits design	Policy, guidance, toolkits sign off	Engagement	Deployment		
Career Conversations	Data gathering and feedback	Data gathering and feedback	Design of materials, training offer & comms strategy	Pilot to some teams and gather feedback	Review and adapt	Launch across gesh	Roll out	Roll out	Embed in new gesh PDR approach			
Appraisal Cycle						Data gathering and engagement	Standards / behaviour design	Standards / behaviour design	Develop proposal for review and sign off	Pilot process	Review and adapt	Launch by March 2027 latest

Group Board

Meeting in Public on Thursday, 08 January 2026

Agenda Item	6.2	
Report Title	**Group Board Assurance Framework: Q3 2025/26 Review**	
Executive Lead(s)	Stephen Jones, Group Chief Corporate Affairs Officer	
Report Author(s)	Stephen Jones, Group Chief Corporate Affairs Officer	
Previously considered by	Finance & Performance Committees	19 December 2025
	Quality Committees	18 December 2025
	Infrastructure Committees	12 December 2025
	People Committees	11 December 2025
	Audit & Risk Committees	10 December 2025
	Group Executive Committee	02 December 2025
	gesh Risk and Assurance Group	24 November 2025
Purpose	**For Review**	

Executive Summary

This paper sets out the strategic risks on the Group Board Assurance Framework (BAF) as at Q3 2025/26 for consideration by the Group Board. The Board's has delegated to its Committees oversight of the relevant strategic risks on the BAF, with 11 of the 14 risks being overseen by the relevant Committees. Three of the 14 strategic risks on the Group BAF are reserved to the Board, all of which relate to collaboration and partnerships.

At Q3 2025/26, it is proposed that the risks on the BAF are maintained at their current positions – there are no proposed changes to any of the assurance ratings or risk scores at this point. While progress has been made in implementing mitigating actions in several areas, this has in places been offset by an increasingly challenging external environment, resulting in a broadly static position at Q3. In some areas, including quality and safety and people and culture, the findings from CQC service inspections and the Well Led review at SGUH materially influence the assurance position. Overall, the statis scores reflect a balance between progress in mitigation and heightened external and regulatory risk.

The Group Board agreed that the BAF would be refreshed in Q4 2025/26 in the context of the Group's Medium Term Plan (MTP), the new transformation programme, significant changes to the external environment and extensive changes in the composition of the Board. A Board session to discuss the refresh is scheduled for February 2026.

Action required by Group Board

The Group Board is asked to:

a) Review and agree the risk scores and assurance ratings for the Strategic Risks on the Group Board Assurance Framework at Q3 2025/26
b) Note the reviews of relevant strategic risks undertaken by Board Committees ahead of the Board review of the BAF.

Appendices	
Appendix No.	**Appendix Name**
Appendix 1	Group BAF: Overview (as at 31 December 2025)
Appendix 2	Group BAF: Full Strategic Risks

Implications				
Group Strategic Objectives				
☒ Collaboration & Partnerships		☒ Right care, right place, right time		
☒ Affordable Services, fit for the future		☒ Empowered, engaged staff		
Risks				
As set out in paper.				
CQC Theme				
☒ Safe	☒ Effective	☒ Caring	☒ Responsive	☒ Well Led
NHS system oversight framework				
☒ Quality of care, access and outcomes		☒ People		
☒ Preventing ill health and reducing inequalities		☒ Leadership and capability		
☒ Finance and use of resources		☒ Local strategic priorities		
Financial implications				
N/A				
Legal and / or Regulatory implications				
Compliance with the Health and Social Care Act (2008), Care Quality Commission (Registration Regulations) 2014, the NHS Act 2006 (as amended), NHS System Oversight Framework, Code of Governance for NHS Providers.				
Equality, diversity and inclusion implications				
SR13 sets out the risks relating to EDI.				
Environmental sustainability implications				
N/A				

Group Board Assurance Framework: Q3 2025/26 Review
Group Board, 08 January 2026

1.0 Purpose of paper

1.1 This paper sets out the strategic risks on the Group Board Assurance Framework (BAF) as at Q3 2025/26 for consideration by the Group Board and asks the Group Board to agree the assurance ratings and risk scores for the 14 strategic risks on the BAF.

2.0 Background

2.1 In line with the *Code of Governance for NHS provider trusts,* the Group Board maintains a Board Assurance Framework (BAF) to identify and oversee the principal risks to the delivery of the Group strategy and the sources of assurance relating to those risks.

2.2 The BAF is distinct from operational risks captured on the Corporate Risk Registers, with decisions on scoring, escalation and de-escalation reserved to the Board following Committee review.

2.3 The Group Board agreed a Group-wide BAF in March 2024, identifying 14 strategic risks to delivery of the Group Strategy, *Outstanding Care, Together 2023–28*, together with an agreed risk appetite for each risk. Of these, 11 risks are overseen by Committees, with three risks relating to collaboration and partnerships reserved to the Board.

Committee	Strategic Risk
Group Board	SR1: Working across our local system SR2: Working with other hospitals through our Acute Provider Collaborative SR3: Working across the Group
Finance & Performance	SR4: Achieving Financial sustainability SR8: Reducing Waiting Times
Infrastructure	SR5: Modernising our Estates SR6: Adopting Digital Technology
Quality	SR7: Developing New Treatments through Research and Innovation SR9: Improving Safety and Reducing Avoidable Harm SR10: Improving Patient Experience SR11: Tackling Health Inequalities
People	SR12: Putting Staff Experience and Wellbeing at the Heart of What We Do SR13: Fostering an Inclusive Culture that Celebrates Diversity SR14: Developing Tomorrow's Workforce

2.4 As well as agreeing the new Group Board Assurance Framework in March 2024, the Group Board also agreed its risk appetite for each strategic risk on the BAF. The risk appetite helps the Board to understand which risks are currently at a level beyond its agreed appetite, the actions required to mitigate each risk to a level the Board is prepared to tolerate, and facilitate effective decision-making based on an understanding of where the Board is prepared to tolerate risks at a higher level and where it wishes to be more cautious. The Group Board's risk appetite now needs to be refreshed and the proposals for undertaking this are set out in section 4 of this report.

3.0 Group Board Assurance Framework: Overview (as at end Q3 2025/26)

3.1 In 2025/26, the Group Board has reviewed the Group Board Assurance Framework biannually, the previous review having taken place at the Group Board meeting on 3 July 2025. This frequency is in line with current practice at a number of other Trusts, however we will be increasing the frequency of BAF reporting through the Board, via Committees, to quarterly in 2026/27 in line with good practice set out in the *Insightful Provider Board* guidance from NHS England, alongside refreshed Corporate Risk Registers for the two Trusts within the Group.

3.2 This report sets out the position for all 14 strategic risks at Q3 2025/26 following review by the relevant Committees. Appendix 1 summarises risk scores, assurance ratings, targets and risk appetite, with full risk entries at Appendix 2.

3.3 The Q3 review takes place in the context of a planned refresh of the BAF in Q4 2025/26, aligned to the Medium-Term Plan and new transformation programme. A Board session to review the BAF is planned for February 2026.

3.4 All risks have been reviewed at Executive and Committee level, with the exception of SR8, which was not reviewed by the Finance & Performance Committee in December. No changes to risk scores or assurance ratings are proposed at Q3. This reflects progress in mitigation offset by increased external risk, including regulatory findings from CQC inspections at SGUH.

3.5 The following provides a summary of the current position of each of the 14 Strategic Risks on the Group BAF at Q3 2025/26, with the detailed positions set out at Appendix 2:

Strategic Risk 1 – Working across our local systems
For SR1, the risk score remains at 16 with “reasonable” assurance at Q3 2025/26. The Group continues to act as a significant system partner across South West London and Surrey Heartlands, with active leadership roles at Place, Integrated Care Board and Integrated Care Partnership level. Progress has been made in strengthening collaborative arrangements with system partners, including delivery of alliance models of care, neighbourhood-based approaches and joint transformation programmes focused on reducing demand for acute services and improving patient flow. Since the July 2025 Board review, further work has progressed to clarify the Group’s role within Place-based partnerships, particularly in Sutton and Surrey Downs, and to develop models of integrated neighbourhood working in Merton and Wandsworth. The Group remains closely engaged with evolving system priorities, including the shift towards community-based care, neighbourhood health and the implications of changes to ICB form and function. These developments present opportunities to strengthen integrated care models but also introduce uncertainty and delivery risk, which continues to constrain assurance. Several material gaps in control remain, most notably in relation to strengthening relationships with local authorities, embedding consistent Place-based operating models across all localities, and developing system-aligned clinical strategies in areas such as frailty and primary care. While a number of mitigating actions are in progress and early benefits are emerging, many remain at an early stage or are not yet fully embedded. As a result, although progress is evident and the control environment is broadly appropriate, it is proposed that the current risk score and assurance rating remain appropriate at Q3 2025/26 2025.

Strategic Risk 2 – Working with other hospitals through the Acute Provider Collaborative
For SR2, the risk score is proposed to remain at 12 with "reasonable" assurance, which is within the Board's agreed risk appetite for collaborative working. The Group continues to play a leading role within the South West London Acute Provider Collaborative (APC), including through the Group Chief Executive's position as Lead CEO. Established collaborative arrangements remain in place across key areas, including recruitment, procurement, pathology, elective recovery and diagnostics, and these continue to support more efficient use of resources and improved access for patients across the system. Since the July 2025 Board review, progress has continued in strengthening APC governance and clinical collaboration. Several important gaps in control remain. In particular, the medium-to-long term APC strategy has not yet been finalised, arrangements for Integrated Care Board oversight continue to evolve, and the relationship between APC activity and the gesh Group operating model requires greater clarity. Some enabling actions remain overdue, including aspects of digital alignment, though progress has been made in other areas such as the development of a system-wide Ambient AI business case. Overall, while collaborative activity through the APC is well established and functioning, it is proposed that there have not been sufficiently material developments since the Board last reviewed SR2 in July 2025 to justify a reduction in risk score or increase in assurance rating.

Strategic Risk 3 – Working across the gesh Group
For SR3, the risk score remains at 20 with limited assurance. While important foundations for Group working have continued to strengthen, assurance remains constrained by both delivery pace and staff confidence in the Group operating model. The CQC Well Led inspection at SGUH highlighted concerns raised by staff regarding the clarity of the benefits of working as a Group and the operation of the Group's governance and operating framework. These concerns reinforce the Board's assessment that assurance remains limited at this stage. Progress in integrating corporate services continues, with several functions now operating on a Group-wide basis; however, delivery has been slower than planned in some areas, notably finance, digital, and elements of HR and estates. In parallel, the Group has made important progress in establishing Clinical Strategy and Standards Groups (CSSGs) across a number of key clinical areas. These groups represent a significant step forward in aligning clinical standards, reducing unwarranted variation and driving performance consistently across the Group. While this work remains at an early stage, the development of CSSGs is expected, over time, to materially strengthen clinical collaboration and provide clearer evidence of the benefits of Group working. The concerns identified by CQC are being addressed through the Group's transformation programme, including workstreams on Developing a Quality Management System and Organisational Form, which are intended to further clarify accountability, operating arrangements and performance management across the Group. Maintaining the risk score at 20 and assurance rating at limited represents a fine balance given the progress being made, but is considered necessary in light of the CQC findings and the fact that clinical collaboration across the Group remains in relative infancy.

Strategic Risk 4 – Achieving Financial Sustainability
The Board's assurance position for Strategic Risk 4 remains "limited" at the end of Q3 2025/26, with an assurance rating of limited and a risk score retained at 25, the maximum risk rating. Both

Trusts' underlying financial positions remain weak given they continue to report material underlying deficits. The Medium-Term Plan (MTP) requires defining a route to financial sustainability in two years for St George's and 3 years for Epsom and St Helier, but despite progress in developing the MPT and making an initial submission to NHS England, detailed plans are not yet established. The Board has noted the high level of risk associated with the MPT plans as developed to date. Progress against recurrent Cost Improvement Plans remains a challenge, with in-year slippage replaced by non-recurrent measures. A new transformation programme has been developed to deliver the changes necessary to become financially sustainable, and work is in progress with identified SROs to scope and take forward identified transformation workstreams. Against this, the control environments are seen as reasonable following the review by Deloitte in November 2024 and an update on the financial control environment considered by the Finance & Performance Committee in June 2025. The key gaps in control for SR4 at Q3 2025/26 are: managing the risks to the delivery of the 2025/26 financial plan; developing a credible and compliant MPT with a route to financial sustainability; other operational pressures outside the agreed financial plans; access to capital; and capacity across the Group to deliver CIP. Key enabling actions to mitigate SR4 are mostly due by year end (31 March 2026), though there has been slippage in delivery of identified CIPs in year and in relation to the restructuring of the two Trusts' finance departments on a Group-wide basis.

The Finance and Performance Committee reviewed this position at its meeting on 19 December 2025 and agreed that the current risk score and assurance ratings remain appropriate, as there has not been a material reduction in the level of risk or in the assurance position since the last review of SR4. The Committee considered whether a maximum score of 25 was appropriate, as a matter of principle, but agreed that this should be considered as part of the wider review of the Group Board Assurance Framework during Q4 2025/26 in the context of the Medium-Term Plan.

Strategic Risk 5 – Modernising Our Estate

The assurance position for Strategic Risk 5 remains "limited", with the risk score retained at the maximum of 25 at Q3 2025/26. The principal drivers of risk remain unchanged and relate to constrained capital availability, the deteriorating condition of estate assets, and delays to the Building Your Future Hospitals programme. These delays materially extend the period over which St Helier Hospital must continue to operate, amplifying the existing estates risks at St Helier, and also impact on plans to consolidate renal services in a new build at St George's. While the Board can take some assurance from improved oversight and assurance on estates issues through the Infrastructure Committee, the completion of the Premises Assurance Model submission to NHS England (which demonstrates strong performance in some areas and highlights areas requiring improvement in others) and progress in integrating estates and facilities teams, executive-level governance arrangements remain under development and several critical mitigation actions are still in delivery. Regulatory enforcement notices, particularly in relation to fire safety at St Helier Hospital and Epsom Hospital, and Authorised Engineer findings continue to constrain assurance. Opportunities exist through the new Estates Safety Fund to address critical infrastructure and safety risks and the Group will actively seek to pursue these. The Infrastructure Committee reviewed this position at its meeting on 12 December 2025 and agreed the current risk score and assurance ratings remained appropriate.

Strategic Risk 6 – Adopting Digital Technology

Strategic Risk 6 continues to attract "limited" assurance, with the risk score maintained at 20 by the Infrastructure Committee at its meeting on 12 December 2025. The Board can take assurance from the implementation of a shared Electronic Patient Record earlier this year, clearer digital governance, improved oversight of digital issues through the infrastructure

Committee, the planned integration of digital teams, and by the progress in developing a new digital strategy. However, significant gaps remain in cyber resilience, digital capacity and IT asset management, reflected in partial internal audit assurance. Improvement in the assurance rating is considered possible upon the finalising of the Group digital strategy, now scheduled for spring 2026. Delivery of the Group Digital Strategy and the Board's digital investment ambitions remain dependent on future capital availability, which constrains the level of assurance that can be taken at this stage.

Strategic Risk 7 – Developing New Treatments through Research and Innovation
The Board can take reasonable assurance in relation to Strategic Risk 7, with the risk score remaining at 12, following review by the Quality Committee at its meeting on 18 December 2025. Controls have strengthened through Group-wide research leadership, integrated research delivery teams and established academic partnerships. Developing a new strategic partnership between the gesh Group and City St George's University is also a key priority. Progress towards a Group Research and Innovation Strategy continues, though timescales have been extended, limiting near-term risk reduction. Some material gaps remain, particularly in aligning research priorities and securing sustainable research capacity across the Group. The Quality Committee agreed that, as part of the review of the BAF in Q4 2025/26, in response to the Medium-Term Plan, the wording of the existing research risk should be revisited with a view to framing the risk in broader terms than in relation to "developing treatments".

Strategic Risk 8 – Reducing Waiting Times
Assurance for Strategic Risk 8 remains limited, with the risk score unchanged at 20 (though the Finance & Performance Committee was unable to review this at its December 2025 meeting). The risk set out in SR8 highlights the fundamental challenges of balancing capacity and demand in a financially constrained environment, with the measures necessary to deliver improvements in waiting times inherently linked to financial performance, with the two often pulling in opposing directions, and with the system judgement and focus on which waiting times matter most moving year-on-year and sometimes within year. At a more granular level, the Board can take assurance that a comprehensive suite of operational controls is in place, including system escalation arrangements, validation of waiting lists, strengthened discharge processes and GIRFT-led improvement activity. Likewise the Board can take assurance from the fact that the Group Executive Committee undertakes a weekly review of key performance issues and regularly reviews the Integrated Quality and Performance Report. Various improvements have been achieved, including in relation to 65-week breaches. However, sustained NHS England Tier 1 oversight for both Trusts and Tier 2 oversight for ESTH, ongoing emergency care pressures, discharge delays and workforce constraints indicate that the underlying risk remains high and well above the Board's agreed risk appetite. In the absence of Finance and Performance Committee review, the Board is asked to review this position, with the detailed position coming back to the Committee.

Strategic Risk 9 – Improving Safety and Reducing Avoidable Harm
Strategic Risk 9 continues to be assessed with "limited" assurance, with the risk score maintained at 20, following review by the Quality Committee at its meeting on 18 December 2025. The Board can take assurance from improved mortality indicators, oversight from the Quality Committee in relation to maternity services and quality and safety in the Group's emergency departments, the approval of a Quality and Safety Governance Improvement Plan, and the operation of Group- and Site-level Quality Impact Assessment processes for reviewing proposed Cost Improvement Plans. However, several key actions remain off track or not fully

embedded, particularly in relation to safety culture, learning from incidents and emergency department pressures. External scrutiny particularly in the context of the CQC's service inspections at SGUH of urgent and emergency care, maternity and surgery, where safety was rated inadequate, as well as the SGUH CQC Well Led report, reinforces the need for sustained focus and greater assurance. Two the key aspects of assurance that the Committee and the Board require are in relation to: (i) the Quality Governance Improvement Plan, where the scope of the Plan in addressing known areas of weakness and, subsequently, delivery of the agreed Plan is necessary to improve the assurance level and reduce the risk score; and (ii) the development of the new Quality Management System as part of the transformation programme. At present the risk score remains significantly above the risk appetite agreed by the Board.

Strategic Risk 10 – Improving Patient Experience
The assurance position for Strategic Risk 10 remains "limited", with the risk score unchanged at 16, following review by the Quality Committee at its meeting on 18 December 2025. Core controls relating to patient involvement, complaints management and experience reporting are in place. However, strategic coordination of patient engagement, outpatient experience improvement and the quality of data for protected characteristics remain underdeveloped. Enabling transformation programmes in relation to Outpatient Transformation and developing a new Quality Management System are at an early stage and have not yet resulted in a measurable strengthening of assurance.

Strategic Risk 11 – Tackling Health Inequalities
Strategic Risk 11 continues to attract "reasonable" assurance, with the assurance level having previously been raised from limited in July 2025, with the risk score maintained at 16, following review by the Quality Committee at its meeting on 18 December 2025. The Board can take assurance from strengthened governance, dedicated Health Equity Leads at both Trusts funded by the respective hospital charities, and the embedding of Health Inequalities Impact Assessments within Quality Impact Assessment process for Cost Improvement Plans. Progress has been made in aligning the programme with system priorities and improving data sharing, though further work is required to evidence sustained impact on outcomes.

Strategic Risk 12 – Putting Staff Experience & Wellbeing at the Heart of What We Do
Assurance for Strategic Risk 12 remains "limited", with the risk score retained at 20, following review by the People Committee at its meeting on 11 December 2025. The Board can take assurance from the existence of a Group People Strategy and established wellbeing initiatives. However, NHS Staff Survey response rates and CQC Well Led findings at SGUH highlight ongoing concerns regarding leadership capacity, staff engagement and employee relations. Several critical mitigating actions remain in delivery.

Strategic Risk 13 – Fostering an Inclusive Culture that Celebrates Diversity
Strategic Risk 13 continues to be assessed with "limited" assurance and a risk score of 20, following review by the People Committee at its meeting on 11 December 2025. While EDI and speaking-up frameworks are in place, CQC Well Led findings at SGUH highlighted significant weaknesses in culture, psychological safety and meaningful progress on equality, diversity and inclusion. Control strengths have been reassessed and downgraded accordingly, and further actions are required but not yet embedded. A key part of the actions required to mitigate this

risk are set out in the report to the January Board on responding to the CQC Well Led report at SGUH.

Strategic Risk 14 – Developing Tomorrow's Workforce
Assurance for Strategic Risk 14 remains limited, with the risk score unchanged at 20, following review by the People Committee at its meeting on 11 December 2025. The Board can take assurance from recruitment initiatives, vacancy controls and leadership development programmes. However, delays to the implementation of talent and succession planning, the alignment of appraisals with the CARE framework, and strengthening rostering arrangements for medical staff continue to constrain assurance.

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

4.1 In March 2025, the Group Board approved a new Group-wide risk management policy and risk escalation framework, following review by the Audit and Risk Committees. The new policy establishes a robust and consistent framework for identifying, scoring, assessing, managing, escalating and monitoring both clinical and non-clinical risks across the Group.

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

4.3 The gesh Risk and Assurance Group is overseeing a refresh of the two Trusts' Corporate Risk Registers, which is scheduled to conclude during Q4 2025/26, enabling the CRRs to be presented on a quarterly basis to Board Committees and to the Group Board from the start of 2026/27.

4.4 In line with NHS England's guidance on the *Insightful Board*, the Group Board will receive the Group Board Assurance Framework and the Corporate Risk Registers on a quarterly basis at the following meetings during 2026/27:

Quarter	Board meeting	Committee review
Q1 2026/27	July 2025	June 2025
Q2 2026/27	November 2025	October 2025
Q3 2026/27	January 2026	December 2025
Q4 2026/27	May 2026	April 2025

5.0 Refreshing the Group Board Assurance Framework

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

5.2 As discussed at the Group Board's December 2025 development session, there have been very significant changes in the Group's external operating environment since the strategy was agreed in April 2023 and a new Medium-Term Plan is in development, the first submissions of which took place in December. That Medium-Term Plan, and the new transformation programme which has been developed to support the Group in delivering the Plan and becoming financially sustainable, in effect becomes a core part of the existing Group strategy. In addition, there has been a very significant turnover in the membership of the Group Board; of the 21 members of the current Group Board, only 8 were members of the Group Board when the BAF was defined and agreed in March 2024 (including 3 Non-Executive Directors and 5 Executive Directors). Seven of 10 NEDs, and 8 of 12 Executives were not part of the Group Board when the BAF was developed less then two years ago. Given that the BAF needs to be owned collectively by the Board, reflecting the risks the Board considers to exist to the delivery of its strategy, a refresh will help ensure that the current Group Board can refresh the risks on the BAF and ensure these reflect both current challenges in a way that reflects the current Board's view of the risk environment and its appetite to risk. A Board development session to review and refresh the BAF will take place in February 2026.

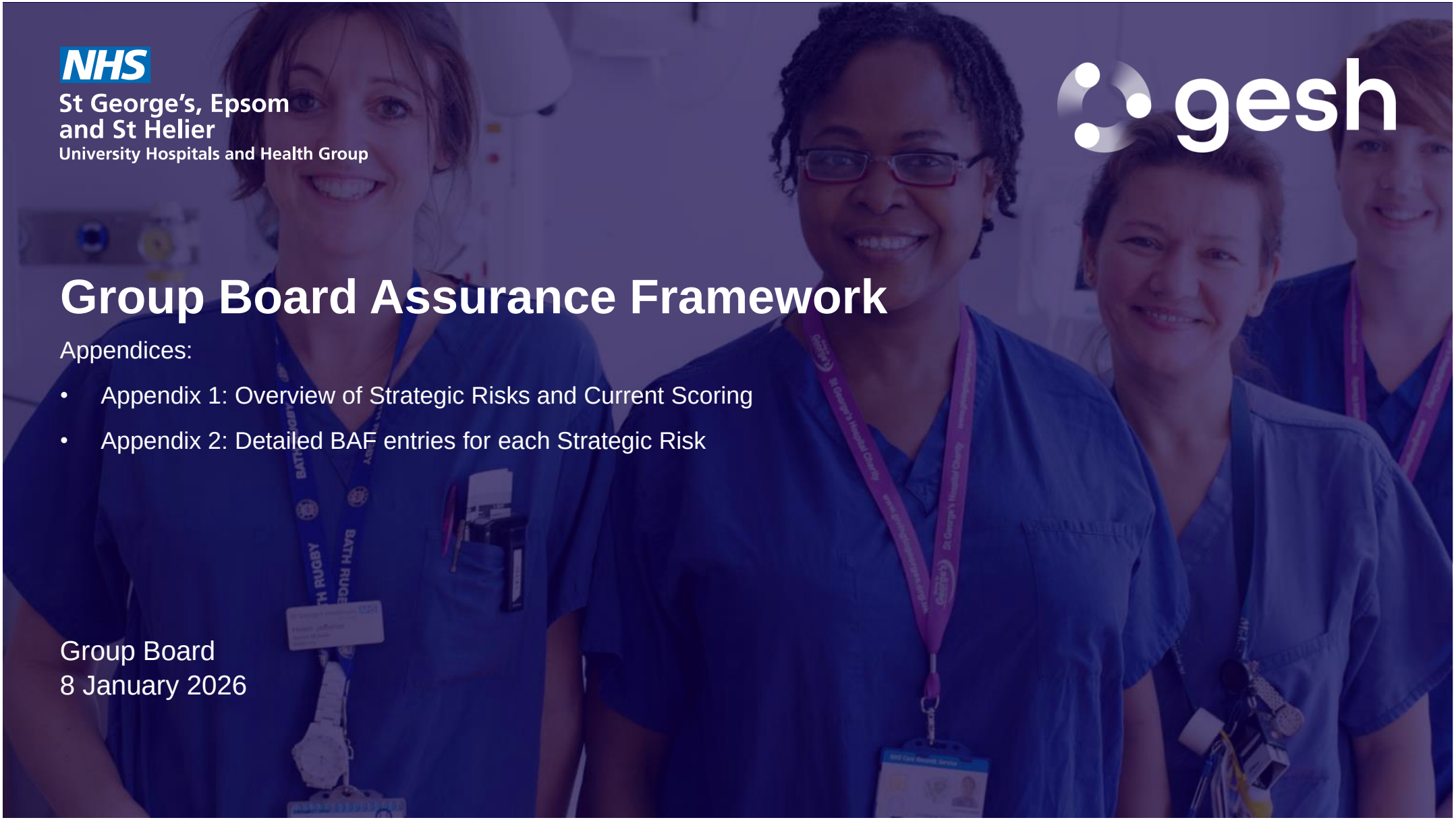
5.3 Also in line with good risk management practice, it is proposed that, alongside the review of the strategic risks on the BAF, the Board reviews and refreshes its risk appetite statement. This is important to undertake on an annual basis, and even more so in the context of the significant changes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

6.0 Recommendations

6.1 The Group Board is asked to:

a) Review and agree the risk scores and assurance ratings for the Strategic Risks on the Group Board Assurance Framework at Q3 2025/26

a) Note the reviews of relevant strategic risks undertaken by Board Committees ahead of the Board review of the BAF.



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Group Board Assurance Framework

Appendices:

- Appendix 1: Overview of Strategic Risks and Current Scoring
- Appendix 2: Detailed BAF entries for each Strategic Risk

Group Board
8 January 2026

Appendix 1: Group Board Assurance Framework
Overview: Structure and Current Scoring

Strategic Objective	Strategic Risk	Summary risk description	Full risk description	Board level oversight (Committee)	Executive lead	Current Risk Score (May 25)	Target Risk Score (Mar 26)	Agreed Risk Appetite	Current assurance rating	Target Assurance rating (Mar 26)
Collaboration & Partnerships	SR1	Working across our local system	If we do not act as an effective, collaborative partner across the whole patient pathway and wider health and care system, then we will not build effective integrated models of care across primary, community, mental health, acute and specialist care, resulting in unsustainable demand for acute services, patients not receiving care in the most appropriate setting, and lower health outcomes.	Group Board	GCEO	16	12	Cautious 8-9	Reasonable	Good
	SR2	Working with other hospitals through our Acute Provider Collaborative	If we do not foster strong, collaborative relationships with other providers through the Acute Provider Collaborative and focus on where we can add the most value in terms of the quality and sustainability of services, then we will not deliver effective, efficient and sustainable services for the benefit of patients across South West London and Surrey, resulting in longer waiting lists, unwarranted variation in and less responsive care, and less efficient use of resources across our system.	Group Board	GCEO	12	8	Open 10-12	Good	Good
	SR3	Working across the Group	If we do not harness the full benefits of collaboration and integration across our Group and capitalise on our strengths, then we will be less than the sum of our parts, fail to keep pace with improving standards and face challenges in retaining the breadth of services for the benefit of our local communities, resulting in unwarranted variation in care and poorer outcomes for patients.	Group Board	GCEO	20	15	Open 10-12	Limited	Reasonable
Affordable services fit for the future	SR4	Achieving financial sustainability	If we do not manage costs effectively, optimise productivity, and ensure our activities are effective, then we will not return to financial balance, resulting in the poor use of public funds and unsustainable services for patients.	Finance & Performance	GCFO	25	20	Cautious 8-9	Limited	Reasonable
	SR5	Modernising our estate	If we do not secure capital funds necessary to address areas of material risk across our estates and deliver our green plans, then we will be unable to maintain a safe estate, reduce our carbon footprint, and transform services for patients, resulting in increased risk to patient and staff safety and to the safe and sustainable delivery of clinical services.	Infrastructure	GCFIEO	25	25	Open 10-12	Limited	Reasonable
	SR6	Adopting digital technology	If we do not build a robust digital infrastructure and adopt transformational digital solutions, then we will not deliver new and innovative models of care or support staff to work more flexibly and efficiently, resulting in poorer patient outcomes, less efficient services and staff disengagement.	Infrastructure	GCTO	20	20	Open 10-12	Limited	Reasonable
	SR7	Developing new treatments through research and innovation	If we do not create the right culture, infrastructure and partnerships……then we will not become a thriving centre for research and innovation and not attract sufficient research funding……resulting in poorer health outcomes for patients, and challenges in attracting and retaining high calibre staff.	Quality	GCMO	12	8	Seek 15-25	Reasonable	Good

Appendix 1: Group Board Assurance Framework
Overview: Structure and Current Scoring

Strategic Objective	Strategic Risk	Summary risk description	Full risk description	Board level oversight (Committee)	Executive lead	Current Risk Score (May 25)	Target Risk Score (Mar 26)	Agreed Risk Appetite	Current assurance rating	Target Assurance rating (Mar 26)
Right Care, Right Place, Right Time	SR8	Reducing Waiting Times	If we do not foster and support continuous improvement to improve the efficiency and effectiveness of our services, then we will not improve flow through our hospitals, resulting in patients waiting too long for treatment, poorer clinical outcomes and risk of harm, and staff disengagement.	Finance & Performance	Site MDs	20	20	Cautious 8-9	Limited	Reasonable
	SR9	Improving safety and reducing available harm	If we do not develop robust quality governance systems and processes, use our data intelligently, and develop a strong safety culture that supports learning, then we will not deliver safe, effective and responsive care to our patients, resulting in increases in avoidable harm and mortality and poorer clinical outcomes.	Quality	GCMO & GCNO	20	20	Minimal 4-6	Limited	Reasonable
	SR10	Improving patient experience	If we do not equip our staff to make improvements in their services and build effective relationships with patient groups, then we will not deliver improvements in the quality, effectiveness and efficiency of our services, resulting in lower quality of care, increased risk of harm, and less efficient services.	Quality	GCMO & GCNO	16	12	Minimal 4-6	Limited	Reasonable
	SR11	Tackling health inequalities	If we do not pursue a more strategic and systematic approach to tackling health inequalities in collaboration with our local partners and act as an anchor institution, then we will fail to play our part in improving the health of our local population, resulting in less equitable access to care and poorer outcomes.	Quality	GCMO	16	12	Open 10-12	Reasonable	Reasonable
Empowered, Engaged Staff	SR12	Putting staff experience and wellbeing at the heart of what we do	If we do not give our staff the tools and support they need or develop high performing teams and outstanding leaders and managers at every level, then our staff will be unable to perform to their best and may not feel fairly treated, resulting in services that are less efficient, poorer quality of care for patients, and difficulties in recruiting and retaining high calibre staff.	People	GCPO	20	16	Cautious 8-9	Limited	Reasonable
	SR13	Fostering an inclusive culture that celebrates diversity	If we do not develop our organisational culture to make the Group a more inclusive place to work that celebrates our diversity and tackle discrimination, then our staff will not feel valued, empowered or psychologically secure, resulting in lower staff engagement, poorer staff wellbeing, challenges with recruitment and retention, and lower quality of care to patients.	People	GCPO	20	16	Cautious 8-9	Limited	Reasonable
	SR14	Developing tomorrow's workforce	If we do not retain, train and transform our workforce for the future, then we will not be able to support the delivery of new models of care, encounter shortages in our workforce, and increase our reliance on agency staff, resulting in lower quality and less efficient services for patients, and higher staffing costs.	People	GCPO	20	16	Cautious 8-9	Limited	Reasonable

Strategic Risk	SR1	Working across our local systems

Cause	Risk	Effect
If we do not act as an effective, collaborative partner across the whole patient pathway and wider health and care system…	*…then we will not build effective integrated models of care across primary, community, mental health, acute and specialist care…*	*…resulting in unsustainable demand for acute services, patients not receiving care in the most appropriate setting, and lower health outcomes.*

Current Risk Score: 16

Assurance: Reasonable

Strategic objective	Collaboration and Partnerships
Last review date	08 January 2026
Monitoring Committee	Group Board
Lead Executive	Group Chief Executive Officer
Risk appetite	Cautious (Moderate)

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

Change since last review: ⟺

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

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

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

Gaps in controls *What do we need to do to control the risk that we are not yet doing?*	
1	Working though how the Group works most effectively at Place, building on how effectively it operates at system level
2	Strengthening collaborative working relationships with local authorities
3	Strengthening partner relationships
4	Need to develop a model for engagement with integrated neighbourhood working
5	Need to develop a gesh frailty service
6	Development of SWL primary care strategy
7	Strengthening processes for feedback from ICBs into Group governance (Executive and Board)

Emerging risks and opportunities *What else is relevant to how we managing the risk?*	
Emerging risks	**Emerging opportunities**
• Changes to the structure and capacity of ICBs in the Model ICB Blueprint	• Focus on neighbourhood health • Changes to the structure and capacity of ICBs in the Model ICB Blueprint • Opportunity to place more of a role at Place in Wandsworth and Merton • SWL ICB clinical review

Material actions to address gaps in controls and assurances *What are we going to do, by when, to further manage and mitigate the risk?*		Executive Lead	Due date	Progress
1	Develop Wandsworth Provider Alliance Memorandum of Understanding signed by all providers	MD-IC	Mar-25	Completed
2	Develop medium term plan in line with emerging SWL clinical strategy and three shifts in the NHS 10 Year Plan	GCEO	Feb-26	On Track
3	Deliver transformation workstream on Transforming Non-Elective Care	MD-SGUH	TBC	On Track
4	Deliver transformation workstream on Transforming Outpatients and Developing New Models of Care	MD-ESTH	TBC	On Track
3	Develop gesh model of engagement for integrated neighbourhood working including proactive care MDT in Merton and Wandsworth	MD-IC / MD-SGUH	Dec-25	On Track
4	Strengthen Partner relationships and Alliance model across Merton through Alliance organisational development	MD-IC / MD-SGUH	Jan-26	On Track
5	Develop gesh integrated frailty services that align to national best practice	MD-IC	TBC	TBC

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

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

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

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

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

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

Current Risk Score: 12

Assurance: Reasonable

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

Strategic objective	Collaboration and Partnerships
Last review date	08 January 2026
Monitoring Committee	Group Board
Lead Executive	Group Chief Executive Officer
Risk appetite	Open (High)

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

Change since last review

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

Key controls *What are we already doing to manage the risk?*		Assurances on controls *How do we have assurance that the controls are working?*		*Control Strength*	*Line of defence*
1	Governance structure for the APC established	1	Updates from APC presented to Executive team	Reasonable	Second - Management
2	SWL APC has established an APC Board comprising the Chairs and CEOs of the SWL providers, which meets bimonthly	2	Updates from APC presented to Executive team	Reasonable	Second - Management
3	Group CEO is lead CEO of the South West London Acute Provider Collaborative	3	Updates from APC presented to Executive team	Reasonable	Second - Management
4	Formal SWL APC partnerships in place for recruitment, orthopaedics, procurement, pathology	4	Review of key performance metrics of APC partnerships through the Site, Executive and relevant Board Committees	Reasonable	Second - Management
5	Agreed set of SWL APC priorities in place for 2023/24	5	Delivery overseen by APC Board	Reasonable	Second - Management
6	A range of elective programmes and clinical networks in place across the SWL APC covering elective recovery, outpatients and diagnostics	6	Delivery overseen by APC Board	Reasonable	Second - Management
7	APC Programme Director in place (new appointment from March 2025)	7	Regular meetings with GCEO and updates provided to Executive	Reasonable	Second - Management
8	Established collaborative partnerships: SWL Recruitment, SWL Procurement, SWLEOC, SWL Pathology	8	Reporting integrated into performance reports to Committees and Group Board	Reasonable	Second - Management
9	System-wide clinical networks: cardiology, neurology, radiology in place	9	Reporting through relevant reports to Committees and Group Board	Reasonable	Second - Management

Gaps in controls *What do we need to do to control the risk that we are not yet doing?*	
1	Need to develop a medium-to-long term APC strategy
2	Need to clarify arrangements for ICB oversight
3	Need for clear outputs from established networks across the APC
4	Need to clarify APC working in the context of the gesh Group
5	Opportunity to explore alignment of EPRs across the APC
6	Development of Surrey Heartlands APC with GESH representation via Surrey Downs Health and Care

Emerging risks and opportunities *What else is relevant to how we managing the risk?*	
Emerging risks	**Emerging opportunities**
• Impact of changes to ICBs	• Priorities set out in the NHS 10 Year Plan

Material actions to address gaps in controls and assurances *What are we going to do, by when, to further manage and mitigate the risk?*		Executive Lead	Due date	Progress
1	Approve 3-5 year strategy for the SWL APC	GCEO	Dec-24	Overdue
2	Define clear outputs from the networks established across the APC	GCEO	Dec-24	Overdue
3	Deliver the SWL-wide PACS programme and agreed forward programme for PACS with provider	GCTO	Sep-24	Overdue
4	Finalise specification and business case for Ambient AI	GCTO	Sep-25	Completed
6	Strengthen APC partnerships hosted by gesh	GCTO	TBC	TBC
7	Delivery transformation programme workstream on transforming non-elective care	MD-SGUH	TBC	TBC
8	Delivery of transformation workstream on transforming outpatients and developing new models of care	MD-ESTH	TBC	TBC

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

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

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

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

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

Strategic Risk	SR3	Working together across our Group

Current Risk Score: 20

Assurance: Limited

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

Strategic objective	Collaboration and Partnerships
Last review date	08 January 2026
Monitoring Committee	Group Board
Lead Executive	Group Chief Executive Officer
Risk appetite	Open (High)

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

Change since last review

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

	Key controls *What are we already doing to manage the risk?*
1	Group-wide strategy in place and approved by Boards, with People strategy, Quality strategy, Green Plan approved by Group Board
2	9 strategic initiatives agreed with Executive leads for each identified, and governance of the initiatives agreed by the Group Board
3	MoU and Information Sharing Agreement in place to support the development of the Group
4	Group Accountability Framework developed and approved by the Group Board
5	Group governance arrangements established at Board, Committee and Executive level
6	Group Corporate Services programme established, with legal agreements in place to support the operation of Group-wide services
7	Executive Collaboration Group now established to oversee the development of clinical and corporate collaboration and integration across the Group
8	Performance data reviewed on Group-wide basis

	Assurances on controls *How do we have assurance that the controls are working?*	*Control Strength*	*Line of defence*
1	Strategy progress updates reviewed by Group Board bi-annually, and by the Executive on a monthly basis	Good	Second - Management
2	Programmes of work for each established, with executive review of Strategic Initiatives on a monthly basis	Reasonable	Second - Management
3	In place and approved by the Boards	Good	Second - Management
4	Framework used to inform where and how decisions are taken and on escalation of issues	Reasonable	Second - Management
5	Group Board and Committees-in-Common established and review effectiveness annually	Good	Second - Management
6	Timescales established for integration of corporate functions across the Group. Corporate Affairs, Communications, DCEO, Corporate Nursing and Phase 1 Corporate Medical completed.	Weak	Second - Management
7	Recently reconstituted and will be providing regular reporting of progress to the Group Executive	Reasonable	Second - Management
8	Group-wide Integrated Quality and Performance Report presented to Committees and Group Board	Good	Second - Management

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

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

Material actions to address gaps in controls and assurances *What are we going to do, by when, to further manage and mitigate the risk?*		Executive Lead	Due date	Progress
1	Develop and agree Group-wide Accountability Framework, drawing on Group Operating Model	GCCAO	Feb-25	Completed
2	Develop a framework for policies across the Group	GCCAO	Feb-25	Completed
3	Develop Group Roadmap to provide a framework for the integration of clinical services across the Group	GDCEO	Apr-25	Completed
4	Align digital and IT systems across the Group through the actions arising from the External Review of Digital	GCTO	Sept-25	Completed
5	Finalise and approve designs for remaining corporate areas for integration, and complete integration of Group Corporate Services to agreed timeline (rebased timeline0	GDCEO	Mar-26	On Track
6	Remaining supporting strategies to be developed, reviewed and approved by the Group Board: Digital, Estates, Research	Exec Leads	Nov-24	Overdue
7	Group-wide Surgery Strategy to be presented to the Group Board in January 2025	GDCEO	Jan-25	Overdue
8	Group-wide Paediatrics Strategy to be presented to the Group Board in June 2025	GDCEO	Jun-25	Overdue
9	Delivery of the new Group transformation programme	GCEO	TBC	TBC
10	Delivery of transformation programme workstream on developing a Quality Management System for the Group	GDCEO	TBC	TBC
11	Delivery of transformation programme workstream on Organisational Form	GDCEO	TBC	TBC
12	Develop aligned Group-wide Standing Orders, Scheme of Delegation and Standing Financial Instructions for each Trust, with as much alignment as possible within the existing legal and regulatory framework	GCCAO	Mar-26	On Track

Related risks on BAF and Corporate Risk Register – SGUH			
Trust	**Datix ID**	**Score**	**Summary risk description**
SGUH	CRR-2963	16	Group Corporate Services

Related risks on BAF and Corporate Risk Register – ESTH			
Trust	**Datix ID**	**Score**	**Summary risk description**
ESTH	CRR-652	16	Group Corporate Services

Related risks on SWL Integrated Care Board BAF	
Score	**Summary risk description**
No specific related risks on the gesh Group on ICB BAF	

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

Group Board Assurance Framework 2025/26

Strategic Risk	SR4	Achieving financial sustainability – Group Assessment

Cause	Risk	Effect
If we do not manage costs effectively, optimise productivity, and ensure our activities are effective…	*…then we will not return to financial balance…*	*The poor use of public funds and unsustainable services for patients.*

Current Risk Score: 25

Assurance: Limited

Strategic objective	Affordable Services Fit for the Future
Last review date	~~03 July 2025~~19 December 2025
Monitoring Committee	Finance Committees-in-Common
Lead Executive	Group Chief Finance Officer
Risk appetite	Cautious (Moderate)

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

Change since last review: ⇔

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

Key controls *What are we already doing to manage the risk?*	
1	Managing income and expenditure in line with budget.
2	Ensuring there is an effective financial control environment.
3	CIPs. Identifying and delivering actions to improve the financial position.
4	Robust understanding of cost structures and productivity.
5	~~Maintaining a five year forward view.~~Compliant Medoum Term Plan to financial balance
6	Maintaining the capacity and capability of the finance team.
7	Capital: clear view of future capital needs and how to meet them
8	Robust processes to forecast and manage cash.
9	Maintaining an effective procurement environment
9	External engagement with SWL, London and national finance teams.

Assurances on controls *How do we have assurance that the controls are working?*		*Control Strength*	*Line of defence*
1	Financial performance is in line with budget/plan	Weak	First - Operational
2	Evidenced through finance reports, audit reports and against KPIs	Reasonable	Second - Management
3	Project Management and meeting structure in place to identify, plan and deliver CIPs in line with target.	Reasonable	First - Operational
4	Costing systems and known areas for improvement in place.	Reasonable	Second - Management
5	~~A five year "long term financial plan" is in place~~Medium Term Plan in development	Weak	Second - Management
6	Clearly defined statement of how demands on dept are meet by available resources.	~~Weak~~Reasonable	Second - Management
	Detail available of prioritised capital need together with available funding.	Weak	Second - Management
7	Daily cashflows for 13 week and rolling 12 months in place.	Reasonable	Second - Management
8	Procurement has effective policies and processes, sufficient capacity and capability and are actively engaged with users.	Weak	Second - Management
9	Good engagement with SWL and London. ICS CFO attends Group FinCom.	Reasonable	Third - External

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Group Board Assurance Framework 2025/26

Group Board Assurance Framework 2025/26

Gaps in controls *What do we need to do to control the risk that we are not yet doing?*	
1	Enhance level of financial support and challenge – esp embed at budget holder level
2	Challenge in continued emphasis on the identification and delivery of CIPs.
3	Improve understanding and actions to address variance in benchmarking
4	Improve understanding and actions to address productivity
5	Clear trajectory to return to financial balance
6	~~Need to revise the five-year model developed as part of SWL planning~~Develop a compliant Medium Term Plan as part of the 2026/27 planning round
7	Capital funding is insufficient to meet identified known investment needs; BAU and developmental
8	Review finance team capacity and capability in respect of current agenda
9	Continued focus on cashflow forecasting and engagement with NHSE
10	Increase communication on and integration of finance into wider agenda (not separate)

Emerging risks and opportunities *What else is relevant to how we managing the risk?*	
Emerging risks	**Emerging opportunities**
• Clear message from NHSE 25/26 plans need to be delivered. • Scale of financial challenge. NHSE have published timeframe to financial balance (SGH 2 years, ESTH 3 years) • Organisational engagement given activity pressures and tired workforce. • Scale of identified investments remain above available funding • Cashflow management	• Working across the Group. • Working across the SWL system. •

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

Related risks on BAF and Corporate Risk Register – SGUH			
Trust	**Datix ID**	**Score**	**Summary risk description**
SGUH	CRR-1411	25	Managing I&E within budget
SGUH	CRR-1865	25	Identifying and delivering CIPs
SGUH	CRR-1085	20	Managing an effective control environment
SGUH	CRR-1414	20	Five-year investment plan
SGUH	CRR-2496	20	Identification of all capital funding
SGUH	CRR-1416	15	Future cash requirements understood

Related risks on BAF and Corporate Risk Register – ESTH			
Trust	**Datix ID**	**Score**	**Summary risk description**
ESTH	CRR-1961	25	Inability to achieve long term financial sustainability
ESTH	CRR-1960	25	Inability to undertake the required capital investment programme with the SWL capital programme CDEL limits

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Group Board Assurance Framework 2025/26

Related risks on SWL Integrated Care Board BAF	
Score	**Summary risk description**
20	Financial sustainability

Related risks on Surrey Downs Integrated Care Board BAF	
Score	**Summary risk description**
16	Failure to deliver the ICB financial plan

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

Strategic Risk	SR5	Modernising our estates

Current Risk Score: 25

Assurance: Limited

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

Strategic objective	Affordable Services Fit for the Future
Last review date	12 December 2025
Monitoring Committee	Infrastructure Committees-in-Common
Lead Executive	Group Chief Infrastructure Officer
Risk appetite	Open (High)

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

Change since last review

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

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

Assurances on controls *How do we have assurance that the controls are working?*		*Control Strength*	*Line of defence*
1	The Infrastructure Committees focus on estates, facilities and health and safety issues on a bimonthly basis.	Good	Second - Management
2	An Executive Estates Governance Group is in development to provide more structured Executive oversight of estates issues.	Weak	Second - Management
3	The PAM is presented regularly to the Infrastructure Committees for oversight and assurance.	Reasonable	Second - Management
4	AE reports are regularly presented to the Infrastructure Committee for oversight and assurance.	Reasonable	Third - External
5	A new 6-facet survey is planned for SGUH in 2025/26 as previous survey was undertaken more than 5 years ago.	Reasonable	Third - External
6	Performance for completion rates of emergency and high priority jobs in a positive place at SGUH and ESTH	Reasonable	Second - Management
7	Internal audits on maintenance undertaken	Reasonable	Third - External
8	Both Trusts have processes for agreeing collectively the annual capital plans, with clinical, operational and E&F input	Weak	Second - Management
9	Group Green Plan approved by Group Board in July 2024. Governance arrangements and KPIs agreed.	Good	Second - Management

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

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

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

Related risks on BAF and Corporate Risk Register – SGUH			
Trust	**Datix ID**	**Score**	**Summary risk description**
SGUH	CRR-762	20	Backlog maintenance

Related risks on BAF and Corporate Risk Register – ESTH			
Trust	**Datix ID**	**Score**	**Summary risk description**
ESTH	CRR-1951	20	Poor condition of external buildings

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

Related risks on BAF and Corporate Risk Register – ESTH			
Trust	**Datix ID**	**Score**	**Summary risk description**
ESTH	CRR-1952	20	Electrical infrastructure
ESTH	CRR-1955	20	Risk of failure of air handling and cooling
ESTH	CRR-1956	20	Risk of failure of mechanical bed lifts
ESTH	CRR-1953	16	Fire prevention systems
ESTH	CRR-1954	16	Sewage and drainage systems
ESTH	CRR-1962	16	Risk that BYFH fails to meet objectives

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

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

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

Strategic Risk	SR6	Adopting digital technology

Current Risk Score: 20

Assurance: Limited

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

Strategic objective	Affordable Services Fit for the Future
Last review date	12 December 2025
Monitoring Committee	Infrastructure Committees-in-Common
Lead Executive	Group Deputy Chief Executive Officer
Risk appetite	Open (High)

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

Change since last review: ⟺

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

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

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

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

Emerging risks and opportunities *What else is relevant to how we managing the risk?*	
Emerging risks	**Emerging opportunities**
• Mismatch between needs/plans and available resources. • Delivery against key projects taking longer than planned • Growing cybersecurity threats • Financial uncertainties, making it challenging to plan digital projects	• Expected emphasis on digital within the NHS 10 Year Plan • Transfer of responsibilities for digital from ICBs to providers in new Model ICB Blueprint • Closer Group working • SWL-wide solutions being explored for the medium/longer term

Material actions to address gaps in controls and assurances *What are we going to do, by when, to further manage and mitigate the risk?*		Executive Lead	Due date	Progress
-	Rollout of Electronic Patient Record: Roll-out of shared EPR across the Group. Rollout undertaken in May 2025 as planned. Post-Go Live optimisation to deliver the benefits of a shared domain ongoing.	COO-ESTH	May-25	Completed
-	Structures: Complete external review of Group digital services and develop plans for addressing actions identified. Final report received and presented to Infrastructure Committee, and restructure plans agreed to implement recommendations.	DGCEO / GCTO	Mar-25	Completed
-	Cybersecurity: Develop cybersecurity dashboard on SWL basis. Dashboard to be considered by Infrastructure Committee in December 2025 (New date: December 2025, original date December 2024)	DGCEO / GCTO	Dec-24	Completed
1	Strategy: Develop Group Digital Strategy and agree at Group Board: Revised plan to bring digital strategy to the Group Board for approval in November 2025. (Revised date: March / April 2026, original date April 2025)	DGCEO / GCTO	Apr-26	On Track
2	Integration: Integrate the two Trusts' ICT departments into a single Group-wide department. This will be informed through the external review. Restructure agreed and underway, Due for completion by end Q4 2025/26. (Revised date March 2026, original date March 2025)	DGCEO / GCTO	Mar-26	Overdue
3	Governance: Refresh the gesh Digital Governance Group. A revised ToR was reviewed by the Group Executive Committee on 3 June 2025. (Revised date: January 2026, previously June 2025)	DGCEO / GCTO	Jan-26	On Track
4	Prioritisation (1): Develop plans to respond to the Group Board's agreement that digital should be prioritised as a key enabler of strategy delivery and organisational transformation. Include as part of this training and development of Executives as sponsors of digital. The national digital boards programme has agreed to support gesh with this.	DGCEO / GCTO	TBC	TBC
5	Prioritisation (2): Develop and agree a set of digital priorities for 2025/26, including a shared view of the plan and the necessary trade-offs. A revised plan is scheduled to be presented to the Digital Governance Group in June 2025.	DGCEO / GCTO	Jul-25	On Track
6	Resilience: Agree priorities with clinical and operational colleagues. Review and apply learning from current projects.	DGCEO / GCTO	Dec-25	On Track
7	Disaster recovery: Enhance visibility and further develop horizon scanning.	DGCEO / GCTO	Dec-25	On Track
8	Artificial Intelligence: Develop a framework / approach for the deployment of AI across the Group with appropriate governance and controls as part of the digital strategy. (Revised date: March 2025, original date Nov 2025)	DGCEO / GCTO	Mar-26	On Track

Related risks on BAF and Corporate Risk Register – SGUH			
Trust	**Datix ID**	**Score**	**Summary risk description**
SGUH	CRR-803	20	ICT Disaster Recovery Plan
SGUH	CRR-1395	20	Network Outage
SGUH	CRR-2700	16	Picture Archiving Communication System (PACS)
SGUH	CRR-1292	16	Telephony
SGUH	CRR-810	15	Data Centre

Related risks on BAF and Corporate Risk Register – ESTH			
Trust	**Datix ID**	**Score**	**Summary risk description**
ESTH	CRR-1958	16	Aging / unsupported IT equipment, systems, platforms; Cybersecurity incidents
ESTH	CRR-697	16	Trust ICT Infrastructure
ESTH	CRR-734	16	St Helier Computer Room Air Conditioning

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

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

Strategic Risk	SR7	Developing new treatments through innovation and research

Current Risk Score: 12

Assurance: Reasonable

Cause	Risk	Effect
If we do not create the right culture, infrastructure and partnerships…	*…then we will not become a thriving centre for research and innovation and not attract sufficient research funding…*	*…resulting in poorer health outcomes for patients, and challenges in attracting and retaining high calibre staff.*

Strategic objective	Affordable Services Fit for the Future
Last review date	18 December 2025
Monitoring Committee	Quality Committees-in-Common
Lead Executive	Group Chief Medical Officer
Risk appetite	Seek (Significant)

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

Change since last review: ⟺

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

	Key controls *What are we already doing to manage the risk?*
1	SGUH research strategy 2019-24 continues to provide a relevant interim guide pending the development of a Group research strategy
2	Delivery arms of research for ESTH and SGUH are now one Group-wide team, restructured through the integration of corporate services
3	Leadership of research across the Group established through a new gesh Group Director for Research and Innovation
4	Partnership with medical school as part of City St George's University of London well established
5	Gesh Group and City St George's are in collaboration on the implementation of the University's restructure of the Joint Research Enterprise Service
3	Key role in London former Clinical Research Network, now Regional Research Delivery Network
4	Translational and Clinical Research Institute (TACRI) established and senior fellowships extended to ESTH
5	NIHR Clinical Research Facility designation – St George's (since 2022)

	Assurances on controls *How do we have assurance that the controls are working?*	*Control Strength*	*Line of defence*
1	Quality Committee receives reporting on progress on research annually	Reasonable	Second - Management
2	Integration implemented and reported through to the Group Executive Committee and People Committee	Reasonable	Second - Management
3	Gesh Group Director of Research and Innovation appointed on June 2025	Reasonable	Second - Management
4	Regular meetings of Joint Clinical Research Committee and new Partnership Group with the University	Reasonable	Second - Management
5	A formal contractual agreement is in development and is anticipated in Q3 2025/26	Reasonable	Second - Management
3	Leadership position: Former Group CEO chaired the former Clinical Research Network. Chair of new Regional Research Delivery Network tbc	Reasonable	First - Operational
4	TACRI Steering Group reporting to SGUH PSQG currently	Reasonable	Second - Management
5	5-year designation (from 2022) as NIHR Clinical Research Facility	Reasonable	Third - External

6	Research governance in place	6	Reporting on research through to the JRES and Quality Cttee	Reasonable	Second - Management
7	Group-wide non-medical research leadership post established & filled through corporate nursing restructure	7	Required wider Group-wide integration of non-medical research support team	Reasonable	Second - Management
8	Multiple active research portfolios at both SGUH and ESTH	8	Reporting on research through to the Quality Committee	Reasonable	Second - Management

Gaps in controls *What do we need to do to control the risk that we are not yet doing?*	
1	Both Trusts' previous research strategies have passed their life span, meaning there is no overarching strategy guiding research and innovation across the Group
2	Further work is needed to align research priorities and strategic focus across the Group (through the Group R&D Strategy)
3	Further work is needed to align research activities across the Group now that the delivery support is provided by a single Group team
4	Further work is needed to develop the strategic relationship with City St George's University
5	Not all major Group clinical activities are yet proportionately reflected in research activity
6	Research IT infrastructure needs strengthening (e.g. full Cerner PowerTrials application)
7	Secure additional NIHR funding – Research Capacity Funding & RDN Strategic Funding
8	Explore opportunities for collaborative research across the Group (through the group R&D Strategy)
9	Strengthen visibility of non-medical research and integrate non-medical research into wider Group-wide research (nursing and AHP research)

Emerging risks and opportunities *What else is relevant to how we managing the risk?*	
Emerging risks	**Emerging opportunities**
• Financial pressures impacting on research opportunities • Ability to secure research funding	• Opportunities for wider partnerships with the merged City St George's University • Opportunity for greater research leadership role in SWL

Material actions to address gaps in controls and assurances *What are we going to do, by when, to further manage and mitigate the risk?*		**Executive Lead**	**Due date**	**Progress**
1	Bring together the delivery arms of research for ESTH and SGUH on a Group-wide basis through the integration of corporate services	GCMO	Mar-25	Completed
2	Appoint a gesh Group Director of Research and Innovation	GCMO	Jun-25	Completed
3	Develop and secure Group board approval for Group-wide research and development strategy (Revised due date: June 2026, previously November 2025)	GCMO	Jun-26	On Track
4	Develop a formal contractual agreement between the gesh Group and City St George's for the Joint Research and Enterprise Service (Revised due date: March 2026, previously December 2025)	GCMO	Mar-26	On Track
5	Create more research capacity through job planning	GCMO	Jun-25	Off Track
6	Establish Secure Data Environment research data warehouse (e.g. OneLondon Programme)	GCMO	Dec-25	Off Track

Related risks on BAF and Corporate Risk Register – SGUH

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

Related risks on BAF and Corporate Risk Register – ESTH

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

Related risks on SWL Integrated Care Board BAF

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

Related risks on Surrey Downs Integrated Care Board BAF

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

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

Strategic Risk	SR8	Reducing waiting times

Current Risk Score: 20

Assurance: Limited

Cause	Risk	Effect
If we do not foster and support continuous improvement to improve the efficiency and effectiveness of our services…	*…then we will not improve flow through our hospitals…*	*…resulting in patients waiting too long for treatment, poorer clinical outcomes and risk of harm, and staff disengagement.*

Strategic objective	Right Care, Right Place, Right Time
Last review date	03 July 2025
Monitoring Committee	Finance Committees-in-Common
Lead Executive	Site Managing Directors
Risk appetite	Cautious (Moderate)

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

Change since last review

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

	Key controls *What are we already doing to manage the risk?*
1	Weekly review of key performance issues at Group Executive Committee and regular review of IQPR by GEC
2	OPEL escalation triggers updated and revised actions in place
3	Daily surge call in place with system partners to help manage capacity and to escalate delayed patients / discharges/repatriations
4	Boarding arrangements to depressurise ED with SOPs in place
5	Transfer of care functions in place to facilitate discharge
6	ED overcrowding mitigating actions in place to manage risks of corridor care
7	Validation of PTLs
8	Long length of stay MDT meetings in place (SGUH) Divisional check and challenge of LLoS. 0-21 day LOS reviews in place and 14 day/complex review panel (ESTH)
9	Regular bed management meetings to help manage flow

	Assurances on controls *How do we have assurance that the controls are working?*	*Control Strength*	*Line of defence*
1	Reports reviewed by GEC with issues escalated to Board Committees and Board as appropriate	Good	Second - Management
2	OPEL triggers regularly used and associated actions activated	Good	Second - Management
3	Used regularly to escalate concerns. Integrated TOCs at SGUH and ESTH means constant updates and escalation. SGUH and ESTH boarding SOPs in place and “live”. ESTH boarding process updated December 2025.	Reasonable	Second - Management
4	ED performance reported to Site, Exec, Committees and Board	Reasonable	Second - Management
5	In place. Integrated TOC teams established on site at both SGUH and ESTH.	Good	Second - Management
6	Actions to mitigate safety risks in ED due to overcrowding reviewed by the Quality Committees-in-Common	Reasonable	Second - Management
7	Decrease in number of patients waiting longer than 52 weeks	Good	Second - Management
8	Oversight of LoS by Site Leadership teams. Meetings in place and increased when needed.	Reasonable	Second - Management
9	Oversight of flow by Site Leadership teams	Reasonable	Second - Management

10	Regular review of activity and RTT performance at each site. Plans to improve productivity and maximise activity within agreed financial envelopes in place.	Reasonable	Second - Management
11	Mutual aid across SWL	Reasonable	Second - Management
12	Virtual wards established	Reasonable	Second - Management
13	Electronic Patient Record system on a shared domain across the gesh Group is now implemented (from May 2025)	Reasonable	Second - Management

10	Activity reviewed and monitored by SGUH and ESTH Site teams	Reasonable	Second - Management
11	Reviewed by Site and Executive teams. Managed via ICB.	Reasonable	Second - Management
12	Hospital@Home capacity used 100% in Wandsworth. Sutton virtual ward now being used at or near capacity	Reasonable	Second - Management
13	Oversight of the implementation of EPR through the EPR Programme Board and Infrastructure Committee	Reasonable	Second - Management

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

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

Emerging risks	Emerging opportunities
• Staff burnout, illness and disengagement • NHSE Tier 1 oversight • ability to physically accommodate further excess demand in site footprint (ESTH) • Social care funding uncertainty	• Focus on leftward shift announced by Govt and expected in NHS 10 Year Plan • Focus on Neighbourhood Health • Local place-based alliances

Material actions to address gaps in controls and assurances *What are we going to do, by when, to further manage and mitigate the risk?*		**Executive Lead**	**Due date**	**Progress**
1	Put in place enhanced arrangements and oversight of ED safety in the context of overcrowding and corridor care	Site MDs	Dec-24	Completed
2	Implementation of electronic patient record system across the Group on a shared domain with SGUH	GCEO and EPR SRO	May-25	Completed
3	Utilising the capacity of EPR to support improvements in care	Site MDs	May-26	On Track
4	Implementation of actions to respond to staff concerns in EDs	Site MDs	May-26	On Track
5	Implementation of partial booking light for elective care at SGUH to support reduction in waiting times – expected to reduce hospital initiated cancellations from >40% to <25%	MD-SGUH	Mar-26	On Track
6	Collaboration with South West London & St George's Mental Health Trust and Surrey and Borders Partnership NHS FT in relation to patients with mental health issues attending EDs.	Site MDs	Jul-26	On Track
7	Confirm funding requirements along with productivity opportunities to support reducing waiting times and meeting operational performance standards in 2026/27	Site MDs	Apr-26	On Track
8	Delivery of transformation programme workstream on Transforming Non-Elective Care	MD-SGUH	TBC	TBC
9	Delivery of transformation programme workstream on Transforming Outpatients and Developing new models of care	MD-ESTH	TBC	TBC

Related risks on BAF and Corporate Risk Register – SGUH

Trust	Datix ID	Score	Summary risk description
SGUH	CRR-2393	20	Regularising flow
SGUH	CRR-2240	20	Long waits for cardiology procedures
SGUH	CRR-2903	20	Emergency Department Overcrowding
SGUH	CRR-2664	16	Cancellation of elective & inpatient vascular patients

Related risks on BAF and Corporate Risk Register – ESTH

Trust	Datix ID	Score	Summary risk description
ESTH	CRR-1942	20	Waiting times
ESTH	CRR-1943	16	Patient flow
ESTH	CRR-1946	20	Cancer Diagnostics Waiting Times
ESTH	CRR-1948	16	Caring for adult mental health patients in ED

SGUH	CRR-1852	16	Hybrid Theatres fragility

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

Related risks on Surrey Downs Integrated Care Board BAF	
Score	**Summary risk description**
16	Capacity in our Urgent and Emergency Care Services

Strategic Risk	SR9	Improving patient safety and reducing avoidable harm

Current Risk Score: 20

Assurance: Limited

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

Strategic objective	Right Care, Right Place, Right Time
Last review date	18 December 2025
Monitoring Committee	Quality Committees-in-Common
Lead Executive	GCMO / GCNO
Risk appetite	Cautious (Moderate)

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

Change since last review: ⟺

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

Key controls *What are we already doing to manage the risk?*		Assurances on controls *How do we have assurance that the controls are working?*	*Control Strength*	*Line of defence*
1	Quality governance structures and processes established at Group and Site levels with processes mapped and documented	Internal reporting to Site, Executive, Committees, and Group Board. Quality & safety concerns raised through executive-led Raising Concerns Oversight & Triangulation Group	Reasonable	Second - Management
2	Development of an Integrated Maternity Improvement Plan	Plan coordinates all actions into a single plan, which is monitored through gesh Quality Group and Quality Committee	Reasonable	Second - Management
3	PSIRF framework has been fully implemented across the Group	Oversight of PSIs by Mortality Monitoring groups and regular reporting to gesh Quality group and Quality Committee	Reasonable	Second - Management
4	Safety data established as core part of Integrated Quality and Performance Report	Safety data reviewed regularly by Site, Executive Quality Committee and Group Board. Summary Hospital-level Mortality Indicator for ESTH improved to "as expected" since May 2025 and for SHUGH improved to "lower than expected" since March 2025	Good	Second - Management
5	Established governance on quality impact assessments of cost improvement plans	QIAs process agreed and individual QIAs reviewed by Site and Executive, with Quality Committee oversight. Cumulative impact of CIPs approved by Group QIA also tracked.	Reasonable	Second - Management
6	Governance and reporting on learning from deaths established	Regular reporting to Quality Committee and Group Board	Good	Second - Management
7	Established clinical audit plan	Reporting on clinical audit plans to Site quality groups and to Quality Committee	Good	Second - Management

8	Establishment of Group-wide functions across Corporate Nursing and Corporate Medical directorates to provide support across gesh		
9	Established ward accreditation programme		
10	Group-wide infection prevention and control governance in place		
11	Influenza and Covid vaccination programme		
12	Commissioned external quality reviews by Royal Colleges and other national bodies		
13	Implementation of a Shared Electronic Patient Record system across the gesh Group in May 2025		

8	Provision of integrated and standardised reporting to gesh Quality Group and Quality Committees	Reasonable	Second - Management
9	Reporting on ward accreditation through IQPR	Reasonable	Second - Management
10	Regular reporting on IPC to Executive, Quality Committee	Good	Second - Management
11	External NHS England data on vaccination rates – compliance rates low but among the best compliance rates in London	Weak	Third - External
12	Tracking action plans developed in response to external reviews	Reasonable	Third - External
13	Oversight of EPR implementation and post-implementation through EPR Programme Board and Infrastructure Committee	Reasonable	Second - Management

Gaps in controls *What do we need to do to control the risk that we are not yet doing?*	
1	Flow through hospitals, discharge and pressures on ED
2	Safety culture, including culture of psychological safety and raising concerns
3	Systematic learning from Never Events: Insufficient evidence in some areas that learning has been embedded
4	Visibility of Getting It Right First Time (GIRFT) findings, data and actions
5	Consistent delivery of fundamentals of care
6	ITU bed demand may exceed capacity at SGUH
7	Out-of-date clinical policies and inconsistency across Group
8	Quality of the Trusts' estates

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

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

Material actions to address gaps in controls and assurances *What are we going to do, by when, to further manage and mitigate the risk?*		**Executive Lead**	**Due date**	**Progress**
1	Commence implementation of Patient Safety Incident Response Framework across the Group in phases	GCMO/GCNO	Mar-24	Completed
2	Develop and secure Group Board approval of new Group quality and safety strategy	GCMO/GCNO	Jul-24	Completed
3	Commence reporting of concerns raised by staff through to the Quality Committee	GCCAO	Dec-24	Completed
4	Map the Quality Governance architecture across the Group to ensure clarity of structures, processes and flows	GCMO/GCNO	Apr-25	Completed
5	Implement strategic initiative on developing a shared electronic patient record across the Group	GCEO	May-25	Completed
6	Develop a Quality & Safety Governance Improvement Plan and agreed this through Quality Committee	GCMO/GCNO	Jun-25	Completed
6	Implement to agreed Quality & Safety Governance Improvement Plan	GCMO/GCNO	Mar-26	Off Track
7	Implement Maternity Improvement Plan	MD-SGUH	Dec-25	On Track
8	Develop and implement Group-wide approach for dissemination of learning on patient safety	GCMO/GCNO	Dec-25	Off Track
6	Bring together and strengthen maternity governance arrangements together across the Group (Extended to April 2026 when new Group Chief Midwifery Officer is scheduled to take up post and new Clinical Strategy and Standards Group for maternity is in place)	GCNO	Apr-26	On Track
8	Implement new Medium Term Plan Transformation programme workstream on developing a Quality Management System	DGCEO	TBC	TBC

Related risks on BAF and Corporate Risk Register – SGUH			
Trust	**Datix ID**	**Score**	**Summary risk description**
SGUH	CRR-2923	20	Emergency Department Overcrowding
SGUH	CRR-2393	20	Regularising Flow
SGUH	CRR-2976	16	Maternity services
SGUH	CRR-2240	20	Elective cardiology -long waits
SGUH	CRR-1862	16	Hybrid theatres fragility

Related risks on BAF and Corporate Risk Register – ESTH			
Trust	**Datix ID**	**Score**	**Summary risk description**
ESTH	CRR-1942	20	Waiting times
ESTH	CRR-1943	16	Patient flow
ESTH	CRR-1946	20	Cancer diagnostic waits
ESTH	CRR-1948	16	Caring for adult mental health patients in ED
ESTH	CRR-1938	15	Out of Hours Services

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

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

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

Strategic Risk	SR10	Improving patient experience

Cause	Risk	Effect
If we do not equip our staff to make improvements in their services and build effective relationships with patient groups…	*…then we will not deliver improvements in the quality, effectiveness and efficiency of our services…*	*…resulting in lower quality of care, increased risk of harm, and less efficient services.*

Current Risk Score: 16

Assurance: Limited

Strategic objective	Right Care, Right Place, Right Time
Last review date	18 December 2025
Monitoring Committee	Quality Committees-in-Common
Lead Executive	Group Chief Nursing Officer
Risk appetite	Open (High)

Risk Score		Impact	Likelihood	Overall Risk Score	Assurance rating
Inherent	Jan-24	4	5	20	Limited
Current	Jan-26	4	4	16	Limited
Target	Mar-26	4	3	12	Good

Change since last review: ⇔

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

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

	Assurances on controls *How do we have assurance that the controls are working?*	*Control Strength*	*Line of defence*
1	Reporting on this through quality management forums and in patient experience reporting to Quality Committee.	Reasonable	Second - Management
2	Reporting of complaints to quality management forums and in complaints and PALS reporting to Quality Committee.	Reasonable	Second - Management
3	Friends & Family Test and complaints data presented to quality management forums, Quality Committee and Group Board	Reasonable	Second - Management
4	Presented to quality management forums & Quality Committee	Reasonable	Second - Management
5	Veterans Covenant Healthcare Alliance accreditation for ESTH and SGUH	Good	Third - External
6	Patient story taken at each group Board meeting	Reasonable	Second - Management
7	Oversight of EPR implementation and post-implementation through EPR Programme Board and Infrastructure Committee	Reasonable	Second - Management

Gaps in controls *What do we need to do to control the risk that we are not yet doing?*	
1	Develop strategic approach to improving patient engagement
2	Improve outpatients experience
3	Improve data collection relating to patients with protected characteristics
4	Improve complaints performance (quality of responses)
5	Recruitment of additional volunteers
6	Ensure audit compliance with Accessible Information Standard
7	Raise profile of patient engagement groups
8	Identify and disseminate good practice across teams on patient engagement

Emerging risks and opportunities *What else is relevant to how we managing the risk?*	
Emerging risks	**Emerging opportunities**
• Proposals to remove Councils of Governors as link to membership including patient community	• Focus on patient experience as part of the NHS 10 Year Plan

Material actions to address gaps in controls and assurances *What are we going to do, by when, to further manage and mitigate the risk?*		Executive Lead	Due date	Progress
1	Strengthen complaints teams through Group-wide corporate restructure	GCNO	May-24	Completed
2	Develop and secure Group Board approval for quality and safety strategy, including strategic vision for patient engagement	GCMO/GCNO	Jul-24	Completed
3	Deliver strategic initiative on a shared electronic patient record across the Group	GCEO	May-25	Completed
4	Develop staff training and support for managers to gain real time data for their areas to support and promote patient involvement	GCNO	Mar-26	On Track
5	Improve complaints response times	GCNO	Mar-26	On Track
6	Deliver Medium Term Plan transformation programme workstream on developing a Quality Management System	DGCEO	TBC	TBC
7	Deliver Medium-Term Plan transformation programme workstream on Transforming Outpatients	MD-ESTH	TBC	TBC

Related risks on BAF and Corporate Risk Register – SGUH

Trust	Datix ID	Score	Summary risk description
No patient experience risks on the CRR.			

Related risks on BAF and Corporate Risk Register – ESTH

Trust	Datix ID	Score	Summary risk description
No patient experience risks on the CRR.			

Related risks on SWL Integrated Care Board BAF

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

Related risks on Surrey Downs Integrated Care Board BAF

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

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

Strategic Risk	SR11	Tackling health inequalities

Current Risk Score: 16

Assurance: Reasonable

Cause	Risk	Effect
If we do not pursue a more strategic and systematic approach to tackling health inequalities in collaboration with our local partners and act as an anchor institution…	*…then we will fail to play our part in improving the health of our local population…*	*…resulting in less equitable access to care and poorer outcomes.*

Strategic objective	Right Care, Right Place, Right Time
Last review date	18 December 2025
Monitoring Committee	Quality Committees-in-Common
Lead Executive	Group Chief Medical Officer
Risk appetite	Open (High)

Risk Score		Impact	Likelihood	Overall Risk Score	Assurance rating
Inherent	Jan-24	4	5	20	Limited
Current	Jan-26	4	4	16	Reasonable
Target	Mar-26	4	3	12	Reasonable

Change since last review

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

Key controls *What are we already doing to manage the risk?*	
1	Group strategy identified health inequalities as key priority for Group
2	Group Health Inequalities Programme is aligned with 2025 national ICB Blueprint and NHSE Statement of information on health inequalities, and is aligning with priorities at Place in local Sector
3	Initial analysis of health inequalities in ED and outpatients across the Group completed. Analysis of sector/community priorities by borough/place also completed.
4	Health Inequalities plan in place with short term and longer term workstreams.
5	A gesh Community of Practice is established with a programme of meetings and a repository of resources
6	Health Inequalities Steering Group established
7	SGH Charity funded Health Equity Lead (clinical, 2 PAs for 3 years) has been in place at SGUH since April 2025 and ESTH Charity funded Health Equity Lead at ESTH has been in place since August 2025.

	Assurances on controls *How do we have assurance that the controls are working?*	*Control Strength*	*Line of defence*
1	Reporting arrangements on progress established through GESH Quality Group and Quality Committee	Reasonable	Second - Management
2	Integrated into Group-wide approach to addressing Health Inequalities	Reasonable	Second - Management
3	Reviewed and considered by Quality Committee, and integrated into wider work programme on HI	Reasonable	Third - External
4	Reporting arrangements on progress established through GESH Quality Group and Quality Committee	Reasonable	Second - Management
5	Structured input into wider HR programme	Reasonable	Second - Management
6	Reporting arrangements on progress established through GESH Quality Group and Quality Committee	Reasonable	Second - Management
7	Inputs into wider HI Programme	Reasonable	Second - Management

8	A new Group Head of Patient Inclusion has been appointed (June 2025) in the People Directorate to support the Public Sector Equality Duty and Health Inequalities Programme	8	Inputs into wider HI Programme	Reasonable	Second - Management
9	A "Data Democratisation" programme is underway to strengthen data sharing between the SWL ICB and the gesh Group. Data sharing agreement with SWL ICB in place to improve ethnicity data quality.	9	Analysis of data through HR Steering Group	Reasonable	Second - Management
10	Health Inequalities Impact Assessment process now embedded in Group and Site Quality Impact Assessments	10	Regular reporting of QIA outputs to Finance & Performance Committee and to Quality Committee	Reasonable	Second - Management

Gaps in controls *What do we need to do to control the risk that we are not yet doing?*	
1	Improve quality of data collection in relation to ethnicity and other important demographic or protected characteristic information
2	Developing reporting on health inequalities (evidenced-based reporting on impact)
3	Reporting of patient health inequalities in our PSED report is not as clear as staff equality, diversity and inclusion

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

Material actions to address gaps in controls and assurances *What are we going to do, by when, to further manage and mitigate the risk?*		**Executive Lead**	**Due date**	**Progress**
1	Establish a GESH Group Health Inequalities Steering Group reporting into the newly formed GESH Quality Group	GCMO	Apr-24	Completed
2	Take up offer from Optum UK, leading health services and innovation company, to provide free development sessions on health inequalities	GCMO	Dec-24	Completed
3	Establish GESH Community of Interest / Health Inequalities Forum for service areas to share learning, good practice and resources	GCMO	Apr-24	Completed
4	Improve research study recruitment to ensure patients from minority ethnic backgrounds are appropriately represented in clinical research	GCMO	Dec-24	Completed
5	Provide regular health inequalities update report to the Quality Committee	GCMO	Mar-24	Completed
6	Include EDI team input into HI Steering Group	GCMO	Mar-25	Completed
7	Launch "Data Democratisation" programme with SWL ICB	GCMO	Mar-25	Completed
8	Address approach to unplanned and emergency care high intensity service users (due date extended for 3 months to March 2026)	GCMO/GCNO	Mar-26	On Track
9	Improve the quality of the data recording by, and data sets used, across the Group, including by developing a PowerBI dashboard	GCMO	Dec-25	On Track
10	Identify priority areas in planned care waiting lists for initial focus	GCMO	Dec-25	On Track
11	Adapt clinical audit and effectiveness to shed light on health inequalities as manifested by differences in access or outcomes (due date extended for 3 months to March 2026)	GCMO	Mar-26	On Track
12	Strengthen patient involvement to recruit service users who can bring particular perspectives on inequalities to help shape services	GCMO	Dec-25	On Track
13	Develop options and plans for gesh acting as an Anchor Institution.	GCMO	Dec-25	On Track

Related risks on BAF and Corporate Risk Register – SGUH

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

Related risks on SWL Integrated Care Board BAF

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

Related risks on BAF and Corporate Risk Register – ESTH

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

Related risks on Surrey Downs Integrated Care Board BAF

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

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

Strategic Risk	SR12	Putting staff experience and wellbeing at the heart of what we do

Current Risk Score: 20

Assurance: Limited

Cause	Risk	Effect
If we do not give our staff the tools and support they need or develop high performing teams and outstanding leaders and managers at every level…	*…then our staff will be unable to perform to their best and may not feel fairly treated…*	*…resulting in services that are less efficient, poorer quality of care for patients, and difficulties in recruiting and retaining high calibre staff.*

Strategic objective	Empowered, Engaged Staff
Last review date	11 December 2025
Monitoring Committee	People Committees-in-Common
Lead Executive	Group Chief People Officer
Risk appetite	Cautious (Moderate)

Risk Score		Impact	Likelihood	Overall Risk Score	Assurance rating
Inherent	Jan-24	4	5	20	Limited
Current	Jan-26	4	5	20	Limited
Target	Mar-26	4	4	16	Reasonable

Change since last review: ⟺

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

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

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

Gaps in controls *What do we need to do to control the risk that we are not yet doing?*	
1	Strengthening Leadership development for managers
2	Strengthening capacity of Employee Relations particularly at SGUH
3	Quality of staff appraisals, and linking of appraisals and objectives to Group strategy at every level
4	Quality of the estates and digital infrastructure impacting on staff experience
5	Up-to-date and accessible HR policies refreshed on Group-wide basis
6	Development of a Quality Management System for continuous improvement across the Group
7	Action plan to respond to CQC Well Led actions for SGUH (relating to culture and EDI)

Emerging risks and opportunities *What else is relevant to how we managing the risk?*	
Emerging risks	**Emerging opportunities**
• Lower levels of staff engagement through NHS Staff Survey 2025	• Results of 2025 NHS Staff Survey

Material actions to address gaps in controls and assurances *What are we going to do, by when, to further manage and mitigate the risk?*		Executive Lead	Due date	Progress
1	Develop new two-year People Strategy in support of the Group strategy	GCPO	May-24	Completed
2	Develop and agreed through the People Committee an implementation plan for the People Strategy	GCPO	Dec-24	Completed
3	Develop Group-wide talent management strategy	GCPO	Feb-25	Completed
4	Implement Group-wide talent management strategy	GCPO	TBC	TBC
5	Implement fully the Employee Relations Service Improvement Plan (completion date revised from June 2024 to March 2026)	GCPO	Mar-26	On Track
6	Conclude restructure of HR / People Functions at both Trusts to establish Group-wide function	GCPO	Mar-26	On Track
7	Conclude the redesign of remaining HR policies on a Group-wide basis to ensure these are up-to-date and easily accessible for staff (completion date revised to March 2026; original date June 2025)	GCPO	Mar-26	On Track
8	Develop transformation programme workstreams on Quality Management System and Organisational Form	GDCEO	Jan-26	On Track
9	Implement changes to appraisals and objective setting to align with new Group strategy	GCPO	TBC	TBC
10	Develop and implement a Group-wide leadership development programme at every level & across professions	GCPO	Jan-26	On Track

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

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

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

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

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

Strategic Risk	SR13	Fostering an inclusive culture that celebrates diversity

Current Risk Score: 20

Assurance: Limited

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

Strategic objective	Empowered, Engaged Staff
Last review date	11 December 2025
Monitoring Committee	People Committees-in-Common
Lead Executive	Group Chief People Officer
Risk appetite	Cautious (Moderate)

Risk Score		Impact	Likelihood	Overall Risk Score	Assurance rating
Inherent	Jan-24	4	5	20	Limited
Current	Jan-26	4	5	20	Limited
Target	Mar-26	4	4	16	Reasonable

Change since last review: ⟺

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

	Key controls *What are we already doing to manage the risk?*
1	Group People Strategy approved by the Group Board
2	Site-based Culture Equity and Inclusion Boards and Group Culture Forum established
3	Workforce Race Equality Standard Action Plan developed
4	Workforce Disability Equality Standard Action Plan developed
5	Group-wide framework for raising concerns in place reflecting national guidance, with FTSU Guardians in place across the Group
6	Raising Concerns Oversight and Triangulation Group established
7	Staff networks in place at both Trusts, with Executive sponsorship refreshed
8	NHS Staff Survey Results reviewed systematically with action plans developed
9	Established values in place at each Trust

	Assurances on controls *How do we have assurance that the controls are working?*	*Control Strength*	*Line of defence*
1	Approved by the Group Board in May 2024, with monitoring of progress through the People Committees-in-Common	Good	Second - Management
2	Updates reported through Site SLTs and Group Executive	Reasonable	Second - Management
3	Action Plan in place. EDI action plan agreed by Board. CQC Well Led findings at SGUH critical of progress.	Partial	Third - External
4	Action Plan in place. EDI action plan agreed by Board and monitored through People Committee	Partial	Third - External
5	Regular reporting of concerns raised through FTSU considered at People Committee and Group Board. CQC Well Led findings at SGUH critical of speak up culture.	Partial	Third - External
6	Reporting of key issues from RCOTG to Group Executive	Reasonable	Second - Management
7	Networks meet regularly and programme of Board engagement with network chairs. Executive sponsorship refreshed.	Reasonable	Second - Management
8	Review of NHS Staff Survey results through Executive, People Committee and Group Board	Reasonable	Second - Management
9	CQC Well Led Report at SGUH critical of embedding of values	Partial	Third - External

Gaps in controls *What do we need to do to control the risk that we are not yet doing?*	
1	Respond to the cultural and EDI issues identified in the CQC Well Led inspection at SGUH
2	Respond to the speak up challenges identified in the CQC Well Led inspection at SGUH
3	Address the lack of diversity at Board level and senior manager levels (from Band 8b and up)
4	Address lack of alignment of values across the two Trusts within the Group
5	Address issues around bullying and harassment identified in successive NHS Staff Surveys
6	Strengthen approach to addressing violence and aggression against staff
7	Plans for developing transforming the way we work as a critical enabler of the delivery of the strategy

Emerging risks and opportunities *What else is relevant to how we managing the risk?*	
Emerging risks	**Emerging opportunities**
• Scale of cultural challenges identified by CQC at SGUH	• Board recruitment in 2026/27 • NHS Staff Survey Results 2025 (available from Jan / Feb 2026)

Material actions to address gaps in controls and assurances *What are we going to do, by when, to further manage and mitigate the risk?*		Executive Lead	Due date	Progress
1	Develop and implement a two-year People strategy in support of the Group Strategy	GCPO	May-24	Completed
2	Develop and implement single Group-wide WRES and WDES action plans	GCPO	Oct-24	Completed
3	Develop Group-wide Raising Concerns policy in line with new national raising concerns policy	GCCAO	Jan-25	Completed
4	Clarify Executive sponsorship of staff networks and align networks arrangements across the Group	GCPO	Feb-25	Completed
5	EDI Action Plan approved by Group Board	GCPO	Feb-25	Completed
6	Establish Inclusion Board to help promote greater diversity in the leadership community across gesh (postponed to April 2026)	GCPO	Apr-26	On Track
7	Develop a Group-wide Raising Concerns strategy in line with good practice from NGO building on SGUH FTSU strategy (Date revised to Jul-26 to reflect CQC Well Led findings)	GCCAO	Jul-26	On Track
8	Implement the Board-approved Talent Management Programme (timeline tbc)	GCPO	TBC	TBC
9	Take forward transformation programme workstreams on developing a Quality Management System and Organisational Form	DGCEO	TBC	TBC
10	Develop plans for improvement of Trusts' positions in relation to the NHSE Violence Prevention and Reduction Standard	GCIFEO	Mar-26	Off Track
11	Develop a set of aligned values across the Group	GCPO	TBC	TBC

Related risks on BAF and Corporate Risk Register – SGUH

Trust	Datix ID	Score	Summary risk description
SGUH	CRR-1967	16	Diversity in senior management positions
SGUH	CRR-881	16	Bullying and harassment of staff
SGUH	CRR-1978	16	Raising concerns
SGUH	CRR-2532	16	Employee relations

Related risks on BAF and Corporate Risk Register – ESTH

Trust	Datix ID	Score	Summary risk description
ESTH	CRR-1933	16	Protected characteristics
ESTH	CRR-1934	16	Staff engagement
ESTH	CRR-2070	16	Raising concerns
ESTH	CRR-2073	20	Harmonisation of staff T&Cs following TUPE

Related risks on SWL Integrated Care Board BAF

Score	Summary risk description
16	Workforce capacity wellbeing and availability

Related risks on Surrey Downs Integrated Care Board BAF

Score	Summary risk description
12	ICB Workforce Instability

Strategic Risk	SR14	Developing tomorrow's workforce

Cause	Risk	Effect
If we do not retain, train and transform our workforce for the future…	*…then we will not be able to support the delivery of new models of care, encounter shortages in our workforce, and increase our reliance on agency staff…*	*…resulting in lower quality and less efficient services for patients, and higher staffing costs.*

Current Risk Score: 20

Assurance: Limited

Strategic objective	Empowered, Engaged Staff
Last review date	11 December 2025
Monitoring Committee	People Committees-in-Common
Lead Executive	Group Chief People Officer
Risk appetite	Open (High)

Risk Score		Impact	Likelihood	Overall Risk Score	Assurance rating
Inherent	Jan-24	4	5	20	Limited
Current	Jan-26	4	5	20	Limited
Target	Mar-26	4	4	16	Reasonable

Change since last review: ⇔

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

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

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

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

Emerging risks and opportunities *What else is relevant to how we managing the risk?*	
Emerging risks	**Emerging opportunities**
• Financial pressures	• Create a competitive advantage through a more engagement people experience • Use workforce analytics to make the most of our talent • Use of HR and technology to improve people experience • Engage easily with flexible talent • Relationship with City University

Material actions to address gaps in controls and assurances *What are we going to do, by when, to further manage and mitigate the risk?*		Executive Lead	Due date	Progress
1	Develop new two-year People Strategy as a sub-strategy of the Group strategy	GCPO	May-24	Completed
2	Develop and agree through the People Committee an implementation plan for the People Strategy	GCPO	Dec-24	Completed
3	Develop Group-wide talent strategy	GCPO	Feb-25	Completed
4	Implement Group-wide talent strategy	GCPO	TBC	TBC
4	Review appraisals process to link appraisals to CARE framework (completion date revised to February 2027; was December 2025)	GCPO	Feb-27	On Track
5	Increase completion rate for and quality of appraisals	GCPO	Dec-25	On Track
6	Develop and implement a Group-wide leadership development programme at every level & across professions	GCPO	Jan-26	On Track
7	Review and revise HR policies on a Group-wide basis to ensure these are up-to-date and easily accessible for staff (revised date: March 2026, was Feb-25)	GCPO	Mar-26	On Track

Related risks on BAF and Corporate Risk Register – SGUH

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

Related risks on BAF and Corporate Risk Register – ESTH

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

Related risks on SWL Integrated Care Board BAF

Score	Summary risk description
16	Workforce capacity wellbeing and availability

Related risks on Surrey Downs Integrated Care Board BAF

Score	Summary risk description
12	ICB Workforce Instability

Group Board

Meeting on Thursday, 08 January 2026

Agenda Item	7.1	
Report Title	**Group Healthcare Associated Infection Report**	
Executive Lead(s)	Elaine Clancy, Group Chief Nursing Officer and Director of Infection Prevention and Control	
Report Author(s)	**Prodine Kubalalika, Group Clinical Director, Infection Prevention and Control**	
Previously considered by	Quality Committees gesh Quality Group	27 November 2025 13 November 2025
Purpose	**For Assurance**	

Executive Summary

This paper provides a quarterly update on Healthcare Associated Infections (HCAIs) and key issues and or concerns arising in Infection Prevention and Control (IPC) across the health group. In Quarter 2, the key issues to highlight are summarised below:

C.difficile Infections (CDI): We continue to see a substantial increase in the number of healthcare acquired CDI infections across the group. This is in contrast with the consistent decline and low-level fluctuations in CDI cases observed prior to the COVID-19 pandemic. Cases are reviewed using the SWARM template; however extensive reviews undertaken highlights potential changes in diagnostic testing, data collection practices and other multifactorial aspects contributing to the rise. No new/emerging themes identified.

Incidents/Outbreaks: Consistent with national reports and local prevalence, a downward shift was noticed for both COVID-19 and Influenza cases in Quarter 2, with a slight increase in cases for both seen at the end of September resulting in bay closures with minimal disruption to operational capacity.

ESTH site: Water safety issues on the St Helier site with legionella and Pseudomonas positive results isolated in C and E Block. Point of use filters (POUs) remain in place as part of mitigation to reduce risk to both patients and staff. This has been added to the corporate risk register due to the vulnerability of patients (neonatal and haematology units) housed in these blocks.

A Carbapenemase-producing Enterobacterales (CPE) outbreak affecting 5 positive patients originated from routine admission screening for 2 patients on the Frailty hub (STH). The incidents generated a total of 43 contacts of whom 3 came back as positive. All patients were clinically well and have since been discharged. No further cases reported since July.

SGUH site: A *C. difficille* outbreak affecting 7 patients was declared on Richmond ward between April to July 2025. An improvement action was developed which included decanting of the bays to enable

enhanced decontamination with hydrogen peroxide vapour (HPV) disinfection. No further cases have been reported to date.
An outbreak involving 3 babies colonised with MRSA was reported on Special Care Baby Unit (SCBU) between 18th and 25th August 2025. Ribotyping of the three isolates reported that two were identical, indicating likely transmission. No further positive cases have been identified since 25th August and all babies are clinically well with one having been discharged.

Group IPC Policies: The work to standardise policies and practices across the group continues, with 13 merged/group policies having been written and approved/going through the ratification process.

Group Patient Leaflets: All patient leaflets have been reviewed and merged into group; however, these have not been published as waiting for the group patient leaflet to be circulated.

Action required by Group Board

The Board is asked to:

- Receive the Healthcare Associated Infection (Infection Control) Report from Sites and Group for assurance
- Make any necessary recommendations

Committee Assurance

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

Appendices

Appendix No.	Appendix Name
Appendix 1	Quarterly Group Infection Prevention and Control Report: July-September 2025

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

The Health and Social Care Act (2008): The Hygiene Code - code of practice on the prevention and control of infections. (Updated 2023) https://www.gov.uk/government/publications/the-health-and-social-care-act-2008-code-of-practice-on-the-prevention-and-control-of-infections-and-related-guidance

Health and Social Care Act (2008) Regulated Activities Regulations 2014: Regulation 12 Safe Care and Treatment

Equality, diversity and inclusion implications

No issues to consider

Environmental sustainability implications

No issues to consider

Group Healthcare Associated Infection Report
Group Board, 08 January 2026

1.0 Purpose of paper

This paper provides a quarterly update on HCAIs and key issues/ concerns arising in Infection Prevention and Control (IPC) across the Health Group.

2.0 Summary of key performance measures

The paper supplements the IPC key performance measures and summary contained in the monthly Integrated Performance Reports for both Trusts.

3.0 Key Issues:

3.1 *C. difficile Infections* (CDI): CDI cases continue to be high and above the locally set trajectories across the group. The IPC team have reviewed and updated the CDI case review template to align more with the SWARM template, to enable to do undertake more robust multi-disciplinary reviews and undertake thematic analysis.

The IPC teams continue to undertake vigilant surveillance, promote antimicrobial stewardship and enforcing strict infection control measures with learning shared in divisional meetings and huddles.

ESTH: During Q2, there were 17 Trust-attributed CDI cases, 12 Healthcare Onset Healthcare Associated (HOHA) and 5 Community Onset Healthcare Associated (COHA). TD 35 against a national trajectory of 63 cases. In comparison with Q1 2025/26, there has not been a significant difference with Q1 reporting a total of 18 cases.

All cases were reviewed using the PSIRF SWARM model to assess if there was any learning and or lapses in care. There were no lapses in care reported in Q2.

Samples are routinely sent to the reference laboratory for ribotyping and none of the cases where similar suggesting there is no same strain that is circulating in our hospitals or evidence of cross infection.

SGUH: During Q2, there were 16 CDI cases (10 HOHA; 6 COHA), YTD 32 against a national trajectory of of 43. Ribotyping undertaken for all cases to identify potential cross transmission.

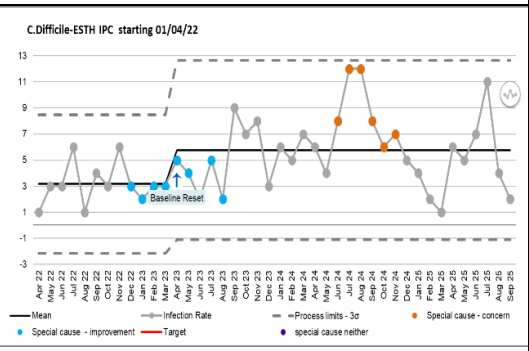
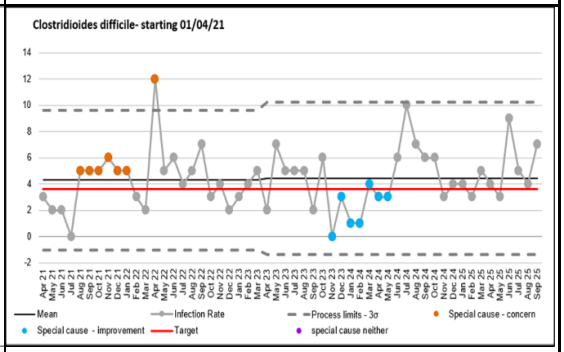
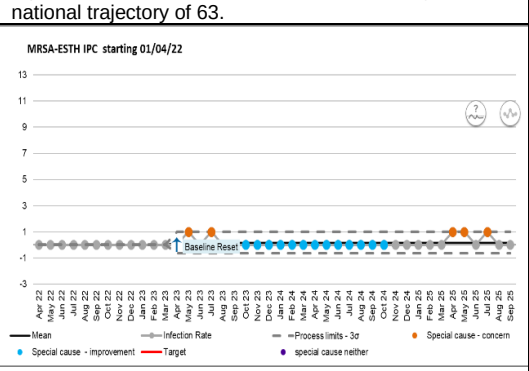
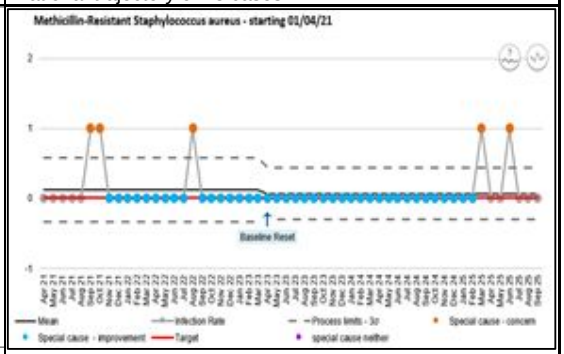
C. difficille outbreak (Richmond ward): An outbreak affecting 7 patients was declared on Richmond between April to July 2025. Ribotyping of the samples established that cross transmission had occurred. Incident meetings were held, and an improvement action plan was developed to manage the incident and draw any learning. The action plan highlighted the IPC challenges related to the integrity of the environment and cleaning.

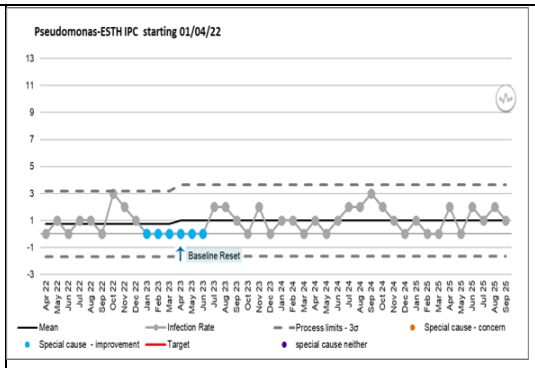
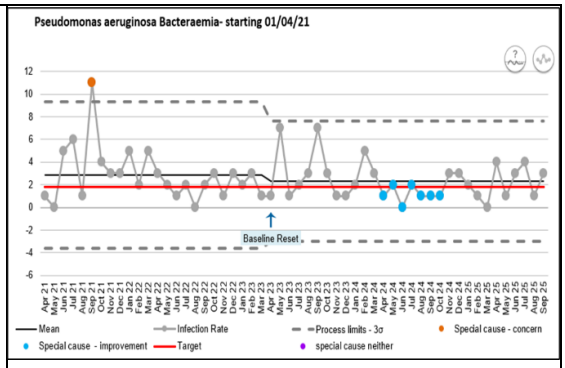
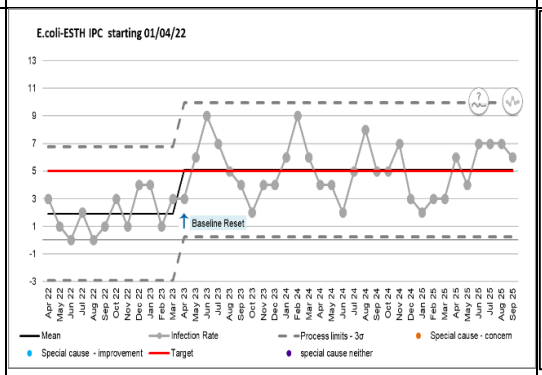
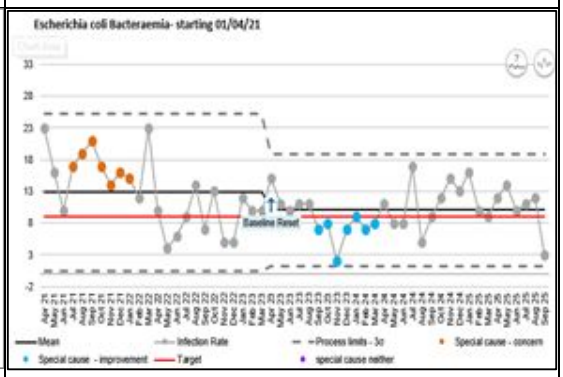
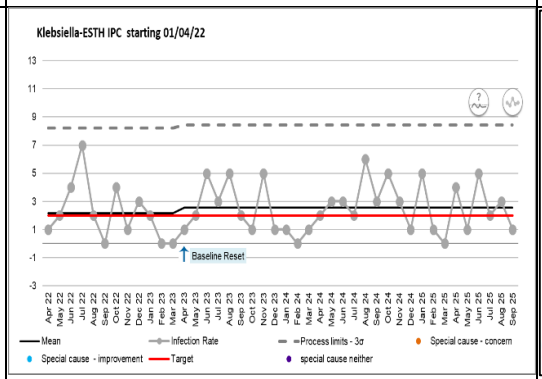
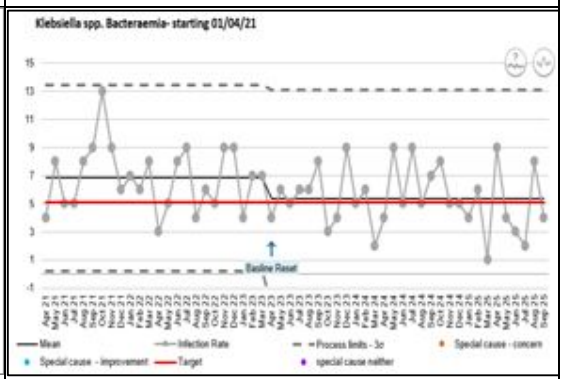
Decanting of all the bays and single rooms to enable enhanced decontamination with hydrogen peroxide vapour (HPV) disinfection was undertaken as part of the action. The site leadership team have agreed for some funding to be allocated to undertake some renovations to the ward but this yet to be commissioned.
All patients were duly treated with no complications. At the time of writing this report, no further cases have been isolated since July.

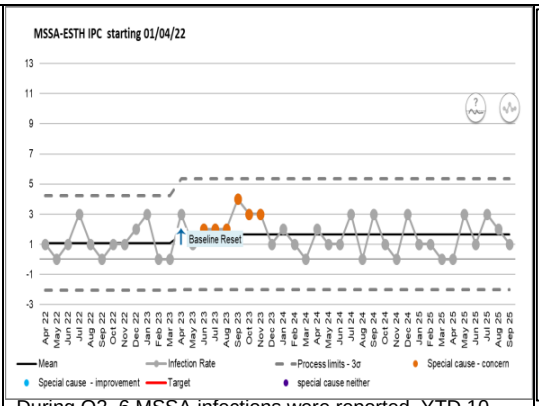
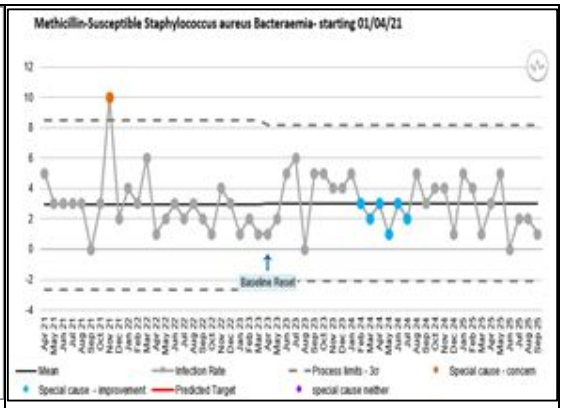
CDI numbers continue to increase across the health group, and this reflects the changing CDI epidemiology at national level. A groupwide CDI action plan has been developed and due to be presented to relevant governance channels.

4.0 Healthcare Associated Infections

The table below summaries the quarterly HCAI position at site level. Efforts continue to achieve the aim of reducing the number of gram-negative infections. The IPC team continues to consistently monitor trends and new local/national initiatives to prevent and manage these infections.

HCAI	ESTH	SGUH
C. *difficile* infection (CDI)		
	During Q2, there were 17 Trust-attributed CDI cases reported, 12 HOHA, 5 COHA. YTD 35 cases against a national trajectory of 63.	During Q2, there were16 Trust-attributed CDI cases reported, 10 HOHA; 6 COHA. YTD 32 cases against a national trajectory of 43 cases.
MRSA bloodstream infection		
	1 MRSA bloodstream infection reported in Q2. YTD is 3 against a threshold of zero avoidable cases. All 3 cases were deemed unavoidable case.	No MRSA bloodstream infection reported in Q2. YTD is 1

Pseudomonas aeruginosa		
	During Q2, 4 *Pseudomonas aeruginosa* bloodstream infections were reported. YTD 8 against a national threshold of 8.	During Q2, 8 *Pseudomonas aeruginosa* bloodstream infections were reported, similar to Q1. YTD 22 against a national threshold of 22.
E-coli		
	During Q2, 20 *Escherichia coli* (E. coli) bloodstream infections reported. YTD is 37 against a national threshold of 57.	During Q2, 26 *Escherichia coli* (E. coli) bloodstream infections reported, compared to 36 during Q1. YTD is 62 against a national threshold of 109.
Klebsiella spp.		
	During Q2, 6 *Klebsiella* spp. bloodstream infections reported. YTD 16 cases against a national threshold of 25.	During Q2, 14 *Klebsiella* spp. bloodstream infections reported. YTD 30 cases against a national threshold of 62.

MSSA	 During Q2, 6 MSSA infections were reported, YTD 10. There is no national trajectory for MSSA BSI.	 During Q2, 5 MSSA infections were reported, YTD 10. There is no national trajectory for MSSA BSI
Covid-19 Update	Covid-19 positive cases:186 Covid-19 deaths: 14 Nosocomial infections: 60 Nosocomial deaths: 2 **YTD positive cases: 710** **YTD nosocomial deaths: 6**	Covid-19 cases: 159 Covid-19 deaths: 12 Nosocomial infections: 54 Nosocomial deaths: 5 **YTD positive cases: 802** **YTD nosocomial deaths: 27**

5.0 Site Specific Updates

Epsom & St Helier Hospital

5.1 COVID-19: Consistent with national reports, there has been a downward trend for COVID-19 positive admissions across the group with a slight increase seen at the end of September. The health group continues to follow national testing (with some derogation to meet local needs and management guidance for COVID-19.

ESTH: In Quarter 2 there were 186 COVID-19 cases across the Trust. There were 14 COVID-19 related deaths in Quarter 2 and 2 nosocomial deaths.

5.2 Surgical Site Infections Surveillance: As per UK Health Security Agency (UKHSA), all NHS Trusts are required to undertake one mandatory SSI orthopaedic module in each financial year. The IPC team will be undertaking the fractured Neck of Femur (NOF) SSI module between October and December.

SWLEOC continues to undertake continuous orthopaedic surveillance for hips, knees, shoulder and spinal surgeries. Data reconciliation for April to June is in progress and the data will be shared when available.

5.3 Water Safety: Water safety issues on the St Helier site with legionella and Pseudomonas positive results isolated in C and E Block. Point of use filters (POUs) remain in place as part of mitigation to reduce risk to both patients and staff. This has been added to the corporate risk register due to the vulnerability of patients (neonatal and haematology units) housed in these blocks.

The Estates team are working through the action plan agreed at the Water Safety Group (WSG) including the recommendations from the external IPC subject matter experts who were commissioned to review the site. One of the key recommendations from their visit and review is the consideration of removing Thermostatic Mixing Valves (TMV) to reduce the risk of legionella. It was agreed at WSG

that this would reduce the risk in particular neonatal unit where scalding risk is minimal. However, it was agreed that a formal risk assessment should be undertaken and a briefing paper presented to site leadership and divisional team to agree with the proposed changes.

Following the recent positive results in C block (resampling from previous positive results), it was agreed at WSG to consider use of biocide treatment (silver/copper) at the main source of water, thus treating water for the whole site instead of focusing on E block only. Extra funding to undertake this at site level is required and this will be presented to SLT by the Estates team.

5.4 High Consequence Infectious Disease (HCID) Pathway: The pathways for both sites have been agreed by key stakeholders with a live exercise to test the pathway being arranged for November in collaboration with the Emergency Preparedness Resilience and Response team.

5.5 Carbapenemase-producing Enterobacterales (CPE) Outbreak: A CPE outbreak affecting 45 patients was identified on the Frailty hub (A& E STH). Due to the nature of the unit, the 2 initial positive cases generated 40 contacts who had moved across different departments across the hospital. An incident meeting was held and extensive contact tracing was undertaken to identify if cross transmission had occurred. Three new cases from the contacts who had been discharged came back as positive resulting in a total of 5 positive patients. All patients were clinically well and have since been discharged. No further cases reported since July.

St George's Hospital

5.6 COVID-19. There were 159 COVID-19 cases reported in Q2, of these 54 were nosocomial infections and 5 deaths where the patient tested positive for COVID-19 during their admission. There were two community acquired patient deaths therefore did not meet the criteria for a patient safety incident review.
During Q2, there were 2 COVID-19 outbreaks (mostly where two cases in the same bay were diagnosed with COVID-19).

5.7 MRSA Outbreak (SCBU): An outbreak involving 3 babies colonised with MRSA was reported on Special Care Baby Unit (SCBU) between 18th and 25th August 2025. Ribotyping of the three isolates reported that two were identical, indicating likely transmission. Enhanced IPC measures were put into place and no further positive cases have been identified since 25th August. At the time of writing this report, all babies are clinically well with one having been discharged.

5.8 Surgical Site Infections Surveillance: Reduction of Long Bone Fracture (April to June)
In Q2, the IPC team followed up 115 procedures and identified 2 organ space infections. The quarterly infection rate for inpatients/ readmissions is 1.7%, marginally above the national benchmark of 0.9%. The report and findings have been shared with relevant clinical leads.

5.10 Fit testing Service: The substantive role for fit testing is currently vacant and currently going through the recruitment process. Temporary bank cover for the role has been approved whilst recruitment is being conducted.

Integrated Care: Surrey Downs Health & Care and Sutton Health & Care

5.11 Sutton Health & Care Reablement Unit: No major IPC issues to report.

5.12 Surrey Downs Health and Care, Water Safety Assurance: The current documentation of water safety management by NHS Property Services does not provide adequate assurance and gaps have been identified in community bedded units Dorking and Molesey. A meeting with NHSP, ESTH site director of Estates, IPC team and senior leadership team at SHDC was held and an action plan has been drafted. The ESTH external Authorising Engineer for water has been tasked with the review of NHSP water safety plans/evidence provided as a subject matter expert. Separate assurance meetings are ongoing with IC SLT and community leads.

Mary Seacole Unit: COVID-19 outbreak was reported in September resulting in bay closures and eventually a full ward closure. An incident meeting was held, and the team managed the outbreak as per policy with no major issues/learning identified.

6.0 Group IPC Update

6.1 Group wide activity in Quarter 2 is summarised below:

Flu season: Expected to peak between December and April as per forecast by epidemiologists using Australia's flu season data. The "triple threat" of RSV, flu, and COVID is also expected. IPC winter guidance has been written and published across the group. The guidance also includes the change in seasonal respiratory testing on reverting to PCR test for respiratory virus diagnosis from October to April 2026.

SGUH IPC team have written guidance for operational/clinical teams to follow in the event of potential use of a cohort ward and prophylaxis administration for high-risk staff ahead of the flu season.

Candida auris Screening: Southwest London Pathology Services have agreed a costing for Candida auris screening as discussed at the ESTH contract meeting. At the time of writing this report, a contract meeting with St George's site is due to be held prior to implementation. Screening is already underway for inter-hospital transfers on both sites.

Flu Campaign: Preparation is underway for the flu campaign to start in October. IPC nurses on both sites are supporting with flu vaccination clinics.

Group Policies: The IPC leads across the group continue with updating/merging suitably identified policies.

Risks: Ventilation non-compliance across the group remains a risk due to the ageing buildings and lack of funding for remedial works to comply with Health Technical Memoranda (HTMs). Estates teams across the group work to an agreed prioritisation model for remedial works/allocation of available funding. It should be noted that no immediate risks to patients have been reported to date.

Risks: Water Safety remains on the risk register including Integrated Care for the bedded units, mitigations in place in identified areas with an ongoing remedial action plan.

7.0 Recommendations

7.1 The Board is asked to:

Receive for assurance the Healthcare Associated Infection (Infection Control) Report from a site and Group perspective and make any necessary recommendations.