gesh

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

Group Board

Agenda

Meeting in Public on Thursday, 05 March 2026, 11:30 – 14:50

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

Feedback from Board visits					
Time	**Item**	**Title**	**Presenter**	**Purpose**	**Format**
11:30	-	Feedback from visits to various parts of the site	Board members	-	Verbal

Introductory items					
Time	**Item**	**Title**	**Presenter**	**Purpose**	**Format**
11:50	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
11:55	1.5	Group Chief Executive Officer's Report	IGCEO	Review	Report

Strategy					
Time	**Item**	**Title**	**Presenter**	**Purpose**	**Format**
12:05	2.1	Five Year Narrative Plan 2026/27 – 2030/31	GDCEO	Note	Report

Quality and Safety					
Time	**Item**	**Title**	**Presenter**	**Purpose**	**Format**
12:15	3.1	Quality Committees Report	Committee Chair	Assure	Report
12:25	3.2	Maternity Services Report	GCNO	Assure	Report

Finance, Performance and Audit					
Time	**Item**	**Title**	**Presenter**	**Purpose**	**Format**
12:35	4.1	Finance and Performance Committees Report	Committee Chair	Assure	Report
	4.2	Finance Report – Month 10	GCFO	Review	Report
12:45	-	*Break*			
13:15	4.3	Integrated Quality and Performance Report	GDCEO	Review	Report
13:35	4.4	Audit and Risk Committees Report	Committee Chair	Assure	Report

People					
Time	**Item**	**Title**	**Presenter**	**Purpose**	**Format**
13:45	5.1	People Committees Report	Committee Chair	Assure	Report

People					
Time	**Item**	**Title**	**Presenter**	**Purpose**	**Format**
13:55	5.2	Pay Gap Report	GCPO	Review	Report

Infrastructure – Items for Review and Assurance					
Time	**Item**	**Title**	**Presenter**	**Purpose**	**Format**
14:05	6.1	Infrastructure Committees Report	Committee Chair	Assure	Report

Closing items					
Time	**Item**	**Title**	**Presenter**	**Purpose**	**Format**
14:15	7.1	New Risks and Issues Identified	Chair	Note	Verbal
	7.2	Reflections on the Meeting	Chair	Note	Verbal
	7.3	Questions from members of the public and Governors of St George's*	Chair		Verbal
	7.4	Any Other Business	All	Note	Verbal
14:25	7.5	Patient / Staff Story	GCNO	Review	Verbal
14:50	-	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
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
In Attendance		
Kelly Brown	Senior Corporate Governance Manager	SCGM
Anna Macarthur	Group Chief Communications Officer	GCCO
Stephanie Sweeney	Group Director of Quality and Safety Governance *(deputising for the GCNO)*	GDQSG
Apologies		
Elaine Clancy	Interim Group Chief Nursing Officer	IGCNO
Phil Wilbraham	Associate Non-Executive Director – ESTH	PW
Observers		
Alfredo Benedicto	SGUH Lead Governor	AB
Sarah Forrester	SGUH Appointed Governor – Wandsworth Healthwatch	SF
John Hallmark	SGUH Public Governor – Wandsworth	JH
Jackie Parker	SGUH Public Governor – Wandsworth	JP

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, 08 January 2026, 09:15 – 12.30

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

PRESENT		
Mark Lowcock	Group Chair	Chair
James Blythe	Interim Group Chief Executive Officer	IGCEO
Lizzie Alabaster	Interim Group Chief Finance Officer	IGCFO
Natalie Armstrong	Non-Executive Director – SGUH & ESTH	NA
Mark Bagnall*^	Group Chief Facilities, Infrastructure and Environment Officer	GCFIEO
Elaine Clancy	Interim Group Chief Nursing Officer	IGCNO
Pankaj Davé	Non-Executive Director – SGUH & ESTH	PD
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 – SGUH & ESTH	AM
Michael Pantlin*^	Deputy Group Chief Executive Officer	GDCEO
Leonie Penna*	Non-Executive Director – SGUH & ESTH (Associate)	LP
Bidesh Sarkar	Non-Executive Director – SGUH & ESTH	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	CPO
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		
Richard Jennings	Group Chief Medical Officer	GCMO
OBSERVERS		
Daniel Pople	Group Deputy Chief Communications Officer	

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

1.0	**INTRODUCTORY ITEMS**
1.1	**Welcome, introductions and apologies**
	The Chair welcomed members to the meeting and noted the attendance of the Interim Group Chief Finance Officer at her first public Board meeting. Apologies were noted from Richard Jennings.
1.2	**Declarations of Interests**
	The Board noted the standing declarations relating to shared Group roles across the two Trusts. No new declarations were made.
1.3	**Minutes of the Previous Meeting**
	The minutes of the meeting held on 6 November 2025 were approved as an accurate record.
1.4	**Action Log and Matters Arising**
	The Board reviewed the action log. • PUBLIC20251104.01: The Tier 1 status and quality/performance metrics report had been received in December (private session). • PUBLIC20251104.02: The SGUH CQC Well Led action plan was included on this agenda. The Board **approved closure** of actions PUBLIC20251104.01 and PUBLIC20251104.02. All remaining actions were noted as not yet due.
1.5	**Group Chief Executive's Officer (GCEO) Report**
	The Board received the GCEO report, and the following issues were discussed: • Winter Pressures: The Board acknowledged that both Trusts were operating under sustained winter pressures consistent with the national picture. The Board recognised the impact on staff and recorded its appreciation for continued professionalism during a challenging period. Members sought assurance regarding resilience planning for the remainder of winter. It was confirmed that escalation processes were active and being monitored through established governance routes. • gesh CARE Awards and Staff Engagement: The Board reflected positively on the CARE Awards event and the celebration of staff achievements. Members explored how the positive patient stories and recognition shared at the event could be more systematically embedded across the organisation. The Board discussed Executive Question Time (EQT) as a vehicle for staff engagement. It was confirmed that EQT continued to attract significant participation and provided direct access to Executive leaders. Recurring themes included operational pressures, IT, parking, flexible working and inclusion. The Board noted that some scepticism regarding diversity and inclusion progress continued to be voiced by staff and agreed that this required sustained engagement and visible follow-through, which the Executive team was committed to. The Board **noted** the report and ongoing focus on winter resilience and staff engagement.
2.0	**QUALITY AND SAFETY**
2.1	**Quality Committees Report**

The Board received the report from the Quality Committees, which set out the key issues and areas of assurance from the meetings held in November and December 2025. The following were discussed:

- Pressure Ulcers:

  The Committee had reviewed Category 4 pressure ulcer performance and reaffirmed the target of zero avoidable harm, notwithstanding the challenges in delivering this in practice.

  The Board discussed whether the zero ambition remained realistic while acknowledging complexity of care. It was agreed that maintaining a zero ambition reinforces a prevention culture, provided learning remained proportionate and evidence-based.

- Venous Thromboembolism (VTE):

  The proposed adjustment to VTE assessment timing was scrutinised, with the Committee having acknowledged that the adjustment would improve data quality but had potential impacts which needed appropriate mitigation.

  The Board explored: the rationale for improved data integrity; potential unintended safety risks; and the adequacy of mitigations. It was confirmed that additional safeguards had been requested and a further report would return to the Committee in three months.

  The Board endorsed the approach proposed by the Committee and emphasised that safety standards must not be compromised in pursuit of reporting clarity.

- Safeguarding and Never Events:

  Limited assurance had been provided on safeguarding compliance at ESTH; improvement was anticipated and the Committee had been assured that the issues would be addressed promptly.

  Never Events continued to attract limited assurance due to volume. The Board discussed the importance of thematic analysis and recurrence prevention and agreed the Committee should continue to monitor this closely.

- Interstitial Lung Disease (ESTH):

  The Committee had received a verbal update on the progress of the Royal College of Physicians Invited Review.

  The Board noted that factual accuracy checking of the report was still in progress but that, once completed, the report would be presented to the Committee for review, and would subsequently be presented to the Board in public.

  Once the report had been finalised, the GCMO write again to impacted patients and families and ensure the Trust had appropriately fulfilled its responsibilities in relation to duty of candour.

- Dementia and Delirium:

  The Committee had been unable to provide an assurance rating due to concerns regarding report clarity and triangulation.

  The Board expressed concern that insufficient linkage between data, narrative and mitigations undermined assurance.

  It was acknowledged that while work had progressed operationally, reporting maturity required strengthening. A revised report would return to Committee.

- Quality Governance:

  The Board recognised that report quality was itself an indicator of governance maturity. Work was underway to strengthen corporate nursing leadership and clinical governance processes.

  An informal Board briefing on the 2024 external quality governance review would be arranged.

	Action GB26.01.08/01: Informal Board briefing to be arranged on the quality governance reviews undertaken and actions agreed. The Board **noted** the report and areas requiring strengthened assurance.
3.0	**FINANCE AND PERFORMANCE**
3.1	**Finance and Performance Committees Report**
	The Board received the report from the Finance and Performance Committees, which set out the key issues and areas of assurance from the meetings held in November and December 2025. The Board noted the following: • Month 8 forecasts remained on plan • Savings delivery risk persisted • Limited assurance remained regarding full-year delivery • The draft Medium Term Plan had been submitted to NHS England The Board recognised the ongoing delivery risk and **noted** the report.
3.2	**Finance Report – Month 8**
	The Board received the Month 8 Finance Report, introduced by the GCFO. Both Trusts remained on plan; however, the forecast was dependent on full delivery of Cost Improvement Plans (CIP) and confirmation of Q4 funding. The Board scrutinised: • Confidence in CIP delivery • Ownership and accountability mechanisms • Recurrent versus non-recurrent savings balance • Exposure to unplanned winter costs It was confirmed that: • The work of the Executive Financial Recovery Board had strengthened CIP accountability • Corporate cost bases were under enhanced scrutiny • Q4 funding confirmation delay was administrative rather than substantive • Performance was comparable to the same point the previous year but was being delivered on a reduced bed base The Board expressed concern regarding limited financial headroom and sustainability into 2026/27. **Action GB26.01.08/02:** Information and analysis of the balance between recurrent and non-recurrent CIPs and 2026/27 implications to be included in future report. The Board reaffirmed commitment to year-end delivery while recognising material risk. The report was **noted**.
3.3	**Integrated Quality and Performance Report (IQPR)**
	The Board received the IQPR, and acknowledged severe winter pressures including respiratory illness, high acuity and workforce sickness. The Board discussed the following issues: • <u>SGUH Performance:</u> ○ 95% elective delivery maintained during industrial action

	○ 65-week waiters reduced to four ○ Cancer trajectory improving ○ The Trust's unadjusted NHS Oversight Framework segment rating had moved from Segment 1 in Q1 to Segment 2 in Q2 with its national ranking declining from 37th to 61st out of 134 acute trusts. The Board discussed cultural indicators within safety segmentation (Segment 4) and agreed that improvement should be monitored longitudinally. • ESTH Performance: ○ 65-week waiters reduced to 35 with trajectory to zero by end January ○ Boarding introduced to eliminate corridor care ○ Flu-related ward closures and staff sickness pressures ○ Cancer waiting times were improving, with risk assessments undertaken and monitored by the Site Cancer Board ○ The Trust's unadjusted NHS Oversight Framework segment rating had moved from Segment 2 in Q1 to Segment 3 in Q2 with its national ranking declining from 61st to 101st out of 134 acute trusts. • Integrated Care: The Board reviewed admission avoidance impact and the decision to maintain service access despite two-hour response target challenges. Children's Therapies were seeing exceptionally long waits, which reflected the wider national data. The Board supported maintaining availability while managing performance risk transparently. The Board also discussed the following cross-cutting themes: • NHS England Tiering: Both Trusts continued to be designated Tier 1 for elective recovery, with ESTH also in Tier 2 for urgent and emergency care pressures. • Emergency Department pressures: The Board scrutinised the boarding decision, seeking assurance on risk mitigation and oversight. Assurance was provided that corridor care had ceased and escalation protocols were in place. • Vaccination and Workforce Sickness: The Board discussed potential links between vaccination uptake and staff absence. While anonymised data limited direct analysis, the Board agreed workforce vaccine confidence required sustained engagement, and that low update was also reflective of the wider national picture. The Board recognised ongoing pressure but noted measurable progress in backlog reduction and cancer performance. The report was **noted**.
3.4	**Audit and Risk Committee Report**
	The Board received the report from the Audit and Risk Committees, which set out the key issues and areas of assurance from the meeting held in December 2025. The Board received the report and noted the following: • External Audit:

	The Committee had received an update on the planning for the 2025/26 audit, with work scheduled to commence in Q4. • Internal Audit: The Committee had been assured by the good progress in the delivery of the 2025/26 internal audit plan, with delivery significantly ahead of the same point in the previous two years. Six final internal audit reports had been reviewed by the Committee. Reasonable assurance was provided in several areas including: Key Financial Controls; Emergency Planning Resilience and Response; NICE Compliance; and Non-Medical Rostering and Agency Use. Partial assurance had been provided in two areas: ESTH Discharges; and ESTH Patient Safety Incident Response Framework. Management completion of agreed follow-up actions from previous internal audits remained an area of concern, with the Committee considering delays an indicator of lack of governance maturity. • Risk Management: The Committee was assured by the strengthening of the risk reporting and oversight, noting that substantial work was in progress to refresh the two Trusts' Corporate Risk Registers, which would be reviewed quarterly in 2026/27 alongside a refreshed Group Board Assurance Framework. The Board discussed: • Accountability for internal audit actions, emphasising the need for clear Executive sign off and ownership of agreed actions • Referral of partial assurance internal audits to the relevant Board Committees • Clarity of cyber oversight between Committees, with the intention to move detailed assurance on cybersecurity to the Infrastructure Committees • Embedding of the Group Risk Management Framework, welcoming the improved governance and oversight that had been put in place over the past year and the plans for further strengthening this. The Board **noted** the report, welcomed the progress on strengthening risk, and emphasised the importance of executive ownership of ensuring timely completion of internal audit follow up actions.
4.0	**PEOPLE**
4.1	**People Committees Report**
	The Board received the report from the People Committees, which set out the key issues and areas of assurance from the meeting held in December 2025. The Board received the report and noted the following key themes: • The Flexible Working Policy had been updated since the last staff survey, but strengthened local governance was required • Sickness absence remained above target, with mental health and MSK the most frequently reported factors; deep dives into departments giving cause for concern would be carried out • The strategic risks related to people had been reviewed, with the culture risk remaining as a risk score of 20, and with limited assurance linked to delivery of progress on equality, diversity and inclusion. • The plans for the commencement of the new Inclusion Board were welcomed, with the Committee expressing its support for the programme being 12 rather than 6 months, subject to the availability of funding

	• The Resident Doctors' 10 Point Plan had been positively received, with the impact of the physical estate acknowledged as a factor in doctors' wellbeing. • Staff survey completion rates were noted, with the full results embargoed until mid-March; the Committee would receive a report on the themes from the survey and the Group's approach to responding to the survey at a future meeting. The Board discussed workforce wellbeing and cultural indicators and emphasised importance of visible action following survey results. The report was **noted**.
5.0	**INFRASTRUCTURE**
5.1	**Infrastructure Committees Report**
	The Board received the report from the Infrastructure Committees, which set out the key issues and areas of assurance from the meetings held in November 2025 and December 2025. The Board received the report and noted the following: • Fire and Water Safety: Fire safety enforcement warning notices had been received for Epsom and St Helier hospitals. Action plans were in place. Short-term water safety mitigations in maternity at St Helier had been independently assured, but medium-term solutions were required and recommendations would be presented to the Committee on this at a future meeting. The Board requested continued oversight of actions to address the fire safety warning notices. • Digital and Cyber: Clarity of oversight responsibilities between Committees was being addressed. • SGUH ITU Build: Delivery had been delayed to June 2026, with fit out likely to take a further 2-3 months. A constructive meeting had been held with the contractors. There remained a risk of further slippage in completion. The Board sought assurance regarding contractual management and mitigation. While constructive discussions had taken place, delivery risk remained. The Board **noted** the report.
6.0	**STRATEGY AND GOVERNANCE**
6.1	**Developing a Well Led Group**
	The Board considered the proposals for developing a well-led Group in the context of the CQC's Well Led inspection findings at SGUH. The proposals addressed culture, governance, accountability and strategy embedding, and contained a specific proposal that the Board adopt a commitment to becoming an explicitly anti-racist organisation. The Board welcomed the coherent consolidation of workstreams and alignment with existing improvement initiatives. Members explored: • Measurement of impact beyond action completion, with general agreement to developing a focused set of high-impact actions to address the findings of the CQC • Ward-to-board quality governance, with the Board agreeing that steps needed to be taken to further strengthen this • Balance of site and group governance, with agreement that effective accountability mechanisms were needed alongside steps to give life to the principle of subsidiarity The proposal to commit explicitly to becoming an anti-racist organisation was discussed at length.

	The Board unanimously supported the principles of anti-racism and addressing systemic inequity. Members debated how such commitment should be articulated to ensure depth, behavioural change and accountability rather than symbolism. It was agreed that further discussion would take place with the Board to work through this in more depth. It agreed that the establishment of a new Inclusion Board was an important step. The Board collectively agreed that the impact of systemic racism on members of staff and quality of care was significant and needed to be addressed purposefully. The Board also agreed that there needed to be consequences for those who did not demonstrate the appropriate values and behaviours. The Board **endorsed** the proposals, supported the commitment to being an anti-racist organisation and agreed further discussion on how to deliver meaningful change and impact was needed. **Action GB26.01.08/03:** A further Board session to be arranged to discuss driving meaningful change on EDI and making a commitment to anti-racism impactful.
6.2	**Board Assurance Framework**
	The Q3 2025/26 Group Board Assurance Framework report was received by the Board, with it noted that each of the Board Committees had each reviewed the relevant strategic risks and all risks were proposed to be held at their current positions. While progress had been made in implementing mitigating actions in several areas, this had in places been offset by an increasingly challenging external environment, resulting in a broadly static position at Q3. The Board had agreed that a refresh of the BAF would be undertaken at a Board development session in Q4 2025/26 in the context of the Group's Medium Term Plan, the new transformation programme, significant changes to the external environment, and extensive changes in the composition of the Board. The Board: • Approved Q3 strategic risk scores and assurance ratings • Noted Committee reviews • Noted that a full refresh would occur in Q4 aligned to the Medium Term Plan and Board composition changes
7.0	**ITEMS FOR NOTING**
7.1	**Healthcare Associated Infections Reports**
	The Board **noted** the report.
8.0	**CLOSING ITEMS**
8.1	**New Risks and Issues Identified**
	No new risks were identified.
8.2	**Questions from members of the public and Governors of St George's**
	The Chair noted that questions in advance had been received from a member of the public: • *Marion Parkes, who was present at the meeting, had submitted questions on the Picture Archiving and Communication System contract between Optum to which the GDCEO responded as follows:* *Q1: The contract with MyOrb was not an extension of an existing contract but a wholly new contract signed under a G-Cloud process (copy sent to the interim CEO James Blythe) for the*

	value of £445k (paid in full to MyOrb on contract signature) which did not need a business case or tender. It should be noted that MyOrb did not have a CDS product at this time. No solution was delivered and the company has now gone into liquidation. A1: The Trust has reviewed its records and can confirm that this was a new contract signed under the G-Cloud framework agreement. *Q2: Contrary to what was stated by Andrew Grimshaw, Live patient data was used for the pilot at GP sites. A record of patients data is in SWL records. What steps have been taken by GESH as signatory to the contract* with MyOrb to ensure that data has been handled according to GDPR? A2: A Data Protection Impact Assessment (DPIA) was undertaken to identify, assess and minimise data protection risks, and the Group is not aware of any indication that patient data was handled in a way contrary to GDPR. With My Orb recently going into liquidation, the Group is taking steps to ensure that data held by My Orb is repatriated/destroyed as appropriate Q3: *Had the referral to Counter Fraud been made?* A3: Yes.
8.3	**Reflections on meeting**
	NA gave her reflections on the meeting, commenting that there had been a good balance of finding positives amongst the challenges. Discussions had included future strategic direction with current issues. The Board had been willing to have difficult conversations, work through live issues, and join up the discussions held across Board Committees. The tone of the meeting had been collegiate but not cosy.
8.4	**Patient Story**
	The parents of Hayley Buzwell, Pete and Elizabeth, were welcomed to the meeting. They spoke in depth and with candour about the death of Hayley in March 2025 of pancreatic cancer aged 39. Although there had been positive aspects and much kindness shown to Hayley and her family while a patient at ESTH, there had also been some distressing interactions during the weeks that she was ill from which there was learning which was relevant across the Group. Pete and Elizabeth also shared their experiences at a Grand Round and, whilst difficult to relive their experience, they had wanted to ensure others did not go through the same experiences: • Themes and key points identified from the Grand Round: ○ Communication: Importance of empathy, asking good questions and clearly breaking bad news ○ Opioid Confidence and Review: Importance of confidence with opioids, avoiding misconceptions regarding addiction and reviewing effect of doses. ○ Palliative care: Importance of escalating any patient whose symptoms are not well controlled. 7-day service and 24-hour on-call. • Areas to consider taking forward as a Trust: ○ Provision of Communication Skills Training (Intermediate and Advanced) to support clinicians to break bad news effectively ○ Protected time for education: Address the challenge of ward nurses not being able to attend training in palliative care, end of life care and communication skills ○ End of life care champions: Enable all wards to release two nurses to be trained and supported to become end of life care champions

	○ Pain relief: Follow up on the concerns of delayed administration of pain relief across our inpatient beds. After their presentation, the Board thanked Pete and Elizabeth for their openness and willingness to share their story. Their offer to speak to other groups across the organisation was gratefully accepted and this would be followed up the GCNO.

CLOSE

The meeting closed at 12.30pm.

ADDENDUM

FEEDBACK FROM WARD VISITS

The Board undertook visits following the conclusion of the Group Board meeting in public. The following record of the key issues emerging from these visits is set out below:

The Board provided the following feedback from their respective visits to a number of wards:

- Maternity (Chair and KM): The unit was observed to be clean and well organised. The team were congratulated on positive CQC Maternity Survey results. Staff raised concerns regarding responsiveness of interpretation services and a preference to move away from the current Language Line provider. The Board noted that service responsiveness was critical to safe and compassionate maternity care and requested that this be reviewed.
- Admin Pods (GDCEO, CSH, PW): Staff reported integration issues within the new system, including incomplete data visibility (e.g. waiting times). The Board discussed the risk of local workarounds emerging if system integration issues were not resolved. It was confirmed that solutions were being explored and that system optimisation was a priority. High theatre utilisation and positive team dynamics were commended.
- Casey Ward (GCOFIE, MD-IC, BS, NA): The ward was reported as busy, clean and well managed, though storage capacity was limited. Equipment governance was confirmed to be robust. A high prevalence of patients with mental health needs was highlighted as a pressure point. The Board noted that the ward was not resourced to meet complex mental health demand and recognised the dependency on wider system solutions as part of Medium-Term Plan delivery.
- Radiology (GCCAO, MD-ESTH, LP, PD): The team demonstrated strong engagement and highlighted benefits from newly installed equipment, including cardiac MRI capability. The Board discussed: opportunities to maximise utilisation of equipment currently used Monday–Friday; recruitment advantages linked to overseas training pathways; and leadership development opportunities within clinical teams. The Board agreed that leadership development should be a standard enquiry during ward visits.
- Home First (GCNO, YJ, GCPO, AM): The Home First team demonstrated measurable impact, including an average 1.4 day reduction in length of stay. The Board discussed: cultural barriers to discharge among some clinicians; patient hesitancy regarding discharge home; and the importance of maintaining multidisciplinary confidence in the model. The Board commended the team's leadership and alignment with the NHS 10 Year Plan ambition.

Group Board (Public) - 5 March 2026

Action Log

ACTION REFERENCE	MEETING DATE	ITEM NO.	ITEM	ACTION	WHEN	WHO	UPDATE	STATUS
GB26.01.08/01	08-Jan-26	2.1	Quality Committee	Informal Board briefing on quality governance actions review and actions to be arranged.	05 March 2026	GCCAO	Session took place on 2 February 2026.	PROPOSED FOR CLOSURE
GB26.01.08/03	08-Jan-26	6.1	Developing a Well Led Group	A further Board session to be arranged to discuss driving meaningful change on EDI and making the commitment to anti-racism meaningful	03 April 2026	GCCAO	Board session arranged for 2 April 2026.	PROPOSED FOR CLOSURE
GB26.01.08/02	08-Jan-26	3.2	Finance Report - Month 8	Information and analysis of the balance between recurrent and non-recurrent CIPs and 2026/27 implications to be included in future report.	08 May 2026	GCFO		NOT YET DUE
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)	~~6 Nov 2025~~ ~~4 Sept 2025~~ Spring 2026	GCPO	Mandatory training is being reviewed across the Group in the context of the recent guidance from NHS England. Proposals are currently being drafted and will be presented to the Group Executive Committee in the Spring 2026.	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.	~~4 Jul 2025~~ Summer 2026	GCCAO	Plans to strengthen speaking up across the Group are being developed in the context of the SGUH CQC Well Led inspection feedback, the 2025 NHS Staff Survey results, and the internal audit of speaking up (due to the Audit Committee in May 2026).	NOT YET DUE

Group Board

Meeting in Public on Thursday, 05 March 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, 05 March 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 and Regional Context and Updates

National maternity investigation

2.1 The establishment of a 'rapid national investigation' into NHS maternity and neonatal services has previously been reported to the Board. The investigation was announced in June 2025 with a remit to examine the worst-performing maternity services across England and review the whole of the maternity system with a view to bringing together the findings of past reviews into maternity into a single set of actions to ensure that every woman and baby received, safe, high quality and compassionate maternity care. In August, the DHSC announced that Baroness Amos had been lead the investigation.

2.2 The investigation published its Interim Report on 26 February 2026. This founds finds that, as a whole, England's maternity and neonatal system is failing many women, babies, families, and staff and is not providing consistent, safe, compassionate care. Persistent inequalities exist, with notably higher risks of adverse outcomes for Black and Asian women and those in deprived areas. The investigation highlights widespread racism and discrimination, as well as cultures of blame, fear, and poor leadership that hinder improvement. Care is fragmented and inconsistent ("postcode lottery"), with capacity pressures, workforce shortages, poor estates, and weak accountability when things go wrong contributing to poor outcomes. Families report being disregarded and not listened to with staff describing strained teamwork, burnout, and inadequate organisational support. The report identifies six pressure factors — capacity, culture, racism, accountability, estates, and workforce — and stresses the urgent need for systemic reform to deliver equitable, high-quality maternity and neonatal care.

2.3 The investigation has not focused on maternity services at either St George's or Epsom and St Helier. However, the findings of the interim report on the position of maternity services across England as a whole are stark and it is important that all NHS provider trusts reflect on and learn from this, and we are committed to doing so. As the Board is aware, we have had our own challenges in relation to maternity services and we are embedding improvements through the integrated maternity improvement plans at each Trust.

Changes at South West London Integrated Care Board

2.4 South West London Integrated Care Board (ICB) and South East London ICB have announced the appointment, by the Secretary of State for Health and Social Care, of Sir Richard Douglas as the joint Chair for the two separate ICBs. In addition, following the conclusion of a recruitment process, Andrew Bland has been appointed as the single, joint Chief Executive Officer across SWL and SEL ICBs. The appointments follow the decision by the Boards of each ICB to collaborate more closely and combine expertise and leadership as strategic commissioners to deliver for south London as a whole. Both ICBs remain separate organisations. We continue to

work with our ICB colleagues on the development of a new clinical strategy for SWL. We are also due to welcome Richard and Andrew to our sites for visits over the next month.

2.5 Katie Fisher, who previously served as Chief Executive Officer of SWL ICB, has moved to a new role as Interim Chief Executive Officer for North Central London and North West London ICB responsible for overseeing the launch of the new West and North London ICB which comes into effect from 1 April.

Renewed focus on eliminating corridor care

2.6 I, along with other members of the executive and ESTH Site Leadership Team, attended a NHS England summit for Trusts reporting particularly high levels of corridor care on 26th February. This was a useful and instructive session which prompted discussions about how corridor care could be eliminated across both Trusts in the group as soon as possible. We have been asked to develop an outline plan to do this for ESTH by the 13th March, but will do this for both Trusts; this will draw on our existing transformation plans and will be shared back with the Board as part of the next round of IQPR reporting. We will also add the new national corridor care metric to the IQPR as soon as it is finalised.

3.0 Our Group

CQC Inspections at Epsom and St Helier

3.1 In my report to the Group Board in January, I explained that the Care Quality Commission (CQC) would be undertaking a Well Led inspection at Epsom and St Helier in March. In February, we heard that the CQC has postponed the inspection, which will now take place between 12 and 14 May 2026. As previously reported, we have begun our preparations to ensure that the inspection goes smoothly, building on the learning from the Well Led inspection at St George's last year. This work includes the ongoing improvement of policy and risk management processes that we highlighted in the well-led report in January.

3.2 At the January Board, I also reported that the CQC had undertaken planned service inspections of Maternity, Urgent and Emergency Care and Surgery at Epsom and St Helier in early December. We understand that the CQC will be sharing the draft inspection reports with us for factual accuracy checking in the coming weeks. CQC inspections provide an opportunity to learn and improve. We have already taken steps to respond to the CQC's initial feedback and we will carefully review the full inspection findings and apply this to both improving our services and preparing for the Well Led inspection.

Our new Inclusion Board

3.3 I made a number of commitments to take action in relation to our collective leadership, responding to the St George's well-led report, and I am pleased to able to report back on a number of those today. In January, we opened applications for our new Inclusion Board, a new pilot programme offering colleagues the opportunity to contribute to shaping the future of the organisation. The Inclusion Board is designed to strengthen inclusive leadership and ensure that diverse perspectives and lived experiences help to inform Board-level discussions and decision-making. Running alongside formal Board meetings, the programme will provide participants with exposure to governance, strategy, and executive-level leadership in a real-time environment.

3.4 The programme aims to: amplify diverse voices and ensure lived experience informs decision-making at the highest level; build leadership capability through insight into board-level

governance, strategy, and inclusive leadership practice; and develop a pipeline of talent for future senior and executive roles, supporting progression across the organisation. Participants in the pilot will: review and discuss Board papers in line with the corporate governance cycle; engage in dialogue with Executive and Non-Executive Directors; take part in development sessions facilitated by the Organisational Development team; receive expert input to support the development of key leadership skillsets; and contribute perspectives to help shape inclusive and equitable organisational decisions.

3.5 The application deadline was on 15 February, and I am delighted that we received over 50 applications from staff across our group. Shortlisting was undertaken on 26 February and interviews will take place in week beginning 2 March. The calibre of applications has been hugely impressive and demonstrates the strength and depth of talent we have across our group, and I look forward to the insight and impact members of the new Inclusion Board will have in bringing greater diversity to our decision-making and developing the next generation of leaders across our group.

gesh People Management Programme

3.6 In addition to our new Inclusion Board, we are also launching a new gesh People Management Programme. This was also highlighted in the January well-led report. Strong leadership starts with strong people management, and the new gesh People Management Programme is our flagship, organisation-wide pathway to effective, inclusive and compassionate leadership. Designed for all people managers and staff with people management responsibilities, the programme will build practical people management capability for day-to-day and long-term leadership across gesh. It takes participants on a purposeful learning journey, from core people management fundamentals through to more complex and nuanced leadership practices, delivered across three progressive tiers. The programme has been thoughtfully developed and successfully piloted, with outstanding feedback from participants. Their experience has helped shape a programme that is practical, relevant and impactful.

3.7 Empowered, engaged staff is one of the core elements of our Group Strategy, and we are committed to putting staff experience and wellbeing at the heart of what we do. Our new People Management Programme is a key part of this and will help nurture our talent for the future while helping to foster the inclusive culture we seek to build across our group.

Gender Pay Gap Report

3.8 On the agenda of our Board meeting in March are our pay gaps reports, setting out the differences in average earnings based on gender, race and disability. While we are required by statute to publish only our gender pay gap, we feel it is important to publish all three as a means to put a spotlight on disparities in pay so that these can be openly addressed. As an Executive team, we have closely looked at all three pay gap reports. In relation to gender, the data demonstrates an overall pay gap between men and women, in favour of men. When we looked more closely at the drivers of this, it was clear that pay differentials in our medical workforce were the key issue, with clinical excellence and clinical impact awards having historically been awarded disproportionately to men which has significantly skewed the results. If this staff group is excluded from the data, the data demonstrates a pay gap in favour of women. These awards are, and have been historically, determined through regional and national processes. While there have been changes in recent years to make the process more inclusive, with more women than men receiving awards in 2024, the impact of the historic trends in clinical excellence awards is likely to skew our overall pay gap position for some years to come.

Launch of MyCare at Epsom and St Helier

3.9 In February, MyCare went live at Epsom and St Helier, marking an important milestone in our Group digital transformation journey. Having supported patients across St George's for the past four years, MyCare is now fully extended to Epsom and St Helier, creating a single, consistent patient portal experience across the Group. The launch has been made possible through close collaboration across clinical leaders, operational teams, digital services and communications, supported by clear governance and shared ownership. It shows what can be achieved when technology, oversight and staff are brought together across the Group, with a clear focus on delivering real measurable benefits.

3.10 The launch is more than a technical go-live. It delivers: a unified, digital-first approach to patient communication across our hospitals; reduced reliance on printed correspondence and the associated cost savings; greater patient empowerment and self-service access to information; and a meaningful contribution to our Group Green Plan.

4.0 Events, Appointments and Our Staff

Thank you to Luci Etheridge

4.1 Luci Etheridge, our Site Chief Medical Officer at St George's, has been appointed as a Registrant Council Member for the General Medical Council (GMC). Luci's appointment to this highly respected and influential national role is a significant achievement and a reflection of her exceptional leadership, professionalism, and commitment to improving care for patients and supporting the medical workforce. As a result of this appointment, Luci will be stepping down from her role as Site Chief Medical Officer in May to begin her four year term with the Council. While we will greatly miss her day-to-day leadership in this position, we are very pleased that she will continue her role as Consultant Paediatrician. The process to appoint a new Site Chief Medical Officer for St George's is underway.

Thank you to you all

4.2 The March Group Board meeting in public will be my last as Interim Group Chief Executive Officer at gesh. May will be my last Board (and in fact my last working day) in my substantive role as ESTH Managing Director before I move to my new role as Chief Executive at Royal Berkshire NHS Foundation Trust in the Spring. I am immensely proud of what we've achieved at gesh and it's been a privilege to work with so many inspiring colleagues. Over the last four years, both as Interim Group Chief Executive Officer and Managing Director for Epsom and St Helier, my focus has always been supporting our people to deliver safe and effective care, and to ensure the organisation continues to innovate and improve.

5.0 Recommendations

5.1 The Group Board is asked to note the report.

Group Board

Meeting in Public on Thursday, 05 March 2026

Agenda Item	2.1	
Report Title	Five Year Plan Narrative 2026/27 – 2030/31	
Executive Lead(s)	Michael Pantlin, Group Deputy Chief Executive Officer	
Report Author(s)	Ralph Michell, Chief Transformation Officer	
Previously considered by	Group Executive Committee	24 February 2026
Purpose	**For Noting**	

Executive Summary

These are very challenging times for the NHS but also, therefore, full of opportunity.

Over the course of 2025, the 10 Year Plan for the NHS was published and the gesh Board commenced its own stocktake of the Group's strategy.

The Board confirmed that the Group's vision for the future remains broadly right, but that the route to delivering that vision requires updating, particularly through a revised transformation portfolio.

As part of the 2025/26 planning round, the Group was required to submit Medium-Term plan to NHS England. This covered operational and financial planning for three years and an accompanying narrative for five years.

A draft narrative was presented to, and endorsed by, the Group Board in private on 5 February 2026 and subsequently submitted, with requested changes, to NHS England on 12 February 2026 as part of the Medium-Term Plan submission. This submission met all NHSE requirements.

This paper shares the five-year plan narrative, including the priorities which are to permeate the group in 2026/27 and the transformation portfolio.

Action required by Group Board

The Board is asked to note the 5-year plan narrative as submitted to NHS England following review and agreement by the Group Board in February 2026.

Committee Assurance	
Committee	Group Board
Level of Assurance	Not Applicable

Appendices	
Appendix No.	**Appendix Name**
Appendix 1	Five Year Plan 2026/27 – 2030/31: Narrative Plan

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

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

gesh

5 Year Plan - 2026/7 to 2030/31

12 February 2026

gesh

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

Contents

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

gesh

Where are we now?

3

In 2025, the Group Board reviewed its strategy, and agreed we should develop a medium-term plan for gesh

Since the 2024 general election, **major structural and policy changes** have reshaped the NHS, including the NHS 10 Year plan, an intention to abolish NHS England, and the reduction of ICB roles & budgets.

The NHS 10-Year Plan outlined **three strategic shifts:**

- Moving care from hospitals to local communities
- Preventing illness, not just treating it
- Realising the potential of digital technology

The **financial climate** within gesh and across South-West London is **significantly more challenging,** requiring serious consideration of infrastructure and opportunities to capitalise on digital innovation, as part of service changes, to release radical savings.

We continue to face **significant estate challenges**. While SECH was originally intended to address these, the earliest estimated timeline for its opening is now 12 years away.

Strategy stocktake

In May 2025, at the midpoint of our CARE strategy, we conducted a stocktake to assess our progress.

There was broad consensus that our vision for the future, along with the CARE framework that underpins it, remains fit for purpose.

However, we agreed to refresh our approach to transformation , particularly in light of the NHS 10-Year Plan released earlier this year, the emerging Clinically Led South West London strategic plan and the substantial financial challenges impacting now.

The Board agreed that the Group should develop a medium-term plan to that end.

gesh

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

Joint work on a SWL clinical strategy has helped us base our plan on a strong understanding of population need

The population profile is ageing with needs varying by geography

- SWL has a **larger proportion of working age adults** compared with England
- The **65+ population will grow by more than 25%** in the next ten years whilst **young people will decline by 12%**
- **Core20 populations** range from 1% in Kingston and Richmond to 18% in Croydon

Current spend is already concentrated on higher-needs cohorts

- **69% of commissioner spend*** supports **16% of the population,** with **medium to high complexity needs,** and **higher use of primary and acute care services**
- **Core20 plus 5 populations with cancer and SMI** utilise a **greater amount of ICB spend** than non-Core 20 plus 5 populations **(52% and 17% higher)**

Disease prevalence and complex needs are rising

- **Dementia prevalence is** higher than peer ICSs and SMI prevalence exceeds the national average
- Conditions such as **CKD and cancer** are growing **faster than the national average**

Variation and inefficiency in care provision exist today

- There is **variation in use of health care resources** by cohorts of patients who have similar needs
- When **quality is considered, spend differences between places remain significant**

These factors drive increases in future demand and intensify capacity requirements

- Forecast demand will fuel **double digit activity growth in all points of delivery by 2035/36** from primary care through to community, acute (physical and mental health) and CHC
- The **highest rates of growth** in activity are forecast to be in **non-elective spells, CHC and community contacts,** including **primary care**

Without change, financial sustainability is at risk

- **By 2035/36, medium and high complexity** cohorts will require **88% of ICB spend** by **2035/36** with frailty and end of life needs alone accounting for 59%
- This trajectory leads to a cumulative **deficit of £1.2bn by 2035/36**

The plan must deliver stretching improvements in elective and urgent care performance by 2029

Headline Metrics	Overview	SGUH Current Performance	SGUH 2026/27 Plan	SGUH 2027/8 Plan	SGUH 2028/29 Plan	ESTH Current Performance	ESTH 2026/27 Plan	ESTH 2027/8 Plan	ESTH 2028/29 Plan
RTT 18 Weeks Performance	Trusts to deliver 7% improvement on March 26 and plan towards delivering the constitutional standard by March 2029	60.2%	67.8%	76.92%	92%	60.1%	72.43%	82.22%	92%
Cancer 28-Day Faster Diagnosis Standard	Achieve new national standard of 80% from 2026/27	74%	80%	80%	80%	75.6%	80%	80%	80%
Cancer 31-Day Standard	Achieve constitutional standard by March 29	87.9%	96%	96%	96%	100%	98.6%	98.6%	96%
Cancer 62-Day Standard	Achieve constitutional standard by March 29	69.5%	80%	82.5%	85%	81.3%	85%	84.02%	85%
Diagnostic (DM01) > 6-Week Standard	3% improvement by March 2027 and 1% constitutional standard by March 29	4.3%	2%	1.52%	1%	13.53%	11.64%	4.3% (tbc)	1%
4-Hour A&E Performance	Improve to 82% by March 2027, and 85% in 28/29	81.3%	82.1%	82.95%	85%	70.8%	82%	83%	85%
12-Hours in ED Performance	Year-on-year improvement	11.4%	<11.4%	2027/28 improvement compared to 2026/27	improvement compared to 2027/28	16%	<16%	2027/28 improvement compared to 2026/27	improvement compared to 2027/28
Supporting Metrics	**2026/27 National Ask**	**Current Performance**	**2026/27 Plan**	**2027/8 Plan**	**2028/29 plan**	**Current Performance**	**2026/27 Plan**	**2027/28 Plan**	**2028/29 plan**
A&E attendances for Children under 16, less than 4 hours in department	Achieve minimum 95% by Sep-26 and maintain 95% or higher from that point onwards	87.3%	95%	95%	95%	70.2%	95%	95%	95%
Percentage of ambulance handovers over 45 minutes	Zero handovers over 45 minutes by March 2027	9%	0%	0%	0%	8.8%	0%	0%	0%

We will need to deliver these improvements whilst also closing a significant financial gap…

	ESTH £m	SGH £m	Group £m	Comment
25/26 Forecast	-5.7	0.0	-5.7	In line with plan
25/26 Underlying	-88.5	-87.9	-176.4	25/26 was supported by National Deficit Support Funding (£81.8m Group) and other one off non recurrent income and cost actions (£94.6m)
26/27 Deficit Support Funding Confirmed	34.3	21.6	55.9	As per allocations but note the reduction from £81.8m received by the Group 25/26
26/27 inflation, income and cost pressures	-4.1	-34.8	-	As per national guidance and identified unavoidable pressures. (ESTH non recurrent income confirmed higher than SGH as per previous years)
Gross gap 2627 before mitigating action	-58.3	-101.1	-159.4	
Total efficiency requirement	58.3	101.1	159.4	5% Business as usual cost out from divisions 2.5% Transformation schemes

- The table to the left illustrates the Board approved route to a financially compliant plan for 2026/27.
- Without taking significant action, the Group faces a financial gap of c. £160m in the first year of this plan.
- The total efficiency requirement is 7.5%, this is above the national guidance of 4.5% for deficit Trusts as a result of the underlying position of both Trusts

gesh

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

…with deficit support withdrawn over the course of the plan

Both Trust have received Deficit Support Funding (DSF) over the last year and current year to support the Trust underlying deficit positions and enable the Trust to deliver the National planning financial targets.

The MTP guidance and allocations assumes a tapering and reduction of DSF that will need to be mitigated by additional Trust efficiency and savings to enable Trusts to continue to deliver plan. The MTP for the Trusts mitigates this reduction with assumed efficiency delivery.

The phasing of the DSF support is in the table below.

ESTH have been given 3 years to return to financial balance and SGH 2 years. This is driven by the fact that reduction is limited to 2% of turnover within the technical guidance and ESTH has a larger % underlying deficit than SGH.

DSF £m	2024/25	2025/26	2026/27	2027/28	2028/29
SGH	45.8	40.2	21/6	3.0	-
ESTH	46.7	41.6	34.3	21.4	8.4

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

gesh

What do we want to achieve

9

gesh

Confidential: Not for wider circulation

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

Our long-term ambition

Our vision is that by 2030/31…

C	Collaboration and partnership	We will be a driving force behind the most integrated health and care system in the NHS
A	Affordable healthcare, fit for the future	We will move from a financial deficit to generating a surplus
R	Right care, right place, right time	We will deliver constitutional standards on waiting times, have lower than expected mortality, and reducing levels of harm
E	Empowered, engaged staff	We will be in the top 5 acute trusts in London for staff engagement

gesh

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

Collaboration and partnership

By the end of this plan, gesh will become a driving force behind the most integrated health and care system in the NHS, delivering better quality and more sustainable care.

We will:

- focus our services around patient needs, working with GPs, local government and community partners to build a 'neighbourhood health service' - keeping people well in the community and reduce unnecessary hospital use.
- Deliver the same high standards of care across our Group, create seamless pathways and a more efficient operating model, and integrate some services across gesh
- Make the case for merger, secure AFT status and augment our capabilities as an IHO.
- collaborate with other south west London hospitals on shared services, elective recovery and financial sustainability.
- strengthen regional networks to ensure our tertiary services are better integrated with primary and secondary care.

gesh

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

Affordable healthcare, fit for the future

gesh will be generating a surplus - bridging a gap of £170m over the course of the period

We will:

- take the difficult decisions needed to achieve ongoing financial balance and make our services sustainable for future generations
- modernise key parts of our estate and reduce our carbon footprint as we move towards Net Zero by 2040.
- accelerate adoption of digital technologies to improve care, efficiency and the working environment.
- strengthen our role as a centre for research and innovation to shape the healthcare of the future.
- deliver a smaller, more satisfied workforce by reducing reliance on temporary staff and managing turnover effectively

gesh

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

Right care,
right place, right time

We will be offering high-quality care to our patients.

We will:

- achieve national standards on access - waiting times brought fully in line with constitutional standards by the end of this plan.
- deliver safer, higher-quality care - sustained improvements in patient safety, experience and outcomes through reducing preventable harm, strengthening governance, and embedding continuous learning.
- tackle health inequalities - proactively narrowing gaps in access, experience and outcomes for our most disadvantaged communities.

13

gesh

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

Empowered, engaged staff

gesh will be among the top five acute trusts in London for staff engagement.

To deliver our ambitions, we will need to make best use of our greatest asset – our highly skilled, committed workforce.

We will:

- Get the basics right – reliable, timely core services (pay, recruitment, ER, people management) that staff can trust.
- Put staff experience and wellbeing first – ensuring everyone has the tools, supportive environments, compassionate leadership and rapid access to wellbeing support they need.
- Foster an inclusive, values-led culture – where diversity is celebrated, our values are lived every day, and every colleague feels they belong and can thrive.
- Become an anti-racist organisation – proactively identifying, challenging and dismantling racism in all its forms.
- Develop tomorrow's workforce – attracting, developing and retaining the talent we need, expanding new roles and workforce models, and strengthening our position as a leading educator.
- Work differently – offering greater flexibility, enabling a digitally supported workforce, and embedding continuous improvement in how we operate.
- Embed a Quality Management System – empowering our staff to deliver consistent, high-quality, continuously improving care across all services.

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

gesh

How we get there

Our approach to delivery

Delivery of our strategic ambitions relies on local improvement, corporate enablers and our new transformation portfolio.

Local improvement

Local action taken by all our staff, Board to Ward, to deliver continuous improvement against our CARE objectives.

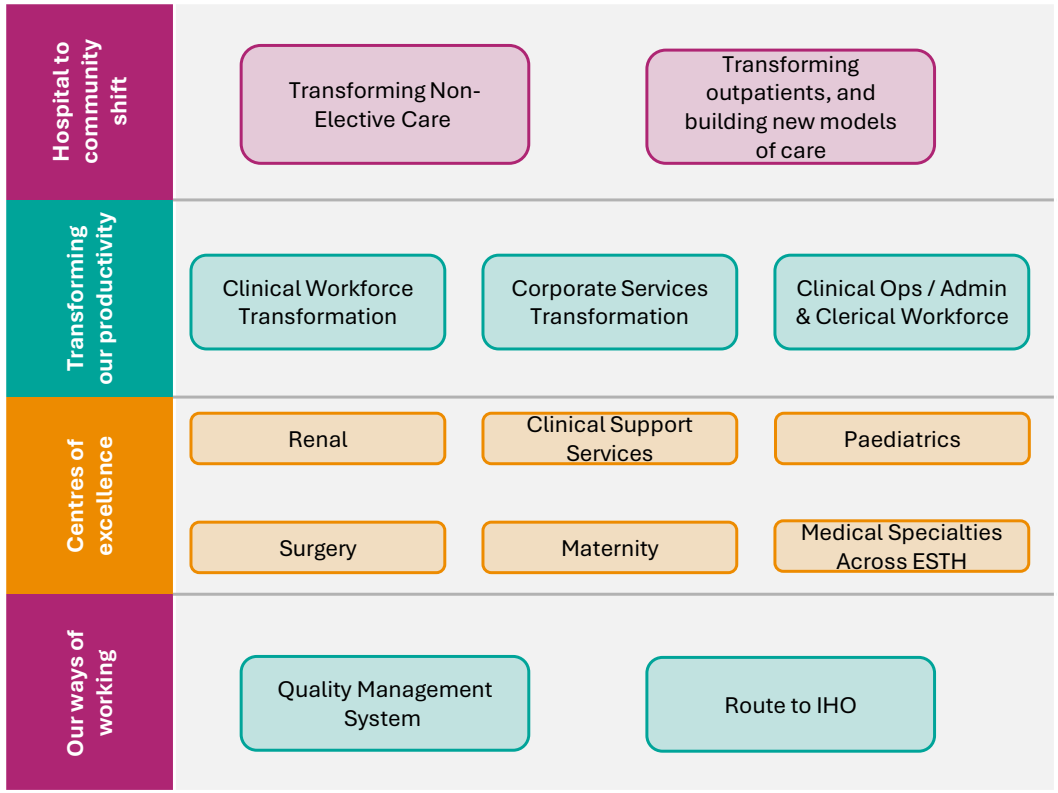
Corporate enablers

Action led by corporate teams against corporate strategies

- Quality & Safety
- People
- Digital
- Estates
- Green Plan
- Research & Innovation

Transformation portfolio

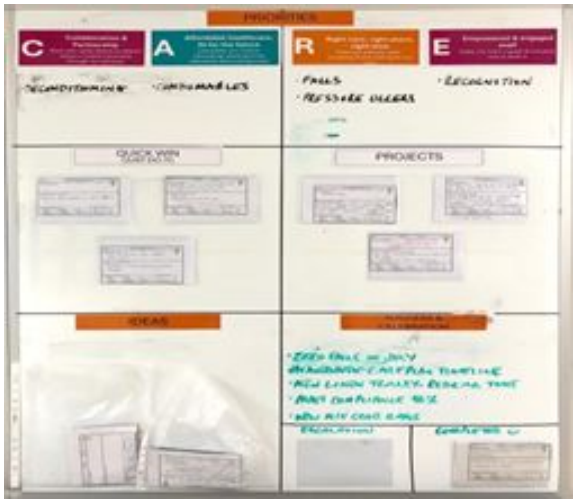
Transformation programmes set up to support delivery of our Medium-Term Plan & NHS 10 Year Plan.



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

Supporting local improvement

gesh



Each year we set 'board to ward priorities', against which we ask all teams to deliver local improvement – backed with a continuous improvement approach and training. Our board to ward priorities for the first year of the plan are set out below

Our Vision : outstanding care together

C Collaboration & Partnership	A Affordable healthcare, fit for the future	R Right care, right place, right time	E Empowered, engaged staff
Ambitions for the end of this plan			
Most integrated health and care system in the NHS	Break even financially	Waiting times in top quartile, lower than expected mortality, reducing harm	Top five acute trusts in London for staff engagement
Board to Ward Priorities for 2026/27 – for <u>all</u> teams			
Work with other teams to reduce delays in patient journeys through our services	Live within our means, reducing our costs	Minimise risk of harm from delays in care	Make this a place we'd recommend to work and receive care
***Rationale**: In October 2025, 4,629 bed days were attributable to discharge delays – 2777 (ESTH) and 1852 (SGUH); Key to delivering the left shift, NEL Transformation programme, safe care, A&E performance targets (4 and 12 hrs).*	***Rationale**: Cost reduction and efficiency are critical to delivering our financial plan, a national priority. Achieving our ambitious 2026/27 plan will require sustained contribution from all teams across the organisation.*	***Rationale:** Mortality rates are at or below expected levels (reducing at ESTH, below expected at SGUH). This objective focuses on reducing long waits while strengthening our processes for assessing and understanding harm. Addressing inequalities will be integral to achieving this priority.*	***Rationale**: Staff confidence in recommending gesh as a place to work and to receive care are key indicators of engagement within the NHS Staff Survey. gesh currently performs around the national average on both measures.*

17

Delivering ambitious transformation

We have developed a medium-term transformation portfolio building on work already underway, and incorporating the ambition of the 10-year plan in order to deliver our vision.

The aims of our medium-term transformation portfolio:

C	• Shifting care from hospital to community: moving away from the traditional model of outpatient care to a new more community-based model of care for long-term conditions; and transforming non-elective care. In time, this will be supported by our ambition to become an Integrated Health Organisation.
A	• Accelerating workforce productivity, including through digital transformation – across our clinical workforce, our corporate services, and our operational administrative & clerical teams.
R	• Building centres of excellence across our clinical services, guided by our Clinical Strategy and Standards Groups, in areas such as surgery, paediatrics and renal care
E	• Building a new look gesh – a merged organisation able to deliver the benefits of being an Advanced FT and ultimately an integrated health organisation; with a quality management system that supports all our teams to be high performing.

The following slides set out the vision and case for change for our programmes in more detail.

Hospital to community shift

Transforming Non- Elective Care

SRO: MD SGUH

BACKGROUND

- We spend some £640m on non-elective care across gesh
- We know some of it is spent on patients who do not need to be in hospital – for them the NHS is delivering suboptimal care at great cost, and to the risk of patients who need inpatient care. For instance, every day some 240 beds across gesh are occupied by patients not meeting the criteria to reside; and in 24/25 c. 80 beds across gesh were occupied at any one time by adults admitted non-electively with ambulatory care sensitive conditions.
- The national plan is to shift care into the community, including by establishing neighbourhood health centres, and creating a 'digital front door' to non-elective care (patients should be able to book into the most appropriate urgent care service for them, via 111 or the app, before attending, by 2028).
- Analysis for the South West London clinically-led plan points to a major opportunities here, particularly to deliver better care for our frail older population.

PROGRAMME MANDATE

- With our place partners, build a new, digitally-enabled model of community care for our patients with frailty/LTCs – significantly reducing the amount of time these patients need to stay in our hospitals.
- If such a model enabled us to halve the number of bed days occupied by patients not meeting the criteria to reside or admitted for ambulatory care-sensitive conditions, it would enable us to take significant cost out of our current model, allowing us to invest in a new model of care

Outpatients / A new model for LTCs

SRO: MD ESTH

BACKGROUND/PROBLEM STATEMENT:

- We spend approximately £400m on outpatient care across gesh
- We know some of it delivers low clinical value and is a poor use of our clinicians' time – e.g. referrals that could be managed in primary care, low-value follow-ups.
- Our patients are waiting too long for care, and the Government wants 92% of patients to be seen within 18 weeks by 2029. We cannot hope to deliver this or our financial targets without transforming outpatients.
- The Government's ambition is to "end" the current model of outpatients as we know it.
- Analysis for the South West London clinically-led plan points to a major opportunities here

PROGRAMME MANDATE

- Take significant of cost out of our 'old outpatient model' through major reduction in follow-up activity & referral management/diversion, and estates rationalisation.
- Re-invest a proportion of those savings in a) returning to constitutional standards, and b) new, digitally-enabled models of community care, built collaboratively with our place-based partners, and including outreach from acute hospital staff

19

Transforming our productivity

Clinical Workforce

SRO: GCNO

BACKGROUND

- Our clinical workforce is central to our purpose, and our largest source of spend.
- We know that we do not make the best use of this resource, with deficiencies in job planning, rota management, tracking & controls
- We also know that we are not supporting our clinicians to operate at the top of their license, with time spent on both administrative and clinical tasks that could be automated / taken on by other staff through a different workforce skill mix – resulting in lower productivity and staff satisfaction.

PROGRAMME MANDATE

- Transform the way we deploy our clinical workforce – starting with the programmes already underway in 25/26 (for instance on medical workforce productivity) which will be the critical foundations/set of controls to build on
- Enable our clinicians to operate at the top of their license through use of technology / newer clinical roles

Corporate

SRO: GCOFIE

BACKGROUND

- Across gesh we spend c. £260m p.a. on corporate services. A fragmented digital infrastructure, suboptimal systems and processes, complex regulatory environment, limited adoption of automation, and limited data integration are impeding workforce efficiency. In places satisfaction with our corporate services is low, and job satisfaction for many of our corporate staff is lower than we would like it to be.
- There is a national expectation (e.g. from the NHS 10-Year Plan and NHSE productivity guidance) to deliver smarter, leaner A&C functions enabled by digital tools and data-informed decision-making.

PROGRAMME MANDATE

- Through service redesign, adoption of digital technology (incl. AI/RPA), self-service solutions, consolidation across gesh or SWL (including estates rationalisation), target a major reduction in cost over the medium term – whilst sustaining/improving staff satisfaction in the long term.

Clinical admin & clerical

SRO: SGUH COO

BACKGROUND

- A fragmented digital infrastructure, suboptimal systems and processes are impeding workforce efficiency for our clinical/ops A&C workforce. In places, satisfaction amongst this staff group is lower than we would like it to be.
- There is a national expectation (e.g. from the NHS 10-Year Plan and NHSE productivity guidance) to deliver smarter, leaner A&C functions enabled by digital tools and data-informed decision-making.

PROGRAMME MANDATE

- To ensure the optimisation of administrative and clerical (A&C) workforce across the Group to achieve sustainable cost reductions through evidence-based workforce analytics and targeted efficiency interventions
- Ensure the right people, processes, and technologies are in place to enhance the flow of patients and information, eliminate inefficiencies, and ultimately deliver better value for money.
- Reduce duplication, improve task clarity and ownership, and empower staff with tools and technologies that enhance their effectiveness.

Centres of excellence

Renal

SRO: MD SGUH

BACKGROUND/PROBLEM STATEMENT:

- SWL has two tertiary renal services, 4 miles apart
- Neither operating at optimum scale
- Inequalities for patients accessing the different services
- St Helier service not co-located with some key tertiary services at St George's
- Both in suboptimal estate

PROGRAMME MANDATE

To deliver an integrated gesh renal service located at St George's, by

- Progressing clinical / IT integration
- Progressing the estates solution

The intended benefits are as set out in the renal outline business case, consisting of a range of quality benefits, net neutral financial impact (range of financial benefits offset by revenue impact of capital).

Children's Services

SRO: SGUH CMO

BACKGROUND/PROBLEM STATEMENT:

- There is a long-standing consensus that the configuration of paediatric services in South-West London / Surrey is not sustainable – for both quality and financial reasons – and needs to change.
- The case for reconfiguring Epsom and St Helier's services, agreed by commissioners across the region in 2020 was based on concerns around our ageing infrastructure, the sustainability of our workforce, financial pressures and inefficiencies, and concerns around patient outcomes / minimum safety levels.
- Changing demographics (e.g. 23% reduction in births in SWL over the last 10 years) strengthen the case for change .

PROGRAMME MANDATE

- Deliver a paediatric strategy for gesh, aligned to the wider SWL clinical strategy
- Mobilise a programme to deliver that strategy, including improvements in our collective use of theatres, our tertiary paediatric portfolio, our model of care for children with complex needs, and the way we run our secondary paediatric services (surgical theatres and wards).

Maternity and Neonatal Strategy

SRO: ESTH CMO

BACKGROUND/PROBLEM STATEMENT:

- There is a long-standing consensus that the configuration of maternity services in South-West London / Surrey is not sustainable – for both quality and financial reasons – and needs to change.
- The case for reconfiguring Epsom and St Helier's services, agreed by commissioners across the region in 2020 was based on concerns around our ageing infrastructure, the sustainability of our workforce, financial pressures and inefficiencies, and concerns around patient outcomes / minimum safety levels.
- Changing demographics (e.g. 23% reduction in births in SWL over the last 10 years) strengthen the case for change

PROGRAMME MANDATE

- Deliver a maternity strategy for gesh, aligned to the wider SWL clinical strategy, targeting a range of quality benefits and financial benefits
- Mobilise a programme to deliver that strategy

21

Centres of excellence (2)

Surgery Strategy

SRO: SGUH COO

BACKGROUND/PROBLEM STATEMENT:

- There is a long-standing consensus that the configuration of NHS services in South-West London / Surrey is not sustainable for both quality and financial reasons and needs to change.
- SGUH struggles with capacity to deliver tertiary work (with significant outflows from SWL), and some SWL DGHs struggle to attract/retain the surgical workforce. Collectively SWL has a significant challenge to return to constitutional performance standards.
- Other changes envisaged above (e.g. renal),will likely require space to be freed up at SGUH.

PROGRAMME MANDATE

- Deliver a surgery strategy for gesh, aligned to the wider SWL clinical strategy, based on building centres of surgical excellence across the Group – with St George's acting as the centre for tertiary surgery, and our district hospitals as 'surgical hubs' for high-volume low-complexity work, building on the SWL Elective Orthopaedics model.

Clinical Support Services

SRO: MD ESTH

BACKGROUND/PROBLEM STATEMENT:

- Across our clinical support services, we have instances of service fragility, and demand outstripping capacity
- The case for forming the gesh Group assumed that a range of quality/financial benefits could be derived from bringing together clinical support services, operating at scale across SGUH/ESTH
- With the launch of the EPR at ESTH, there is now an additional opportunity to embed Group-wide standards in the shared EPR(e.g. to reduce unnecessary demand for testing)

PROGRAMME MANDATE

- Strengthen and align the Clinical Support Services across the Group to ensure they are sustainable, resilient, and consistently high quality – starting with a single Group-wide pharmacy function
- Address areas of service fragility, better match capacity to demand, reduce areas of high cost spend, and reduce unwarranted variation in clinical practice.
- Through having a shared EPR embed Group-wide standards, streamline pathways, and deliver quality and financial benefits.

Medical Specialties Across ESTH

SRO: MD ESTH

BACKGROUND/PROBLEM STATEMENT:

- A range of medical specialties operate across both Epsom and St Helier, at suboptimal scale
- This results in a range of quality/workforce/financial challenges

PROGRAMME MANDATE

- Deliver a more networked model of care for some medical specialties across the Epsom and St Helier sites – as part of a gesh-wide network
- Starting with exploring the potential for this approach in gastroenterology, respiratory, cardiology
- Aiming to improve service quality/robustness, and deliver improved financial sustainability

Our ways of working

Quality Management System

SRO: DCEO

BACKGROUND/PROBLEM STATEMENT:

- Evidence and experience shows us that by creating the right conditions for continuous improvement and high performance, systems and organisations can respond to today's challenges, deliver better care for patients and give better outcomes for communities.
- C. 20% of our staff say they are not able to make improvements happen in their area of work.
- Embedding continuous improvement as the primary method for addressing clinical, operational, and financial challenges is best achieved through a coherent & explicit management system in an organisation

PROGRAMME MANDATE

- To design and implement an evolved quality management system for gesh which will enable our organisations to meet the needs of our populations and continuously improve the care and experience provided.
- To develop, test and embed essential functions of a Quality Management System – Quality Planning, Control, Assurance and Improvement.
- Implement improved quality & performance insight capabilities (such as measuring outcomes, value and predictive analytics)
- Develop and scale up processes to grow QI capability in our teams.
- Engage and co-design, with focus, the specific behaviours helping to create the leadership & culture which is essential to our success.

Organisational form

SRO: DCEO

BACKGROUND/PROBLEM STATEMENT:

- ESTH and SGUH being separate legal entities limits the benefits we can deliver from Group-wide working. Certain clinical and corporate functions must be duplicated by law, adding cost and complexity.
- Each Trust operates under its own financial and performance frameworks.
- Despite strong collaboration, staff often remain aligned to their individual organisations. This can create hesitation around designing integrated services, especially when future organisational change is anticipated.
- Even where collaboration is legally permissible, the dual-organisational model introduces complexity and slows progress.

PROGRAMME MANDATE

- To identify and develop the appropriate organisational form to enable our journey to IHO status.
- Develop a strategic business case and subsequently a full business case setting out a clear, evidence-based rationale for exploring a merger between SGUH and ESTH, testing whether a merger would deliver improved quality, safety, and sustainability of services for patients, key risks and opportunities and a robust long term financial case.
- Change programme to take us to Day 1 of transaction and beyond to IHO status

gesh

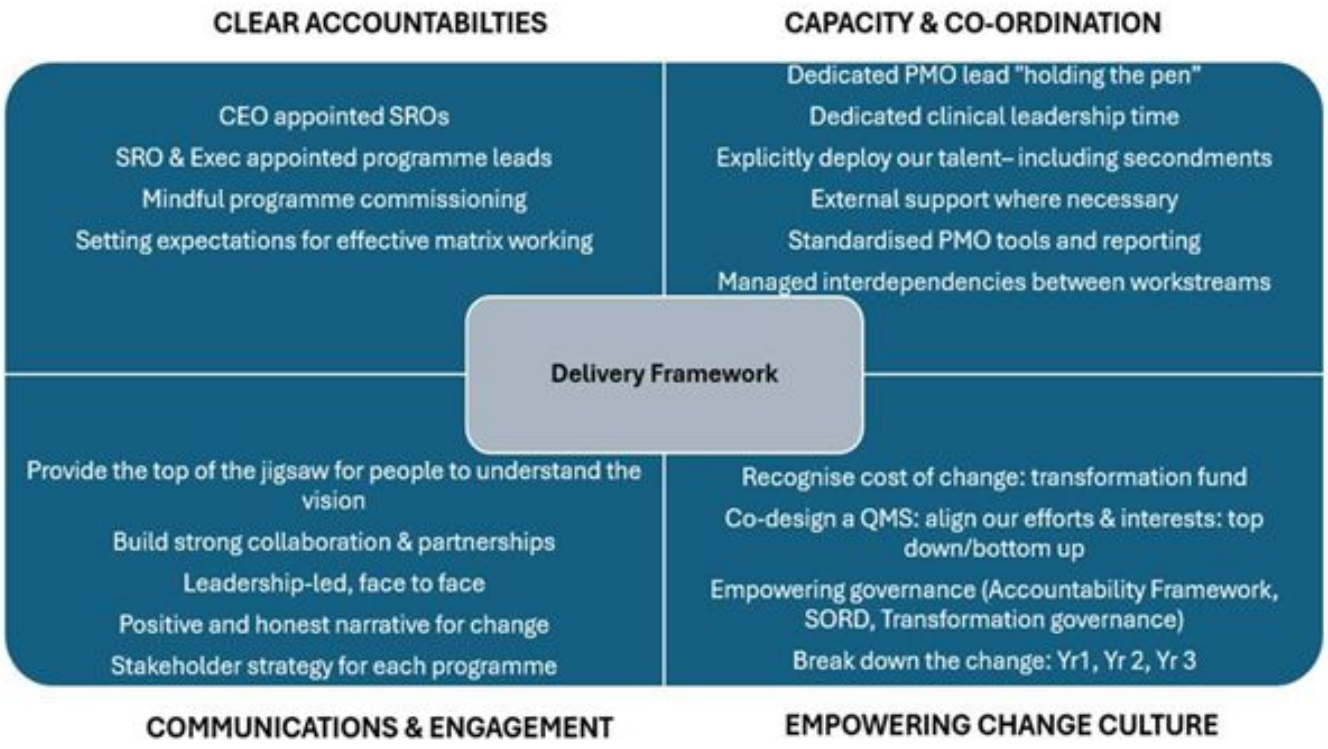
Confidential: Not for wider circulation

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

Delivery framework

This transformation portfolio is underpinned by a delivery framework, combining:

- Clear accountabilities
- Capacity & coordination
- Communications & engagement
- Empowering the right culture for change



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

gesh

Enablers

Key enabler – analogue to digital shift

Our Digital and Data Strategy for 2025–2028 is a cornerstone of the Group's transformation plans to deliver the Medium-Term Plan's strategic ambitions, in alignment with Group, Trust-wide and national NHS priorities. It sets out how we will move from fragmented systems and under-investment to a digitally mature, secure, and inclusive health ecosystem. The emerging strategy recognises that we have significant opportunities: national funding linked to digital readiness, AI and automation to reduce administrative burden, and tools like the NHS App and Single Patient Record to empower patients and integrate care. Below outlines what we want to achieve and where we are going to prioritise our efforts over the coming years.

gesh Digital Strategy - emerging vision and mission

Vision:
To be a digitally enabled health system that delivers outstanding, equitable care – at anytime, anywhere - by harnessing data and technology to improve health outcomes and save lives

Mission:
"Provide a digitally mature, resilient, and inclusive health system where seamless, secure, and intelligent digital and data services empower our workforce, connect our communities, and transform care delivery - enabling every patient to access personalised, data-driven care wherever they are."

Rock-Solid Foundations

We commit to building the infrastructure on which all modern care depends. This includes major upgrades across **infrastructure, end-user devices, and cyber security**, ensuring the Group operates from a resilient, secure and high-performing digital platform. Without these foundations, transformation cannot scale.

Data & AI

With the transition to the **Federated Data Platform (FDP)**, we will unify reporting, consolidate business intelligence, and open the door to advanced **predictive analytics**. This will empower clinicians and operational teams with timely, accurate insights—and position us at the forefront of safe, responsible AI adoption within the NHS.

Optimised EPR and EMIS Functionality

Optimising this functionality would allow Clinicians across both trusts to access a single, comprehensive patient record, eliminating duplication and gaps in information. Patients could move between hospitals, clinics, and community services without repeating tests or providing the same information multiple times.

Digital front door for our patients

Through the NHS app, patients will be able to access appointments, test results, personalised health advice, and remote monitoring tools. This would improve transparency, reduce missed appointments, and foster self-management.

Ambient AI scribing

Clinicians would spend significantly less time looking at a computer screen to manually document consultations as AI would transcribe and summarise patient interactions in real time, freeing up time for direct care. This would reduce burnout, improve documentation accuracy, and allow clinicians to focus on complex decision-making.

Single AI enhanced management solution

A unified service desk powered by AI would replace fragmented support systems. Staff could access help via chatbots, voice assistants, or mobile apps—reducing wait times and improving resolution speed. AI would triage requests, predict issues, automate routine tasks (e.g. password resets, equipment bookings), and improve access to corporate services.

IT system consolidation

The gesh Group will look and feel like "One gesh" to the workforce by aligning our very significant number of corporate/clinical systems. There will be operational and corporate efficiencies with the potential to bring about significant savings and create a sense of working as one organisation where patients and staff will be better supported moving between our sites.

gesh

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

Key enabler – supporting our workforce

Strategic vision for workforce
By 2028 gesh will be among the top five acute trusts in London for staff engagement.
We will achieve this through a focus on the following areas: Get the basics right for all our staff; Improve staff wellbeing; Ensure our culture is inclusive and driven by our values; Develop our workforce for the future; Embrace different ways of working

Our workforce is a core driver of transformation. New workforce models are essential to delivering reconfiguration, enabling the 'left shift', and supporting new ways of working. Our strategy sets out the workforce we need to achieve our ambitions over the next five years.

Workforce model:
- Aligns workforce planning with transformation, service change, performance and finance.
- Built on realistic financial envelopes, productivity expectations and workforce supply assumptions.
- Depends on sustained productivity improvements and reduced reliance on temporary staffing to ensure long-term sustainability.

Get basics right	• Transform our HR function • Strengthen job planning, establishment control, rostering and SafeCare.
Improve staff wellbeing	• Improve line management and leadership • Improve training and career development • Reform the way we recognise and reward staff • Reduce sickness absence
Inclusive culture	• Develop a shared set of values across gesh • Deliver our culture, diversity & inclusion programme
Develop workforce	• Develop new workforce models through BYFH • Reduce reliance on temp staff • Explore strategic collaboration with SGUL and City • Grow multidisciplinary teams and extended practice roles.
Different ways of working	• Enable collaboration across the gesh Group • Develop high-performing teams/continuous improvement • Reduce admin burden through digital tools and ambient voice technology.

gesh

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

Key enabler – improving our estate

Improving estate safety	Improving value for money	Improving environmental sustainability	Strategic estates change
• Improve the safety and compliance of our estate, including essential upgrades to our Emergency Departments at St Helier and St George's, and the E Block at St Helier.	• Modernise how we work through digital innovation, smarter use of our estate, and estates rationalisation (particularly for non-clinical spaces). • Ensure robust capital planning that drives standards and aligns with our strategic objectives over the medium term.	• Deliver our green plan by cutting emissions, reducing waste and creating a more sustainable estate and operational model.	• Progress major strategic estates developments, including the new renal unit and ICU at St George's, and towards the end of this five year period, remobilising to deliver the Specialised Emergency Care Hospital in Sutton in the 2030s.

Environmental sustainability as a cross-cutting issue

The NHS 10-Year Plan reinforces existing commitments from Delivering a Net Zero Health Service, including reaching net zero by 2040 for emissions the NHS directly controls and 2045 for those it can influence. The health system will be required to decarbonise, minimise environmental impact, and strengthen resilience to climate risks, in line with the Health and Care Act 2022.

Collaboration and partnerships	Affordable healthcare, fit for the future	Right care, right place, right time	Empowered, engaged staff
• Embed sustainable models of care, including reducing unnecessary hospital activity and shifting to community-led, prevention-focused pathways, consistent with both the NHS 10-Year Plan and our Green Plan. • Working local partners to mitigate the health impacts of climate change at scale	• Recognising that our planetary ecosystem provides the basis for human health achieving Net Zero Carbon will make us fit for the future. • Strengthening our adaptation and resilience to climate risks enables us to become more efficient save money and improve clinical outcomes.	• Modernise how we work through digital innovation, supporting the national shift from analogue to digital and enabling more efficient, lower-carbon models of care. • Supporting a shift to preventative healthcare through active travel & transport, healthy diets and reduced pollution.	• Equip our leadership and workforce with the ability and tools to drive sustainable quality improvement across clinical and operational teams.

Group Board Meeting (Public)

Meeting on Thursday, 05 March 2026

Agenda Item	3.1	
Report Title	**Quality Committees Report**	
Executive Lead(s)	Elaine Clancy, Interim Group Chief Nursing Officer Richard Jennings, Group Chief Medical Officer	
Report Author(s)	Leonie Penna, Co Chair of Quality Committees	
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 January and February 2026 and the matters the Committees wish to bring to the attention of the Group Board. These include:

1. Quality Priorities Quarterly Update: Committees members agreed that limited assurance could be taken against the progress in delivering the quality priorities. Committees members agreed that on reflection, it was crucial that realistic priorities are set for 2026/27 to ensure that colleagues are able to deliver against what is set.
2. Maternity Services Report: Committees members agreed that reasonable assurance could be taken that controls are in place to manage the maternity services effectively, however members included a caveat to this assurance which was dependant on mitigations being provided for the maternity risks in future reports
3. Maternity CNST Submission: Upon receiving delegated authority from the Group Board, the Committees approved the Maternity Incentive Scheme Compliance (CNST) submission. Both SGUH and ESTH are on track to achieve all 10 Safety Actions for MIS Year 7. Compliance was reviewed and agreed with the Integrated Care Board (ICB) in February 2026.

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 January and February 2026.

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, 05 March 2026

1.0 Purpose of paper

1.1 This report sets out the key issues considered by the Quality Committees at its meetings in January and February 2026 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 29 January 2026 and the 26 February 2026 the Committees considered the following items of business:

29 January 2026	26 February 2026
• Group Key Issues Report • Maternity Services Report • Medicines Management Update • Winter Plans - QIA • Association for Perioperative Practice Theatre Safety Report • Quality Impact Assessment of Cost Improvement • SHMI Analysis	• Group Key Issues Report • Patient Safety Incident Response • Internal Audit Report: Patient Safety Incident Response Framework (ESTH) • Maternity Services: Maternity Incentive Scheme Compliance (CNST) • Quality Priorities 2025/26: Update on Progress • Internal Audit Report: Maternity Services (SGUH) – Partial Assurance • Integrated Quality Performance Report: Focus on Quality and Safety Metrics • Internal Audit Report: NICE Compliance – Reasonable Assurance • Quality and Safety Concerns Raised by Staff • Committees Effectiveness Review

2.2 The Committees was quorate at both meetings.

3.0 29 January 2026 – Key Issues for Escalation to Group Board

3.1 <u>Maternity Services Report</u>

3.1.1 Committees members agreed that an area of concern was regarding patient experience at St George's for women from global majority ethnicities., A maternity colleague had reported informally that her experience was that black & brown women are treated differently to white women. The Director of Midwifery advised that she has also had similar discussions with colleagues and that she plans to establish an EDI working group which will review both external and internal reports to determine how to ensure that patient experience is consistently positive for patients of all ethnicities.

3.1.2 Members noted that when detailing the CQC must-do actions, the report advised that the 3 remaining actions were being discussed at the Evidence Assurance Panel on the 21st January, she asked what the outcome of the meeting was with regards to those actions. It was

advised that the panel was satisfied that the work around medicine management had been completed, allowing this action to be closed, however the actions relating to appraisal and documentation remain open. There will be a further Evidence Assurance Panel in April 2026, where hopefully evidence of sustainable improvement in these areas can be presented.

3.1.3 Committees members agreed that **reasonable** assurance could be taken that controls are in place to manage the maternity services effectively, however members included a caveat to this assurance which was dependant on mitigations being provided for the maternity risks in future reports.

3.2 Key Issues Report

3.2.1 Non-Executives requested that the draft Quality Priorities for 2026/27 are presented for discussion by the Committees before the end of the financial year. Members agreed that flow was of upmost priority, but noted that this can be difficult to monitor in the way that other priorities are measured and so therefore it may become part of trust wide priority which focuses on maintaining dignity for patients in all aspects of care, or something to similar.

3.2.2 Executives were asked for detail on the patient harm which was referenced in the report in relation to the Resident doctors industrial action. CMO-SGUH advised that one particular patient had their operation cancelled due to the industrial action. They were rebooked for the following week, but as that week was Christmas they declined the appointment and sadly died shortly after before their admission date Although this was the only incident of harm noted this time, incidents systematically collected to ensure a full understanding of patient harm.

4.0 29 January 2026 – Key issues to which the Committees received assurance

4.1 Winter Plans - QIA

4.1.1 The Committees Co-Chair noted that the QIA for the plans has been delayed in its presentation to the Committees, he asked what the process will be for the next winter plans to ensure they are presented in a timely manner. GCNO advised that the QIA for the plans should rather be named the EQIA to ensure that equality is included and advised that she is currently working through the process to ensure that it is improved for the upcoming year, with the view for the EQIA to be presented to the Committees and possibly Group Board by December at the latest.

4.1.2 Committees members agreed that **reasonable** assurance could be taken that the appropriate mitigations are in place with regards to delivering the winter plans.

4.2 Association for Perioperative Practice Theatre Safety Report

4.2.1 Members noted that the culture piece was very interesting, asking how any culture change in the theatres could be measured. CMO-SGUH noted that the staff survey will provide crucial insight into how staff experience has changed since the last survey. The theatres team have also co-created the charter around how they want the culture to feel like in their theatres. The team now monitor how incidents relating to behaviour are managed, particularly what the outcomes are in relation to those types of issues.

4.2.2 The Committees agreed that **reasonable** assurance could be taken that appropriate mitigation are in place to effectively manage theatre safety.

4.3 Quality Impact Assessment of Cost Improvement

4.3.1 Committees members welcomed the paper, noting that the Executive summary provided an excellent overview of they key issues. The Co-Chair commented that the detail of the CIPs which were rejected was helpful in providing significant assurance that this process in undertaken in a robust manner.

4.3.2 Non-Executives referred to the approval of the increase in staff car parking costs asking if the panel had considered the potential inequitble effect this might have on some of our staff suchas disproportionate impact on staff with lower incomes orcommunity-based roles. GCMO advised that the panel had considered this and acknowledged that such impacts were unavoidable but felt they were acceptable in the context of the need to run a financially sustainable organisation

4.3.3 Committees members agreed that **substantial** assurance could be taken that the appropriate mitigations and processes are in place to manage the Quality Impact Assessment of Cost Improvement.

4.4 Medicines Management Update

4.4.1 Committees members discussed the challenges and success throughout this reporting period. It was noted that one success is around the alignment across gesh, particularly in the way that controlled drugs are managed. The education and training of staff has also been aligned which has created a consistent workforce. The vacancy rate from an ESTH perspective has considerably improved, with vacancy rate now down to less than 10%, which is the trust target.

4.4.2 Committees members agreed that **reasonable** assurance could be taken that the mitigations are in place with respect to medicines management.

5.0 26 February 2026 – Key issues to which the Committees received assurance

5.1 Patient Safety Incident Response Framework

5.1.1 Committees members discussed how at SGUH, colleagues have identified an emerging theme relating to delays in assessment, follow-up results, plans and decisions, of which similar issues have been identified repeatedly over time, representing an ongoing organizational risk requiring a coordinated system wide approach. An MDT review of a cluster of cases was undertaken and the team is now working to understand what actions can be taken to resolve issues internally, but also what issues may require system help to resolve broader outpatient transformation. A number of operational risks relating to this will be added to the corporate risk register to ensure there is appropriate oversight of the mitigations in place relating to this.

5.1.2 The Committees noted that there has been a number of never events this year, agreeing it would be beneficial to have an overview of what actions have been taken as a result of these never events as well as information to confirm that they were effective. It was agreed that members would discuss this outside of the meeting and determine how to best to provide this assurance to the Committees in the future.

5.1.3 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 could be increased once the report into the patient safety investigations has been considered.

5.2 Maternity Services: Maternity Incentive Scheme Compliance (CNST):

5.2.1` The Committees received delegated authority from the Group Board to approve the CNST submissions for both SGUH and ESTH. It was noted that although earlier trajectory modelling suggested that SGUH may achieve only 8 of the 10 Safety Actions, final review and evidence validation has now confirmed that SGUH is able to declare compliance with all 10 Safety Actions for MIS Year 7. ESTH has remained on track to achieve all 10 Safety Actions for MIS Year 7. Compliance was reviewed and agreed with the Integrated Care Board (ICB) in February 2026.

5.2.2 The Committees **approved** the Maternity Incentive Scheme Compliance (CNST) submission.

5.3 Quality Priorities

5.3.1 Committees members received the report, which detailed the Group performance as below:

Areas of Improvement

- Sustained reduction in Category 4 pressure ulcers.
- Improving VTE trajectory at SGUH.
- Falls harm reduction improving at ESTH.
- Continued governance oversight of ED risks through the UEC Transformation Programme.

Areas Requiring Further Focus

- VTE compliance below 95% target at both Trusts.
- Delirium assessment data collection is now established. The next step will be to deliver improvement plans to achieve the 90% target.
- ED 4-hour performance below target at ESTH.

5.3.3 The Non-Executive Directors noted that the VTE performance has improved at SGUH, seeking clarification on whether this improvement is due to the success of the implemented actions or due to the change in how VTE is reported against. It was advised that the reporting method was changed in October, and the quarter prior to October saw an improvement from around 60% compliance to in the 70s as a result of the actions taken.

5.3.4 Committees members discussed that the low number of recorded pressure ulcers at ESTH raises a concern regarding the accuracy of this data. As a result, the GCNO has suggested that peer reviews are undertaken as pressure ulcers can be subjective in terms of grading. Once this review has been completed, an update will be presented to the Committees.

5.3.5 Committees members agreed that **limited** assurance could be taken against the progress in delivering the quality priorities. Committees members agreed that it is crucial that realistic priorities are set for 2026/27 to ensure that whilst providing challenge for quality improvement that the priorities identified are deliverable.

6.0 26 February 2026 – Items for noting by the Committees.

6.1 Internal Audit Reports

6.1.1 The Audit and Risk Committees referred the following reports to the Quality Committees:

- Internal Audit Report: Patient Safety Incident Response Framework (ESTH) – Partial Assurance
- Internal Audit Report: Maternity Services (SGUH) – Partial Assurance
- Internal Audit Report: NICE Compliance – Reasonable Assurance

6.2 IQPR

6.2.1 Committees members received this report, noting the recommendation form the Committee Effectiveness review that focus on Quality and Safety Metrics is undertaken by QCiC.

6.3 Committee Effectiveness Review

6.3.1 Committees members reviewed the report and agreed that the findings should be considered as part of the development of the forward plan for next year. It was agreed that ideally the forward plan should be presented at the next meeting for agreement ahead of the next financial year.

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 January and February 2026.

Group Board

Meeting in Public on Thursday, 05 March 2026

Agenda Item	3.2	
Report Title	**Maternity Update**	
Executive Lead(s)	Elaine Clancy, Interim Group Chief Nursing Officer	
Report Author(s)	Annabelle Keegan, Director of Midwifery and Gynaecology Nursing	
Previously considered by	gesh Quality Group Quality Committees	12 February 2026 26 February 2026
Purpose	**For Assurance**	

Executive Summary

1.0 Purpose
This report is submitted to provide oversight of maternity service across the gesh Group and escalate for review as required. It contains current metrics within the appendices and a CNST summary.

Key risks and issues for escalation
Although there is good evidence presented within this report of progress and improvement across the services (see appendices) there still remain some key areas of risk that need to be highlighted to the Board.

GESH

1. **iClip issues**:
   SGH - Since the implementation of iClip Pro at SGUH in February 2024, several challenges have arisen post-implementation. A risk assessment has been completed and added to the Risk Register. The update has now completed and we have been in the February test platform stage, aiming for go-live at the end of February. The Divisional Tri are cognisant that immediate action must be taken should the update not resolve the specific concerns such as MEWS and VTE.
   ESTH – the MIS system in place for maternity records is Badgernet and, as a separate system to iClip, the same issues do not apply.

2. **CNST:** The sign-off meeting for both sites took place earlier in February with details outlined below. CNST yr 8 will be significantly different, with a total of 6 Safety Actions (SAs) expected. This does not mean a reduction in workload rather a different approach overall. We await further details. The current year's Maternity Incentive Scheme compliance position for both Trusts was reviewed and approved by the Quality Committees under delegated authority from the Board:
   SGUH - It is confirmed that SGH have met 10/10 SA's for this MIS yr7.
   ESTH - It is confirmed that ESTH have met 10/10 SA's for this MIS yr7.

3. **STAN monitoring and storage of CTG's issues:** Issues relating to the storage of fetal monitoring records was identified in January 2025 and escalated to Neoventa. SWL fetal

monitoring midwives and Directors of Midwifery (DoMs), including Chief Nurse Information Officer (CNIO) and IT, have met to discuss the on-going issues across SWL are waiting for a confirmed date to meet with Neoventa as part of escalation, requested for early March 2026.
SGUH - Mitigation is in place to ensure safe storage of CTG's via Omniview and confirmed via manual download weekly, with no CTG records have been lost to date.
ESTH – As ESTH does not use Omniview, it relies on direct uploading of CTG records from the STN machine to the patient record. There are a number of identified lost CTG's found to date with mitigation now in place to ensure safe storage of CTG's and confirmed via manual download weekly. It is on the risk register at '15 - Extreme'

Site specific

ESTH:

4. **Training** – Fetal monitoring training for Resident Doctors has fallen below 90% which has been mapped into the study day planning to ensure it moves to above 90% as the safety standard KPI. This should be seen as an improved trajectory over the coming 2 months

SGUH:

5. **Fresh Eyes -** There is currently no requirement to audit completion of fresh eyes. Saving Babies lives removed that aspect in April 2025 saying it was not effective use of time and was being used as a false proxy marker of safety. They also highlighted that despite efforts there was not a national agreement for audit standards and how the aim is 80% compliance was defined and so there was inconsistency and results were not comparable across trusts. SBL recommend that fresh eyes is still considered through local case reviews following incidents or as part of other meetings to see if it has or hasn't been completed and in turn consider whether it would have made any difference to the care. This is being done and so far no issues have been raised regarding completion.

   SGH have continued to audit frequency of hourly case midwife classification, % of correct classification and % evidence of escalation. This is detailed, and is 10/month, although we will consider an increase if we are not meeting the target or if internal or external governance processes raise any concerns. These measures were chosen because levels of correct classification and escalation will give us more detail about practice than simply whether or not a fresh eyes review was carried out, and if they are high will provide assurance of following guidance.

6. **MSSP –** this has now changed to MatNeoIST and SGH remains in targeted support for 6 months until June 2026. This is reported through the Trust maternity Oversight meeting

Action required by Group Board

The Group Board is asked to:

a) Note the maternity service updates and the key risks and points for escalation
b) Note that both ESTH and SGUH are compliant against all 10 Safety Actions in the Maternity Incentive Scheme, following review and approval by the Quality Committee in February 2026 under delegated authority from the Board.
c) Consider any aspects where further assurance is required.

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	ESTH Maternity Services Summary report
Appendix 2	SGH Maternity Services Summary report

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 report.

CQC Theme

☒ Safe	☒ Effective	☐ Caring	☐ Responsive	☒ Well Led

NHS system oversight framework

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

Financial implications

SGUH: Achieved 10/10 Safety Actions
ESTH: Achieved 10/10 Safety Actions

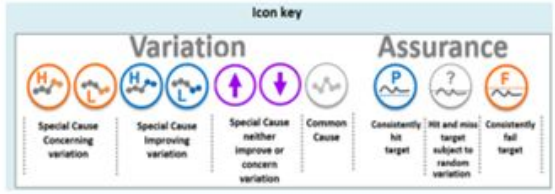
Legal and / or Regulatory implications

SGUH: There is an ongoing requirement to achieve compliance in the MUST and SHOULD Do actions issued by the CQC 2023 inspection at SGH maternity services in line with the Health and Social Care Act 2008 (Regulations 2014) and CQC Registration Regulations.
In January 2025, SGUH maternity received a section 29A following their CQC inspection in October 2024. Maternity have completed an action plan, which is being monitored via the maternity oversight group. CQC Inspection Report October 2024 was published in September 2025. Overall SGH maternity services were rated as Requires Improvement which demonstrates some improvement although concerningly CQC theme Safe remained at Inadequate.
ESTH: Sign off required for reports as outlined. CQC inspected maternity services as part of the Trust inspection in December 2025, awaiting feedback.

Equality, diversity and inclusion implications

Maternity services across GESH remain committed to delivering equitable, person-centred care that recognises and responds to the diverse needs of women, birthing people, and families using the service. Data continue to show disparities in maternity outcomes across ethnic groups, levels of deprivation, and other protected

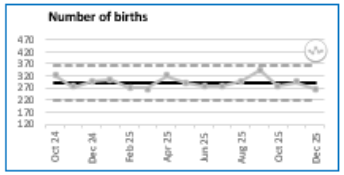
characteristics; ongoing review of outcome data aims to identify and address any inequalities. Targeted community engagement strengthened use of interpretation services, and culturally sensitive care planning are being embedded to support informed choice and improve access to care. Staff continue to undertake mandatory equality, diversity and inclusion training, with a focus on cultural awareness and unconscious bias. The services also promotes inclusive workforce practices through staff networks and equitable access to professional development. These actions collectively support the maternity objective to reduce health inequalities and ensure all service users receive safe, respectful and responsive maternity care.
Environmental sustainability implications
SGH: none noted ESTH: none noted



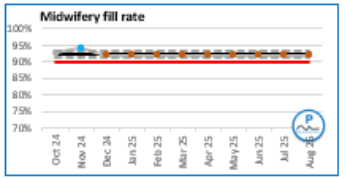
Appendix 1: ESTH Maternity Overview

Maternity overview | **ESTH**

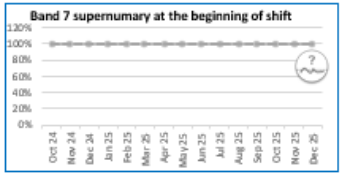
Latest month 01/12/25
Number of birth 263
No significant change



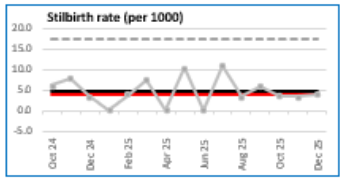
Latest month 01/08/25
Midwifery fill rate 90%
Significant deterioration



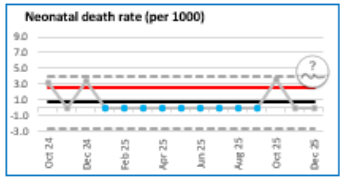
Latest month 01/12/25
Supernumary status 100%
No significant change



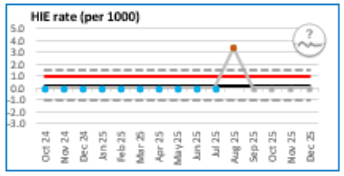
Latest month 01/12/25
Still birth rate/1k 3.8
No significant change



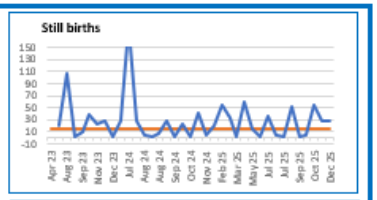
Latest month 01/12/25
Neonatal Death 0.0
No significant change



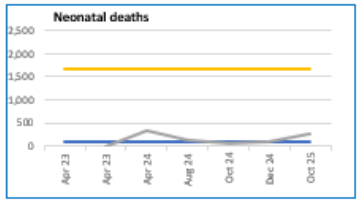
Latest month 01/12/25
HIE rate/1000 0.0
No significant change



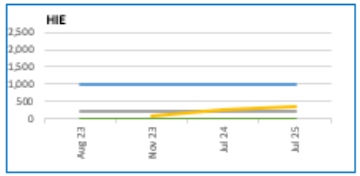
Date of last stillbirth 25/12/25
Average days between 15.4
No significant change



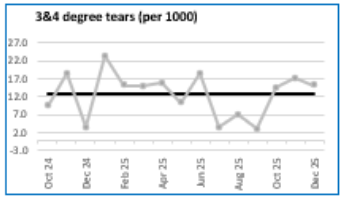
Date of last neonatal death 06/10/25
Average days between 91.1
No significant change



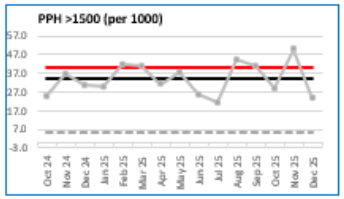
Date of last HIE 30/07/25
Average days between HIE 207.4
No significant change



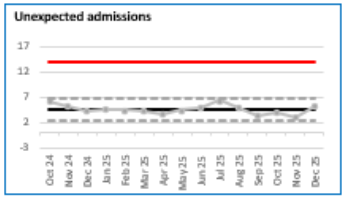
Latest month 01/12/25
3&4 degree tears (per 1000) 15.2
No significant change



Latest month 01/12/25
PPH >1500 (per 1000) 23.3
No significant change



Latest month 01/12/25
Unexpected admissions to NNU ATAIN 5.1
No significant change



1

Response to Moderate Harm Incidents

In ***December 2025*** there were 5 incidents reported which resulted in moderate or above harm; 3 related to Post Partum Haemorrhage >1500mls and 1 related to a 3rd degree tear. These incidents will be downgraded to low harm is following review, there were no patient safety incidents which contributed to the outcome.

There was one stillbirth which occurred in December 2025 and this will be review through the Perinatal Mortality Review Tool panel meetings.

Training – All staff groups PROMPT, CTG, and NLS training.

Total n=compliant		In Month Performance (+bank)	Rolling 12 months % compliant
Midwives total:	*223 (248 with bank)*		
Fetal Monitoring	212	10+3	95.07% (95.16% with bank)
Virtual Essentials	194	20	87%
Maternity Essentials (MW only)	66 (new)	18	29.60% (new)
Obs CRISIS(PROMPT)	206	24+2	92.38% (91.94% with bank)
MSWS total:	*56 (73 with bank)*		
MSW specific day	53	0	94.64%
Obs CRISIS(PROMPT)	54	5+2	96.43% (97.26% with bank)
Obs Consultants total:	*30*		
Fetal Monitoring	28	1	93.33%
Obs CRISIS(PROMPT)	29	3	96.67%
Obs MGs total:	*26 (17 without GP trainees)*		
Fetal Monitoring	15	6	88.24%
Obs CRISIS(PROMPT)	24	5	92.31%
Anaesthetists total:	*43*		
Obs CRISIS(PROMPT)	41	7	95.35%

Key headlines

- **CNST –** all 10 SA's have been achieved and have been signed off by the ICB.
- **Health inequalities** – the EDI working group is now in place with service user involvement. The aim is to review maternity services and understand the gaps and improvements to meet the needs of service users to provide parity and equity to all
- **CQC patient survey 2025** – this action plan will be co-produced with the MNVP and integrated into the Maternity and Neonatal Unified plan for oversight
- **IOL transformation project** – Data at EGH in July 2025 showed an increase in delays to the Induction of Labour (IoL) process. This is being reviewed as part of a wider IoL transformation project to understand the cause and enable action to be targeted to improve the pathway
- **Homebirth review** – In light of the Coroner's recommendation from the N England maternal and neonatal death, a review of homebirth services is being undertaken. There have not been any patient safety incidents however a reduced workforce in this specialist team has led to an increase in service user contact
- **CQC Patient Survey 2025** – work has commenced to co-produce an action plan to improve the areas of focus, although ESTH remain in the top 3 providers in the region

Progress updates

- **Feedback** - There has been a large number of positive birth experiences sent to the service via PALS.
- **Estates works** – these continue over both sites with bathroom refit on the ward at STH, complete refurbishment of the Birth Centre with 2 new pools at STH and major works to bring MAU and triage up to standard at EGH making good progress

Staff feedback to Maternity Safety Champions

- Staff feedback from CQC visit was positive with many curious to know when the report will be available
- Positive feedback regarding the ongoing estates improvement works on both sites
- Concerns raised regarding the ongoing infestation of mice on the St Helier site.

Midwifery Fill Rates

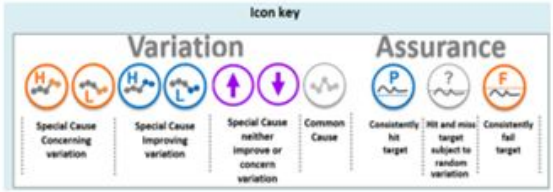
- St Helier 93%
- Epsom 92 %

Improvement from previous months due to the onboarding of 5 wte newly qualified midwives who have now completed their induction which will enable us to work towards the Trust target of 94% (please note SPC chart did not update on slide 1 for this aspect)

Progress in achievement of CNST 10 – Launched April 2025

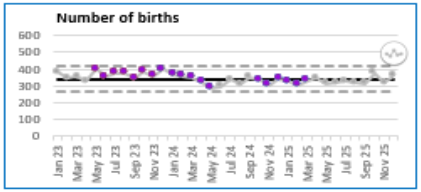
SA1		**SA6**	
SA2		**SA7**	
SA3		**SA8**	
SA4		**SA9**	
SA5		**SA10**	

Appendix 2: SGUH Maternity Overview



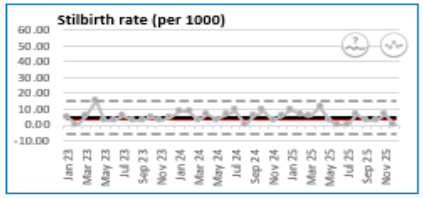
Latest month 01/12/25
Number of births 357

No significant change



Latest month 01/12/25
Still birth rate/10 0.0

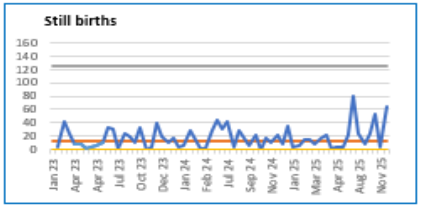
No significant change



Date of last stillbirth 29/01/26

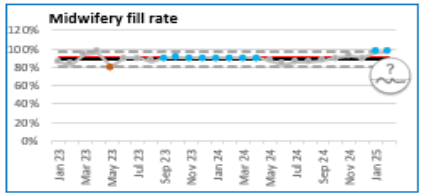
Average days between 13.0

No significant change



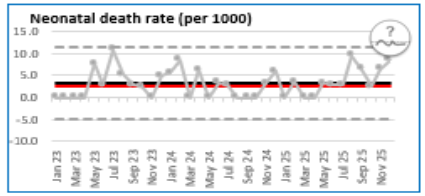
Latest month 01/02/25
Midwifery fill rate 90%

Significant Improvement



Latest month 01/12/25
Neonatal Death rate/1000 8.4

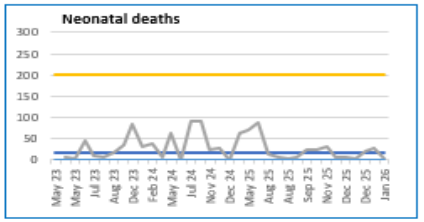
No significant change



Date of last neonatal death 28/01/26

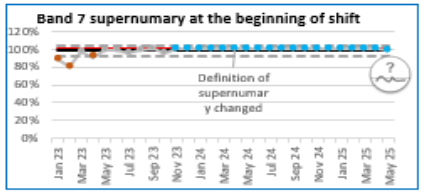
Average days between 19.1

No significant change



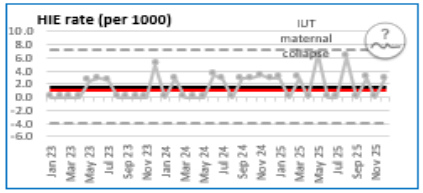
Latest month 01/05/25
Supernumary status 100%

Significant Improvement



Latest month 01/12/25
HIE rate/1000 2.8

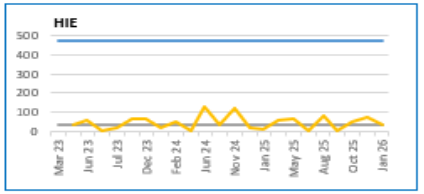
No significant change



Date of last HIE 19/01/26

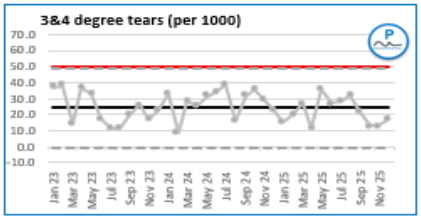
Average days between HIE 35.2

No significant change



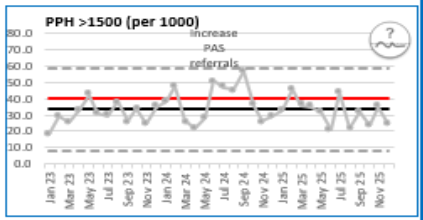
Latest month 01/12/25
3&4 degree tears (per 1000) 17.0

No significant change



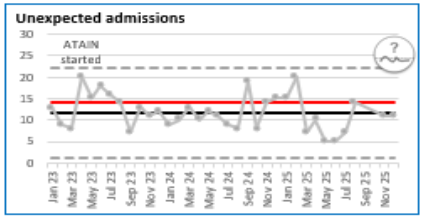
Latest month 01/12/25
PPH >1500 (per 1000) 25.0

No significant change



Latest month 01/12/25
Unexpected admissions to NNU ATAIN 11.0

No significant change



Response to Moderate Harm Incidents

In ***December 2025*** there were 14 incidents reported which resulted in moderate or above harm; 7 PPH's over 1.5 litres, 5 third degree tears, 1 admission to NNU, I HIE, and 2 related to midwifery staffing. All of these cases were reviewed in moderate cases MDT and the HIE case was referred and accepted by MNSI. Immediate learning has been implemented following 72-hour review.

Training –PROMPT, CTG, and NLS training. Outlined below

CNST Training Statistics

Dec-25

Staff Group	PROMPT			Fetal Monioring			NBLS			Saving Babies Lives (3 years)		
	Total Establishment	Number Trained	CNST compliance %	Total Number	Number Trained	CNST compliance %	Total Number	Number Trained	CNST compliance %	Total Number	Number Trained	CNST compliance %
Midwives and Nurses	212	197	93%	204	167	82%	204	192	94%	204	194	95%
Obstetric Cons	19	19	100%	19	18	95%						
Trainees and Fellows	33	28	85%	32	27	84%						
HCA and MSWs	38	36	95%									
Junior Anaesthetists	18	15	83%									
Obstetric Anaesthetic Cons	17	16	94%									
Neonatal Consultants									#DIV/0!			
Neonatal Resident Doctors									#DIV/0!			
Neonatal Nurses									#DIV/0!			
ANNP									#DIV/0!			
Overall total	337	311	92%	255	212	83%	204	192	#DIV/0!	204	194	95%

Key headlines

- **iClip** – the Trust wide upgrade has now moved into the test phase with the schedule on track to be live by end February. An immediate assessment is then needed to review the critical maternity elements, those being MEWS and VTE, to ensure they are now usable and live.
- **Birth Centre** – a paper went to Board with 3 options being proposed. A meeting to review these with the ICB was undertaken in Jan with a planned meeting with the MNVP service leads in place for 13th Feb. The options will be thoroughly discussed to understand the service user perspective and gain valuable input on service modelling. Further staff engagements are planned through February
- **Maternity helpline** – the helpline remains functioning with business as usual. The grievance is moving to conclusion which will then enable a further review of this vital maternity triage service
- **MatNeoIST** (replacing MSSP) – targeted work continues for a 6-month period until June 2026 on the following 5 areas: Culture and leadership, Clinical pathways, Digital, Governance and board effectiveness, Workforce planning.

Positive progress

CNST – SGH can confirm that they have achieved compliance in 10/10 SA.
Recruitment – 14 band 5 RM's have joined the team with 2 Band 6 RM's starting in March. 8 B3 MSW are being interviewed
Feedback – very positive service user feedback has been shared

Staff feedback to Maternity Safety Champions - awaiting feedback from Jan 2026 walkabout

Feedback raised by staff	Action and progress
Theatre RN would like to rotate to main theatres for a shift to maintain skills	B7 RN now rostered all members of maternity RN team to rotate to main theatres
STH ward bathrooms require modernisation	Nov 25 – all 9 bathrooms in process of complete modernisation
Night staff continuing to park in staff, rather than patient car parks making it difficult for day staff to park	A reminder has been issued in the weekly bulletin
Feedback raised by service users	**Action and progress**
Homebirth service availability reduced	Consultation completed and moving through options appraisal to support second on-call from the community service
Additional safety champions intelligence	**Action and progress**
N/A	N/A

Progress in achievement of CNST 10 – Launched April 2025

SA1		SA6	
SA2		SA7	
SA3		SA8	
SA4		SA9	
SA5		SA10	

Group Board Meeting (Public)

Meeting on Thursday, 05 March 2026

Agenda Item	4.1	
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 January and February 2026 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	Choose an item.
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]
Appendix 2	[Add name or delete if not required]
Appendix 3	[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, 05 March 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 January and February 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 30th January and 27th February 2026, the Committee considered the following items of business:

30th January 2026	27th February 2026
PUBLIC MEETING • Oversight Framework update • IQPR • Integrated Finance report M9 • Forecast update M9 • Costing update • Medium Term Financial Plan • Productivity update • Finance Policies update • SWLPP quarterly update	**PUBLIC MEETING** • IQPR • Integrated Finance report M10* • Forecast update M10* • Medium Term Financial Plan* • Productivity update • Committee Effectiveness update • Annual Workplan 26/27 • SWLP quarterly update

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

2.2 The Committee was quorate for both meetings.

4.0 Sources of Assurance

4.1

a) Financial Performance M10/Forecast update

SGH and ESTH remain on plan at M10 despite risks in both financial positions. The group has identified a series of actions required to deliver the financial plan, nothing that at this stage of the financial year some of the risks previously outlined have been partially or fully mitigated. It is now expected that the group will deliver their individual financial plans in 2025/26.

b) Productivity update

The Committee reflected on the latest iteration of productivity metrics from NHSE. Discussion was had on the level of granularity of the information presented and being able to use the information to drive better decision making.

c) Medium Term Financial plan

The Committee noted the 12th February submission of the Medium-Term Financial Plan which included a compliant I&E position including Deficit Support Funding of £55.9m across the group. Committee members noted some of the challenges with contract alignment for SWL, other London and out of areas commissioners. Discussion also focussed on the importance of progressing the CIPs to fully delivered and having capacity to deliver the operational metrics as outlined in planning guidance.

d) Costing update

The Committee noted the quarterly update on costing.

e) Operational Performance

The Committee noted the good work going on across operational performance, whilst discussing the fragility of Children's therapy services in Integrated Care, sickness absence across different staffing categories, and the Urgent and Emergency care challenges at ESTH.

f) Financial policies update

The Committee welcomed the bi-annual update on Financial policies and expected progress in the coming months to have more group policies including the updated Standing Financial Instructions (SFIs) which are scheduled to be ratified by the Group Board in March 2026.

g) Committee Effectiveness update

The Committee welcomed the committee effectiveness feedback report and the themes that were documented. Discussion focussed on the length of papers produced and whether a more succinct set of papers that covered the key points would be preferred. Colleagues noted the need to have a certain level of content in line with other NHS organisations. It was agreed that a further discussion be had when all committee effectiveness results are collated at the Group Board.

h) SWL Procurement partnership update

The Committee noted work being done to recruit to vacancies in the commercial function and the offer to support a review of SWL governance rules between the 4 partners to reduce complexity on contract sign offs.

i) SWL Pathology update

The Committee noted the quarterly update on SWLP

5.0 Risk Implications

5.1 The Committee did not consider any changes necessary to recommend to Group Board on the BAF operational-related risk SR 8 – Reducing Waiting Times. The score remains ‘20’ and limited assurance. The forecast for the year end is ‘20’ and Reasonable assurance.

5.2 The Committee did not consider any changes necessary to recommend to Group Board on 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.

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 January and February 2026.

Group Board

Meeting in Public on Thursday, 05 March 2026

Agenda Item	4.2	
Report Title	**Finance Report – Month 10**	
Executive Lead(s)	Lizzie Alabaster, Interim Group Chief Finance Officer	
Report Author(s)	Lizzie Alabaster, Interim Group Chief Finance Officer George Harford, Site Chief Finance Officer – SGUH Robert Chidlow, Site Chief Finance Officer – ESTH	
Previously considered by	Finance and Performance Committee	27 February 2026
Purpose	**For Review**	

Executive Summary

This report sets out the financial position of both Trusts within the gesh Group at Month 10. The position was reviewed at the Finance and Performance Committee on 27 February 2026.

Both Trusts remain on plan at M10, and the plans will be delivered by both Trusts at year end.

Action required by Group Board

The Board is asked to:

a) Note that both Trusts are on plan at Month 10 and are expected to deliver the financial plans for 2025/26
b) Note that SGUH had an underlying position that was £4.1m off plan in month, which was being mitigated by non-recurrent items

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				
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 paper.				
Legal and / or Regulatory implications				
As set out in paper.				
Equality, diversity and inclusion implications				
N/A				
Environmental sustainability implications				
N/A				

gesh

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

Group Board-in-Common – Public

5th March 2026

Finance Report M10

GCFO/Site CFOs

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

2.1 ESH – Executive Summary

gesh

- Trust is on plan at YTD at M10, however YTD £8.9m of additional technical actions have been used to meet the plan.
- Resident Doctors Industrial action costs of £2.0m YTD have been matched by income from SWL.
- Trust will deliver the financial plan for 25/26

Performance YTD £'000	YTD Plan	Actual	Variance
Income	609,216	622,034	-12,818 F
Total Pay	**-411,402**	**-420,275**	**8,873 A**
Non-Pay	-207,093	-211,046	3,953 A
Non Operating Items	-5,498	-5,489	-8 F
Performance Target	**-14,777**	**-14,776**	**-0 F**
DSF	-31,203	-31,203	0
Excluding DSF	**-45,980**	**-45,979**	**-0 F**

Performance Forecast	Annual Plan	Forecast	Variance
Income	733,035	769,492	-36,457 F
Total Pay	**-493,469**	**-517,838**	**24,369 A**
Non-Pay	-238,421	-251,077	12,656 A
Non Operating Items	-6,845	-6,277	-568 F
Performance Target	**-5,700**	**-5,700**	**-0 F**
DSF	-41,604	-41,604	0
Excluding DSF	**-47,304**	**-47,304**	**-0 F**

Performance £'000	YTD Plan	Actual	Variance
Substantive	-364,869	-361,580	-3,289 F
Bank	-39,187	-52,407	13,220 A
Agency	-5,557	-4,631	-926 F
All Other pay	-1,789	-1,657	-132 F
Total Pay	**-411,402**	**-420,275**	**8,873 A**

Workforce	YTD Plan WTE	Actual WTE	Variance WTE	Move from M09 WTE	M9 Actual WTE
Substantive	6,381	6,433	-52 A	-17 A	6,416
Bank	820	1,007	-187 A	-62 A	945
Agency	76	82	-6 A	-19 A	63
Total	**7,277**	**7,522**	**-244 A**	**-98 A**	**7,424**

Key Metrics		Plan	Actual	Variance	M9 actual	Movement
Bed Number	**No**	**607**	**615**	**-8 A**	**591**	**24**

Income

- Patient Care Income: Patient income from NHS England is £1.0m ahead of plan at the end of January. £0.2m of this is due to the true up of the Cancer Drug Fund (relates to prior financial year), £0.2m in respect of 65-week waiters WLI Push, £0.2m in respect of the SWLEOC Revision Hub and the receipt of £0.1m in August in respect of 'Marsha's Rule'.
- ICB income is above plan by £11.7m at the end of January. The main drivers of this are the recognition of £5.9m of additional non-recurrent support from SWL ICB, £1.7m to cover the costs of industrial action (in July, November and December), £1.3m in respect of 24-25 ERF Clawback provision release and £1.0m of winter funding.
- Other Operating Income: Non-patient income is £0.9m adverse to plan at the end of January with R&D income £0.7m adverse.

Non pay

- Non pay overall is £4.0m adverse to plan YTD but with an overspend of £2.5m in non pay relating to EPR offset by underspends in clinical supplies.

Pay and workforce

- Trust is 244 WTE adverse to plan a 98 WTE increase from last month due to a combination of HCSW industrial action and operational pressures.
- Pay overall is reported £8.9m adverse to plan, with £2.0m related to resident doctors industrial action, £0.3m on HCSW action and £9.3m shortfall on expected CIP.
- £13.2m adverse position on bank £ largely triangulates with the WTE variance and has also been impacted by the industrial action cover. The Trust is forecast to breach its bank cap in 26/27, but is forecast to meet the agency cap and is on track to have reduced agency expenditure by 50% in 25/26 compared to prior year.

Other key metrics

- G&A beds at M10 are 615 compared to 607 plan and an adverse movement of 8 since M9 due to escalation pressures at St Helier. 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.

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

3.1 SGH – Executive Summary page 1

gesh

M10 Commentary

Trust is on plan in M10 but with an underlying position that is £4.1m off plan in month. This is a deterioration from previous months' variance due to the increase in CIP target from M10. This has been mitigated using the following non-recurrent items:

- £3.4m of additional income from SWL to cover the CIP shortfall.
- £0.5m of baseline pressures the from medical pay and non pay pressures which have been mitigated with additional NR actions.

Trust will deliver the financial plan for 25/26

Jan-26

Performance	Plan £'000s	Actual £'000s	Variance £'000s	Annual Plan £'000s	Forecast £'000s	Variance £'000s
Income	1,089,465	1,092,814	3,349	1,305,149	1,320,997	15,848
Total Pay	-692,481	-694,402	-1,921	-826,590	-831,501	-4,911
Non-Pay	-390,950	-392,607	-1,657	-457,845	-469,498	-11,653
Non Operating Items	-17,291	-17,062	229	-20,714	-19,998	716
Performance Target	**-11,257**	**-11,257**	**0**	**0**	**0**	**0**
DSF	-30,150	-30,150	0	-40,200	-40,200	0
Excluding DSF	**-41,407**	**-41,407**	**0**	**-40,200**	**-40,200**	**0**

Workforce YTD	Plan £'000s	Actual £'000s	Variance £'000s	Plan £'000s	Forecast £'000s	Variance £'000s
Substantive	-633,111	-642,109	-8,998	-755,527	-765,438	-9,911
Bank	-46,430	-44,208	2,222	-55,566	-53,566	2,000
Agency	-10,272	-5,412	4,860	-12,297	-9,297	3,000
Other Pay	-2,668	-2,673	-5	-3,200	-3,200	0
Total	**-692,481**	**-694,402**	**-1,921**	**-826,590**	**-831,501**	**-4,911**

Workforce	Plan WTE	Actual WTE	Variance WTE	Move from M09 WTE
Substantive	9,622	9,950	-328	15
Bank	645	769	-125	-28
Agency	58	69	-11	-4
Total	**10,325**	**10,789**	**-463**	**-18**

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

YTD Commentary

Income

- Income is £3.3m favourable YTD, with patient care income £3.8m favourable and other operating income £0.5m adverse.
- Patient Care income is driven by £2.1m industrial action income and additional SWL Income.
- Other Operating Income is driven by Pharmacy (£1.2m adverse) which is partially offset by savings in pay and non pay expenditure.

Non-pay & Non-Operating Items

- Non-Pay & Non-Operating items are £1.4m adverse YTD. This is driven by a £0.8m underperformance on CIP and consumables pressures in the Clinical Divisions.

Pay and workforce

- Pay is £1.9m adverse to plan YTD where underspends in bank and agency are offset by overspends elsewhere.
- Bank and Agency both remain below plan with CIPs focussed on temporary staff reduction.
- Trust is 463 WTE adverse to plan in M10 due to decrease in WTE plan from M4 onwards of 425 WTE linked to stepped increase in CIP target.
- The movement from M9 shows an increase in temporary staffing driven by Nursing.

Other key metrics

- G&A beds M10 are 797 which is in line with the plan.

Group Board

Meeting in Public on Thursday, 05 March 2026

Agenda Item	4.3	
Report Title	**Group Integrated Quality & Performance Report (IQPR)**	
Executive Lead(s)	Michael Pantlin, Group Deputy Chief Executive Officer	
Report Author(s)	Ed Nkrumah, Group Director of Performance & PMO	
Previously considered by	Quality Committees Finance & Performance Committees	26 February 2026 27 February 2026
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.

The report includes the NHS Oversight Framework assessments and rankings for Quarter 2 2025/26, published on 11 December 2025. Both Trusts have retained Segment 3 status. However, relative rankings have declined, reflecting a combination of performance deterioration in a small number of areas and improved performance by other acute Trusts.

At SGUH, significant progress in eliminating 65-week RTT waits resulted in the Trust exiting NHSE Elective Tiering. ESTH remains in Tier 1 for elective recovery (national oversight) and Tier 2 for UEC (regional oversight). RTT recovery actions have delivered improvement across both Trusts and at ESTH, there are targeted efforts to eliminate >65-week waits, reduce 52-week waits to 1% or less, and deliver on the operational plan targets for 18 weeks RTT performance.

Cancer Faster Diagnosis Standard performance improved through December 2025 with both Trusts exceeding their respective targets. However, capacity constraints in dermatology persist and is being addressed. At SGUH 62-day performance has improved however it remains below target at 73.9%, driven by lung thoracic capacity pressures associated with limited robotics theatre availability and increased screening referrals. RMP funded weekly lists (total of 8) are in place and will continue through March 2026, supporting service resilience and pathway performance. At ESTH 62-day performance was 86.2% achieving both plan and national target.

Waiting times in children's services at Sutton Health and Care remain under pressure, with 47.4% of children waiting less than 18 weeks to start treatment against the new national ambition of 78%. This reflects a wider South West London demand and capacity imbalance, driven largely by increasing

patient complexity. Sixty children are currently waiting over 52 weeks against an ambition of zero. A consolidated SWL-wide recovery plan is being developed with the ICB to support improvement.

In relation to Urgent and Emergency Care (UEC), performance against the 4-hour A&E standard was challenged in January 2026 across all sites, reflecting sustained pressures across the wider South West London system. Against the 78% 4-hour A&E standard target, SGUH delivered 76.1% driven by significant department capacity constraints particularly impacting the non-admitted pathway performance. ESTH delivered 72.8% - an improvement on previous month but materially below target. Both Sutton Health and Surrey Downs achieved the 70% national target for Urgent Community Response within 2 hours. Virtual ward occupancy rates remain consistently above the 80% target, supporting admission avoidance. The Group continues to focus on reducing average length of stay to improve flow, cost and patient outcomes.

Both Trusts are addressing ongoing challenges in patient safety and clinical compliance. Key areas of focus include VTE risk assessments, delirium assessments, pressure ulcer prevention, and infection control. VTE risk assessment compliance has improved at both sites — St George's (82.8%) and Epsom & St Helier (77%). A detailed action plan is in place to support further progress towards the 95% national target. Recently developed reports on delirium assessments rates show less than 5% of patients eligible for an assessment are being assessed across gesh. Both Trusts are developing plans to deliver improvements. The incidence of category 3 and 4 pressure ulcers remain high at St George's. At Epsom & St Helier, there were no category 3 or 4 ulcers reported in January, but both Trusts are closely monitoring and improving prevention strategies.

Infection prevention and control remain a priority for the Group with action plans in place to prevent MRSA, and reduce C. difficile E Coli infections. Mortality rates at both hospitals are either as expected or better than anticipated, with both Trusts continuing to refine strategies to improve patient outcomes

Action required by Group Board

The Committee is asked to:

a) Note performance at both Trusts as set out in the paper.
b) Note that the progress in eliminating 65-week waits has resulted in St George's exiting NHS England's Tier 1 oversight for elective performance
c) Note that Epsom and St Helier remains in Tier 1 and Tier 2 oversight for elective and urgent and emergency care performance respectively.

Committee Assurance	
Committee	Finance Committee and Performance Committee
Level of Assurance	Not Applicable

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

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

gesh

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

Group Integrated Quality & Performance Report

January 2026

Outstanding Care, Together: Our strategy 2023 to 2028

Publication Date: 20th February 2026 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): Jan 26

	Actual	Plan	Trend
SGUH	10.8	8.4	normal variation
ESTH	10.4	10.9	normal variation

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

	Actual	Trend
SGUH	1 day	deteriorating
ESTH	1.4 days	normal variation

Enable increase in referrals to Urgent Community Response Team: Jan 26

	Actual	Trend
Sutton	478	normal variation
Surrey	659	Increasing trend

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

Deliver Financial Plan (month 10)

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

Improve (Implied) Productivity (YTD Sep 25)

	YoY Change	National Benchmark
SGUH	-0.4%	Lowest Quartile
ESTH	-1.6%	Lowest Quartile

Deliver CIP Target (month 10)

	YTD Delivery	Note
SGUH	£68.1m to date	In line with plan. Includes £0.9m of nr b/f and £3.3m of nr additional to support
ESTH	£45.9m to date	Includes £5.4m of nr balance sheet to support the non-delivery of planned CIP

Improve Cash Position (month 10)

	Current balance and Cash stress expected based on current cash flow		
SGUH	£58.8m	£39.1m favourable	As per MTP
ESTH (M8)	£29.6m	£20.6m favourable	As per MTP

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

Improve VTE Performance: Jan 26

	Actual	Plan	Trend
SGUH	82.8%	95%	no significant change
ESTH	77.0%	95%	no significant change

Reduce RTT 52week waiters: Dec 25

	Actual	Plan	Trend
SGUH	1.51%	1.0%	improved
ESTH	1.51%	1.0%	improved

Maintain 12-hour waits in ED at or below 24/25 levels: Jan-26

	Actual	Plan	Trend
SGUH	10.9%	13.5%	normal variation
ESTH	16.7%	11%	normal variation

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: Jan-26

	Actual	Plan	Trend
SGUH	5.54%	4%	deteriorating
ESTH	6.38%	4%	deteriorating
Sutton	7.13%	4%	deteriorating
Surrey	6.40%	4%	deteriorating

2

National Oversight Framework

NHS Oversight Framework assessments and rankings for Quarter 2 were published on 11 December 2025. Both SGUH and ESTH have seen ranking (acute Trusts) fall, impacted by a number of metrics worsening through Q2. As this reflects only two data points, it should not be over-interpreted when assessing trends.

SGUH Unadjusted Segment shifted from Segment 1 in Q1 to Segment 2 in Q2, with its ranking declining from 37 out of 134 in Q1 to 61 out of 134 in Q2. Changes driven by operational performance however noted Patient Safety domain remains in segment 4.

ESTH's Unadjusted Segment remained at Segment 3 in both Q1 and Q2; however, its ranking fell from 61 of 134 in Q1 to 101 of 134 in Q2, placing it close to the boundary of Segment 4.

Assessment Period: Q2 2025/26				SGUH Q1	SGUH Q2	ESTH Q1	ESTH Q2
			Trust Segment (adjusted)	3	3	3	3
			Ranking (Acute Trusts)	37/134	61/134	61/134	101/134
			Unadjusted Segment (pre finance override	1	2	3	3
			Overall Metric Score (breakdown below)	2.05	2	2.41	2.64
Domain	**No.**	**Metric**	**Data Period**	**Metric Scores**	**Metric Scores**	**Metric Scores**	**Metric Scores**
Access	1	RTT 18 weeks Performance	Sep-25	2.34	2.62	1.81	2.11
	2	RTT 18 weeks Performance vs Plan	Sep-25	1.00	1.00	1.12	3.17
	3	RTT 52 Weeks Performance	Sep-25	2.73	2.94	2.32	2.76
	4	Community Services - % waits over 52 Weeks	Sep-25	1.00	1.00	2.35	2.06
	5	Cancer - 28-Day Faster Diagnosis Standard	To Sep 2025	2.20	3.65	2.04	3.67
	6	Cancer - 62-Day Treatment Standard	To Sep 2025	1.00	2.15	1.00	1.00
	7	A&E 4-Hour Wait Standard	To Sep 2025	1.00	1.00	3.37	2.62
	8	A&E 12-Hour Waits (from arrival)	To Sep 2025	2.82	3.11	3.78	3.67
	9	Annual change in CYP accessing MH services	To Sep 2025	N/A	N/A	2.34	3.74
		Access to services domain score	**Q2-25/26**	1.76	2.18		2.75
Effectiveness & experience of care	10	Summary Hospital Level Mortality Indicator	R12 - Jun-25	2.00	2.00	2.00	2.00
	11	Average number of days between planned and actual discharge date	Sep-25	1.74	2.38	Not Reported (DQ)	3.64
	12	CQC inpatient survey satisfaction rate	2023	2.00	2.00	2.00	2.00
	13	Urgent community response 2-hour performance	Q2-25/26	N/A	N/A	2.24	2.76
		Effectiveness and experience of care domain score	**Q2-25/26**	1.91	2.13		2.60
Patient Safety	14	NHS Staff Survey -raising concerns sub-score	2024	3.12	3.12	2.78	2.78
	15	CQC safe inspection score (if awarded within the preceding 2 years)	N/A	N/A	N/A	N/A	N/A
	16	Rates of MRSA infections	R12 -Sep-25	2.37	2.33	2.63	2.60
	17	Rates of C-Difficile infections	R12 -Sep-25	3.62	3.30	2.62	1.00
	18	Rates of E-Coli infections	R12 -Sep-25	3.39	3.37	2.05	2.15
		Patient Safety to services domain score	**Q2-25/26**	3.12	3.06		2.35
People and workforce	19	Sickness absence rate	Q1 2025/26	1.72	1.60	2.44	2.68
	20	NHS Staff Survey engagement theme score	2024	2.38	2.38	2.20	2.20
		People and Workforce domain score	**Q2-25/26**	2.05	1.99	2.05	2.44
Finance and productivity	20	Planned surplus/deficit	2025/2026	4.00	4.00	4.00	4.00
	21	Variance year-to-date to financial plan	M6 2025	1.00	1.00	1.00	1.00
	22	Implied Productivity Level	M3 YTD 25/26	1.74	3.28	3.26	3.44
		Finance and productivity domain score	**Q2-25/26**	1.87	2.64	2.63	2.72

Executive Summary
Safe, High-Quality Care

St George's Hospital

Key Messages

- **Patient Safety Incident Investigations (PSII) and Never Events:** No new Never Events were reported at SGUH in January 2026. Two new Patient Safety Incident Investigations (PSIIs) were declared, both relating to unexpected admissions to the Neonatal Unit in Maternity. These incidents will be investigated through the Maternity and Newborn Safety Investigations (MNSI) programme, rather than the standard Trust process.
- **VTE Risk Assessments:** The Trust delivered an assessment rate of 82.8% against the national ambition of 95%. Improvement plans are in place.
- **Falls Prevention and Management:** In January 2026, there was one extreme, two high, and two moderate harm falls. The extreme harm fall resulted in an intracranial haemorrhage and the patient subsequently died; the cause of death is under review by the coroner. The two high-harm falls involved fractured necks of femur, with one patient also sustaining L2 and pubic rami fractures; both are awaiting rehabilitation. Of the moderate-harm falls, one involved a nasal fracture and the other a radial fracture. All incidents have undergone Swarm reviews and were discussed at the relevant Divisional Incident Response Group (DIRG) meetings.
- **Pressure Ulcers:** In January 2026, no category 4 pressure ulcers and 12 category 3 pressure ulcers were reported, none of which were medical device related (MDR). The Trust has breached the category 3 pressure ulcer target for the fourth consecutive month. The Trust's pressure ulcer prevention action plan has been updated, and governance meetings continue.
- **Delirium Assessments:** In January 2026, completion of the 4AT/delirium assessment within 24 hours of admission was 4.66%, while nursing delirium assessments were completed in 25.7% of cases. Improvement work has now begun to address these rates.
- **Infection Prevention and Control:** No new C. diff cases were reported in January 2026. However, the annual threshold of 43 cases has been exceeded, with 44 cases year-to-date. A group-wide action plan is in place, with ongoing reviews and learning shared with relevant teams.
- **Respiratory infections**: Flu cases are showing a downward trend, although some clusters have led to bay or partial ward closures.
- **Complaints:** All complaints were acknowledged within three working days in January 2026 and 76.5% of responses were provided within 35 working day against a target of 85%.
- **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 29 October 2025 may negatively affect future SHMI results. This continues to be monitored closely.

Epsom & St Helier

Key Messages

- **Patient Safety Incident Investigations (PSII) and Never Events:** One new Never Event was reported at ESTH in January 2026, relating to a retained foreign object following knee surgery. Learning has been identified and immediate risk mitigation actions have been implemented, including notifying the supplier. No new Patient Safety Incident Investigations (PSIIs) were commenced at ESTH during the month.
- **VTE Risk Assessments:** The Trust delivered an assessment rate of 77% against the national ambition of 95%. Improvement plans are in place.
- **Falls Prevention and Management**: In January 2026, no moderate or higher harm falls were reported. This marks the seventh consecutive month in which both overall and adult inpatient falls rates have remained below the Trust mean.
- **Pressure Ulcers:** There were no category 3 or 4 pressure ulcers declared in January 2026.
- **Delirium Assessments:** In January 2026, assessment rates using 4AT remained around 1% and 30.6% for nursing delirium assessment. Improvement work has now commenced.
- **Infection Prevention and Control:** Nine new C. diff cases were reported in January 2026 (51 year-to-date against an annual threshold of 63). Learning from case reviews continues to be shared, and a dedicated C. diff action plan remains in place. **Water safety** issues continue to be monitored through the Water Safety Group and associated action plan. Discussions regarding long-term mitigation for E Block are ongoing, following the external reviewer's recommendations. **Respiratory and viral infections:** Clusters and outbreaks of norovirus continue, resulting in ward and bay closures and increased pressure on isolation capacity. New flu cases are showing a downward trend, consistent with national prevalence. **Integrated Care:** Another large Norovirus outbreak occurred on the reablement unit. A deep dive is being undertaken to identify themes and lessons. Focused IPC training and education campaign has also been launched.
- **Complaints:** In January 2026, 100% of complaints were acknowledged within three working days. Complaints responded to within 35 working days has dipped to 77% below the target of 85%.
- **Mortality:** Mortality rate, as measured by the Summary Hospital-level Mortality Indicator (SHMI), performance is as expected, and continues to be closely monitored.

Executive Summary

Operational Performance & Productivity

St George's Hospital

Successes

- Significant progress in eliminating 65-week RTT waits has resulted in the Trust exiting NHSE Elective Tiering. There is continued improvement and focus on reducing 52 week wait performance, with Independent Sector being utilised effectively to treat long waiting patients in General Surgery, Vascular Surgery, Cardiology and Gynaecology.
- Performance against the Cancer Faster Diagnosis Standard improved in December 2025, achieving 83.5%, driven by targeted actions that have significantly reduced the skin pathway backlog and improving turnaround times for swab results within Gynae.
- Diagnostic performance continues to exceed 95% achieving 95.7% at the end of December 2025. Recovery actions in cardiac MRI are continuing to support performance.
- Theatre utilisation rates are performing in the top quartile nationally with all theatre areas sustaining capped utilisation levels above 80% though January 2026.

Challenges

- Performance pressures persist across some key RTT metrics, with waits over 18 weeks for first appointment below plan. Specialties are focusing on forward view for March 2026 to ensure all patients over 40 weeks are booked for their first appointment, and the Trust is focusing on the Q4 Sprint (NHSE initiative) to deliver additional first outpatient appointments above the baseline plan. Actions continue to be overseen by the Chief Operating Officer (COO).
- Cancer 62-day standard performance improved to 73.9% however remained below target. This has been impacted by theatre capacity constraints: Lung Thoracic impacted by robotics availability. Further £55K funding from RMP in January 2026 is supporting service resilience and pathway performance..
- Day-case and outpatient procedure rates fell through September and October 2025 due to increased inpatient activity and reduced day-case capacity following the QMH theatre closure, with urology and vascular services particularly affected as major users of the QMH Surgical Treatment Centre.
- 4-Hour performance fell to 76.1% in January 2026, below target of 78%. The drop was driven by significant emergency capacity constraints which also impacted non-admitted pathway performance. Further delivery of 78% depends on sustaining a reduced daily breach rate and the execution of known actions.
- The Trust saw increased inpatient length of stay with an increase in the number of bed days lost due to delayed discharges. A number of beds were also closed downstream due to Infection Control.

Epsom & St Helier

Successes

- All cancer performance standards were achieved in December 2025: 62-day Referral to treatment, (86.2%); 28-day Faster Diagnosis (85.1%); and 31-day decision-to-treat to treatment (99%).
- Theatre utilisation rate remained high at 82% in January 2026. Work is ongoing to standardise the perioperative pathway, including a shared health screening form and full pre-operative assessment in iClip. The Golden Patient initiative will launch on 9 February 2026 to improve start times and theatre efficiency.
- RTT >52-week and >65-week waits reduced again in December 2025, supported by external funding. The Trust is working towards eliminating 65-week waits by the end of February 2026 and deliver <1% 52-week waits by the end of March 2026.
- DNA rates improved marginally in January 2026 to 7%, the first time since iClip implementation.
- 4-hour performance improved in January 2026 to 72.8% from 70.8% in previous month, but trajectory target of 75.5% driven primarily by challenged in the admitted pathway.

Challenges

- The iClip Pro implementation, supported by a six-week activity reduction, impacted performance. Teams are actively addressing workflow and data issues and improvement are being seen.
- Following the December 2025 iCLIP release, an integration issue prevented RTT status codes transferring correctly, resulting in ~14,000 outpatient appointments (3 Dec 2025–23 Jan 2026) being incorrectly recorded and inaccessible for amendment. A retrospective fix (applying the latest RTT status per pathway) will be applied with manual validation to ensure accuracy.
- Diagnostic performance dipped in December 2025 after 4 consecutive months of improvement. Recovery actions are in place with January 2026 is expected to show an improved position. Echo and Endoscopy continue to be the most challenged modalities.
- Capacity constraints in Dermatology are impacting delivery against all cancer targets. Delays in endoscopy and shortages of anaesthetic staff are affecting gastrointestinal pathways, while lung cancer diagnosis remains constrained by external waiting times for navigational bronchoscopy and endobronchial ultrasound.
- Non-elective LOS increased to 11.6 days in January 2026. This rise was influenced by the discharge of 10 complex patients, including one patient with a length of stay of 275 days.
- NHSE London Region and GIRFT UEC teams continue to supporting ESTH with the following improvement priorities: developing a UTC-first mindset and model; strengthening ED front-door processes; acute medicine peer support; enhanced advice and guidance; UEC therapies; and actions to decompress the emergency department.

Executive Summary
Integrated Care

Safe, High-Quality Care Key Messages

Sutton Health & Care (SHC)

- Safety and infection control indicators: Reablement Unit was closed in December 2025 with Norovirus and Cdiff.
- No reported falls with harm - moderate or above.
- Community FFT results are positive, and complaints remain low showing a steady performance although present challenges around the provision of End-of-Life Care in the community.
- Cold Chain Supply issue affecting Flu Vaccine programme for Housebound Adult caseload

Surrey Downs Health & Care(SDHC)

- Safety and control indicators - MRSA, Cdiff, Ecoli and Falls are stable, with no significant issues reported in January 2026.
- No reported falls with harm - moderate or above.
- Flu has been a particular challenge for our bedded units in this time period. IPC has supported the teams appropriately.

Community wide

An increase in Category 3 pressure ulcers at SHC and SDHC reflects more consistent reporting. The complexity of our patient cohort has changed, with PCNs managing an increased number of end-of-life care (EOLC) patients. A robust assurance process is in place to review all incidents.

Operational Performance Key Messages

Sutton Health & Care (SHC)

- 2-hour Urgent Community Response response performance improved in January 2026, achieving 70.1% and meeting target. Referrals are within normal range however there are variations especially out of hours with referrals peaking at 6pm, having an overall impact on capacity.
- Virtual ward admissions remain high and above upper confidence limits with occupancy rate during December-2025 at 96.5% (target: 85%).
- Children's services waiting list remains high, with a consolidated action plan in development across South West London. Waiting lists remain a challenge due to increased demand, driven predominantly by increasing complexity of need. This is a national issue and has been highlighted on the risk register. Long waits for Children's SALT improved earlier in the year, however, it declined again from November 2025 resulting in 60 patients waiting over 52 weeks at the end of January 2026, mainly in SALT services. Overall, 49% of children are waiting less than 18 weeks to start treatment.

Surrey Downs Health & Care(SDHC)

- Service Continues to exceed the 2 –hour Urgent Community Response (UCR) target achieving 88.2% in January 2026. Significant increase in the number of referrals rising to 659, above the upper control limits and 21% higher compared to January 2025.
- Virtual ward occupancy rates exceeded target at 92.5% in January 2026 with demand continuing to be above average. Work continues to expand Virtual Ward provision and ensure it remains a viable alternative to acute care.
- 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

Overview Dashboard

KPI	St George's Latest month	St George's Previous Month Measure	St George's Measure	St George's Target	St George's Variation	St George's Assurance	St George's Benchmark	Epsom & St Helier Latest month	Epsom & St Helier Previous Month Measure	Epsom & St Helier Measure	Epsom & St Helier Target	Epsom & St Helier Variation	Epsom & St Helier Assurance	Epsom & St Helier Benchmark
Never Events	Jan 26	1	0	0			N/A	Jan 26	1	1	0			N/A
Patient Safety Incident Investigations	Jan 26	0	2	0			N/A	Jan 26	0	0	0			N/A
Moderate and Severe Harm from Falls	Jan 26	1	5	2			N/A	Jan 26	1	0	1			N/A
Pressure Ulcers - Acquired Category 3	Jan 26	15	12	7			N/A	Jan 26	1	0	6			N/A
Pressure Ulcers - Acquired Category 4	Jan 26	0	0	0			N/A	Jan 26	0	0	0			N/A
Infection Control - Number of MRSA	Jan 26	0	0	0			3rd Quartile	Jan 26	0	0	0			3rd Quartile
Infection Control - Number of Cdiff - Hospital & Community	Jan 26	1	0	5			2nd Quartile	Jan 26	5	9	6			2nd Quartile
Infection Control - Number of E-Coli	Jan 26	5	9	9			Lowest Quartile	Jan 26	2	7	5			2nd Quartile
Delirium Assessment Compliance	Jan 26	5.0%	4.4%	90.0%			N/A	Jan 26	2.0%	3.2%	90.0%			N/A
Delirium Assessment Nursing Compliance	Jan 26	34.9%	29.9%	90.0%			N/A	Jan 26	38.4%	37.6%	90.0%			N/A
Delirium RDAR Compliance	Jan 26	11.8%	14.5%	90.0%			N/A	Jan 26	15.7%	15.5%	90.0%			N/A
30-Day Emergency Readmission Rate	Dec 25	9.0%	9.0%	-			TBC	Apr 25	5.3%	5.7%	-			TBC
VTE Risk Assessment	Jan 26	84.5%	82.8%	95.0%			N/A	Jan 26	75.6%	77.0%	95.0%			N/A
Mortality - SHMI	Sep 25	0.85	0.89	-			Better than Expected	Sep 25	1.12	1.11	-			As Expected
% Births with 3rd or 4th degree tear	Jan 26	1.7%	1.9%	-			3.0%	Jan 26	3.6%	5.5%	-			2.7%
% Births Post Partum Haemorrhage >1.5 L	Jan 26	1.1%	2.2%	-			3.0%	Jan 26	2.3%	2.4%	-			3.2%
Stillbirths per 1,000 births	Jan 26	0.0	3.2	-			3.3	Jan 26	3.8	3.4	-			3.3
Neonatal deaths per 1,000 births	Jan 26	8.4	6.3	-			1.6	Jan 26	0.0	0.0	-			1.6
HIE (Hypoxic ischaemic encephalopathy) per 1,000 births	Jan 26	2.8	3.2	-			N/A	Jan 26	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	Jan 26	75.0%	76.5%	85.0%			N/A
Complaints - Acknowledgement within 3 working days	Jan 26	100.0%	100.0%	100.0%			N/A
Number of complaints not completed within 6 months from date of receipt	Jan 26	2	2	0			N/A
Friends and Family Test - Inpatients Score	Jan 26	99.1%	98.2%	90.0%			Top Quartile
Friends and Family Test - Emergency Department Score	Jan 26	75.6%	75.3%	90.0%			2nd Quartile
Friends and Family Test - Outpatients Score	Jan 26	94.7%	94.7%	90.0%			3rd Quartile
Friends and Family Test - Maternity Score	Jan 26	90.9%	100.0%	90.0%			2nd Quartile
Friends and Family -Inpatient Response Rate	Jan 26	31.6%	29.5%	-			N/A
Friends and Family -Emergency Department Response Rate	Jan 26	9.4%	10.4%	-			N/A
Friends and Family - Outpatient Response Rate	Jan 26	9.8%	11.4%	-			N/A
Friends and Family - Maternity Response Rate	Jan 26	1.9%	3.0%	-			N/A

Epsom & St Helier

Latest month	Previous Month Measure	Measure	Target	Variation	Assurance	Benchmark
Jan 26	83.0%	77.0%	85.0%			N/A
Jan 26	100%	100%	100%			N/A
Jan 26	11	8	0			N/A
Jan 26	92.0%	94.9%	90.0%			3rd Quartile
Jan 26	80.0%	77.9%	90.0%			Lowest Quartile
Jan 26	94.0%	93.0%	90.0%			Top Quartile
Jan 26	93.8%	100.0%	90.0%			3rd Quartile
Jan 26	10.2%	12.1%	-			N/A
Jan 26	4.0%	4.1%	-			N/A
Dec 25	2.4%	4.8%	-			N/A
Jan 26	7.4%	6.0%	-			N/A

Sutton Healthcare

KPI	Latest month	Previous Month Measure	Latest Month Measure	Target	Variation	Assurance
Patient Safety Incidents Investigated	Jan 26	0	0	0		
Number of Falls with Harm (Moderate and Above)	Jan 26	0	0	-		
Pressure Ulcers Category 3	Jan 26	7	7	-		
Pressure Ulcers Category 4	Jan 26	0	2	0		
Infection Control - Number of MRSA	Jan 26	0	0	-		
Infection Control - Number of Cdiff	Jan 26	1	0	-		
Infection Control - Number of Ecoli	Jan 26	0	0	-		
Complaints	Jan 26	0	3	-		
Community FFT	Jan 26	96.8%	98.0%	90.0%		

Surrey Downs

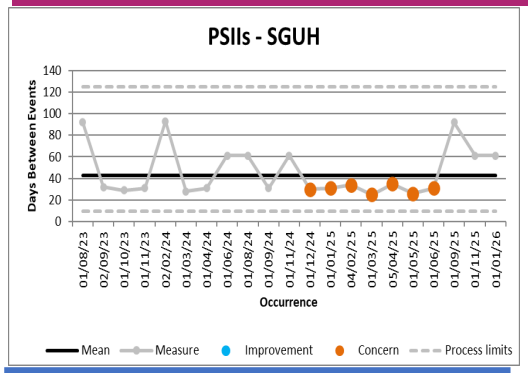
Latest month	Previous Month Measure	Latest Month Measure	Target	Variation	Assurance
Jan 26	0	0	0		
Jan 26	0	0	-		
Jan 26	7	6	-		
Jan 26	0	1	0		
Jan 26	0	0	0		
Jan 26	0	1	-		
Jan 26	1	0	-		
Jan 26	2	5	-		
Jan 26	95.8%	97.0%	90.0%		

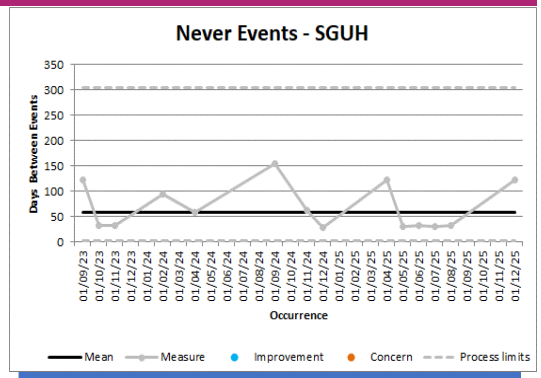
- Community FFT is a subset of Epsom and St Heliers FFT data.
- IC (Dorking and Molesey Hospitals – community do not have set national trajectories for HCAIs although all cases are reviewed and investigated)

Safe, High-Quality Care

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

St George's





Summary & Actions

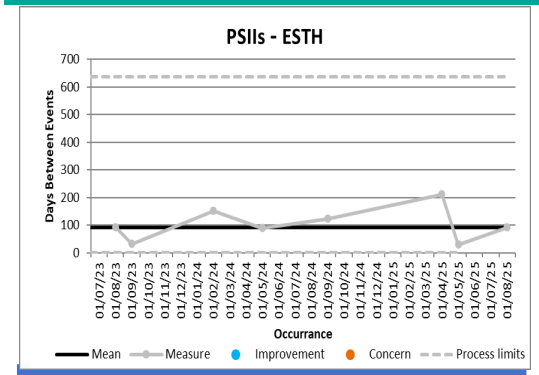
There were two new Patient Safety Incident Investigations (PSIIs) declared at SGUH in January 2026.

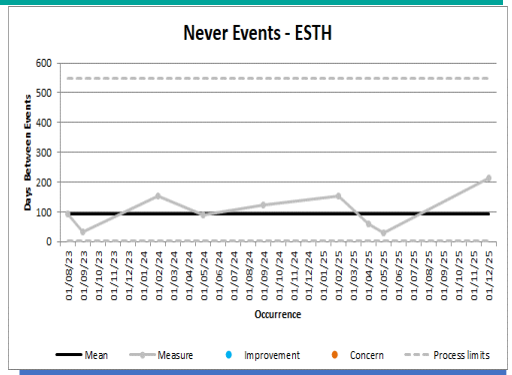
Both involved unexpected admissions to Neonatal unit in Maternity and the incidents have been accepted for investigation by the Maternity and Newborn Safety Investigations (MNSI) programme, replacing the standard Trust investigation process.

Summary & Actions

No new Never Events were reported at SGUH in January 2026.

Epsom & St Helier





Summary & Actions

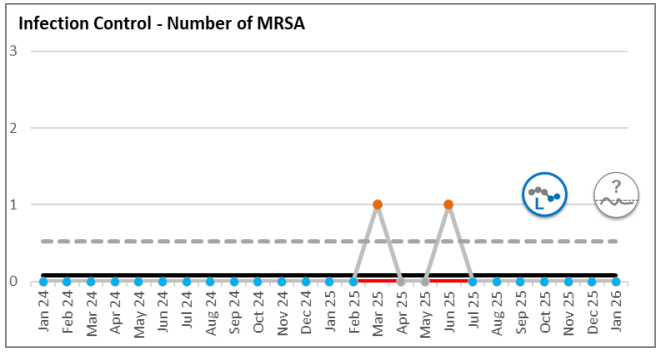
No new Patient Safety Incident Investigations (PSIIs) were initiated at ESTH in January 2026.

Summary & Actions

One new Never Event was reported at ESTH in January 2026 (retained foreign object following knee surgery.) The patient's procedure was changed on the day to single stage (lengthier procedure.) Following the post-op xray, the patient and surgeon agreed to return to theatre to remove the piece of broken trocar which had broken at the time of surgery. Key learning identified includes ensuring all instruments are fully accounted for in every surgical procedure (including confirming their integrity.) To strengthen safety practices, instrument integrity checks will now be performed routinely as part of the count and a visual reference will be collated of disposable items used in theatre as a cognitive aid for staff. Ongoing compassionate engagement continues plus a re-review of the cluster NE PSII learning to ensure learning is incorporated into the Divisional Safety Improvement Plan.

Safe, High-Quality Care

Exception Report | SGUH - Infection Prevention and Control

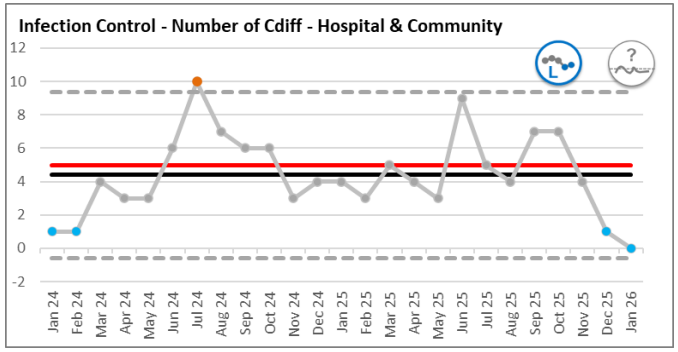


SGUH - Summary & Actions

Healthcare Associated MRSA Bacteraemia:

Trust	In-Month	Year-to date	Annual Threshold
SGUH	0	1	0

No HOHA MRSA bacteraemia cases reported in January 2026. We had 1 COCA MRSA bacteraemia case reported in January 2026, case review being completed as a recent patient to SGH under surgery.



SGUH - Summary & Actions

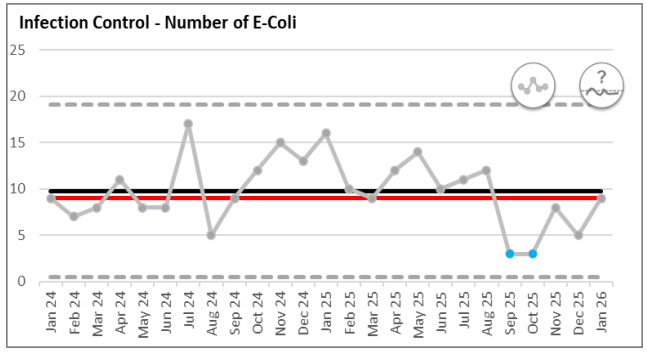
Healthcare Associated CDIs– Hospital & Community

Trust	In-Month	Year-to-date	Annual Threshold
SGUH	0	44	43

The trust exceeded the annual threshold in December with 44 incidents year to date against an annual target of 43.

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 decontamination for the environment post C difficile case discharge/transfer. 2x 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	In-Month	Year-to-date	Annual Threshold
SGUH	9	99	109

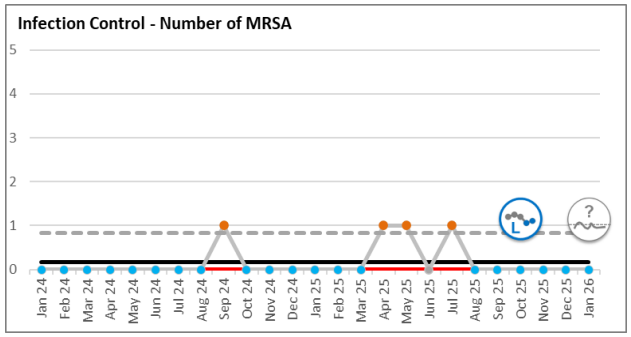
In January 2026, the trust reported 9 cases of E.coli bringing the year-to-date total to 99 cases. With an annual target of 109, the number of cases by March must remain below this threshold to meet the target

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

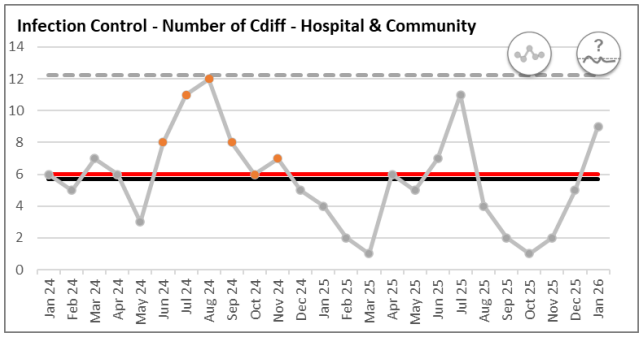


ESTH - Summary & Actions

Healthcare Associated MRSA Bacteraemia

Trust	In-Month	Year-to-date	Annual Threshold
ESTH	0	3	0
IC	0	0	0

MRSA: No MRSA bacteraemia reported in January 2026.



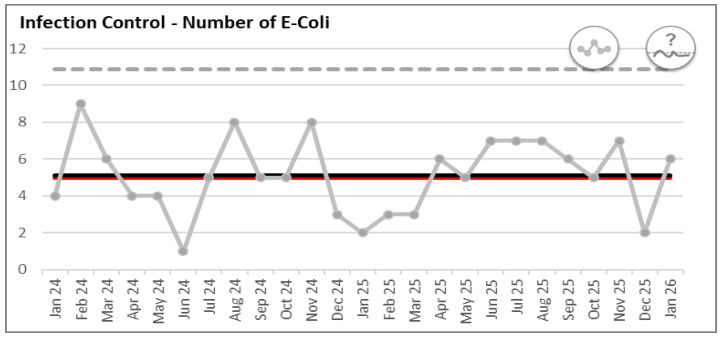
ESTH - Summary & Actions

Healthcare Associated CDIs:

Trust	In-Month	Year-to-date	Annual Threshold
ESTH	9	51	63
IC	1	3	0

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

- **Water safety:** Water safety issues continue to be monitored via the Water Safety Group and the Water Safety action plan. Awaiting Board decision on long term plan to manage concerns.



ESTH - Summary & Actions

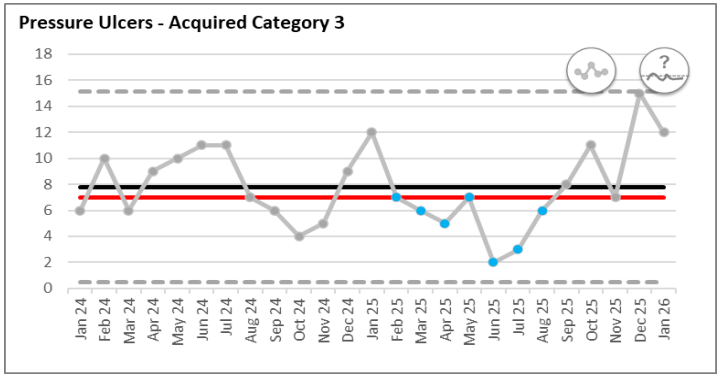
Healthcare Associated E. coli

Trust	In-Month	Year-to-date	Annual Threshold
ESTH	7	58	57
IC	0	3	0

Actions:
Working with iClip documentation team to upload/have a digital urinary catheter passport (One London passport created by NHSE) to help with management/reviews for both hospital and community staff.

Safe, High-Quality Care

Exception Report | SGUH Pressure Ulcers - Category 3

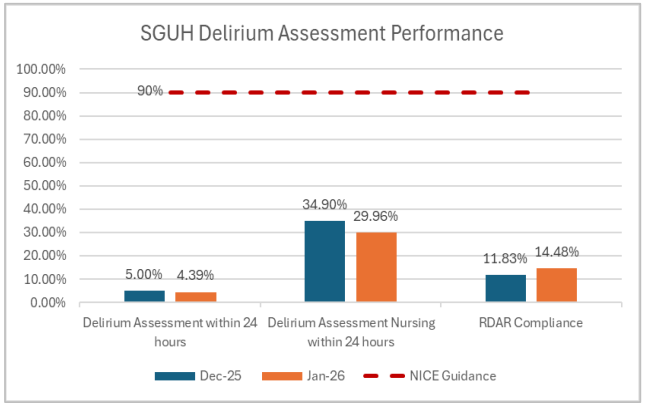


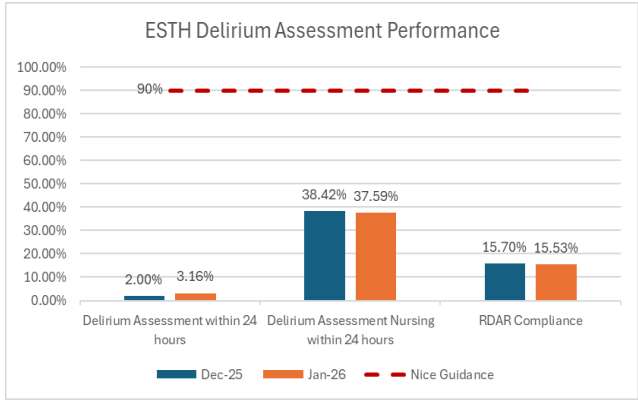
Indicator	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26
Pressure Ulcers - Acquired Category 3	5	7	2	3	6	8	11	7	15	12

Site & Metric	Cause of variance/ non-compliance	Actions: Completed since last update, New, and Ongoing	Recovery Date	Data Quality
SGUH Pressure Ulcers Category 3: 12 cases in January 2026 Pressure Ulcers Category 4: No incidents occurred in January 2026	• There were 12 category 3 pressure ulcers and zero category 4 pressure ulcers in January 2026 (third consecutive month) • Zero category 3 pressure ulcers were medical device related • Most pressure ulcer occurred within the MedCard division (7) • Pressure ulcers in January 2026 were mostly acquired around the sacral/ coccyx area and all patients were acutely unwell • There are concerns regarding the efficacy of the current hybrid pressure relieving mattress on all non-critical care beds. If these mattresses are not off-loading as they should this will have a negative impact on pressure ulcer acquisition	• Tissue Viability, Corporate Nursing and Medical Engineering have been working together over the last 6 months to explore alternatives to the current hybrid mattress in use. An alternative produce was agreed after a trial and extensive testing in January 2026, an initial business case to failed to be approved as a capital bid. The case has been updated by the Group Director for Medical Engineering and this is due to be re-presented • As an interim measure, Tissue Viability and Corporate Nursing have drafted a plan to trial the use of 20 dynamic high spec mattresses (usually used in ICU) for high-risk patients. This will commence in March 2026 • Ward Managers, Matrons and Practice Educators in MedCard came together at the beginning of February 2026 to explore and discuss pressure ulcer acquisition in their areas using a SEIPs approach. This resulted in several actions, the first being to implement 'get-up, get dressed, get moving' across the division • Feedback on the new pressure ulcer incident SWARM template speer headed by MedCard has been positive; this is now being trialled Trustwide	As part of 2026/27 Quality Priorities this is being reviewed	Sufficient for assurance

Safe, High-Quality Care

Exception Report | SGUH & ESTH Delirium Assessment



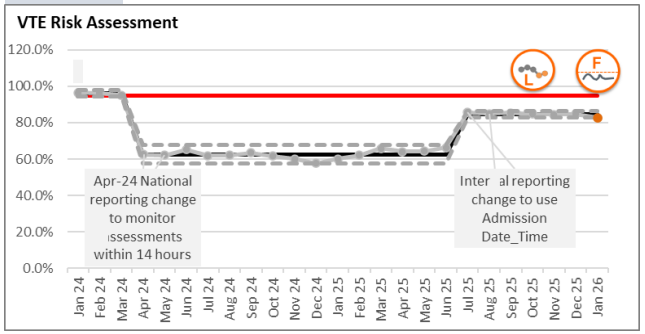


- Delirium assessment includes a validated tool 4AT (4 A's Test) to detect acute changes in attention, awareness, and cognition, often aided by collateral history and cognitive screening
- R.A.D.A.R. (Recognizing Acute Delirium as Part of Your Routine) is a quick, bedside screening tool for nurses to spot early signs of delirium in hospitalized older adults, focusing on changes in drowsiness, following instructions, and slowed movements during routine medication rounds, helping to catch this serious fluctuating confusion before it worsens.

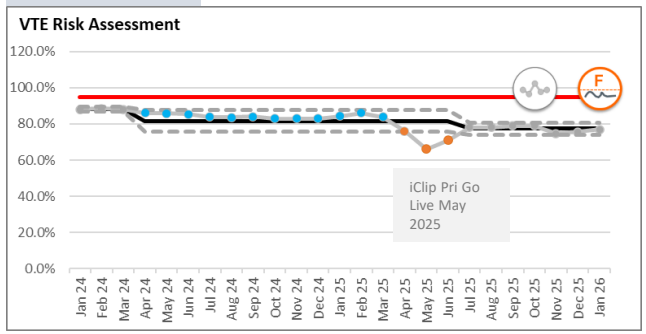
Site & Metric	Cause of variance/ non-compliance	Actions: Completed since last update, New, and Ongoing	Recovery Date	Data Quality
SGUH: Delirium Assessment within 24 hrs – 4.39% Delirium Assessment Nursing within 24 hrs – 29.96% RADAR Compliance (Daily Ax) – 14.48%	• In Jan-2026, 50.63% of eligible patients were assessed for delirium using at least 1 of the delirium assessment methods available on iCLIP during their inpatient stay, however completing within 24 hours as per NICE guidance is not yet being met. • Accurate compliance data has been available for all delirium assessment types from December 2025, however the new dashboards are yet to be embedded within existing divisional governance processes.	• Delirium Lead to attend Divisional Governance Groups • Provide training for Care Groups where performance is low – on-going • Risk Assessment reviewed with ESTH colleague post feedback from frontline staff – amendments to increase useability requested	Aiming for 10% improvement per quarter; 15% by June '26 25% by Sep '26 35% by Dec '26 45% by Mar '27	Sufficient for assurance
ESTH: Delirium Assessment within 24 hrs – 3.16% Delirium Assessment Nursing within 24 hrs – 37.59% RADAR Compliance (Daily Ax) – 15.53%	• In Jan-2026, 74.26% of eligible patients were assessed for delirium using at least 1 of the delirium assessment methods available on iCLIP during their inpatient stay, however completing within 24 hours as per NICE guidance is not yet being met. • Accurate compliance data has been available for all delirium assessment types from December 2025, however the new dashboards are yet to be embedded within existing divisional governance processes.	• Dementia and Delirium Clinical Nurse Specialist to meet with Divisional Medical Director for Medicine to discuss set-up of an ESTH task & finish group focused on delirium assessment completion • Dementia and Delirium Clinical Nurse Specialist has connected with Care of the Elderly medical colleagues with the aim of commencing a collaborative improvement project. • Risk Assessment reviewed with SGUH colleague post feedback from frontline staff – amendments to increase useability requested		Sufficient for assurance

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

St George's



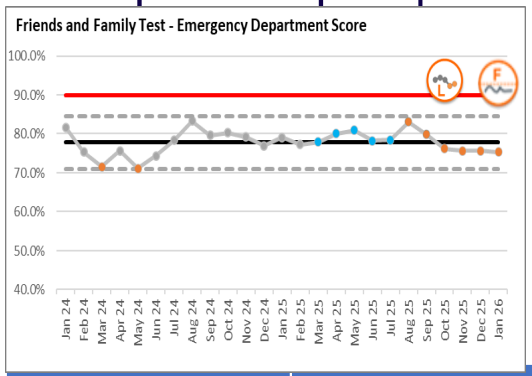
Epsom & St Helier

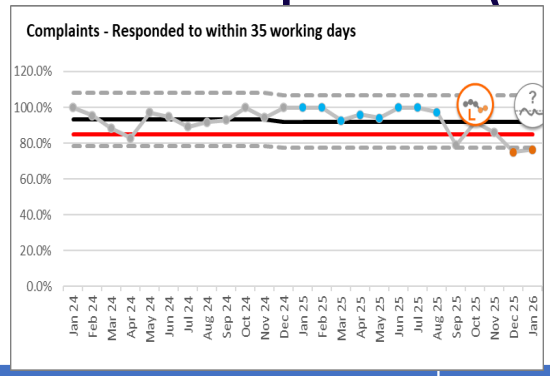


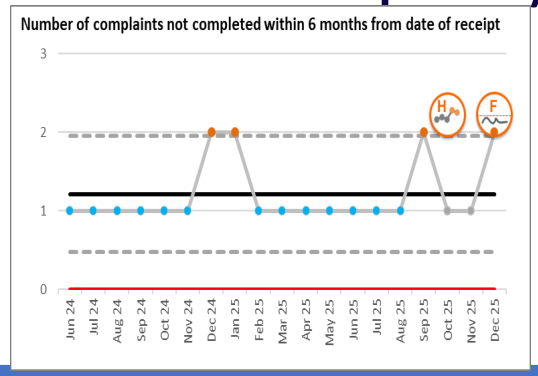
Site & Metric	Cause of variance/ non-compliance	Group Actions: Completed since last update, New, and Ongoing	Recovery Date	Data Quality
SGUH: VTE 82.8%. Not meeting target of 95%,	• The Chief Medical Officers at gesh have reviewed the reporting logic for VTE assessments. The Trusts now records the *admission time* (when the patient is placed in a bed) instead of the Decision to Admit time. Reported VTE risk assessments rates have consequently improved. Since July 2026, performance has been above 80%	Other Actions include: • VTE champions form a multiprofessional group to boost assessment compliance. • 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	Sufficient for assurance
ESTH: VTE 77% Not meeting target of 95%	• Reporting at ESTH has been adversely affected by the implementation of the new EPR: ○ Incorrect coding of low-risk cohorts remains an issue, with nearly 50% of the non-compliance attributed to incorrect low-risk cohorts in November 2025. An updated list of incorrectly coded low-risk cohort locations has been produced, protocols for each area will need to be approved prior to this change		Trajectories under review for 2025/26	Not sufficient for assurance until Maternity resolved (mid Jan-26)

Safe, High-Quality Care

Exception Report| SGUH Patient Experience (Satisfaction & Complaints)



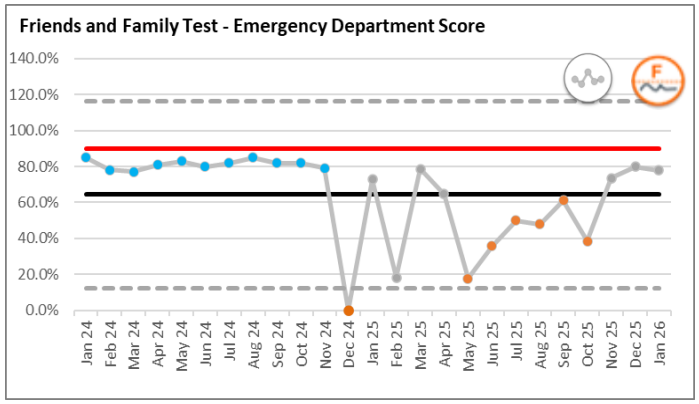


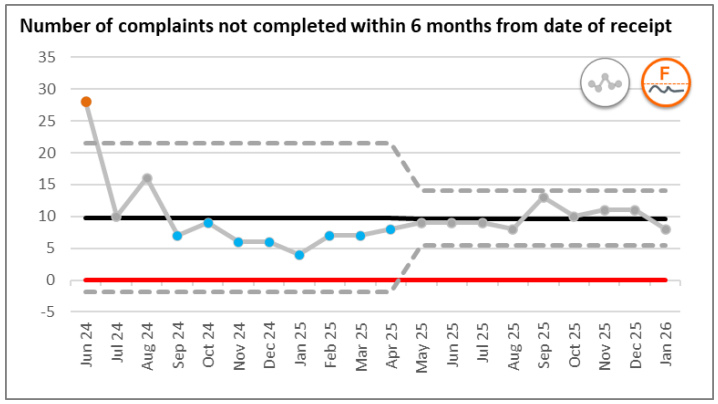


Site & Metric	Cause of variance/ non-compliance	Actions: Completed since last update, New, and Ongoing	Recovery Date	Data Quality
SGUH FFT ED Score 75%	In January 2026, 75% of patients said they would recommend the department. Scores have been below the mean for four consecutive months which is reflecting ongoing challenges such as long waits and corridor care. Our results are below the national average of 78% in Dec-25 (data is a month behind). 1,232 patients completed the FFT survey, this is in line with previous months. Compared with national data, STG continues to be well above the national average for response rate and were ranked 21st out of 244 sites for their response rate in Dec-25 (data is a month behind)	1. Patient feedback review and ongoing corridor care checks. 2. Standardised RN documentation; comfort packs for all patients. 3. Daily safety checks; RAT rota Mon–Fri for early senior review. 4. Digital check-in launched Jan 2025 for efficiency. 5. SDEC expansion: 10 new medical pathways; surgical streaming ongoing.	Ongoing	sufficient for assurance
SGUH Complaints Acknowledged within 3 working days.	Staffing issues in Sept 2025 impacted complaint acknowledgements. Action plans improved performance: 66% in Oct, 76% in Nov, and 100% in December, now showing stable variation.	• Mitigation in place to cover complaints during sickness, improving response rates. Weekly oversight meetings between SGUH Senior Nursing and Group Complaints teams. Action plan implemented to address staffing shortfalls and restore targets. Permanent recruitment successful to stabilize the team.	March 2026	sufficient for assurance
SGUH Complaint' responded to within 35 working days and not completed within 6 months of receipt showing special cause variation of a concerning nature.	A small increase in complaints not completed within 6 months have arisen due to patient choice with meeting availability with the clinical teams. Increased long term sickness in the team has impacted response rates in addition there have been some challenges with divisions getting complaints in on time.	• Complaints reviewed weekly with the Divisions to monitor progress and provide support / advice if necessary	June 2026	sufficient for assurance

Safe, High-Quality Care

Exception Report | ESTH - Patient Experience (Satisfaction & Complaints)





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. Text messaging re-commenced in October 2025 with a noticeable influence on response rates. 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 • 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; recruitment has not yielded results to date • The Medicine Division is committed to enhancing patient experience during periods of heightened emergency care demand by increasing staffing levels, 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
Number of complaints not completed within 6 months of referral – not meeting target. In January this improved slightly from 11 to 8	Progress to reduce the number of complaints not completed within 6 months of receipt has been limited by a number of factors including staffing shortages within the ESTH complaints team, lack of timely responses from the divisional teams to progress a complaint response and complex external causes.	• Review of complaint response accountability with divisional teams, clarify roles and responsibilities. This work will take place alongside the training plans which are being progressed to support complaint responses from divisional teams. • Group complaints policy • Review of complaint allocation within complaints team and the available resource • Improve response rates with focus on current backlog from 2025. • Changed the way our administrators work to make the logging and sending on to division quicker which should also give the divisions more time to answer the complaints.	June 2026	

Section 2.1:
Operational Performance

Operational Performance

Overview Dashboard

KPI	St George's Latest month	St George's Previous Month Measure	St George's Measure	St George's Target	St George's Variation	St George's Assurance	St George's Benchmark	Epsom & St Helier Latest month	Epsom & St Helier Previous Month Measure	Epsom & St Helier Measure	Epsom & St Helier Target	Epsom & St Helier Variation	Epsom & St Helier Assurance	Epsom & St Helier Benchmark
RTT - Waits over 65 weeks	Dec 25	99	4	0			Lowest Quartile	Dec 25	116	34	0			Lowest Quartile
RTT - Percentage of waits over 52 weeks	Dec 25	1.86%	1.51%	1.00%			2nd Quartile	Dec 25	1.82%	1.51%	1.00%			3rd Quartile
RTT - Percentage of waits within 18 weeks	Dec 25	60.4%	60.2%	60.0%			3rd Quartile	Dec 25	60.6%	60.1%	65.4%			3rd Quartile
RTT - Percentage of waits within 18 weeks for first appointment	Dec 25	64.2%	63.0%	66.6%			3rd Quartile	Dec 25	75.4%	74.0%	81.3%			2nd Quartile
RTT- Waiting List – total children under 18	Dec 25	6444	6392	7715			-	Dec 25	6714	7404	6449			-
Cancer - 28 Day Faster Diagnosis Standard	Dec 25	74.0%	83.5%	82.7%			Lowest Quartile	Dec 25	75.6%	85.1%	86.8%			Lowest Quartile
Cancer 62 Day Referral to Treatment Standard	Dec 25	69.5%	73.9%	85.0%			2nd Quartile	Dec 25	81.3%	86.2%	86.6%			Top Quartile
Diagnostics - 6 Week Waits	Dec 25	3.7%	4.3%	5.0%			Top Quartile	Dec 25	11.5%	13.5%	5.0%			3rd Quartile
4 Hour Operating Standard	Jan 26	81.3%	76.1%	78.0%			2nd Quartile	Jan 26	70.8%	72.8%	78.0%			3rd Quartile
Over 12 Hours in ED from Arrival (%) Type 1	Jan 26	8.0%	10.9%	13.0%			3rd Quartile	Jan 26	15.7%	16.7%	13.5%			Lowest Quartile
Ambulance average Handover Time (min)	Jan 26	00:24:33	00:26:32	00:24:00			TBC	Jan 26	00:25:55	00:27:13	00:22:00			TBC

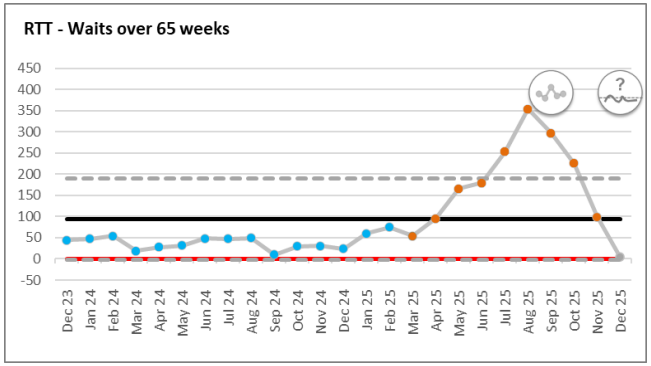
Targets based on Operating Plan end of year March 2026 position (trajectories in place)
Benchmark Position in arrears in line with model hospital publication dates

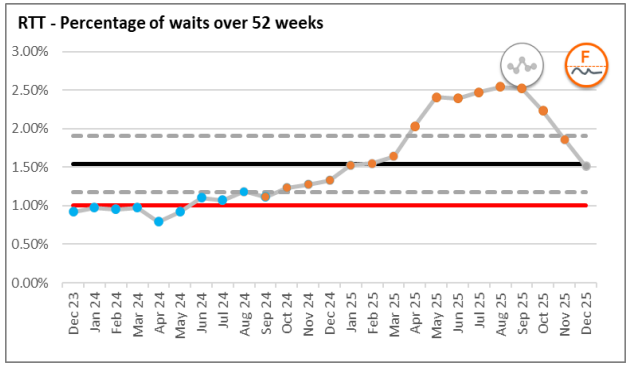
Operational Performance

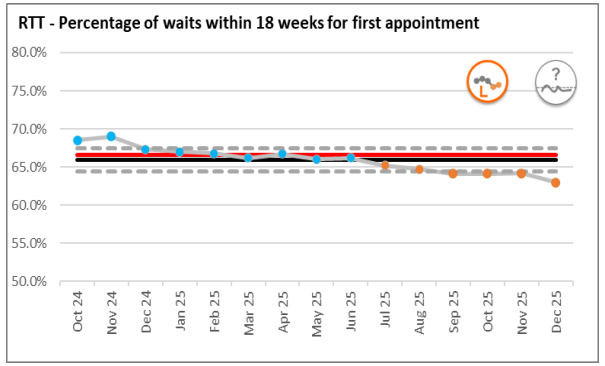
Overview Dashboard

KPI	Sutton Healthcare						Surrey Downs					
	Latest month	Previous Month Measure	Latest Month Measure	Target	Variation	Assurance	Latest month	Previous month measure	Lastest month measure	Target	Variation	Assurance
Two hour UCR performance	Jan 26	67.3%	70.1%	70.0%			Jan 26	87.2%	88.2%	70.0%		
Virtual ward - Bed Occupancy	Jan 26	95.3%	96.5%	85.0%			Jan 26	82.0%	92.5%	80.0%		
Number of waits Adults >52wks	Jan 26	1	1	0			Jan 26	0	0	0		
Percentage of waits Adults <18wks	Jan 26	99.3%	98.8%	78.0%			Jan 26	97.0%	97.1%	78.0%		
Number of waits Children >52wks	Jan 26	58	60	0								
Percentage of waits Children <18wks	Jan 26	47.4%	49.0%	78.0%								

Operational Performance
Exception Report | SGUH Referral to Treatment RTT



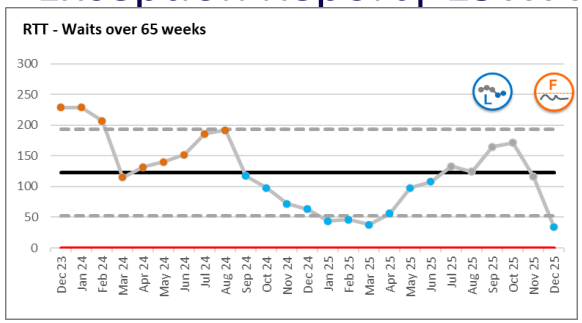


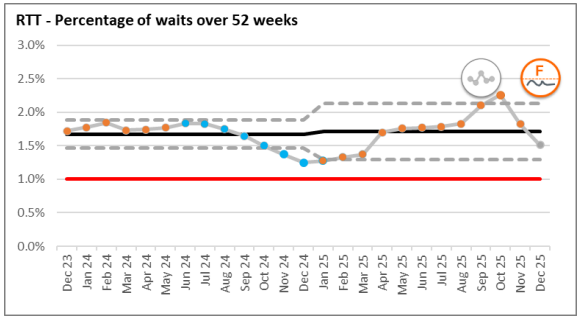


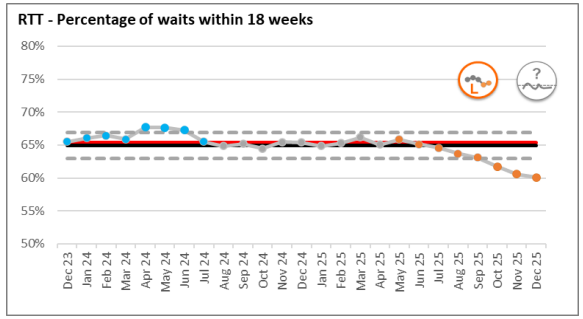
Site & Metric	Cause of variance/ non-compliance	Actions: Completed since last update, New, and Ongoing	Recovery Date	Data Quality
SGUH Waits over 65 weeks - reduction Waits over 52 weeks - reduction	**65 Week Waits** Continuing to see a monthly reduction with a total of 4 patients waiting at the end of December 2025. 3 of which were patient choice to delay treatment. **52 Week Waits** Continuing to see a monthly reduction and ahead of plan with the percentage of 52 weeks waits reducing to 1.51% at the end of Dec-25. Highest proportion of waits are within Diabetes / Endocrine, Gynaecology and Bariatric Surgery. **Bariatric Surgery** remains the risk within General Surgery. The increase in demand from out of area referrals has outweighed capacity – this impacts our long waits position. **Gynaecology** has a high conversion rate from outpatients to theatres, resulting in a high volume of patients on the admitted pathway	Significant progress in eliminating 65-week RTT waits has resulted in the Trust exiting NHSE Elective Tiering. **Ongoing:** Specialist Weight Management patients: Agreement was reached with the ICB on funding for this pathway for the long waiting cohort. The team is now working at pace to stand up a number of OP clinics to address the backlog and have zero patients waiting over 52 weeks by the end of March 2026. Independent Sector being utilised effectively to treat long waiting patients in General Surgery, Vascular Surgery, Cardiology and Gynaecology. Weekly Tier One committee meetings continue to be held. With a focus on eliminating 65 weeks, reducing 52 week waits to >1% of the overall PTL and improving RTT performance Specialties now focusing on forward view for March to ensure all patients over 40 weeks are booked for their first appointment **New:** Trust focusing on Q4 Sprint. To deliver activity numbers for first appointments above baseline plan with agreed additional activity. To reduce long wait position and drive towards 52 week reduction in line with national ask.	52 week waits – Mar 2026 Multiple metrics - Mar 2026	sufficient for assurance

Operational Performance

Exception Report | ESTH Referral to Treatment RTT





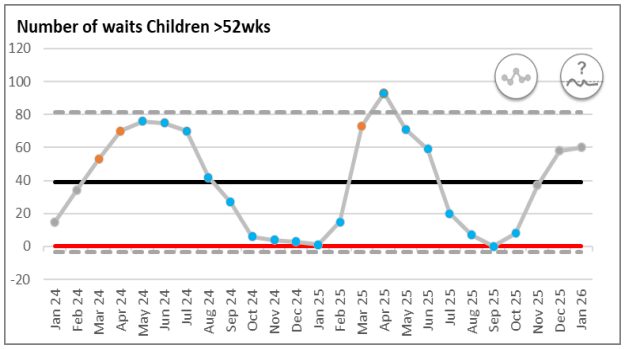


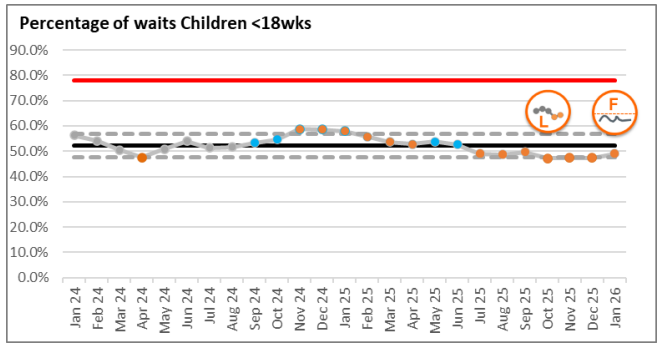
Site & Metric	Cause of variance/ non-compliance	Actions: Completed since last update, New, and Ongoing	Recovery Date	Data Quality
ESTH Proportion of waits over 52 weeks – above monthly trajectory of 1.06% Percentage within 18 weeks – below monthly trajectory of 65.43% Percentage waits for first appointment under 18 weeks –below monthly trajectory of 81.30%	• 52WW did not achieve the ambition of being below 1.06% in December 2025, with a performance of 1.51%. However, 52WW did reduce again for the second consecutive month following nine consecutive months of increases, falling from 1054 in November 2025 to 888 in December 2025. The highest volumes were in Dermatology (132), Gynaecology (112) & Gastroenterology (111). • 65WW also reduced from 116 in November 2025 34 in December 2025. • The RTT PTL increased for the first time following three consecutive months of reductions, increasing from 57834 in Nov-25 to 58752 in December 2025. • Percentage waits for first appointment under 18 weeks was below plan in Dec-25, with a performance of 74.5%.	**Total PTL** -ESTH's PTL has been reducing month on month since September 2025, following four months of increases post-EPR. However, there was an increase in PTL size in December 2025, mainly driven by an iCLIP issue following the latest software release. Additional validation resource is being sourced to support recovery from this issue and to expedite the reduction of other data quality within the cohort. **Long Waiters -52WW** - Recovery plans remain in place and ongoing for the most challenged specialties. • Dermatology: Long waits are driven by reduced activity following EPR implementation and cancer demand pressures. A recovery plan for RTT and cancer is in place, with additional capacity secured via Medinet until the end of January 2026 and external funding from RMP and NHSE. A teledermatology pilot is due to start on 26th January 2026 to improve Two week wait referrals and routine capacity, and further use of the Virtual Lucy platform is being explored. A locum consultant is due to start at the end of January 2026. • Gynaecology: Gynaecology continues to face sustained pressure from demand and workforce capacity constraints, alongside the requirement to support Cancer performance. The starting position for 65-week waits was high, and while the ambition was to achieve zero 65WW breaches by December 2025, this was not fully realised. These breaches occurred despite focused validation, booking and escalation activity. Further recovery actions remain focused on 65 and 52-week long-waiter management, optimisation of capacity (including outsourcing), continued validation, and alignment of Cancer and RTT priorities to actively manage risk. • Gastroenterology: Key challenges include 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 challenging, and a text-reminder service is now in use. A Patient Tracking List (PTL) coding change at iCLIP, splitting TFC 301 into Gastroenterology and Endoscopy, caused pathway delays which are now being reviewed and aligned to the correct service. Endoscopy capacity constraints have delayed some pathways.	25/26 trajectories expected to be achieved by March 2026	Dec-25 data sufficient for assurance

Operational Performance

Exception Report | Sutton Health: Community Services Waiting Times (Children)

Sutton Healthcare

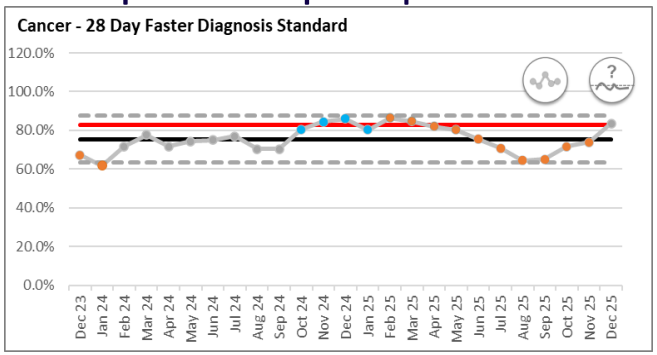


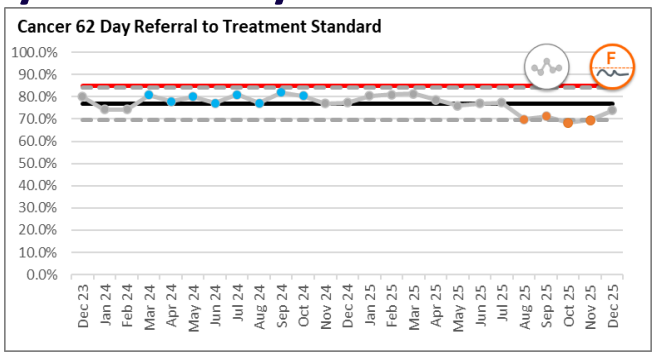


Site & Metric	Cause of variance/ non-compliance	Actions: Completed since last update, New, and Ongoing	Recovery Date	Data Quality
Sutton Health & Care % of waits over 52 weeks % of waits within 18 weeks	Overall waiting list size for children's services remains high with a consolidated action plan in development across Southwest London. Waiting lists are challenged due to demand driven predominantly by increasing complexity of need. 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 January 2026 this increased to 60. Children's Occupational Therapy (OT) have successfully maintained waiting times under 52 weeks. At the end of January 2026, 49% 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.	• Harm reviews continue to take place to ensure there is no harm to these children, with delayed waiting times. No concerns have been 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

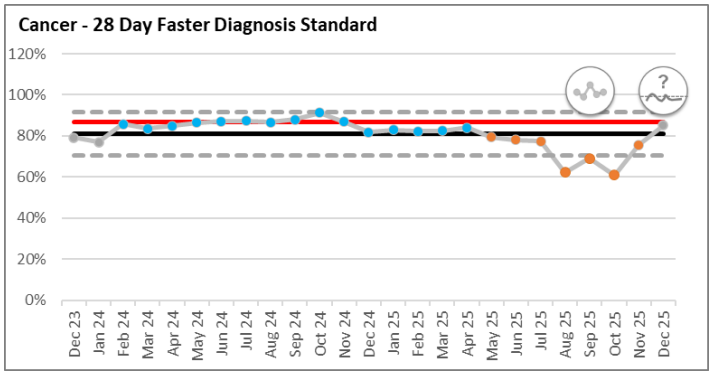




Site & Metric	Cause of variance/ non-compliance	Actions: Completed since last update, New, and Ongoing	Recovery Date	Data Quality
SGUH 28 Day – Normal variation meeting target 75% 62 Day Below target of 75%	**28-Day Standard:** December 2025 83.5% an improvement on 74% reported in November 2025. Eight Tumour sites were compliant. Both Skin (73.8% and Gynae (82.7%) where performance has been significantly challenged, reduced backlog through December 2025. **62-Day Standard:** December 2025 73.9% and improvement on 69.5% reported in November 2025 Key Drivers • Lung (33.3%) Thoracic: Theatre capacity pressures, particularly in Thoracic surgery receiving sector wide referrals and Limited access to robotic lists. • Plastics due to delays to clinic	**Dermatology -**A dedicated workgroup has been convened to develop and oversee a sustainable service improvement plan. Key actions underway include: • Daily image review clinics • Standardised template letters being rolled out across all clinics to expedite discharge communication and reduce administrative delays. • Imaging pathway optimisation, target for all image appointments to be completed by day 7 and reviewed by day 10. • Job planning alignment to ensure clinical capacity reflects current and forecasted demand. • Development of the Dermatology Summer Plan, incorporating expected seasonal increases in referral volumes. **Gynaecology** : • The 12-month pilot for cervicovaginal swab testing for patients presenting with abnormal bleeding, launched in November 2025, continues to progress. • A formal audit is scheduled for February 2026, with early findings indicating improved performance against the FDS standard and enhanced diagnostic efficiency. **Lung/Thoracic** - RMP-funded weekly lists (total of 8) are in place and will continue through March 2025, supporting service resilience and pathway performance. **H&N and Maxfax** – Between January 2026 and March 2026, a total of 12 additional RMP-funded clinics and biopsy lists have been planned to increase diagnostic and treatment capacity. **Winter Resilience Funding:** A total of £55K RMP funding in January 2026 supporting Max-fax, LGI, theatre capacity (lung, urology, plastics) and Oncology capacity. **Daily Monitoring:** All patients on the FDS pathway at day 21–28 are reviewed daily to ensure actions are in place.	FDS sustainability is, subject to robust skin summer plan to manage expected seasonal increase.	Sufficient for assurance

Operational Performance

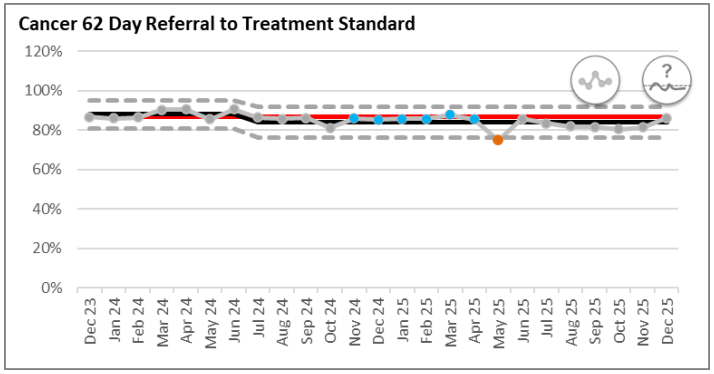
Exception Report | ESTH 28-Day Cancer Faster Diagnosis Performance



Site & Metric	Cause of variance/ non-compliance	Actions: Completed since last update, New, and Ongoing	Recovery Date	Data Quality
28 Day Faster Diagnosis **85.1%** below trajectory of 86.9% but above the national target of 77%	**Gynaecology (73.7%):** **FDS performance for Gynaecology has improved compared to 62.6% in Dec-25** • 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 –Regular review of breaches in Business meetings to understand challenges in the pathway and provide necessary mitigations to improve performance and patient care.** Penthrox (introduced in October) improves pain management and reduction in repeat procedures.	February 2026	Sufficient for assurance
	Upper GI (75%): **FDS performance for Upper GI has improved compared to 74.8% in Dec-25.** • Complex caseload (elderly/incapacitated patients) requiring F2F review and multiple investigations	• Endoscopy booking turnaround times are gradually improving. • Complex patients requiring multiple investigations. • The Upper GI team currently relies on an external diagnostic test—EUS (Endoscopic Ultrasound)—which is only performed at the Royal Marsden Hospital. The average waiting time for this test is approximately six weeks. The Planned Care team has submitted a business case to introduce EUS within the endoscopy unit; however, this is currently pending approval. **Next Steps –** Cancer Services are working with the service team and setting up regular meetings to improve patient pathways at various levels. Weekly validations and escalations have been introduced to address issues in real time.		

Operational Performance

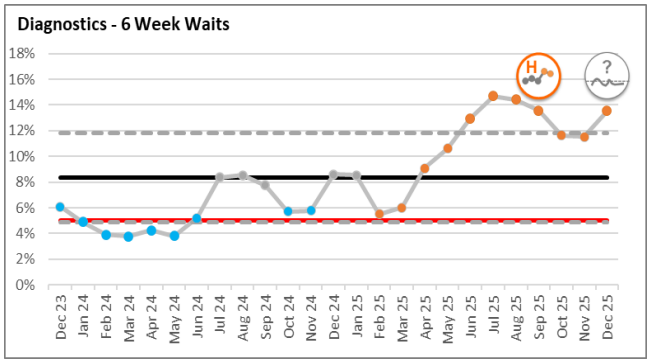
Exception Report| ESTH 62-Day Cancer Waits Performance



Site & Metric	Cause of variance/ non-compliance	Actions: Completed since last update, New, and Ongoing	Recovery Date/Status	Data Quality
62 Day Standard **86.2%** meeting trajectory of 86.2% and national target of 85%	**Gynaecology (50%)** Delays in arranging follow appointments and limited JCC clinic capacity were key contributors to breach values for Gynaecology. These bottlenecks impacted timely access to diagnostics and pathway progression.	• Joint Cancer clinic capacity is regularly reviewed so patients are scheduled per Multidisciplinary Team (MDT) outcomes, with non-priority cases redirected to suitable clinics. Pre-Operative Assessment capacity at St Helier has also increased, supporting timely bookings. • Service plan to set up a one-stop nurse-led hysteroscopy clinic to boost diagnostic capacity once the nurse completes training. • Service team are now working on audits to improve clinic efficiency and hysteroscopy failures. Business meetings scheduled monthly to discuss any pathway challenges and to implement robust management of patients requiring urgent diagnostics.	February 2026	Sufficient for assurance
	Lung (70%) Delays to CT-guided biopsies and Navigational Bronchoscopy at Royal Brompton .	• Diagnostic delays persist for navigational bronchoscopy . A risk assessment was completed and presented in cancer strategy Board. The waiting times are likely to be increased due to capacity issues at Royal Brompton Hospital. RMP are trying to look for alternatives and set up group meetings for further discussions. • Radiology now recruited a Chest radiologist providing CT guided biopsies internally from January 2026. • Continue collaboration with RMP to benchmark Lung diagnostic pathway with high performing trust.		
	Urology (83%) We did a high number of patient choices breaches during the holiday period which resulted in low performance for Urology.	All breach reports were thoroughly reviewed by the clinical team. Patient choices contributed to significant delays in the pathway. The nursing and administrative teams have been advised to proactively highlight any delays in order to support timely and constructive discussions, and to enhance patient engagement.		
	Haematology (78.9%) - Complex patients.	Patients required multiple complex investigations to establish diagnosis prior to treatment planning.		

Operational Performance

Exception Report | ESTH Diagnostic Performance

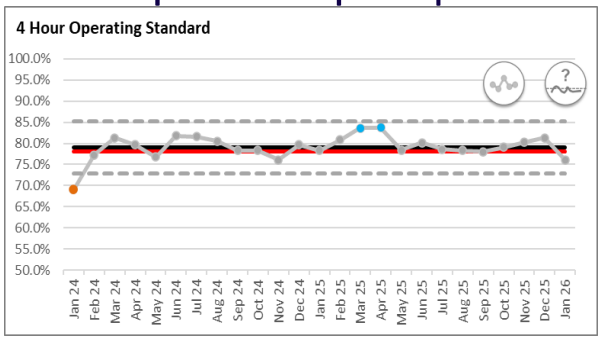


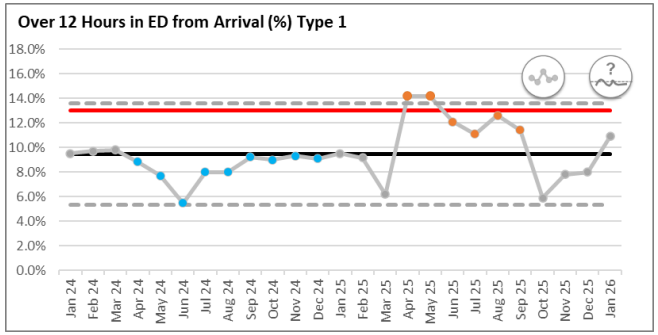
Modality	6 Week Breaches	>6 Week Performance
Magnetic Resonance Imaging	66	3.4%
Computed Tomography	45	3.9%
Non-obstetric ultrasound	279	4.1%
DEXA Scan	13	3.1%
Audiology - Audiology Assessments	234	28.6%
Cardiology - echocardiography	632	42.0%
Neurophysiology - peripheral neurophysiology	0	0.0%
Urodynamics - pressures & flows	73	30.8%
Colonoscopy	341	43.6%
Flexi sigmoidoscopy	81	39.3%
Cystoscopy	38	20.1%
Gastroscopy	249	37.4%

Site & Metric	Cause of variance/ non-compliance	Actions: Completed since last update, New, and Ongoing	Recovery Date	Data Quality
ESTH 6Wk waits 13.5% not meeting national interim target of 5%	At the end of December 2025, there were 2,051 patients waiting more than six weeks for their diagnostic (DM01), an increase from 1,773 in November 2025. Performance also deteriorated from 88.46% in November 2025 to 86.47% in December 2025, remaining below the national interim target of 95%. The modalities with the highest volumes waiting >6 weeks at the end of December 2025 were Endoscopy (671), ECHO (632) & NOUS (279). Imaging modalities all remain above 95%.	• **ENDOSCOPY:** An Endoscopy recovery plan is in place to address backlog resulting from reduced activity during the iClip Pro launch and issues with the new booking system. Six additional Saturday Waiting List Initiative sessions have been approved at Epsom and St Helier for February and March 2026, enabling a further 210 procedures and supporting delivery of cancer and RTT targets. Mandatory clinical triage for all deep sedation referrals has also been introduced to manage demand and streamline patient pathways. • **ECHOs:** The number of breaches increased from 487 at the end of November 2025 to 632 at the end of December 2025, reflecting reduced capacity over the festive period, including weekday bank holidays, annual leave, staff shortages due to unplanned sickness, and a temporary reduction in weekend clinics. Weekly waiting list validation is currently paused due to administrative staffing pressures, and data quality issues linked to the new EPR system remain under review. Recruitment to the substantive Band 7 post is ongoing, with a temporary locum approved from 5 January 2026. Service recovery includes 22 additional clinics (220 echocardiograms) scheduled for January 2026 compared with December 2025. • **NOUS:** Ultrasound performance declined from 99% in November 2025 to 95% in December 2025. This drop was primarily driven by significant sickness absence across both clinical and booking teams, which reduced available capacity and delayed the processing of partial booking letters. Mitigation for January 2026 will be close monitoring of the waiting lists with daily list validation. Additional capacity options are being evaluated to further enhance performance and sustain progress. Position has been recovered in January 2026 DMO1 performance.	March 2026	December 2025 data still includes a degree of data quality following EPR implementation that continues to be worked through with BI and operational teams. This data quality is mainly within outpatient modalities Neuro-Physiology, Urodynamics and Cystoscopy.

Operational Performance

Exception Report | SGUH A&E Waits and Ambulance Handovers

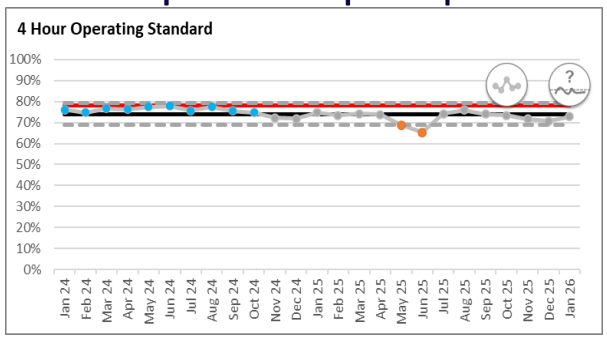


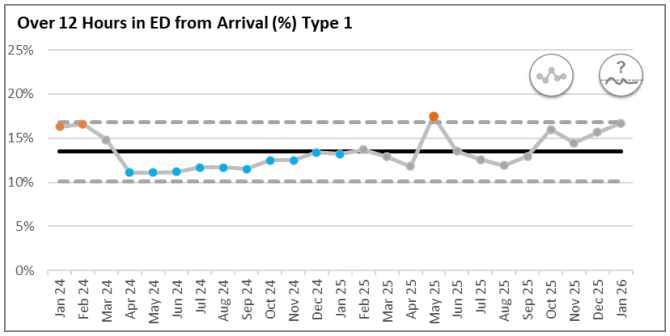


Site & Metric	Cause of variance/ non-compliance	Actions: Completed since last update, New, and Ongoing	Recovery Date	Data Quality
SGUH 4 Hour Target not met in January 2026 12 Hour Waits – increased not meeting <10% ambition	Jan-26 4 hour performance deteriorated to 76.1%, falling below 78% national target. Non-admitted pathway performance at 85% (decrease of approx. 5%) seeing an increase of over 600 breaches compared to Dec-25. 12 hour type 1 performance increased to 10.9% through Jan-26 Driven by significant ED capacity constraints, 4% increase in attendances compared to Dec-25, beds closed downstream due to Infection Control. Significant pressures across whole SWL system High volume of mental health patients attending ED, with long waits for mental health beds.	• 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. • Launch of Patient Check In has reduced average time in streaming queue from 28 mins to 8. • Access to book GP slots via EMIS beyond M&W to be launched – procurement and ICT delays, not yet in place • 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: • EP, ACP and PA providing cover Mon-Fri to ensure 3 at front door • Appointment bookings for local GPs from streaming – reduction in availability in 2026, taking forward with ICB • Confirmed focus on performance with daily oversight at an SLT level • Full capacity protocol actions delivered to support flow • Timely validation of breeches being reviewed and the opportunity of a “Bot” supporting first validation being explored	Mar-26	4 hour waits Sufficient for assurance 12-hour waits Data source NHSE, internal data under review

Operational Performance

Exception Report | ESTH A&E Waits and Ambulance Handovers

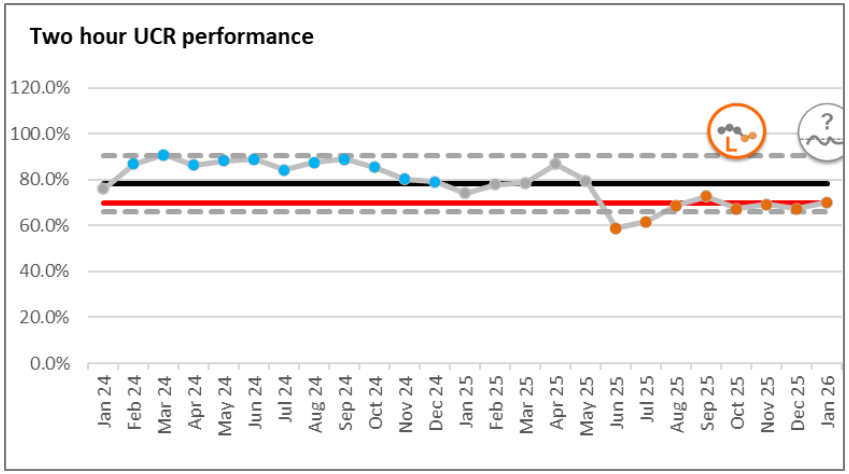




Site & Metric	Cause of variance/ non-compliance	Actions: Completed since last update, New, and Ongoing	Recovery Date	Data Quality
ESTH 4 Hr performance below trajectory of 75.5% ED Type 1 LOS>12 Hours - normal variation	• ESTH 4-hour emergency department (ED) performance improved in January 2026 delivering 72.8% versus 70.8% in December 2026 albeit against an agreed trajectory of 75.5% performance. Failure to meet the trajectory was mainly due to adult patients requiring admission, with admitted performance at 25.4% versus 78.8% for non-admitted adults in January 2026. • 12-hour wait times for type 1 attendances rose to 16.7% in January 2026 driven by limited bed availability and Trust-wide infection control constraints, which affected timely admissions and performance across both sites.	Tier 2 interventions: GIRFT Urgent Emergency Care (UEC) site visits (August–October 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 the emergency department (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 and are now conducted as BAU in both departments. • Weekly meetings convened with SWL pathology to support the reduction in delays of pathology sample waiting times. • 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 including admission avoidance.	February 2026	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	• January 2026 2-hour response performance was 70.1%, against a 70% target. Referrals are within normal range however there are variations especially out of hours with referrals peaking at 6pm, having an impact on capacity.	• Reviewing out of hours referrals to identify the underlying causes and implement urgent mitigating actions to ensure the service continues to perform above target. • There is a continued focus to ensuring the service meets targets vis a vis its capacity to deliver.	TBC after detailed analysis which is in progress	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	Sep 25	0.5%	-0.4%	-	N/A	N/A	Lowest Quartile	Sep 25	-2.8%	-1.6%	-	N/A	N/A	Lowest Quartile
Non Elective Length of Stay (SWL Methodology exc 0 days, exc <18 years)	Jan 26	10.7	10.8	8.4			N/A	Jan 26	10.4	11.6	10.9			N/A
Average days from Discharge Ready Date to date of discharge (inc 0 day delays)	Dec 25	0.8	1.0	-			2nd Quartile	Dec 25	1.3	1.4	-			Lowest Quartile
Theatre Utilisation (Capped)	Jan 26	81.4%	82.6%	85.0%			Top Quartile	Jan 26	82.0%	82.0%	85.0%			2nd Quartile
BADS All Daycase & Outpatient Procedures % of total procedures	Oct 25	78.4%	78.7%	83.6%			Lowest Quartile	Oct 25	63.6%	65.4%	83.6%			Lowest Quartile
Outpatients Patient Initiatied Follow Up Rate (PIFU)	Jan 26	2.2%	2.3%	5.0%			Lowest Quartile	Jan 26	4.6%	4.7%	5.0%			2nd Quartile
Outpatients Missed Appointments (DNA Rate)	Jan 26	10.2%	10.0%	8.0%			Lowest Quartile	Jan 26	7.4%	7.0%	6.0%			3rd Quartile
First and Procedure Attendances as a proportion of Total Outpatients	Dec 25	52.7%	52.5%	49.0%			2nd Quartile	Dec 25	42.0%	43.1%	49.0%			Lowest Quartile

Operational Productivity

Implied Productivity – Headline NHSE Metric

The implied productivity measure for acute and specialist trusts compares year-on-year growth in outputs (cost-weighted activity) with growth in inputs (operating expenditure).

Data source: NHSE Official statistics portal

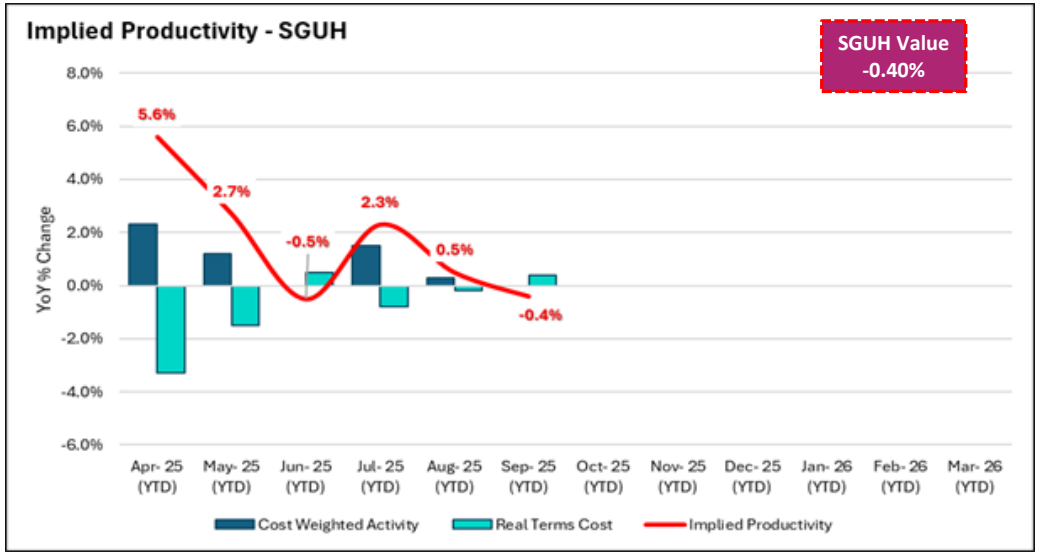
SGUH Summary

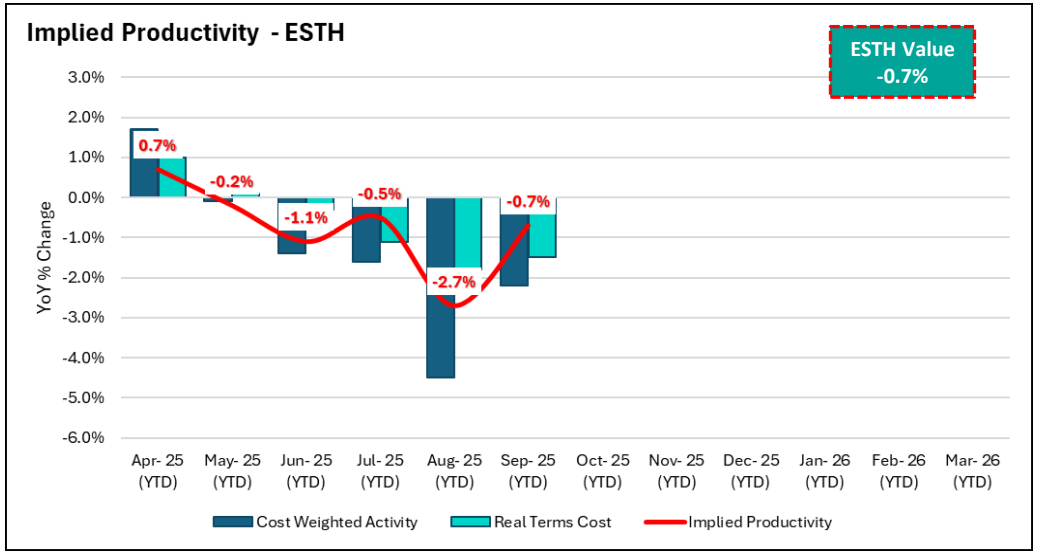
Decrease in productivity (-0.4%) in 2025/26 Month 6 YTD compared to same period the previous year. Driven by 0.4% growth in operating expenditure against zero growth in cost weighted activity.

ESTH Summary

Productivity decreased by 0.7% in 2025/26 Month 6 YTD compared with the same period last year, driven by a 1.5% reduction in cost-weighted activity, which exceeded the 2.2% reduction in costs.

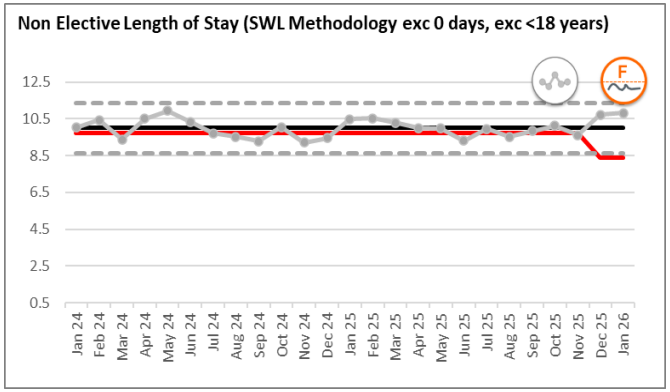
Activity data remains volatile following EPR implementation, resulting in significant month-on-month changes that are currently under review.



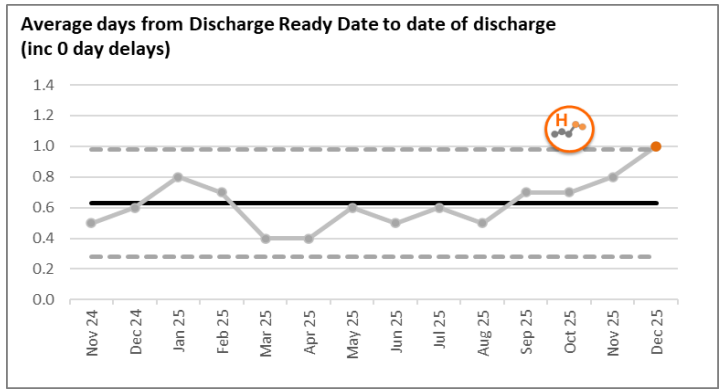


Operational Productivity

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).

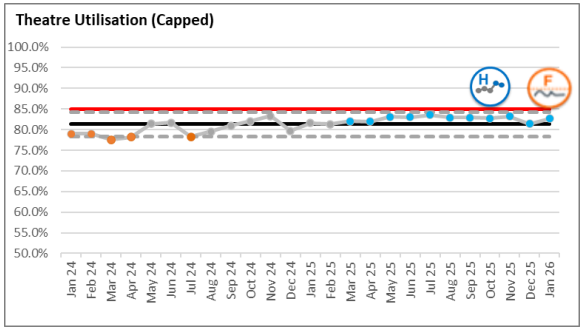


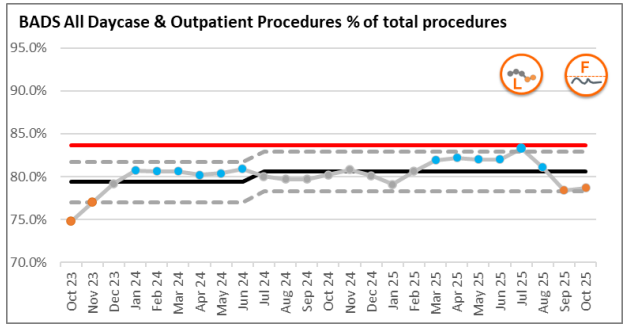
Acute discharges and bed days after the Discharge Ready Date averaged over a month.
Numerator: The total aggregate number of days from discharge ready date to date of discharge for all patients discharged in the period
Denominator: The total number of patients that have been discharged in the period

Metric	Reporting Month	Productivity Opportunity vs Target
NEL Length of Stay.	Jan-26	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	• December 2025–January 2026 data shows average delay to discharge breached the upper control limit, indicating deteriorating flow performance, due to patient acuity. • Length of stay increased to 10.7 days vs. 8.4 plan, with only 45% of Pathway 0 discharges within 24 hours (80% KPI). • Not Meeting Criteria to Reside (NCTR) volumes improved, but correlation with 21+ day stays requires further analysis to understand variation. • Delays remain below peer and national averages, suggesting the issue is primarily internal flow and LOS. • Position is likely linked to (winter pressures, acuity, capacity and workforce factors) and will continue to be monitored.	• Review of discharge functions continues to identify further efficiencies and reduce internal delays across pathways. • The NEL Length of Stay Transformation Programme (ACE) has been refreshed presented to the Senior Leadership Team for approval ahead of implementation, focusing on reducing delays without additional workforce or capacity. • Full Capacity Protocol remains in use with a focus on divisional responses in line with the policy, any learning will be incorporated from previous iterations and aligning with national expectations on handovers, corridor care, and 12-hour ED delays. • A GESH-wide Non-Elective Transformation Programme is in development, with supporting business cases progressing (SRO: Managing Director). • Deployment of an AI solution to support CTR identification and tracking, improving data quality and enabling teams to focus on true NCTR cohorts rather than misclassified CTR patients.	tbc	Sufficient for assurance

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





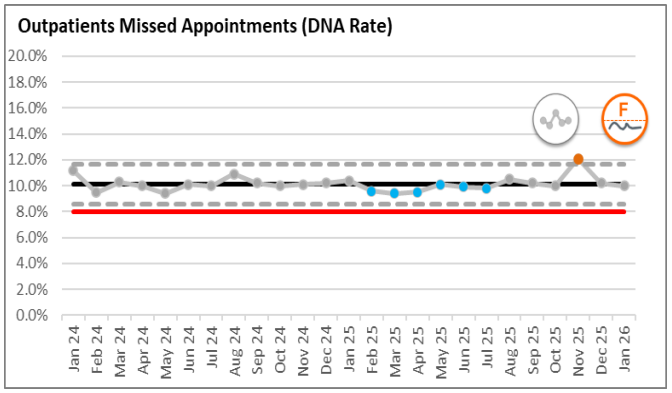
Metric	Reporting Month	Productivity Opportunity vs Top Quartile
Capped Theatre Utilisation	Jan-26	35 cases (based on an average case time of 124 min) to hit 85%
Day cases and outpatient procedures (BADS)	Oct-25	148 cases opportunity to move to OP (3 month period)

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 – January 2026 Overview** Capped theatre utilisation showed a slight increase in the first four weeks of Jan-26, with a validated rate of 83.3%. Performance remained within the top quartile when benchmarked nationally and especially in SWL. All theatre areas sustained capped utilisation levels above 80% in Jan-26 Same-day cancellations decreased to 3% compared with the previous month, indicating an improvement in operational efficiency and schedule stability.	**Theatre Scheduling** – Weekly 642 meetings, chaired by the Divisional Director, focus on improving theatre allocation and reducing dropped sessions. These are supported by a digital tool that is already driving early improvements in ACPL. **Same-Day Cancellation Policy** – A new policy has been developed to ensure alignment with national guidelines. CICG has approved an IT change request, with prioritisation and resource scoping currently underway. **Day Surgery Utilisation** – A four-week review of DSU usage, focusing on late starts and early finishes, has been completed. New measures have been implemented, resulting in an increase in utilisation from the low 70% range to 82% capped utilisation. Starting with 7 day and 48-hour reminder calls to patients prior to surgery.	TBC	sufficient for assurance
SGUH: Increasing trend, below top quartile peer	**Day Case Rate** SGUH continues to treat a higher proportion of inpatient cases than peer organisations, largely reflecting greater patient complexity. This results in increased demand for inpatient beds for procedures that are commonly delivered as day cases elsewhere. Inpatient activity increased in Sep-2025.	**BADS Compliance** Work is underway to strengthen planning processes and support the transition of more eligible procedures to the DSU. Surgical teams are actively engaged through the Theatre Transformation Programme to improve BADS compliance. This is being driven by the “Right Procedure, Right Place” approach within local Theatre User Groups (TUGs).	TBC	Sufficient for assurance

Operational Productivity

SGUH - Missed Appointments (DNA Rate)

St George's



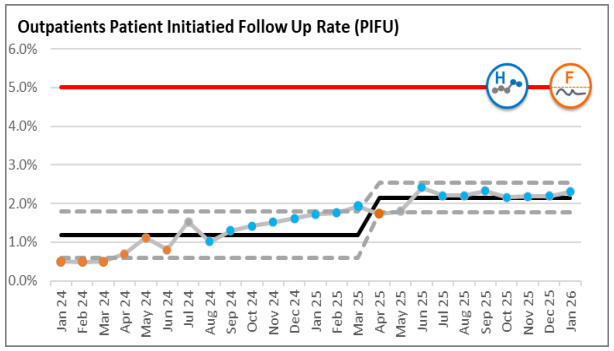
Metric	Reporting Month	Productivity Opportunity vs Top Quartile
Outpatients: DNA rates	Dec-25	1,445 appointments

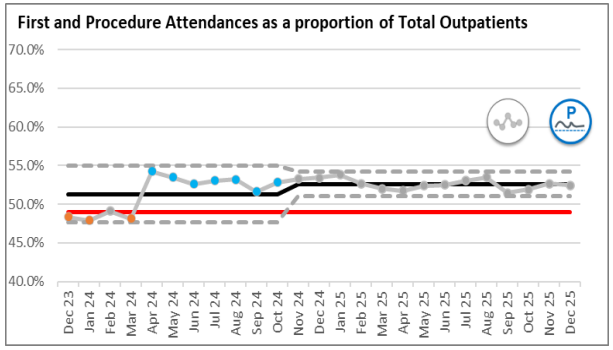
The methodology to calculate the opportunity to reduce the number of missed outpatient appointments is based on how your average missed outpatient appointments rate (from the last 6 months) compares to the national missed appointments profile for providers for the previous month.

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%	Run rate Now showing normal variation after the SMS failures in November 2025 causing a rise is DNA rates.	- Charity bid to their Health Inequalities fund to allow for expansion of Automated call reminder trial submitted b ut was declined. Charity have indicated they may be able to fund this from a different pot and will be in contact to discuss. - Improvements to Zesty Patient Portal planned and being tested 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). Contracts for functionality expansion signed awaiting implementation dates. - Plan identified to protect vacated short notice (patient cancelled) slots for use with Long waiting patients. Go live planned for March 2nd. - Plan underway to expand Portal to encompass Paediatrics. - Partial Booking light to commenced in November with first service to go live (Paediatric Respiratory). 1st go live successful. Work commenced to implement with Plastics, Urology and T&O. - Trial planned to improve DNA rebooking management within T&O. Awaiting It Cerner changes before go live. - Plan being developed to trial changing the timing of sms reminders and to supplement further with automated call reminders.	Under review at Outpatient Transformation Board	sufficient for assurance

Operational Productivity

SGUH – Reduction in Outpatient Follow-Ups



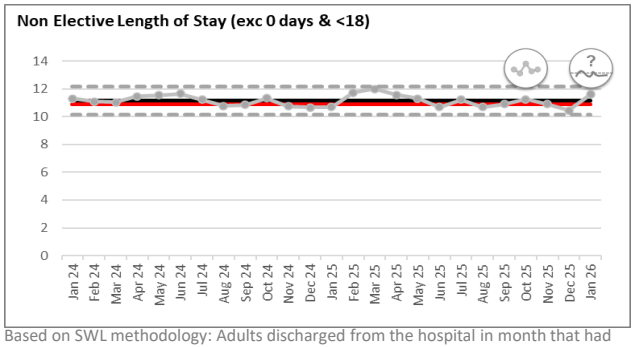


Metric	Reporting Month	Productivity Opportunity vs Top Quartile
1st + Proc as a % of Total OP	Dec-25	*0 (exceeding target)*
PIFU Rates	Jan-26	*Not quantified to avoid double-counting with New: FU Ratio opportunity*

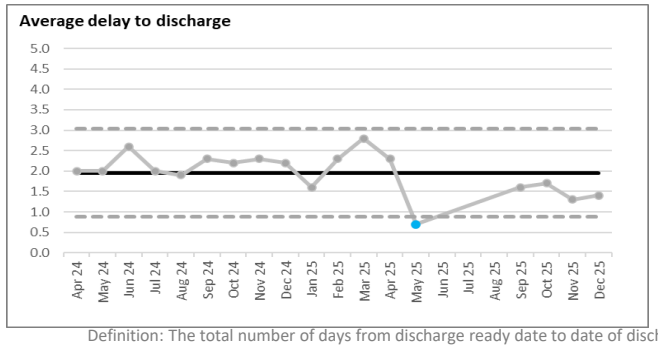
Site & Metric	Cause of variance/ non-compliance	Actions: Completed since last update, New, and Ongoing	Recovery Date	Data Quality
SGUH PIFU Rate: Consistently not meeting target, improving trend.	The operational plan signed off by the Board SGUH had a target of 3% due to the delay in starting PIFU. Whilst 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. • Work continues to develop PIFU by default pathways for post surgery 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



Based on SWL methodology: Adults 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.



Definition: The total number of days from discharge ready date to date of discharge for all patients discharged from an acute bed in the period, as a % the total number of patients discharged in the period.

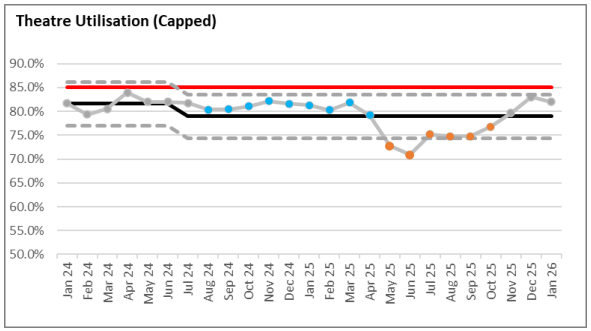
Metric	Reporting Month	Productivity Opportunity vs Target (annualised)
NEL Length of Stay.	Jan-2026	TBC

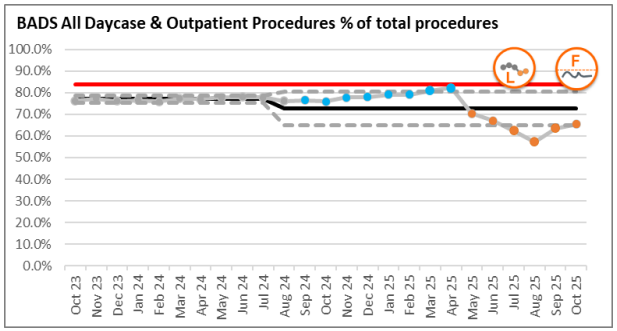
Site & Metric	Cause of variance/ non-compliance	Actions: Completed since last update, New, and Ongoing	Recovery Date	Data Quality
ESTH LOS Normal Variation Average delay to discharge normal variation	• Non-elective LOS increased from 10.4 days in December 2025 to 11.6 days in January 2026, influenced by the discharge of 10 complex patients, including one patient with a length of stay of 275 days. • Increases are observed across the >7-day, >14-day, and >21-day stranded patient cohorts; however, this reflects a consistent year-on-year trend seen between December2025 and January 2026. • January 2026 Not Meeting Criteria to Reside (NCTR) local reporting shows an average of 1.5 days from Date Ready for Discharge (DRD) to discharge.	**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, rollout continues to progress Trustwide. • Therapies – Improving productivity and workforce deployment to deliver timely, needs-based care through targeted process enhancements and models, including acute Trusted assessor adoption into community interface capacity. • Bed Reduction Plans - agree and implement a redesign of the internal bed base trust wide optimising estate footprints and staffing, relocation of Gloucester ward completed December 2025 supporting improved efficiency and capacity requirements. • Acute Medicine Workforce -Reviewing the acute medicine workforce to optimise available resources versus demand. • Operational Flow Management -Strengthening patient flow through improved daily systems, escalation processes, and governance including the commencement of overnight boarding and review of full capacity protocol. • Developing a KPI dashboard to monitor progress across programme and workstreams • Daily discharge reports resumed post EPR cutover, aiding internal, Transfer of Care & external partners with tracking medically fit patients. • Daily CTR and DRD reporting and validation continues to support compliance and includes alerts by site, division, and ward. • 0–21-day LOS patient reviews continue to support flow in line with Trust's OPEL status, alongside complex discharge reviews involving external partners to ensure oversight of all acute inpatients. • Ongoing work to ensure compliance and validation of the NCTR position. A targeted review is assessing the timelines between patients' DRD and actual discharge, including the reasons and accuracy of recorded delays following the EPR rollout.	N/A	Sufficient for assurance

Length of stay activity for Epsom and St Helier includes activity for two community wards located in the acute hospital setting.

Operational Productivity

ESTH - Theatre Utilisation & Outpatient & Daycase Procedure Rates

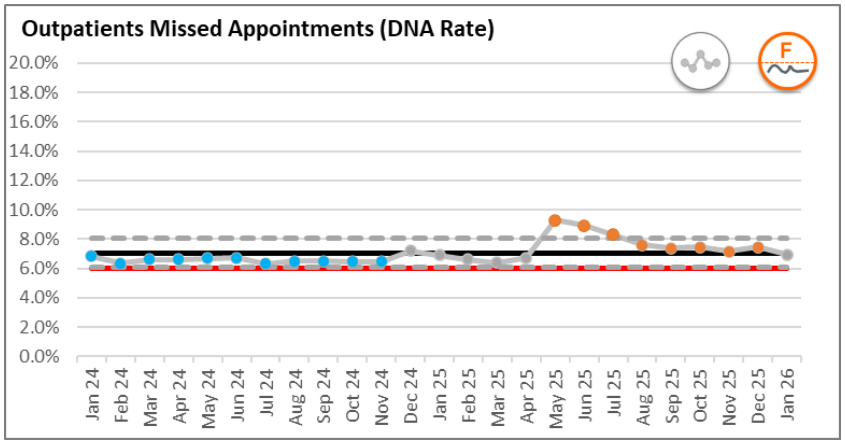




Metric	Reporting Month	Productivity Opportunity vs Top Quartile
Capped Theatre Utilisation	Jan-26	103 cases (based on an average case time of 63 min) to hit top quartile
Day cases and outpatient procedures (BADS)	Oct 25	130 cases opportunity to move to OP (3 month period)

Site & Metric	Cause of variance/ non-compliance	Actions: Completed since last update, New, and Ongoing	Recovery Date	Data Quality
ESTH Theatre Utilisation between upper and lower confidence limits BADS performance Not meeting target CONCERNING trend	Theatre utilisation was sustained at 82% in January 2026, reflecting continued operational stability and the ongoing impact of recent transformation work following the introduction of iClip. As of October 2025, BADS performance without SWLEOC is 84.3%. Including SWLEOC performance is 65.4% - drop in performance driven by reduced levels of coding. The Model Hospital metric is set to look at the first procedure code, so if a relevant procedure code is captured in a secondary position it will not count towards the performance. This needs to be altered in the iClip application.	**Perioperative Care & Screening -** A gesh working group, made up of clinical and operational staff from SGUH and Epsom/ESTH, has been formed to deliver the electronic Pre-Operative Assessment by March 2026, ensuring representation from all in-scope services so decisions reflect everyday practice across both sites **Late-start** performance remained strong in January 2026, averaging 22 minutes lost and within the 30-minute target. The February 2026 launch of the Golden Patient, alongside protected admission-nursing time and oversight from the Theatre Start Times Task & Finish Group, is expected to further improve on-time starts. **Day Case & Theatre Efficiency -** From February 2026, SWLEOC will review inpatient bookings weekly, reclassifying suitable patients as day cases based on physiotherapy assessment to improve intended-management accuracy and day-case reporting while protecting bed capacity A January 2026 audit assessing the effectiveness of Pre-TCI calls for surgical admissions demonstrated that **365 On-The-day Cancellations were prevented** between April 2025 and January 2026 (average of 36.5 cancellations avoided per month) Services finalising booking rules for consultant lists, which will support daily theatre huddles and list planning **Staffing & Workforce -**Additional Anaesthetic staff are being recruited and trained to support new processes. Robotic surgery will launch in Epsom Theatre 5 with three fixed and two flexible days per week, coordinated through clinical, operational and scheduling workstreams, with the Theatre Planner updated as plans are finalised **BADS -** A 4-week income recovery project (Jan–Feb) is retrospectively coding outpatient procedures, including SWLEOC injection clinics. Ongoing clinical engagement and training will ensure elective and outpatient procedures are accurately recorded on iClip going forward	March 2026 Q2 2026/27	Sufficient for assurance - sustained benefits from recent transformation work Not sufficient for assurance due to reduced levels of OP coding

Operational Productivity
ESTH Missed Appointments (DNA Rate)



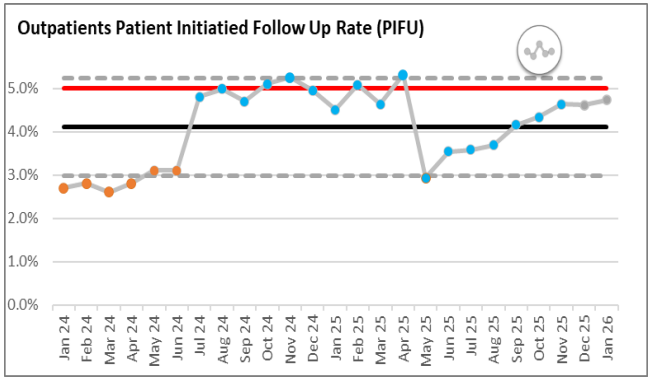
Metric	Reporting Month	Productivity Opportunity vs Top Quartile
Outpatients: DNA rates	Dec-25	699 Appointments

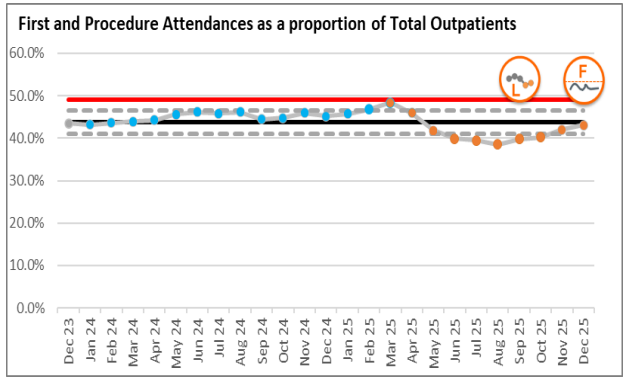
The methodology to calculate the opportunity to reduce the number of missed outpatient appointments is based on how your average missed outpatient appointments rate (from the last 6 months) compares to the national missed appointments profile for providers for the previous month.

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	Text message reminder issues continue. DNA rate in January 2026 <7% for first time since iClip implementation.	**Text reminders:** Further work continues to rectify the text message reminder issues. This work is being led by Patient Services with input from Service Management colleagues. **Patient Portal:** The introduction of the patient portal was delayed until 23 February 2026. Its implementation is expected to support increased visibility of appointments for patients to further support DNA reduction.	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	Dec-25	£600k based on adhoc clinic spend and out of hours clinics
Outpatients: PIFU Rates	Jan-26	*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 – normal variation	An issue with small numbers of staff not fully completing the PIFU process in iClip has been identified. A report has been shared with services to support these individuals and fully complete the PIFU process. PIFU rate is continuing to grow again after the slight reduction in December 2025. Model Hospital November 2025 – Peer av. 2.3%. SWL Highest peer – Kingston 4.6%. ESTH 4.7% - highest in South West London.	**Patient Initiated Follow Up:** ***Gynaecology:*** PIFU Posters now in use. Monitoring impact. ***Paediatrics – Gastroenterology –*** PIFU rate reached 4.8% for the first time in January. Transformation continue to congratulate services with rises in PIFU and offers of support for those where PIFU has declined. ***Endoscopy*** – PIFU introduced, issues with recording. Solution is being found. ***Gastroenterology PIFU recovery*** - A return to >4% for first time since iClip implementation. **Follow-up reduction:** ***Gastroenterology:*** Enhanced triage project is delivering a 5% increase in GP referral diversion rate, from a pre implementation av. of 12% per month to 17%. Each month this is saving on av. 21 patients waiting for secondary care and equates to saving 2 clinics worth of outpatient appointments per month.	March 2026	Not sufficient for assurance post go live - **Expected to be resolved by end of March 2026**

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	Jan 26	5.7%	5.4%	4.0%			2nd Quartile
Agency rates	Jan 26	0.4%	0.5%	-			
MAST	Jan 26	91.4%	91.4%	85.0%			Top Quartile
Vacancy Rate	Jan 26	5.3%	5.5%	10.0%			
Appraisal Rate Medical	Jan 26	84.8%	84.4%	90.0%			
Appraisal Rate Non Medical	Jan 26	78.7%	76.3%	90.0%			Top Quartile
Turnover	Jan 26	9.2%	9.2%	13.0%			4th Quartile
Workforce WTE	Jan 26	10771	10789	10325			
Percentage BAME staff band 8 and above	Jan 26	32.6%	32.9%	-			

Epsom & St Helier

Latest month	Previous Month Measure	Measure	Target	Variation	Assurance	Benchmark
Jan 26	6.7%	6.4%	4.0%			3rd Quartile
Dec 25	1.0%	0.9%	-			
Jan 26	89.1%	88.8%	85.0%			Top Quartile
Jan 26	10.9%	10.6%	10.0%			
Jan 26	90.5%	91.7%	90.0%			
Jan 26	82.1%	80.8%	90.0%			Top Quartile
Jan 26	8.9%	8.9%	12.0%			4th Quartile
Jan 26	7424.00	7522.00	7173.49			
Jan 26	30.3%	30.0%	-			

Sutton Healthcare

KPI	Latest month	Previous Month Measure	Latest Month Measure	Target	Variation	Assurance
Sickness Rate	Jan 26	8.0%	7.1%	4.0%		
Agency rates	Dec 25	1.6%	1.6%	-		
MAST	Jan 26	92.9%	92.3%	85.0%		
Vacancy Rate	Jan 26	14.3%	16.6%	10.0%		
Appraisal Rate Medical	Jan 26	100.0%	100.0%	90.0%		
Appraisal Rate Non Medical	Jan 26	77.3%	74.4%	90.0%		
Turnover (12-Month)	Jan 26	9.2%	8.9%	12.0%		
Percentage BAME staff band 8a and above	Jan 26	24.5%	24.5%	-		

Surrey Downs

Latest month	Previous Month Measure	Measure	Target	Variation	Assurance
Jan 26	6.4%	6.4%	4.0%		
Dec 25	1.3%	0.5%	-		
Jan 26	94.1%	94.3%	85.0%		
Jan 26	10.7%	10.8%	10.0%		
Jan 26	100.0%	100.0%	90.0%		
Jan 26	88.6%	85.7%	90.0%		
Jan 26	11.1%	9.9%	12.0%		
Jan 26	10.9%	10.9%	-		

External report on Turnover from Model Hospital includes fixed term contracts, and Resident Doctors. The Trust excludes these in their reports and would explain discrepancies.

gesh

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

Appendices

Appendix 1 - Statistical Process Control (SPC)

Interpreting Charts and Icons

	Variation/Performance Icons		
Icon	***Technical Description***	***What does this mean?***	***What should we do?***
	Common cause variation, NO SIGNIFICANT CHANGE.	This system or process is **currently not chaging 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	Jan 26	112	107	0			Highest Quartile
Number of Complaints Received	Jan 26	67	102	-			N/A
Number of re-opened complaints in month	Jan 26	5	4	-			N/A
Parliamentary and Health Service Ombudsman (PHSO) Received	Jan 26	1	0	-			N/A
Parliamentary and Health Service Ombudsman (PHSO) Closed	Jan 26	0	0	-			N/A
RTT - Total Size Incomplete Waiting List	Dec 25	68490	68668	74003			3rd Quartile
Community Percentage of waits within 18 weeks	Nov 25	64.7%	64.7%	78.0%			TBC
Cancer 31 Day Decision To Treat to Treatment Standard	Dec 25	87.9%	92.1%	96.0%			2nd Quartile
On the Day Cancellations not re-booked within 28 days	Dec 25	2	4	0			2nd Quartile
Outpatient Advice & Guidance Rate per 100 First OPA	Nov 25	23.3	21.5	16.0			2nd Quartile
Emergency Department Attendances per day	Jan 26	413	430	-			N/A
Mental health delays 4 Hour Breaches	Jan 26	140	165	-			N/A
Length of stay > 21 days (super stranded)	Jan 26	166	174	-			3rd Quartile
Overnight G&A beds occupancy - Adults	Jan 26	96.6%	96.7%	96.0%			3rd Quartile
Number of patients not meeting criteria to reside (Daily Avg)	Jan 26	114	113	-			2nd Quartile

Epsom & St Helier

Latest month	Previous Month Measure	Latest Month Measure	Target	Variation	Assurance	Benchmark
Jan 26	40	45	0			Highest Quartile
Jan 26	48	75	-			N/A
Jan 26	2	3	-			N/A
Jan 26	1	3	-			N/A
Jan 26	0	1	-			N/A
Dec 25	57834	58752	50386			3rd Quartile
Dec 25	100.0%	99.0%	96.0%			Top Quartile
Dec 25	0	2	0			Top Quartile
Nov 25	66.4	0.6	16.0			Top Quartile
Jan 26	436	433	-			N/A
Dec 25	231	219	-			N/A
Jan 26	149	180	-			Lowest Quartile
Jan 26	90.9%	87.9%	96.0%			2nd Quartile
Jan 26	171	139	-			3rd Quartile

Sutton Healthcare

KPI	Latest month	Previous Month Measure	Latest Month Measure	Target	Variation	Assurance
Urgent Community Response (UCR) Referrals	Jan 26	456	478	-		
Virtual ward - Admissions	Jan 26	385	387	-		
Virtual ward Length of Stay (Average)	Jan 26	6.6	5.5	-		
Discharge to Assess- Pathway 0-3 Delays (Median Days)	Jan 26	4	3	-		
Total number of adult patients on the waiting list	Jan 26	2052	2103	-		
Total number of children patients on the waiting list	Jan 26	1032	1070	-		

Surrey Downs

Latest month	Previous month measure	Latest month measure	Target	Variation	Assurance
Jan 26	602	659	-		
Jan 26	271	323	-		
Jan 26	9.1	8.3	-		
Jan 26	2	2	-		
Jan 26	5316	5538			

Appendix 3 - Cancer Performance by Tumour Type

Overview Dashboard

St George's Cancer - 28 Day Faster Diagnosis Standard

KPI	Latest month	Previous Month Measure	Measure	National Average	Variation
Suspected brain/central nervous system tumours	Dec 25	0.0%	100.0%	96.2%	
Suspected head & neck cancer	Dec 25	96.8%	93.6%	80.2%	
Suspected breast cancer	Dec 25	94.6%	96.3%	93.0%	
Exhibited (non-cancer) breast symptoms - cancer not initially suspected	Dec 25	95.1%	96.2%	94.1%	
Suspected lung cancer	Dec 25	76.7%	90.2%	88.4%	
Suspected upper gastrointestinal cancer	Dec 25	70.0%	75.0%	79.5%	
Suspected lower gastrointestinal cancer	Dec 25	78.2%	79.9%	74.9%	
Suspected gynaecological cancer	Dec 25	67.8%	82.7%	73.2%	
Suspected testicular cancer	Dec 25	100.0%	N/A	96.7%	
Suspected haematological malignancies (excluding acute leukaemia)	Dec 25	66.7%	70.0%	78.5%	
Suspected skin cancer	Dec 25	44.2%	73.8%	91.7%	
Suspected sarcoma	Dec 25	N/A	N/A	58.3%	
Suspected children's cancer	Dec 25	100.0%	75.0%	93.5%	
Suspected cancer - non-specific symptoms	Dec 25	61.0%	63.6%	78.3%	

St George's Cancer – 62 Day Standard

KPI	Latest month	Previous Month Measure	Latest Month Measure	National Average	Variation
Breast	Dec 25	70.6%	77.8%	74.9%	
Other (a)	Dec 25	100.0%	86.7%	90.5%	
Lower Gastrointestinal	Dec 25	81.0%	75.9%	75.9%	
Head & Neck	Dec 25	75.0%	85.7%	81.5%	
Lung	Dec 25	31.9%	31.0%	66.2%	
Skin	Dec 25	82.8%	70.5%	94.1%	
Gynaecological	Dec 25	40.0%	75.0%	55.1%	
Haematological - Lymphoma	Dec 25	66.7%	66.7%	69.7%	
Urological - Other (a)	Dec 25	73.9%	70.7%	80.6%	
Upper Gastrointestinal - Oesophagus & Stomach	Dec 25	85.7%	100.0%	87.8%	
Urological - Prostate	Dec 25	91.7%	92.3%	73.7%	
Haematological - Other (a)	Dec 25	100.0%	100.0%	100.0%	
Upper Gastrointestinal - Hepatobiliary	Dec 25	66.7%	66.7%	81.7%	

Epsom & St Helier - Cancer - 28 Day Faster Diagnosis Standard

KPI	Latest month	Previous Month Measure	Measure	National Average	Variation
Suspected brain/central nervous system tumours	Dec 25	100.0%	100.0%	96.2%	
Suspected head & neck canceR	Dec 25	94.2%	89.5%	80.2%	
Exhibited (non-cancer) breast symptoms -	Dec 25	N/A	N/A	94.1%	
Suspected breast cancer	Dec 25	N/A	N/A	93.0%	
Suspected lung cancer	Dec 25	88.6%	91.4%	88.4%	
Suspected upper gastrointestinal cancer	Dec 25	74.8%	73.5%	79.5%	
Suspected lower gastrointestinal cancer	Dec 25	78.4%	78.4%	74.9%	
Suspected gynaecological cancer	Dec 25	62.6%	73.2%	73.2%	
Suspected testicular cancer	Dec 25	N/A	N/A	96.7%	
Suspected urological malignancies (excluding testicular)	Dec 25	96.1%	89.9%	71.1%	
Suspected acute leukaemia	Dec 25	N/A	N/A	100.0%	
Suspected skin cancer	Dec 25	23.5%	93.6%	91.7%	
Suspected sarcoma	Dec 25	N/A	N/A	-	
Suspected other cancer	Dec 25	83.3%	N/A	58.3%	
Suspected childrens cancer	Dec 25	100.0%	100.0%	93.5%	
Suspected cancer - non-specific symptoms	Dec 25	20.0%	100.0%	78.3%	

Epsom & St Helier - Cancer – 62 Day Standard

KPI	Latest month	Previous Month Measure	Latest Month Measure	National Average	Variation
Gynaecological	Dec 25	37.5%	50.0%	55.1%	
Skin	Dec 25	87.5%	96.2%	94.1%	
Lung	Dec 25	45.7%	70.0%	66.2%	
Other (a)	Dec 25	100.0%	83.3%	90.5%	
Lower Gastrointestinal	Dec 25	91.7%	100.0%	75.9%	
Head & Neck	Dec 25	100.0%	83.3%	81.5%	
Breast	Dec 25	0.0%	100.0%	74.9%	
Upper Gastrointestinal - Oesophagus & Stomach	Dec 25	100.0%	100.0%	87.8%	
Haematological - Lymphoma	Dec 25	87.5%	73.3%	69.7%	
Upper Gastrointestinal - Hepatobiliary	Dec 25	71%	88%	82%	
Urological - Prostate	Dec 25	87%	85%	74%	
Urological - Other (a)	Dec 25	100%	83%	81%	
Haematological - Other (a)	Dec 25	100%	100%	100%	

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 in Public on Thursday, 05 March 2026

Agenda Item	4.4	
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 / Approval**	

Executive Summary

The report sets out the key issues discussed and agreed by the Audit and Risk Committee at its meeting held on 18 February 2026. The key issues the Committee wishes to highlight to the Board are:

- **External Audit and year-end:** Work on the annual external audits at both Trusts has commenced, with the Committee having reviewed the external audit plans and feed for SGUH and ESTH. The Committee also approved the accounting policies to be used for the audit. The Committee reviewed plans and timetable for the preparation of the two Trusts' annual reports, deadline for submission being 26 June 2026.
- **Internal Audit:** The Committee was encouraged by stronger delivery of the 2025/26 internal audit plan, with only one audit (with a planned Q4 start date) yet to conclude. The Committee reviewed two final internal audit reports, maternity at SGUH and data quality (emergency department) at ESTH, both of which received partial assurance. The Committee also reviewed cross-cutting themes from internal audit reports, which it will discuss further at its next meeting. The Committee noted the continuing challenges with timely completion of agreed internal audit actions, but welcomed the increased focus of the Group Executive Committee in reviewing these. The Committee also reviewed and approved the internal audit plans for both Trusts, which are appended to this report for visibility to the Board as a whole.
- **Financial limits:** The Committee reviewed and endorsed proposals to update the two Trusts financial limits within the Scheme of Delegation, increasing the thresholds for approval by Board and Finance and Performance Committee in line with benchmarking. The proposed changes, as endorsed by the Committee, are appended to this report for approval.
- **Risk:** The Committee welcomed the progress achieved in refreshing and aligning the risks on the two Trusts' Corporate Risk Registers, with refreshed risks on finance, people and emergency department having been developed and agreed for inclusion on the two Corporate Risk Registers. The Committee was assured by the progress made in 2025/26 in strengthening risk management across the Group and in strengthening the Committee's role in relation to risk, with plans in place for 2026/27 for quarterly review of the Corporate Risk Registers and Group Board Assurance Framework.

Action required by Group Board
The Board is asked to: a) Note issues considered by the Audit and Risk Committee at its February 2026 and the matters highlighted for the Board's attention. b) Note the internal audit plans for 2026/27 for SGUH and ESTH set out in Appendix 1, noting the scope for in-year flexibility to respond to emerging issues, which are recommended to the Board by the Audit and Risk Committee. c) Approve the changes to the Financial Limits in the Scheme of Reservation and Delegation of Powers as set out in Appendix 2 as recommended by the Audit and Risk Committee.

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

Appendices	
Appendix No.	**Appendix Name**
Appendix 1	Internal Audit Plans 2026/27
Appendix 2	Proposed Changes to the Financial Limits in the Scheme of Delegation

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, 5 March 2026

1.0 Purpose of paper

1.1 The gesh Audit and Risk Committee met on 18 February 2026. The Committees agreed to bring the following matters to the attention of the Group Board.

2.0 External Audit and Year-End Planning

2.1 The Committee received an update from its external auditors, Grant Thornton, on the planning for and progress of the 2025/26 external audit. The Committee reviewed and endorsed the audit plans and fees for both Trusts, and approved the accounting policies to be used for the 2025/26 annual accounts. As the Trusts remain two separate legal entities, two separate sets of annual accounts and two separate external audit reports will be prepared, as in previous years. The Committee reviewed the work undertaken by the auditors a risk assessment for both audits, the purpose of which was to ensure an effective two-way communication between the external auditors and Committee. The Committee was assured that work on the external audit, which had commenced at the start of Q4, was progressing well, even though it remained at an early stage.

2.2 The Committee also reviewed plans for the preparation of the two Trusts' annual reports, which again needed to be produced for each separate statutory entity within the Group. Both organisations were required to produce annual reports in accordance with statutory requirements, though each was governed by a distinct regulatory framework, with SGUH needing to comply with the provisions of the *NHS Foundation Trust Annual Reporting Manual* and ESTH, as an NHS Trust, needing to follow the provisions of the *Department of Health and Social Care Group Accounting Manual*. The deadline for submission of the annual reports and accounts was 26 June 2026, and the Committee noted that the dates for review by the Committee and each Trust's Board had been confirmed.

3.0 Internal Audit

3.1 The Committee received a regular report from the Group's internal auditors, RSM UK, and reviewed progress against the delivery of the in-year internal audit programme.

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. For SGUH, of 11 planned audits, a total of 8 had been finalised and reviewed by the Committee, two further drafts had been issued, and the final audit – which had a planed Q4 start – was underway. For ESTH, of 9 planned audit reviews, 7 had been finalised and reviewed by the Committee, one had been issued in draft, and the final review – again with a planned Q4 start – was underway. Since the last meeting of the Committee in December 2025, two final internal audit reports had been completed: Maternity (*Partial Assurance*) (SGUH); and Data Quality - Emergency Department *(Partial Assurance)* (ESTH). Two internal audit reports had been issued in draft form, which the Committee would review at its next meeting once finalised: International Recruitment – Certificate of Sponsorship; and Raising concerns.

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

- Maternity (SGUH): Partial Assurance: The audit found that the Trust's maternity framework was well defined, with adequate controls currently in place. These included effective policies and procedure, structured communication channels and multidisciplinary practices that promote safety, accountability and continuous improvement. However, the audit also found the following areas that the auditors considered required improvements which led them to their partial assurance rating: challenges in addressing health inequalities in maternity services; gaps in training compliance across maternity staff groups; need for regular baby abduction training and security enhancement; ongoing IT fault affecting CTG trace storage across maternity units; and evidence to confirm whether an Independent Senior Advocate had been appointed. One high level action was identified by the audit in relation to the concerns over the ongoing IT fault affecting CTG trace storage access. The Committee learnt of the mitigations which were in place while these concerns were resolved. It was noted that there were four further medium level actions.

- Data Quality–Emergency Department (ESTH): Partial Assurance: The audit found a number of areas of good practice, including: the ED breach validation standing operating procedure; the urgent and emergency care (UEC) dashboard, UEC transformation programme governance; and the work of the UEC delivery Group. However, the audit also identified a number of areas that the auditors considered required improvement, which led them to their partial assurance rating: data analytics testing identified a large number of instances where admission and discharge data was missing or appeared incorrect, such as discharge times occurring prior to admittance and treatment; daily breach reporting was not taking place and issues of data quality persisted with implications for data validation and reporting; the absence of breach reporting meant the Trust was unable to undertake regular breach analysis which the auditors considered to impact on identification of common causes in delays in care and operational delivery, and could impact on work to meet the Trust's ED performance targets; current limitations in breach reporting and analysis inhibited the effective use of data, identification of underlying trends and limited forecasting capabilities; and the Data Quality Policy had passed its review date at the time of the audit, though had since been reviewed and updated while a Group-wide data quality policy was developed. Two high priority actions were identified, the first relating to breach analysis and the second to reviewing resourcing arrangements for data quality management beyond routine data collection and validation.

In line with the Committee's established protocols, it will review progress against the action plans agreed by management in six months' time. The partial assurance reports are also being referred to the respective Board Committee for detailed oversight (maternity to the Quality Committee and data quality to the Infrastructure Committee).

3.4 At its meeting in December 2025, the Committee had requested that the internal auditors review the cross-cutting themes from internal audit reports and these themes were presented to the Committee at its February 2026 meeting. The main themes identified across internal audit reviews were: non-compliance with processes; process processes inconsistently embedded; variable compliance with policies as well as some being past their review dates; variable practice in disseminating lessons learnt across the Group; issues around organisational culture, training and development; and consistently reporting and monitoring arrangements. The Committee recognised that these were areas that were core elements of internal audit testing but it was clear that there was cross-organisational learning, and a report will be presented to the next meeting considering how these cross-cutting themes can be addressed.

3.5 Since the Committee met in December, a number of additional internal audit actions have become due and, as in December, the Committee noted that a number of these actions had

been extended as they had not yet been completed. Without repeating the issues highlighted in the Committee's previous report, the Committee noted that all internal audit actions and due dates were agreed by management, with scope to review, refine and reshape actions with the internal auditors. The Committee welcomed the fact that the Group Executive Committee has increased its oversight of the delivery of these actions and looks forward to progress in completion of these actions being reported to its next meeting in May 2026.

3.6 The Committee received and approved the Internal Audit plans for 2026/27 for both Trusts within the Group. The plan had been developed through discussions with Executive and Site Directors and had been reviewed and endorsed by the Group Executive Committee prior to review by the Audit and Risk Committee. The Committee noted that the internal audit plan had been aligned to the strategic risks on the Group Board Assurance Framework, and had a clear focus on key areas of risk and core priority areas which should ensure that the internal audit plan for 2026/27 had real value to both Trusts. The planned audits in relation to the Group transformation programme, Quality Impact Assessment process, and Quality Governance Improvement Plans, which were planned for the back end of 2026/27, had the potential to help provide assurance that these programmes, which were fundamental to the Group's success, were set up in the right way, with an opportunity to course correct at an early stage should any control issues or areas for improvement be identified. The Committee also noted that the planned internal audit of procurement was being undertaken on a South West London basis. The internal audit plans for both Trusts for 2026/27 are appended to this report to ensure that the areas of focus are visible to the Group Board as a whole, noting that there is scope within the plans to vary planned audits in-year where needed.

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 10 December 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 had been received since the last Audit and Risk Committee, 8 cases had been closed, and 18 remained ongoing across the two Trusts.

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

- Completed fieldwork and held a debrief meeting following a joint Internal Audit proactive review into International Recruitment, Certificate of Sponsorship.
- Continuing fieldwork into the area of the expenses and credit cards, as part of the Local Proactive Exercise (LPE), at the Group level.
- Quarter four Cyber fraud awareness session delivered.
- Delivered a bespoke fraud and bribery awareness session to the Group Freedom to Speak Up Guardian team, to support continued collaboration between LCFS and FTSU.
- Five intelligence bulletins had been issued and disseminated during the reporting period.

4.3 The Committee also received and approved the proposed Counter Fraud Work Plan for 2026/27. The work plan had been discussed with management and was aligned to the NHS Counter Fraud Authority's counter fraud, bribery and corruption strategy and the Trusts' emerging, internal and external fraud risks.

5.0 Finance

5.1 The Committee reviewed a regular report from the finance team focusing on losses & special payments, breaches and waivers, and aged debt. The key points to highlight are:

- On debtors and bad debts, ESTH was in a stable debt position and SGUH had seen a £8m decrease in debt since the last report to the Audit and Risk Committee in December 2025. There was ongoing management action on ensuring timely debt repayment, particularly in the context of cash pressures on the Trusts.
- Better Payment Practice Code (BPPC) performance was within acceptable bounds, with performance at 92.95% (ESTH) and 91.9% (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 (stock losses) and Cardiology (stock losses).

5.2 At its December 2025 meeting, the Committee had requested further information and benchmarking on the Trusts' position in relation to the amount of overseas visitors' debt. On an income basis, SGUH was consistently the 6th / 7th highest in capturing and recognising overseas visitors income, with the top seven providers nationally all being London trusts. ESTH was in the lower quartile of capturing overseas visitors' income. SGUH write off of overseas visitors' debt was comparable to other large London trusts, and reflected the challenges of recovering charges for highly specialised procedures. Work was underway to review ways of working internally and learn from the best performing trusts to identify improvements and ensure lower levels of debt write off. The Committee was assured by the work being undertaken across the Group to manage overseas visitors and that appropriate actions were being taken that to recover payments and debt where appropriate.

5.3 The Committee received a proposal to update the Financial Limits within the Scheme of Reservation and Delegation of Powers for both Trusts. A review of the Financial Limits had been undertaken with some external benchmarking. Currently, there were some significant differences between the financial limits at the two Trusts, with ESTH Board approval thresholds set £1m and with the SGUH equivalent set at £3m. In the context of the benchmarking and analysis reviewed, the Committee supported the proposed changes to the Financial Limits, specifically aligning the limits across the Group and increasing the threshold for Board approval to £5m and the thresholds for approval at the Finance and Performance Committees to £3m. The proposed revisions to the Financial Limits are set out at Appendix 2 to this report, for approval by the Board.

6.0 Risk and Governance

Risk Management

6.1 During 2025/26, the Committee has strengthened its oversight of risk, and has received regular reports on risk management and the progress in reviewing and updating the Corporate Risk Registers (CRRs) of the two Trusts. The Committee was assured with the progress being achieved in refreshing the two CRRs, noting in particular that:

- Three new finance risks, common across the Group, had been developed and approved by the Executive to replace the existing 6 finance risks at SGUH and 2 existing finance risks at ESTH;
- A detailed review of people risks had been undertaken, with 4 people risks on the SGUH CRR and 5 people risks on the ESTH CRR having been closed, and a further 1

people risk at SGUH and 3 people risks at ESTH having been de-escalated from the CRRs. Two new people risks had been added to the SGUH CRR (industrial action, sickness absence) and two new risks had likewise been added to the ESTH CRR (sickness absence, bullying and harassment). The result was that the core people risks were now aligned at the two Trusts.

- A new risk had been escalated to the ESTH CRR on Emergency Department overcrowding, reflecting the level of risk in our EDs, bringing the ESTH CRR into line with the similar risk on the SGUH CRR.

6.2 The Committee heard that work was continuing on refresh digital risks and estates and facilities risks on the two Trusts' Corporate Risk Registers, with further refreshed risks to be reviewed by the Executive in February and March 2026. The Committee also reviewed an analysis of the risks across the two Trusts CRRs, noting that significant alignment had been achieved with further scope to promote this, while recognising the need for each CRR to reflect Trust-specific risks.

6.3 The Committee acknowledged the significant work that had been undertaken to refresh the two Corporate Risk Registers and strengthen reporting on risk through the Committee, and noted the plans to further strengthen this into 2026/27 with quarterly reporting of both the CRRs and refreshed Group Board Assurance Framework through the Committees and the Board.

Committee Effectiveness

6.4 The Committee reviewed the outcome of its annual effectiveness review, the full details of which will be presented to the Group Board at its next meeting alongside a refreshed terms of reference, 2026/27 workplan, and Committee annual report. In summary, the responses to the effectiveness survey suggested the Committee was operating effectively, with a number of strengths and areas of good practice highlighted, including: the structure of meetings, agendas and terms of reference; the participation of the external and internal auditors and counter fraud; the chairing of Committee meetings; the support from corporate teams; the Committee's strengthened focus on risk over the past year; and the Committee's practice of requesting management follow-up reports six months on from receipt of a partial assurance internal audit review. Areas for improvement were highlighted as: addressing the length and volume of papers; adding an additional NED member of the ESTH Committee; the clarification of the respective roles of the Audit and Risk and Infrastructure Committees in relation to cybersecurity and information governance; and follow through on management actions from internal audit. Response rates to the survey were lower this year than last, and the Committee will seek to secure further responses from members and attendees to ensure that the learning from the survey is as rich as possible. This will be reported to the Board at the next meeting alongside the annual report, workplan and terms of reference review.

7.0 Recommendations

7.1 The Board is asked to:

a) Note issues considered by the Audit and Risk Committee at its February 2026 and the matters highlighted for the Board's attention.

b) Note the internal audit plans for 2026/27 for SGUH and ESTH set out in Appendix 1, noting the scope for in-year flexibility to respond to emerging issues, which are recommended to the Board by the Audit and Risk Committee.

c) Approve the changes to the Financial Limits in the Scheme of Reservation and Delegation of Powers as set out in Appendix 2 as recommended by the Audit and Risk Committee.

APPENDIX 1a: INTERNAL AUDIT PLAN 2026/27:
St George's University Hospitals NHS Foundation Trust

Internal Audit	Focus	Lead Executive Director	Strategic Risk	Audit Approach	Proposed Timing	Audit & Risk Committee Review Date
Sickness Absence (Group-wide)	We will assess the adequacy and effectiveness of the Trust's processes for managing sickness absence including long term sickness and whether appropriate controls are in place to ensure timely reporting, monitoring, and follow up of staff absences. We will examine the handling of medical evidence such as doctor's notes, the completion and quality of return to work interviews, and the consistency and appropriateness of referrals to Occupational Health. We will also evaluate the governance arrangements supporting absence management, including oversight mechanisms and accuracy of reporting, compliance with policy requirements, and how well sickness absence data is used to inform workforce decisions and mitigate operational risks.	Victoria Smith, Group Chief People Officer	Strategic Risk 12 – Staff Engagement and Wellbeing	Risk Based	April 2026	September 2026
Backlog Maintenance	We will review the process for development and approval of a capital plan for backlog. maintenance. We will evaluate the processes in place for the identification, recording, prioritisation and delivering of maintenance schemes. We will review monitoring and reporting of KPIs and budgets through the governance structure and consider whether remedial action plans are in place for any areas falling off-track.	Mark Bagnall, Group Chief Infrastructure, Facilities and Environment Officer	Strategic Risk 5 – Modernising our Estates	Risk Based	April 2026	September 2026
Procurement (Group-wide)	We will consider the extent to which the new Procurement Act has been embedded into agreed processes at SWL Procurement Hub. We will review the Trust's Procurement Policy to assess whether it clearly sets out the required procurement processes and reflects current statutory and regulatory requirements. We will evaluate how effectively the Trust complies with this policy in practice, including processes for supplier selection, contract management, and adherence to mandatory procurement standards. As part of this work, we will examine a sample of contracts procured during the current financial year to ensure compliance. We will also review the reporting and monitoring arrangements in place for procurement activity including capital procurement and	Mark Bagnall, Group Chief Infrastructure, Facilities and Environment Officer	Strategic Risk 5 – Modernising our Estates	Risk Based	May 2026	September 2026

APPENDIX 1a: INTERNAL AUDIT PLAN 2026/27:
St George's University Hospitals NHS Foundation Trust

Internal Audit	Focus	Lead Executive Director	Strategic Risk	Audit Approach	Proposed Timing	Audit & Risk Committee Review Date
	prioritisation and evaluate whether procurement decisions demonstrate value for money for the Trust. This will be a joint review with LCFS.					
Flexible Working (Group-wide)	We will consider the design and application of the flexible working policy, including how requests are submitted, assessed, approved or refused, recorded, and reviewed. We will examine whether decisions are made consistently and fairly, supported by clear rationale, and whether the operational impact on service delivery, staffing, and patient care is appropriately considered. We will consider staff understanding of flexible working. We will also evaluate governance and reporting arrangements, including monitoring of uptake, equality impacts, and how flexible working supports workforce wellbeing, retention, and organisational culture. This review may be led by our HR specialist and include a staff survey.	Victoria Smith, Group Chief People Officer	Strategic Risk 12 – Staff Engagement and Wellbeing	Risk Based	May 2026	September 2026
Key Financial Controls – Accounts Payable (Group-wide) **CORE AUDIT**	Our review will assess whether adequate procedures are in place to ensure that the management of accounts payable is robust and supports key financial processes that enable accurate recording and reporting of financial transactions. We will consider whether purchase orders, supplier invoices, Goods Received Notes (GRNs), and payments are raised, matched, and approved in accordance with delegated authority limits. We will also consider PO vs Non-PO usage. We will review the organisation's monitoring arrangements over accounts payable, including the timeliness of payments, management of overdue liabilities, oversight of high value suppliers, and the effectiveness of controls designed to prevent duplicate or fraudulent payments. We will also assess whether regular reconciliations are undertaken between the creditor ledger and the general ledger, and whether these are appropriately reviewed and any discrepancies resolved promptly. This review will be supported using data analytics and may be undertaken jointly with LCFS where appropriate.	Lizzie Alabaster, Group Chief Finance Officer	Strategic Risk 4 – Financial Sustainability	Core	June 2026	September 2026

gesh

APPENDIX 1a: INTERNAL AUDIT PLAN 2026/27:
St George's University Hospitals NHS Foundation Trust

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

Internal Audit	Focus	Lead Executive Director	Strategic Risk	Audit Approach	Proposed Timing	Audit & Risk Committee Review Date
Quality Impact Assessments (Group-wide)	We will assess whether the Trust has robust and effective arrangements in place for the completion, review, and use of Quality Impact Assessments (QIAs) to inform decision-making. The review will consider whether QIAs are consistently applied to relevant service, workforce, financial, and transformation decisions; whether they are completed to an appropriate standard; and whether impacts on patient safety, quality of care, staff wellbeing, patient experience, and equality are clearly identified and mitigated. We will also examine governance arrangements, including the review, escalation, and approval of QIAs, and assess whether the outcomes of QIAs meaningfully influence decisions and are monitored post-implementation.	Elaine Clancy, Group Chief Nursing Officer; Richard Jennings, Group Chief Medical Officer	Strategic Risk 9 – Patient Safety	Risk Based	July 2026	December 2026
Quality Governance Improvement Plan (Group-wide)	We will assess whether the Trust has effective arrangements in place to deliver, monitor, and sustain the Quality Governance Improvement Plan developed in response to identified internal and external assurance gaps, including CQC findings. The review will evaluate the clarity of actions, ownership and accountability, timescales, evidence to support implementation of actions and success measures within the plan, as well as the robustness of governance structures overseeing delivery. We will examine how progress is monitored and reported to senior management and the Board, whether risks and issues are appropriately escalated, and whether improvements are embedded into Business as Usual (BAU) processes to strengthen leadership oversight, quality assurance, and organisational learning.	Elaine Clancy, Group Chief Nursing Officer; Richard Jennings, Group Chief Medical Officer	Strategic Risk 9 – Patient Safety	Risk Based	August 2026	December 2026
Cyber Security (Group-wide)	We will review whether cyber risks are identified and managed within tolerance levels, staff receive training to raise awareness, and data backup and contingency plans support business continuity. We will check internal and external validation of cyber security processes, reporting arrangements for breaches, and evaluate compliance with the ten control areas defined by the National Cyber Security Centre (NCSC). Review to be led by our IT specialists.	Michael Pantlin, Group Deputy Chief Executive Officer	Strategic Risk 6 – Adopting Digital Technology	Risk Based	September 2026	December 2026

APPENDIX 1a: INTERNAL AUDIT PLAN 2026/27:
St George's University Hospitals NHS Foundation Trust

Internal Audit	Focus	Lead Executive Director	Strategic Risk	Audit Approach	Proposed Timing	Audit & Risk Committee Review Date
Health and Safety	We will assess whether the Trust has effective arrangements in place to manage health and safety risks in compliance with statutory requirements and internal policies. We will consider the adequacy of governance and accountability structures, risk assessments, incident and near miss reporting, training and competency arrangements, and the management of workplace hazards. We will also examine how health and safety performance is monitored and reported, including oversight of corrective actions arising from incidents, inspections, and audits, to determine whether risks to staff, patients, visitors, and contractors are being appropriately mitigated and escalated where necessary.	Mark Bagnall, Group Chief Infrastructure, Facilities and Environment Officer	Strategic Risk 5 – Modernising our Estates	Risk Based	October 2026	December 2026
Risk Management (Group-wide) **CORE AUDIT**	We will focus on the effectiveness of the risk management processes for the BAF and Corporate Risk Register and the systems used to capture this data. We will review whether the risk register has adequate content, with a specific review of the design pertaining to risks, controls, mitigation of risks and, where appropriate, assurance identified. We will review the level of scrutiny and focus on risk registers during governance meetings. We will focus on the risk management culture and will undertake a series of interviews/questionnaire with a range of stakeholders to gauge their perceptions of the organisation's approach to risk management and the extent to which there is a clear and embedded risk management culture across the organisation.	Stephen Jones, Group Chief Corporate Affairs Officer	All	Core	November 2026	February 2027
Transformation Programme (Group-wide)	We will review the governance arrangements relating to specific programmes, to be determined at the time of scoping. This will incorporate the processes around objectives, budget monitoring, effectiveness of the programme in achieving goals and benefits, risk assessment, outcomes tracking and the ongoing review and improvement of the programme.	Michael Pantlin, Group Deputy Chief Executive Officer	All	Risk Based	December 2026	February 2027

APPENDIX 1a: INTERNAL AUDIT PLAN 2026/27:
St George's University Hospitals NHS Foundation Trust

Internal Audit	Focus	Lead Executive Director	Strategic Risk	Audit Approach	Proposed Timing	Audit & Risk Committee Review Date
CAF-Aligned Data Security and protection Toolkit **CORE AUDIT**	Our review will consider; o Action plans in place to improve performance. o The Governance arrangements in place for the delivery, completion and sign off of the DSP Toolkit return and wider requirements. o Compliance reviews by the information centre and their impact on compliance with DSP Toolkit requirements. o The validity of the toolkit. This review is aligned with the Cyber Assessment Framework. Review to be led by our IT specialists and conducted in line with NHSE requirements.	Michael Pantlin, Group Deputy Chief Executive Officer	Strategic Risk 6 – Adopting Digital Technology	Risk Based	March 2027	May 2027
DSPT Follow-Up **CORE AUDIT**	Additionally, as requested by NHSE, we will also complete a DSPT Follow Up review to follow up actions raised in the previous DSPT review.	Michael Pantlin, Group Deputy Chief Executive Officer	Strategic Risk 6 – Adopting Digital Technology	Risk Based	March 2027	May 2027

gesh

APPENDIX 1a: INTERNAL AUDIT PLAN 2026/27:
Epsom and St Helier University Hospitals NHS Foundation Trust

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

Internal Audit	Focus	Lead Executive Director	Strategic Risk	Audit Approach	Proposed Timing	Audit & Risk Committee Review Date
Sickness Absence (Group-wide)	We will assess the adequacy and effectiveness of the Trust's processes for managing sickness absence including long term sickness and whether appropriate controls are in place to ensure timely reporting, monitoring, and follow up of staff absences. We will examine the handling of medical evidence such as doctor's notes, the completion and quality of return to work interviews, and the consistency and appropriateness of referrals to Occupational Health. We will also evaluate the governance arrangements supporting absence management, including oversight mechanisms and accuracy of reporting, compliance with policy requirements, and how well sickness absence data is used to inform workforce decisions and mitigate operational risks.	Victoria Smith, Group Chief People Officer	Strategic Risk 12 – Staff Engagement and Wellbeing	Risk Based	April 2026	September 2026
Procurement (Group-wide)	We will consider the extent to which the new Procurement Act has been embedded into agreed processes at SWL Procurement Hub. We will review the Trust's Procurement Policy to assess whether it clearly sets out the required procurement processes and reflects current statutory and regulatory requirements. We will evaluate how effectively the Trust complies with this policy in practice, including processes for supplier selection, contract management, and adherence to mandatory procurement standards. As part of this work, we will examine a sample of contracts procured during the current financial year to ensure compliance. We will also review the reporting and monitoring arrangements in place for procurement activity including capital procurement and prioritisation and evaluate whether procurement decisions demonstrate value for money for the Trust. This will be a joint review with LCFS.	Mark Bagnall, Group Chief Infrastructure, Facilities and Environment Officer	Strategic Risk 5 – Modernising our Estates	Risk Based	May 2026	September 2026
Flexible Working (Group-wide)	We will consider the design and application of the flexible working policy, including how requests are submitted, assessed, approved or refused, recorded, and reviewed. We will examine whether decisions are made consistently and fairly, supported by clear rationale, and whether the operational impact on	Victoria Smith, Group Chief People Officer	Strategic Risk 12 – Staff Engagement and Wellbeing	Risk Based	May 2026	September 2026

APPENDIX 1a: INTERNAL AUDIT PLAN 2026/27:
Epsom and St Helier University Hospitals NHS Foundation Trust

Internal Audit	Focus	Lead Executive Director	Strategic Risk	Audit Approach	Proposed Timing	Audit & Risk Committee Review Date
	service delivery, staffing, and patient care is appropriately considered. We will consider staff understanding of flexible working. We will also evaluate governance and reporting arrangements, including monitoring of uptake, equality impacts, and how flexible working supports workforce wellbeing, retention, and organisational culture. This review may be led by our HR specialist and include a staff survey.					
Key Financial Controls – Accounts Payable (Group-wide) **CORE AUDIT**	Our review will assess whether adequate procedures are in place to ensure that the management of accounts payable is robust and supports key financial processes that enable accurate recording and reporting of financial transactions. We will consider whether purchase orders, supplier invoices, Goods Received Notes (GRNs), and payments are raised, matched, and approved in accordance with delegated authority limits. We will also consider PO vs Non-PO usage. We will review the organisation's monitoring arrangements over accounts payable, including the timeliness of payments, management of overdue liabilities, oversight of high value suppliers, and the effectiveness of controls designed to prevent duplicate or fraudulent payments. We will also assess whether regular reconciliations are undertaken between the creditor ledger and the general ledger, and whether these are appropriately reviewed and any discrepancies resolved promptly. This review will be supported using data analytics and may be undertaken jointly with LCFS where appropriate.	Lizzie Alabaster, Group Chief Finance Officer	Strategic Risk 4 – Financial Sustainability	Core	June 2026	September 2026
Quality Impact Assessments (Group-wide)	We will assess whether the Trust has robust and effective arrangements in place for the completion, review, and use of Quality Impact Assessments (QIAs) to inform decision-making. The review will consider whether QIAs are consistently applied to relevant service, workforce, financial, and transformation decisions; whether they are completed to an appropriate standard; and whether impacts on patient safety, quality of care, staff wellbeing, patient experience, and equality are clearly identified and mitigated.	Elaine Clancy, Group Chief Nursing Officer; Richard Jennings, Group Chief Medical Officer	Strategic Risk 9 – Patient Safety	Risk Based	July 2026	December 2026

APPENDIX 1a: INTERNAL AUDIT PLAN 2026/27:
Epsom and St Helier University Hospitals NHS Foundation Trust

Internal Audit	Focus	Lead Executive Director	Strategic Risk	Audit Approach	Proposed Timing	Audit & Risk Committee Review Date
	We will also examine governance arrangements, including the review, escalation, and approval of QIAs, and assess whether the outcomes of QIAs meaningfully influence decisions and are monitored post-implementation.					
Quality Governance Improvement Plan (Group-wide)	We will assess whether the Trust has effective arrangements in place to deliver, monitor, and sustain the Quality Governance Improvement Plan developed in response to identified internal and external assurance gaps, including CQC findings. The review will evaluate the clarity of actions, ownership and accountability, timescales, evidence to support implementation of actions and success measures within the plan, as well as the robustness of governance structures overseeing delivery. We will examine how progress is monitored and reported to senior management and the Board, whether risks and issues are appropriately escalated, and whether improvements are embedded into Business as Usual (BAU) processes to strengthen leadership oversight, quality assurance, and organisational learning.	Elaine Clancy, Group Chief Nursing Officer; Richard Jennings, Group Chief Medical Officer	Strategic Risk 9 – Patient Safety	Risk Based	August 2026	December 2026
Cyber Security (Group-wide)	We will review whether cyber risks are identified and managed within tolerance levels, staff receive training to raise awareness, and data backup and contingency plans support business continuity. We will check internal and external validation of cyber security processes, reporting arrangements for breaches, and evaluate compliance with the ten control areas defined by the National Cyber Security Centre (NCSC). Review to be led by our IT specialists.	Michael Pantlin, Group Deputy Chief Executive Officer	Strategic Risk 6 – Adopting Digital Technology	Risk Based	September 2026	December 2026
Theatre Safety	We will consider how safety behaviours, teamwork, communication, and psychological safety are embedded across multidisciplinary theatre teams, including the use of safety briefings, WHO surgical safety checklists, investigating, reporting and learning from near misses and never events. We will evaluate staff engagement mechanisms, the effectiveness of leadership presence and oversight in theatres, and how concerns are raised and acted upon.	Elaine Clancy, Group Chief Nursing Officer; Richard Jennings, Group Chief Medical Officer	Strategic Risk 9 – Patient Safety	Risk Based	September 2026	December 2026

APPENDIX 1a: INTERNAL AUDIT PLAN 2026/27:
Epsom and St Helier University Hospitals NHS Foundation Trust

Internal Audit	Focus	Lead Executive Director	Strategic Risk	Audit Approach	Proposed Timing	Audit & Risk Committee Review Date
	We will also examine governance and assurance arrangements, including how theatre specific safety culture issues are identified, monitored, escalated, and addressed to support continuous improvement in patient and staff safety. This review may be supported by an RSM Clinician.					
Risk Management (Group-wide) **CORE AUDIT**	We will focus on the effectiveness of the risk management processes for the BAF and Corporate Risk Register and the systems used to capture this data. We will review whether the risk register has adequate content, with a specific review of the design pertaining to risks, controls, mitigation of risks and, where appropriate, assurance identified. We will review the level of scrutiny and focus on risk registers during governance meetings. We will focus on the risk management culture and will undertake a series of interviews/questionnaire with a range of stakeholders to gauge their perceptions of the organisation's approach to risk management and the extent to which there is a clear and embedded risk management culture across the organisation.	Stephen Jones, Group Chief Corporate Affairs Officer	All	Core	November 2026	February 2027
CAF-Aligned Data Security and protection Toolkit **CORE AUDIT**	Our review will consider; o Action plans in place to improve performance. o The Governance arrangements in place for the delivery, completion and sign off of the DSP Toolkit return and wider requirements. o Compliance reviews by the information centre and their impact on compliance with DSP Toolkit requirements. o The validity of the toolkit. This review is aligned with the Cyber Assessment Framework. Review to be led by our IT specialists and conducted in line with NHSE requirements.	Michael Pantlin, Group Deputy Chief Executive Officer	Strategic Risk 6 – Adopting Digital Technology	Risk Based	March 2027	May 2027
DSPT Follow-Up **CORE AUDIT**	Additionally, as requested by NHSE, we will also complete a DSPT Follow Up review to follow up actions raised in the previous DSPT review.	Michael Pantlin, Group Deputy Chief Executive Officer	Strategic Risk 6 – Adopting Digital Technology	Risk Based	March 2027	May 2027

gesh

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

Appendix 2
Audit & Risk Committee Report

Review of Financial Limits in Scheme of Delegation

Board
5 March 2026

GCFO

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

Executive Summary

gesh

Background

- ESTH and SGH came together as a Group in 2022 and have since then maintained separate policies for Standing Financial Instructions and Financial Limits in the Scheme of Reservation and Delegation of Powers. The SFIs within these policies are currently very different, for example, ESTH Board approval limits are £1m and SGH £3m.
- As the Trust's continue and increase the level of Group working, it is clear an aligned set of financial limits would simplify and ensure consistency across the Group.

Scope of review

- This review covers and makes recommendations for a Group-wide set of the financial limits in the Scheme of Delegation. The wider set of Standing Orders and Scheme of Reservation and Delegation of Powers as a whole are being reviewed and aligned by the Group Chief Corporate Affairs Officer and team.
- The review has compared the SGUH and ESTH financial limits and also benchmarked these against Kings College Hospital NHS FT and Chelsea and Westminster NHS FT SFIs to inform a recommendation for the Group policy.

Summary of key conclusion:

- Contract and business case approval limits are not consistent between SGH and ESTH, with more requiring be signed off at a senior level at ESTH
- Benchmarking indicates higher Board approval limits at Kings and Chelseas and Westminster in most areas.
- NHS Income contracts at SGH have a specific section with greater limits, relates to ICB/commissioner contracts which are high value.
- No SFI in benchmarking exercise sufficiently covered Contract variations, where initial contract values are exceeded due to variable elements to the contract no formal limits exist.
- Procurement limits are out of date with a new procurement policy in draft and Procurement act 2023.

Recommendations:

- Align group limits across Contracts, Business case approval and requestion .
- Increase limits to reduce number requiring board sign off, noting the need to maintain oversight, recommendation of £5m threshold for Board approval and £3-5m for Finance & Performance Committee.
- Include Contract variation limits to strengthen process.
- Update limits to align to the latest procurement policy and Procurement Act 2023.

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

Process Summary

gesh

- The SFI recommendations cover the following areas of spend

    - **Contract (NHS & non NHS)** – defined as the sign off rights for Contracts in budget or within inflationary uplifts. Contract Value is defined as spend over full contract length including allowable extension.
    - **Requisitions / Invoices / Purchase Orders**: System approval limits for spend within approved contracts or within existing procurement frameworks.
    - **Business Cases (Capital or Revenue)** - New investments or service changes covering out of budget spend.
    - **Tendering / Quotations (Non-construction)** – Requirements for non construction spend in line with procurement policy
    - **Tendering / Quotations (Construction)** - Requirements for construction spend in line with procurement policy
    - **Write offs / special payments** – Write offs of obsolete or damaged stock, aged debt write-offs and ad-hoc payments for losses and compensation for staff and patients

- Options and recommendation are outlined on slide 4. Recommendations have been informed by the following:

    - Benchmarking detail compare ESTH and SGH current policies and recommendations to other Trust policies.
    - Existing contract register slide 5; this identified how many contracts would fall under each category of recommendations
    - Past year contracts reviewed at FPC and Board slide 5 and how this would have changed in number with recommendations outstanding
    - Detail of NHS contracts has informed NHS contract limits

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

Options and Proposal

gesh

		Lower Risk Tolerance	Recommendation	Higher Risk Tolerance
NHS Contracts: SLAs and ICB agreements		0-£10m CEO £10m+ Trust Board	0-£10m CFO £10m+ CEO	0-£20m CFO £20m+ CEO
Non NHS Contracts: Approval for non-NHS contracted spend / within budget or inflationary		£0–£250k: Director of Procurement £250k-£1m Site CFO / Deputy CFO / Exec Director £1m-£3m: Group CFO / CEO £3m / TDL: Trust Board	£0–£250k: Director of Procurement £250k-£1m Site CFO / Deputy CFO / Exec Director £1m-£3m: Group CFO / CEO £3m–£5m: FPC £5m / TDL: Trust Board	£0–£250k: Director of Procurement £250k-£1m Site CFO / Deputy CFO / Exec Director £1m-£5m: Group CFO / CEO £5m–£10m: FPC £10m / TDL: Trust Board
Contract Variations: Approval for overspends against contracted values		Contract changes and variations need to be treated the same as new awards, with the same governance and authority requirements.	Contract changes and variations need to be treated the same as new awards, with the same governance and authority requirements.	Contract changes and variations need to be treated the same as new awards, with the same governance and authority requirements.
Requisitions / Invoices / Purchase Orders: System approval limits for spend within approved contracts		less than £10k: Budget holder £10k: Divisional Leads £100k: Non Board Director £500k: Board Director £1m: Finance Director (GCFO) £3m: Chief Executive (CEO) Over £3m: Trust Board (oversight)	less than £10k: Budget holder £10k: Divisional Triumivate £100k: Non Board Director £500k: Board Director £1m: Finance Director (GCFO) £5m: Chief Executive (CEO) Over £5m: Trust Board (oversight)	less than £35k: Budget holder £35k: Divisional Leads £100k: Non Board Director £500k: Board Director £1m: Finance Director (GCFO) £10m: Chief Executive (CEO) Over £10m: Trust Board (oversight)
Business Cases (Capital or Revenue) - New investments / Out of budgets		£0m-£3m: GEC £3m / TDL: Trust Board	£0k-£1m Exec Director (SLT) & Group CFO / Site CFO £1m-£3m: GEC £3m–£5m: FPC £5m / TDL: Trust Board	£0k-£1m Exec Director (SLT) & Group CFO / Site CFO £1m-£5m: GEC £5m–£10m: FPC £10m / TDL: Trust Board
Tendering / Quotations - Non-construction		N/A	£0-£10,000 1 written quote £10,001-£30,000 3 written quotes £30,001-£139,687 Appropriate competition inline with procurment policy >£139,687 Formal tender in line with Procurment act 2023	N/A
Tendering / Quotations - Construction		N/A	£0-£10,000 1 written quote £10,001-£30,000 3 written quotes £30,001-£5,372,609 Appropriate competition inline with procurment policy >£5,372,609 Formal tender in line with Procurment act 2023	N/A
Write-offs & Special payments		CFO £0–£10k Audit Committee £10k–TDL	CFO £50k Audit Committee >£50k	CFO £100k Audit Committee >£100k

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

Contracts Analysis – Contracts register & Previous approvals

gesh

Table 1 uses the contract registers for both trust the expected figures split by category are below this has been used to estimate the frequency of approval at each category.

- Board level approval:
  - Current limits of ESTH £1m+ and SGH £3m+ means c10 contract per year require board approval.
  - Adjusting to the proposed £5m+ limit for board approval this would reduce to 4.65 per year and would account for 81% of analysed spend.
- FPC would need to approve a further 2.92 and GEC 6.56 per year.

Table 2 looks at the FPC approvals this year, over the last year 5 business cases and 15 contracts came to FPC / board for approval. With new recommended limits:

- 1 business case remains at board level
- 3 business cases goes to FPC only
- 1 business case would be approved at GEC

Table 1: Contract Register

Contracts per spend category (number)	< £1m	£1–3m	£3–5m	£5m+	Grand Total
Epsom and St Helier University Hospitals NHS Trust	102	12	9	17	140
St George's University Hospitals NHS Foundation Trust	190	18	9	22	239
Grand Total	**292**	**30**	**18**	**39**	**379**

Average duration of contracts (yrs)	< £1m	£1–3m	£3–5m	£5m+	Grand Total
Epsom and St Helier University Hospitals NHS Trust	3.4	5.1	7.4	8.3	4.4
St George's University Hospitals NHS Foundation Trust	3.5	4.2	4.9	8.5	4.1
Grand Total	**3.47**	**4.57**	**6.16**	**8.39**	**4.19**

Number esitmated contract for approval per year	< £1m	£1–3m	£3–5m	£5m+	Grand Total
Epsom and St Helier University Hospitals NHS Trust	29.63	2.36	1.21	2.05	31.62
St George's University Hospitals NHS Foundation Trust	54.45	4.25	1.84	2.60	58.91
Grand Total	**84.07**	**6.56**	**2.92**	**4.65**	**90.37**

Contracted value per spend category	< £1m	£1–3m	£3–5m	£5m+	Grand Total
Epsom and St Helier University Hospitals NHS Trust	£15.7m	£21.5m	£35.6m	£203.2m	£276.1m
St George's University Hospitals NHS Foundation Trust	£33.6m	£32.2m	£32.1m	£514.9m	£612.9m
Grand Total	**£49.3m**	**£53.7m**	**£67.8m**	**£718.1m**	**£888.9m**
Coverage	6%	6%	8%	81%	100%

Table 2: Contracts & Business cases approved at FPC

FPC date	Detail	Type	Value	New forum
Mar-25	ESTH SPECT CT	C	£1.020m	GEC
May-25	SGH L&L	C	£3.2m	FPC only
	ESTH L&L	C	£2.1m	GEC
	SWLP POCT Main	C	£22.7m	FPC and Board
	ESTH Tissue Typing	C	£2.7m	GEC
Jun-25	SGH NIPT	C	£3.392m	FPC only
	SWLP POCT Blood Glucose	C	£3.473m	FPC only
	ESTH EPR Addendum	BC	£3.3m capex	FPC only
Aug-25	SWLP POCT Blood Glucose	C	£7m	FPC and Board
	SWLP Mass Spec Molecular	C	£3.23m	FPC only
	SGH Utilities	C	£21.4m	FPC only
Oct-25	SGH NEPT	C	£22.4m	FPC and Board
Nov-25	(South London) Cardiology	C	£6.4m ESTH and £43.8m SGH	FPC and Board
	ESTH- Gen Med	C	£18.64m	FPC and Board
	ESTH- Surgical Robot	BC	£2.4m capex	GEC
Dec-25	ESTH Epsom Car Park	BC	£11m-£12m	FPC and Board
Jan-26	Group Ambient AI	BC	£3.4m capex (cross group)	FPC only
	SWLP GP Hub	BC	£4.5m capex	FPC only
	ESTH Patient Ready Meals	C	£3.9m	FPC only
	SGH Catering	C	£3.7m	FPC only

Group Board Meeting (Public)

Meeting on Thursday, 05 March 2026

Agenda Item	5.1	
Report Title	**People Committees Report to Group Board**	
Non-Executive Lead	Yin Jones, People Committees Chair, SGUH & ESTH NED	
Report Author(s)	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 February 2026 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 covering national, SW London, and gesh-specific contexts. NHS England confirmed a 3.3% pay raise for Agenda for Change staff starting in April 2026. SGUH listening sessions following the SGUH CQC Well Led report concluded in February 2026.

- Pay Gap Report 2025: Gender, Ethnicity and Disability
  The report covered not just Gender but also Ethnicity and Disability, using data collected on 31 March 2025. The reports were reviewed and approved for submission to the Group Board. The Committees discussed the structural imbalance of historic Clinical Excellence Awards, noting that when medical staff are excluded, the data demonstrated an inverse gender pay gap.

- People Strategy Delivery Update
  The Committees reviewed the revised implementation plan for People Strategy's final year which outlined specific timelines, deliverables, and the new performance dashboard. Engagement plans were being developed to ensure strategy resonance at divisional levels.

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 February 2026.

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 on the Group Board Assurance Framework (Staff Experience and Wellbeing, Culture and EDI, and Developing Tomorrow's Workforce) remained scored at 20 (Extreme) as at January 2026.

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

Set out in the report.

Equality, diversity and inclusion (EDI) implications

Set out in the report.

Environmental sustainability implications

N/A

People Committees Report
Group Board, 05 March 2026

1.0 Purpose of paper

1.1 This report sets out the key issues considered by the People Committees at its meeting in February 2026 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 on 19 February 2026, the Committees considered the following items of business:

19 February 2026
• Group Chief People Officer Report
• Pay Gap Report 2025: Gender, Ethnicity and Disability
• Amendment to 2022 ESTH Pay Gap Report following complaint
• People Strategy Delivery Update
• People Function Target Operating Model
• Workforce KPI Performance Report
• Area of Focus: Performance and Development
• Guardian of Safe Working Q3 Report
• Area of Focus: Apprenticeships
• Committee Effectiveness Review 2025/26

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 19 February 2026 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. NHS England confirmed a 3.3% pay rise for Agenda for Change staff starting in April. SGUH listening sessions held in response to the CQC's Well Led inspection report on SGUH had concluded in February 2026.

b) Pay Gap Report 2025: Gender, Ethnicity and Disability
The report covered not just Gender but also Ethnicity and Disability, using data collected on 31st March 2025. The Committees discussed the structural imbalance of historic CEAs (Clinical Excellence Awards), noting that when medical staff are excluded, an inverse gender pay gap could be created. It was also noted that international recruitment patterns influenced ethnicity pay data and suggested a deeper analysis of controllable factors. The Committees requested executive summaries for each of the three reports to provide context for public

readers. The reports were reviewed and approved for submission to the Group Board. The Committees also noted that, due to a clerical error regarding staff contract status, the 2022 Pay Gap report had been corrected and republished.

c) People Strategy Delivery Update
The Committees reviewed the revised implementation plan for People Strategy's final year which outlined specific timelines, deliverables, and the new performance dashboard. Engagement plans were being developed to ensure strategy resonance at divisional levels. In response to a question about whether and how gesh workforce was being future-proofed for AI and new technologies, the members learned that a use-case-led approach was being adopted, including AI for theatre scheduling and Copilot training.

4.0 Key Issues on which the Committees received assurance

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

a) People Function Target Operating Model (TOM)
The new Target Operating Model includes plans for a single front door for digital HR services and replacing EST with a Future Workforce Solution. The implementation will be phased, with SLT and Head of Service restructures already complete. The Committees stressed the importance of process simplification and introduction of the Hire-to-Retire (H2R) lifecycle. The Committees noted the report and requested a further update with more granular detail later in the year.

b) Area of Focus: Performance and Development
The Committees received an update on Performance and Development. A new approach was proposed to appraisals and leadership development, moving away from annual box-ticking events and toward continuous "moments that matter" conversations. The plan was to launch a three-tiered gesh management development program, following a successful 350-person pilot. The Committees welcomed the new focus on making appraisals more valued by staff rather than being target driven.

c) Committee Effectiveness 2025/26
The Committees reviewed the summary of the annual committee effectiveness survey that highlighted positive feedback on chairing and paper quality improvement. Suggestions for improvement included shorter meetings (2.5 hours) and more focus on EDI beyond regulatory reporting.

5.0 Other issues considered by the Committees

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

a) Workforce KPI Performance Report
The report summarised the December 2025 data. WTE (whole time equivalents) saw a slight reduction despite the strikes and the vacancy rate stood at 7.5% group wide. The sickness absence reached 6.1%, primarily due to cold/flu and anxiety/stress. The turnover reduced to 9% compared to 11.5% the previous year. The Committees requested a deep dive on sickness absence at a future meeting.

b) Guardian of Safe Working (GOSW) Q3 Report

Exception Reporting remained concentrated in Acute Medicine (AMU) due to workload pressures. The Committees noted that a process change was being implemented to allow reports to bypass departments to ensure confidentiality. It was discussed and agreed that the 10-point plan updates would remain with the People Committee, while the GMC training survey reporting would be moved to the Quality Committee.

c) Area of Focus: Apprenticeships
The Committees welcomed the news that there was a shift in government rules allowing for more flexible, shorter-term programmes (three months instead of 16 months), which was expected to reduce the historical challenges of enrolling staff who could not commit to long-term sessions without backfill. It was agreed to review nursing apprenticeships and backfill models and report back at a later date.

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 19 February 2026.

Group Board

Meeting in Public on Thursday, 05 March 2026

Agenda Item	5.2	
Report Title	**Pay Gap Report – Snapshot 31/03/25**	
Executive Lead(s)	Victoria Smith, Group Chief People Officer	
Report Author(s)	Joseph Pavett-Downer (EDI) and Phil Longley (WI)	
Previously considered by	People Committees-in-Common	19 February 2026
Purpose	**For Approval / Decision**	

Executive Summary

The Equality Act 2010 requires all organisations with over 250 employees to report on and publish their gender pay gap on a yearly basis. To gain an improved understanding of pay gaps across the group we have developed our first gesh Pay Gap Report, which covers Gender, Ethnicity and Disability. This report captures data on 31st March 2025.

Gender: Across both organisations, women represent the majority of the workforce (71% at STG and 75% at ESTH); however, men continue to earn more on average. At STG, the mean gender pay gap increased to 12.2% (from 11.6% LY) and the median gap rose to 9.0% (from 8.6% LY), indicating a slight worsening position compared to the previous year. At ESTH, the mean gender pay gap widened further to 15.0% (from 13.6% LY), while the median gap shifted from favouring women to favouring men at 2.6%, representing a deterioration in gender pay equity overall.

Ethnicity: At STG, BME staff make up the majority of the workforce (55%) but continue to experience a significant pay gap compared to white staff; the mean ethnicity pay gap reduced slightly to 14.6% (from 14.9% LY) and the median gap narrowed to 17.2% (from 17.5% LY), showing modest improvement year-on-year, although the gap remains substantial. At ESTH, the ethnicity pay gap continues to favour BME staff and has widened, with the mean gap increasing to -4.3% (from -1.9% LY) and the median gap to -4.2% (from -2.3% LY).

Disability: Disabled staff remain under-represented across both organisations (4% at STG and 5% at ESTH) and continue to earn less on average than non-disabled staff. At STG, the mean disability pay gap reduced to 8.2% (from 10.2% LY) and the median gap narrowed to 3.8% (from 6.4% LY), demonstrating clear improvement year-on-year. At ESTH, the mean disability pay gap also reduced to 7.9% (from 8.6% LY), indicating progress, although the median gap increased to 2.5% (from 0.8% LY), suggesting mixed outcomes and ongoing inequality at middle pay levels.

Action required by Group Board

The Group Board is asked to:

a. Review the Pay Gap Report
b. Approve the report for publication on the Trusts' websites

Committee Assurance	
Committee	People Committees-in-Common
Level of Assurance	Not Applicable

Appendices	
Appendix No.	**Appendix Name**
Appendix 1	GESH Pay Gap Report 31.3.25 (final)

Implications

Group Strategic Objectives

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

Risks

Failing to publish our Gender Pay Gap information each year can lead to governance risks such as non-compliance, reputational damage, and legal exposure, while attracting increased scrutiny from regulatory bodies.

CQC Theme

☐ Safe	☐ Effective	☐ Caring	☐ Responsive	☒ Well Led

NHS system oversight framework

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

Financial implications

None identified.

Legal and / or Regulatory implications

The Equality Act 2010 (Gender Pay Gap Information) Regulations 2017 require all organisations with over 250 employees to report on and publish their gender pay gap on a yearly basis. This is based on a snapshot from 31st March of each year, and each organisation is duty bound to publish information on their website.

Equality, diversity and inclusion implications

Completion and publication of our Gender Pay Gap report and other equality reports demonstrates our on-going commitment to transparency and accountability. It evidences the board's commitment and shows a willingness to review and learn from equality information.

Environmental sustainability implications

None identified.

Gender Pay Gap
Group Board, 05 March 2026

1.0 Purpose of paper

1.1 The paper provides the Board with an overview of the group and sites gender pay gap information. It is intended to show our performance against the previous years and highlight areas of improvement or deterioration. The paper requires approval to move forward for publication.

2.0 Background

2.1 The Equality Act 2010 (Gender Pay Gap Information) Regulations 2017 require all organisations with over 250 employees to report on and publish their gender pay gap on a yearly basis. This is based on a snapshot from 31st March of each year, and each organisation is duty bound to publish information on their website. This report captures data as at 31st March 2025. The NHS has issued guidance on how to calculate the gender pay gap which we follow closely to produce the attached report.

The statutory requirements of the Gender Pay Gap legislation require that each organisation must calculate the following:

- The mean basic pay gender pay gap
- The median basic pay gender pay gap
- The proportion of males and females in each quartile pay band
- The mean bonus gender pay gap
- The median bonus gender pay gap
- The proportion of both males and females receiving a bonus payments.

Who is included? All staff who were employed across the GESH Group on full pay on 31st March 2024, with the exception of Non-Executive Directors, are included. Bank staff who worked a shift on the snapshot date are also included. Consultant Additional Programmed Activities (APA's) are included, but general overtime pay and expenses are excluded. Employees who are on half or nil absence or maternity leave, hosted staff (e.g. GP Trainees) and agency staff are not included.

What pay is covered? Both Basic pay and Bonus pay is covered. Bonus pay is defined as any remuneration that is in the form of money, vouchers, securities or options and relates to profit sharing, productivity, performance, incentive or commission. This includes Clinical Excellence Awards and Distinction Awards. Recruitment & retention payments (RRP's) are only included if they are a one-off payment at the start of recruitment, but not if they are continuous. Workplace vouchers that are paid in addition to basic salary are included, unless they take the form of a salary sacrifice arrangement.

This year, we have produced our first Pay Gap Report covering Gender, Ethnicity and Disability.

3.0 Key Findings

This report contains a number of detailed info graphics and charts to provide a clearer picture of the data. This is presented alongside a brief narrative to help readers understand that data. Below provides a high-level overview in relation each category: Gender, Ethnicity and Disability.

Please see attached report for further information, including a breakdown by professional group, AFC grades, bonus payments and trend analysis.

Gender: STG employed 10,826 staff - 7,700 (71%) were female and 3,126 (29%) were male. The mean hourly pay for males was £3.77 higher than that of females, which is a gap of 12.2% (an increase from 11.6% in the previous year). Male median rate was £2.44 higher than females, which is a gap of 9.0% (an increase from 8.6% in the previous year). **ESTH** employed 7.321 staff - 5,506 (75%) were female and 1,815 (25%) were male. The mean hourly pay for males is £4.31 higher than that of females, which is a gap of 15.0% (an increase from 13.6% in the previous year). Male median rate was £0.60 higher than females, which is a gap of 2.6% (a shift from -1.9% in the previous year).

Ethnicity: STG employed 10,826 staff – 5,921 (55%) BME staff, 4,573 (42%) white staff and 332 (3%) not declared. The mean hourly pay for BME staff was £4.47 lower than white staff, representing a pay gap of **14.6%** - a slight improvement from 14.9% the previous year. The median hourly rate was £4.79 lower for BME staff, resulting in a gap of **17.2%**, down from 17.5% last year. **ESTH** employed 7,321 staff – 3,501 (48%) BME staff, 3,573 (49%) white staff and 247 (3%) not declared. The mean hourly pay for BME staff was £1.08 higher than white staff, representing a pay gap of -4.3% - a further widening from -1.9% in the previous year. The median hourly rate was £0.91 higher for BME staff, resulting in a gap of -4.2%, down from -2.3% last year.

Disability: STG employed 10,826 staff – 9,766 (90%) were non-disabled, 460 (4%) were disabled and 600 (6%) not declared. The mean hourly pay for disabled staff was £2.29 lower than non-disabled, which is a gap of 8.2% (a decrease from 10.2% in the previous year). Disabled median rate was £0.96 lower than non-disabled, which is a gap of 3.8% (a decrease from 6.4% in the previous year). **ESTH** employed 7,321 staff – 6,408 (88%) were non-disabled, 367 (5%) were disabled and 546 (7%) not declared. The mean hourly pay for disabled staff was £2.00 lower than non-disabled, which is a gap of 7.9% (a decrease from 8.6% in the previous year). Disabled median rate was £0.55 lower than non-disabled, which is a gap of 2.5% (an increase from 0.8% in the previous year).

4.0 Sources of Assurance

4.1 The requirement to publish a Gender Pay Gap (GPG) report was introduced in March 2016, with the first reports published in March 2017 to allow organisations time to put in place appropriate data-collection systems. Since then, the national reporting framework has operated on a one-year lag, meaning published reports are based on data that is already 12 months old. As a result, findings and actions can be out of date by the time reports are published.

4.2 In line with the commitment made last year, the GESH Group has produced its first 2025 Pay Gap Report. Following publication, we will review our current approach and reporting templates to ensure that the 2026 report is produced in real time, aligned to the current financial year, and presented in a more streamlined and user-friendly format.

4.3 This change will ensure that pay gap reporting is more timely, supports more meaningful Board oversight, and enables actions to be developed and implemented in direct response to current and live findings, rather than historic data.

5.0 Implications

5.1 The implications are set out in the report.

6.0 Recommendations

6.1 The Group Board is asked to:

a. Review the paper
b. Approve the report for publication on the Trusts' websites.

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

gesh

Pay Gap Report – Gender, Ethnicity & Disability

Snapshot Date: 31 March 2025

Features: ESR data on 31/03/2025 (extracted on 30 April 2025)
Published: TBC
By: Workforce Systems & Intelligence and Equality, Diversity and Inclusion teams

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

gesh

Gender Pay Gap Report

Snapshot Date: 31 March 2025

Features: ESR data on 31/03/2025 (extracted on 30 April 2025)
Published: TBC
By: Workforce Systems and Intelligence / Equality, Diversity and Inclusion

Gender Pay Gap

Executive Summary

This report sets out the Gender Pay Gap position for St George's University Hospitals NHS Foundation Trust and Epsom and St Helier University Hospitals NHS Trust as at 31 March 2025. The reported gaps continue to reflect workforce composition and national pay structures rather than unequal pay for equal work. Both organisations remain predominantly female, particularly across Agenda for Change roles, while male representation is proportionately higher within senior medical and consultant grades.

At STG, the overall mean and median gender pay gaps have increased slightly compared to the previous year. At ESTH, the mean gap has widened and the median has shifted from favouring female staff to favouring male staff. These movements are primarily driven by the distribution of staff across grades and the impact of consultant earnings, rather than changes to pay rates within roles.

Key Themes

Workforce profile and grade distribution

Across both organisations, women represent the majority of the workforce. However, there are higher proportions of men in senior medical roles, which attract higher average earnings. This distribution continues to influence headline pay gap calculations.

Agenda for Change position

When isolating Agenda for Change (AFC) staff, including Very Senior Managers, the pay gap position is neutral or in favour of female staff across both organisations. This demonstrates that within structured national pay bands, there is no systemic pay inequality. The headline gap is therefore largely attributable to workforce mix rather than pay policy.

Consultant and senior medical impact

Consultants sit outside AFC pay structures and have access to additional earnings elements, including programmed activities and award schemes. As this is a comparatively small but high-earning group, changes in representation or earnings within this cohort materially affect overall pay gap outcomes.

Clinical Excellence Awards and Bonus-Like Payments

Bonus payments in both organisations relate exclusively to consultants. In 2025, there was a substantial reduction in the number of consultants receiving bonus payments compared to 2024, reflecting national reform of the consultant pay framework and changes to award structures and eligibility criteria.

The proportion of male consultants receiving bonuses remains significantly higher than female consultants in both organisations. At STG, both the mean and median bonus gaps increased in favour of male consultants. At ESTH, the mean bonus gap narrowed significantly, and the median shifted in favour of female consultants, demonstrating the variability that can arise when award volumes reduce, and recipient numbers are small.

Given that bonus payments are concentrated within a limited and highly paid professional group, relatively small changes in participation or award values can produce notable shifts in reported bonus gaps year on year. This sensitivity reinforces the need to interpret bonus data within the context of consultant reward reform and workforce composition.

Conclusion

The 2025 results continue to demonstrate that the Gender Pay Gap across both organisations is primarily structural in nature. The AFC workforce shows parity or advantage for female staff, while senior medical representation and consultant bonus participation remain the principal drivers of the headline gap.

National changes to consultant reward arrangements have significantly reduced bonus participation and introduced greater year-on-year variability. Future progress will therefore depend not only on award processes, but on sustained improvement in representation and progression within senior clinical and leadership roles. This would apply to representation of gender, ethnicity and disability.

For detailed information on how the pay gap is calculated please see Appendix A.

Gender Pay Gap

Introduction

The Equality Act 2010 (Gender Pay Gap Information) Regulations 2017 require all organisations with over 250 employees to report on and publish their gender pay gap on a yearly basis. This is based on a snapshot from 31st March each year, organisations are required to publish this information on their public website. **This report captures data as of 31st March 2025.**

The NHS has issued guidance on how to calculate the gender pay gap, and that guidance is followed here (see Appendix 1). At the time of writing, St George's, Epsom and St Helier University Hospitals and Health Group (gesh) employs 18,147 employees. By Trust, this is broken down as 10,826 employees at St George's University Hospitals (STG) and 7,321 employees at Epsom and St Helier Hospitals (ESTH).

All staff at St George's University Hospitals, except for medical and Very Senior Management (VSM) are on Agenda for Change (AfC) pay scales, which provides a structured and transparent approach to pay that supports gender neutrality. In addition to Medical, Very Senior Management (VSM) and Agenda for Change (AfC), Epsom and St Helier Hospitals also employs 570 Estates & Facilities staff on locally agreed pay scales. Non-Executive Directors have been excluded due to the nature of their employment terms and the impact this is having on pay gap disparities.

What is the gender pay gap?
The Gender Pay Gap (GPG) reflects the difference in average hourly earnings between women and men across the organisation.

For example, if an organisation's workforce is predominantly female yet the majority of higher paid roles are held by men, the average female salary would be lower than the average male salary.

It is important to note that the Gender Pay Gap is not the same as equal pay, which is focused on ensuring that men and women earn equal pay for the same or similar jobs, or for work of equal value. It is unlawful to pay people unequally because of their gender.

What do we have to report on?
The statutory requirements of the Gender Pay Gap legislation mandate that each organisation must calculate the following:

- Mean basic gender pay gap
- Median basic gender pay gap
- Proportion of males and females in each quartile pay band
- Mean bonus gender pay gap
- Median bonus gender pay gap
- Proportion of both males and females receiving a bonus payment.

Who is included?
All staff who were employed across the gesh Group on full pay as of 31st March 2025, with the exception of Non-Executive Directors. Bank staff who worked a shift on the snapshot date are included, as are Consultant Additional Programmed Activities.

Excluded categories include:
- Employees on half or nil pay due to absence or maternity leave
- Hosted staff (e.g. GP Trainees)
- Agency staff
- General overtime pay and expenses

What pay is covered?
The report covers both basic pay and bonus pay. Bonus pay is defined as any remuneration that is in the form of money, vouchers, securities or options and relates to profit sharing, productivity, performance, incentive or commission. This includes Clinical Excellence Awards and Distinction Awards.

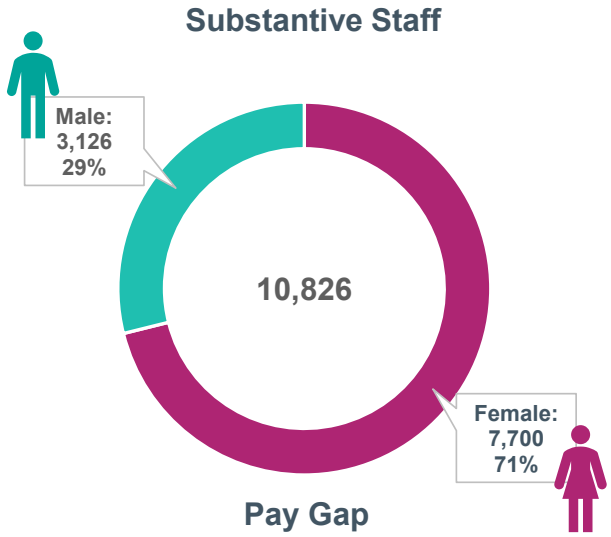
Recruitment & retention payments (RRPs) are only included if they are one-off payments at the start of recruitment. Ongoing RRPs are excluded. Workplace vouchers paid in addition to basic salary are included, unless provided via salary sacrifice arrangements.

For detailed information on how the pay gap is calculated please see Appendix A.

Gender Pay Gap

Site Overview

St George's University Hospital (STG)



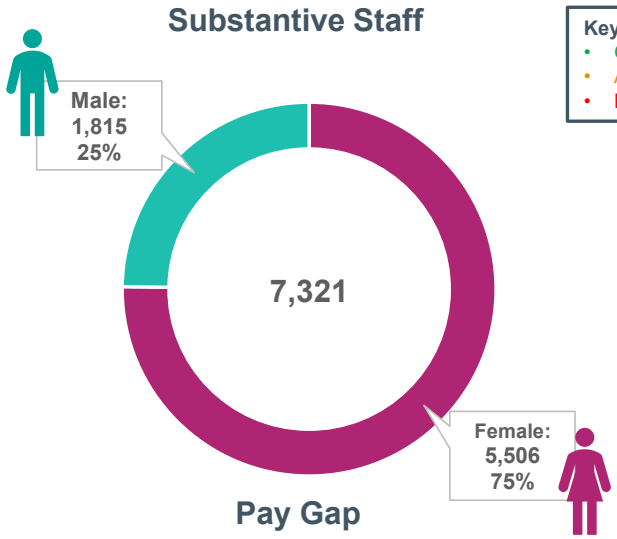
12.2%
Mean Pay Gap

↑ (+0.6% from 2024)

9.0%
Median Pay Gap

↑ (+0.4% from 2024)

Epsom and St Helier Hospital (ESTH)



Key:
- Green +/- 0-3%
- Amber +/-3-5%
- Red +/- 5% & above

15.0%
Mean Pay Gap

↑ (+1.4% from 2024)

2.6%
Median Pay Gap

↑ (+4.5% / shift from 2024)

Gender Pay Gap

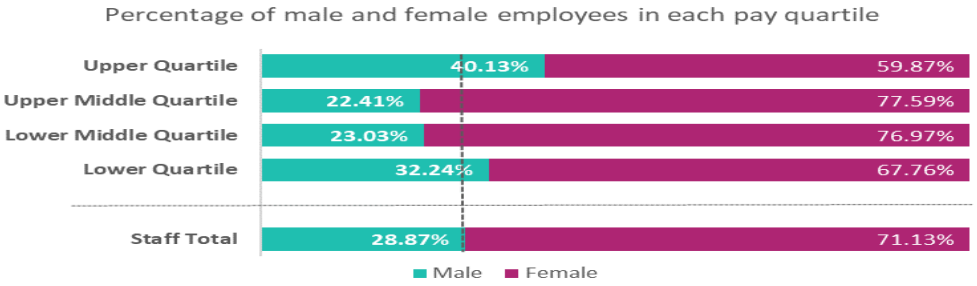
Basic Pay – Mean and Median Gap

Definitions of Pay Gap

The **mean pay gap** is the difference between the average pay of all male employees and the average pay of all female employees.

The **median pay gap** is the difference between the pay of the middle male and middle female, when all male employees and then all female employees are listed from the highest to the lowest paid.

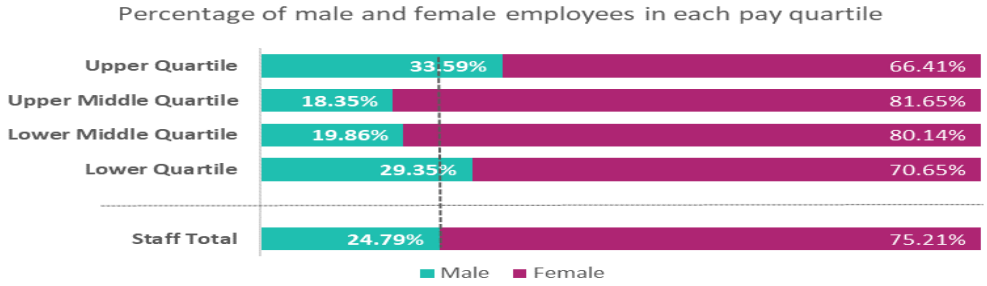
St George's University Hospital (STG)



On 31st March 2025 STG employed 10,826 staff - 7,700 (71%) were female and 3,126 (29%) were male. The mean hourly pay for males was £3.77 higher than that of females, which is a gap of **12.2%** (an increase from 11.6% in the previous year). Male median rate was £2.44 higher than females, which is a gap of **9.0%** (an increase from 8.6% in the previous year).

For AfC (including VSM) staff, the average hourly rate for females was £0.54 higher than for males (**-2.3%** pay gap), an increase from -1.2% in the previous year. The median hourly rate for females is £1.52 higher, resulting in a pay gap of **-7.1%**, which is a slight improvement from -7.9% last year.

Epsom and St Helier Hospital (ESTH)



On 31st March 2025 ESTH employed 7.321 staff - 5,506 (75%) were female and 1,815 (25%) were male. The mean hourly pay for males is £4.31 higher than that of females, which is a gap of **15.0%** (an increase from 13.6% in the previous year). Male median rate was £0.60 higher than females, which is a gap of **2.6%** (a shift from -1.9% in the previous year).

For AfC (including VSM) staff, the average hourly rate for males was £0.06 higher than for females (**0.3%** pay gap), an increase from 0.2% in the previous year. The median hourly rate for females is £0.42 higher, resulting in a pay gap of **-1.9%**, which is an improvement from -5.8% last year.

Gender Pay Gap

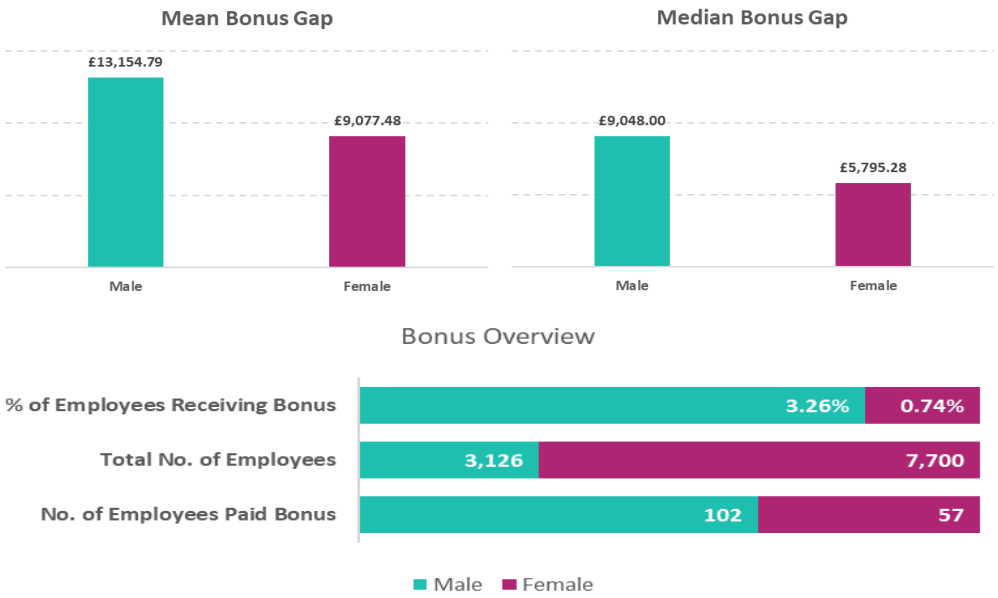
Bonus Pay – Mean and Median Gap

Definitions of Bonus Pay Gap

Mean Bonus Gap: The difference between the average bonus received by all male employees and the average bonus received by all female employees.

Median Bonus Gap: The difference between the bonus received by the middle-ranking male and the middle-ranking female when all eligible employees of each gender are listed in order from highest to lowest bonus received.

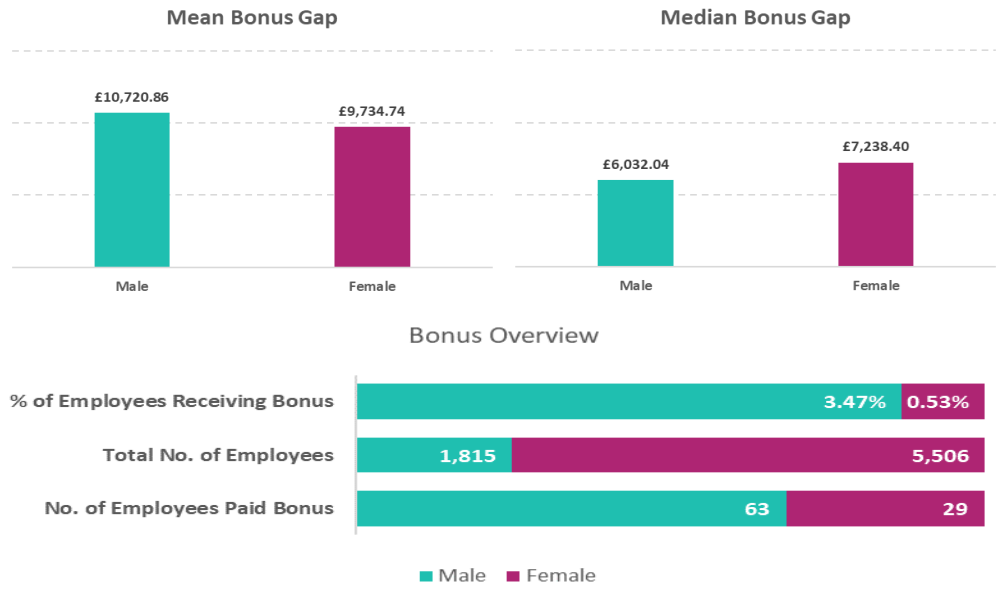
St George's University Hospital (STG)



A total of 159 staff received a bonus payment during this reporting period, all of whom were Consultants. Of these, 57 were female (representing 0.74% of the female workforce) and 102 were male (representing 3.26% of the male workforce).

The mean bonus pay for male staff was £4,077.31 higher than for females, resulting in a **31.0%** gap - up from 23.6% in 2024. The median bonus gap was £3,252.72 (resulting in a **35.9%** gap), up from 0% in the previous year. Both mean and median pay gaps increased in favour of male Consultants. In 2024, 618 staff received a bonus – 335 males and 283 females.

Epsom and St Helier Hospital (ESTH)



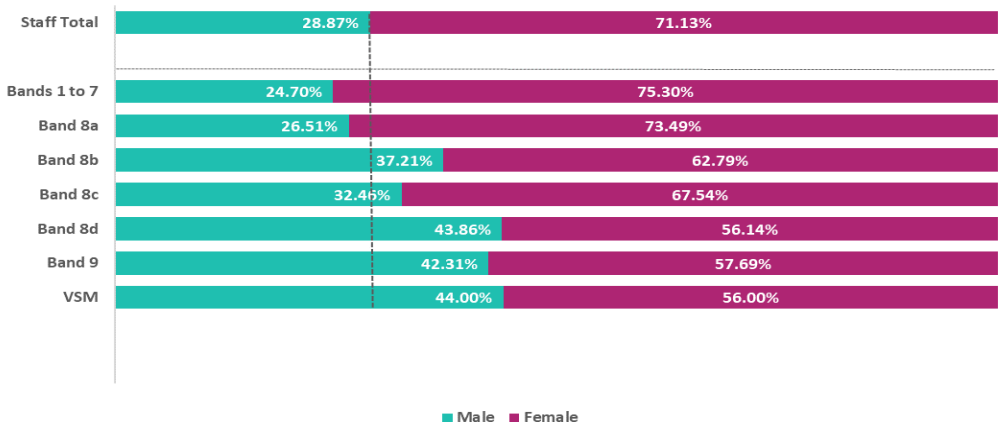
A total of 92 staff received a bonus payment during this reporting period, all of whom were Consultants. Of these, 29 were female (representing 0.53% of the female workforce) and 63 were male (representing 3.47% of the male workforce).

The mean bonus pay for male staff was £986.12 higher than for females, resulting in a **9.2%** gap - down from 16.7% in 2024. The median bonus gap was £1,206.36 in favour of females (resulting in a **-20.0%** pay gap), marking a shift from 0% in the previous year. Mean gap significantly narrowed, while the median now favours female Consultants. In 2024, 299 staff received a bonus – 183 males and 116 females.

Gender Pay Gap

Spotlight on AfC (and local contracts)

St George's University Hospital (STG)



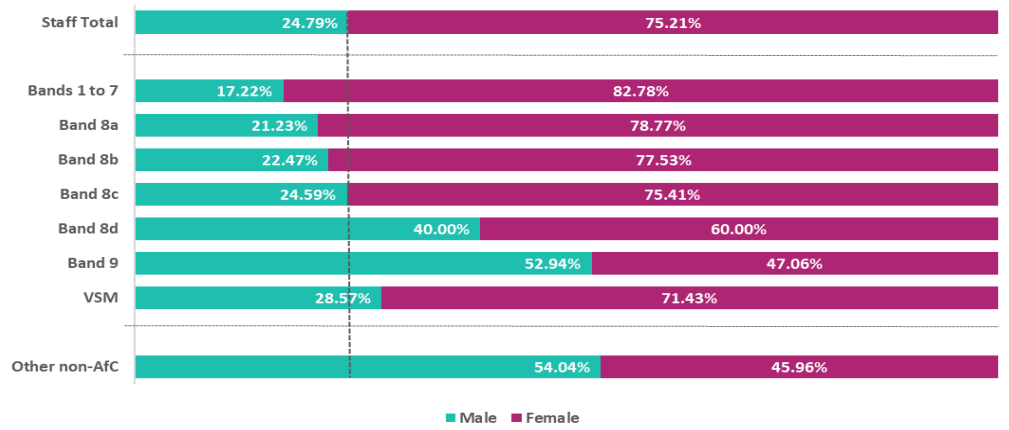
As an organisation, female staff make up 71% of the workforce. The workforce composition is within range of representative at bands 3, 4 and 8a (68% to 74%). There is an over representation of female staff at bands 5 to 7 (75% and above).

From band 8b and above, female representation reduces, and we see a higher proportion of male staff. Female representation is lowest at VSM at 56% (a 6% increase to 2024). Band 9 saw a significant increase, from 35% female representation in 2024 to 58% in 2025.

Male staff represent 29% of the STG workforce overall; the highest representation is 44% at VSM and 44% at band 8d.

The largest mean pay gap was observed in **Estates and Ancillary**, at **15.1%**, representing an increase from **10.6%** in the previous year. This was followed by **Administrative and Clerical**, with a mean pay gap of **10.7%**, marking a decrease from **12.0%** in 2024.

Epsom and St Helier Hospital (ESTH)



As an organisation, female staff make up 75% of the ESTH workforce. The workforce composition is within range of representative at bands 2, 8b and 8c (72% to 78%). There is an over representation of female staff at bands 3-8a (79% and above).

From band 8d and above, female representation reduces, and we see a higher proportion of male staff. Female representation is lowest at band 9 at 47%, followed by Facilities (Other non-AfC) representation is also low at 46%.

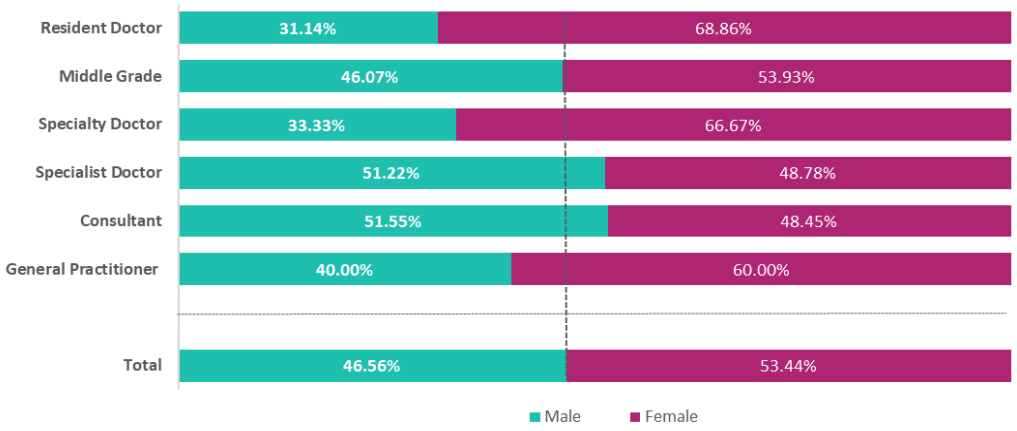
Male staff represent 25% of the ESTH workforce overall; the highest representation is 54% within the Facilities staff on local contracts.

The largest mean pay gap was observed in **Administrative and Clerical**, with a mean pay gap of **14.8%**, marking a decrease from **13.9%** in 2024.

Gender Pay Gap

Spotlight on Medical Staff

St George's University Hospital (STG)



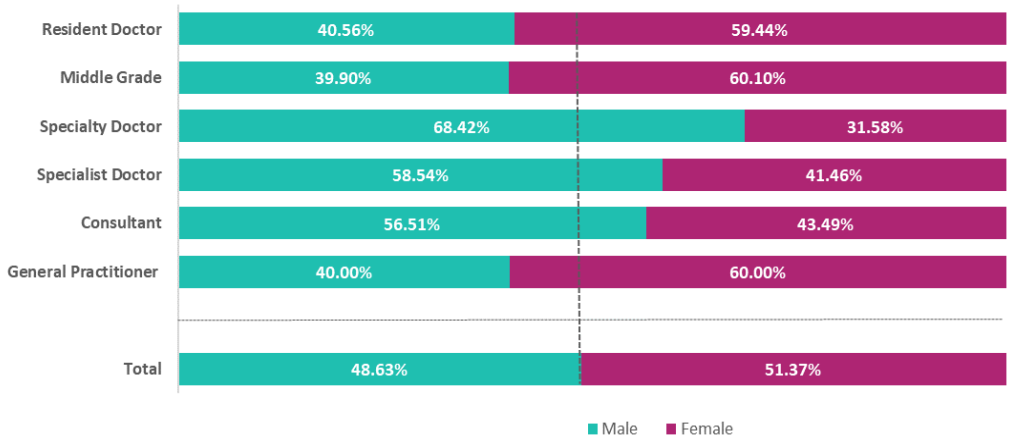
The Medical Staff group includes all 'Doctor in Training' through to 'Consultant' roles.

The proportion of male to female staff is 47% to 53%.

The mean hourly pay for males is £4.26 higher than that of females, which is a gap of **8.6%** (an increase from 4.7% in the previous year). Male median pay is £5.26 higher than females, which is a gap of **11.1**% (an increase from 6.3% in the previous year).

While the Medical Staff group continues to show disparity, the consultant subgroup has seen a modest narrowing of the pay gap. In 2025, male consultants earned £2.01 more per hour than female consultants, down slightly from £2.11 in the previous year, resulting in a **3.1%** gap.

Epsom and St Helier Hospital (ESTH)



The Medical Staff group includes all 'Doctor in Training' through to 'Consultant' roles.

The proportion of male to female staff is 49% to 51%.

The mean hourly pay for males is £5.30 higher than that of females, which is a gap of **10.8%** (a decrease from 16.6% in the previous year). Male median pay is £9.37 higher than females, which is a gap of **19.3**% (a decrease from 24.6% in the previous year).

While the wider Medical Staff group continues to show the largest disparity, consultants have seen a narrowing of the gap. In 2025, male consultants earned £1.32 more per hour than their female counterparts, down from £2.26 in the previous year, resulting in a **2.0%** gap.

Gender Pay Gap

Spotlight on Staff Group (excluding Medical and Dental)

St George's University Hospital (STG)

The largest pay gap in favour of male staff was seen within Estates and Ancillary roles, with a **mean gap of 15.1%** (up from 10.6% in 2024) and a **median gap of 16.2%** (up from 13.7%). Admin and Clerical roles followed, with a **mean gap of 10.7%.** Smaller mean gaps were reported in Healthcare Scientists (**2.4%**), Qualified Nursing staff (**0.7%**) and Allied Health Professionals (**0.4%**).

In contrast, pay gaps in favour of female staff was seen within Add Prof Scientific and Technical, with a **mean gap of -4.6%** and **median gap of -13.0%**. Additional Clinical Services also showed a small gap in favour of female staff, at **-0.8% mean** and **0.7% median**.

Epsom and St Helier Hospital (ESTH)

The largest pay gap in favour of male staff was observed within Admin and Clerical roles, with a **mean gap of 14.8%** (up from 13.9% in 2024) and a **median gap of 5.7%** (up from 2.5%). Smaller gaps in favour of male staff were seen in Estates and Ancillary (**5.8%**) and Healthcare Scientists (**3.6%**).

In contrast, pay gaps in favour of female staff were recorded among Allied Health Professionals, with a **mean gap of -4.3%** and **median of -6.6%**, followed by Additional Professional Scientific and Technical roles (**-1.9% mean**), Qualified Nursing staff (**-1.3% mean**) and Additional Clinical Services (**-0.9%**).

Gender Pay Gap

Site Trend 2020 - 2025

St George's University Hospital (STG)

	2020	2021	2022	2023	2024	2025	Line Trend
Mean Pay Gap	13.71%	14.83%	14.59%	12.86%	11.60%	12.24%	
Median Pay Gap	9.49%	7.94%	9.51%	10.02%	8.62%	9.02%	
Mean Bonus Pay Gap	29.23%	35.10%	34.17%	32.10%	23.58%	30.99%	
Median Bonus Pay Gap	33.33%	33.33%	33.33%	0.00%	0.00%	35.95%	
% males getting bonus	5.03%	4.57%	4.00%	12.07%	11.31%	3.26%	
% females getting bonus	1.33%	1.07%	0.94%	4.66%	3.84%	0.74%	

- The mean pay gap widened by 0.6% in 2025
- The median pay gap widened by 0.4% in 2025
- The mean bonus gap has widened by 7.4% in 2025
- The median bonus gap has significantly increased to 35.9%
- The % of males receiving a bonus reduced to 3.3%.
- The % of females receiving bonus reduced to 0.7%.

Epsom and St Helier Hospital (ESTH)

	2020	2021	2022	2023	2024	2025	Line trend
Mean Pay Gap	19.52%	18.46%	14.28%	13.16%	13.58%	14.98%	
Median Pay Gap	12.25%	10.38%	1.88%	-1.23%	-1.89%	2.64%	
Mean Bonus Pay Gap	15.17%	16.06%	21.55%	24.90%	16.73%	9.20%	
Median Bonus Pay Gap	0.00%	0.00%	1.25%	0.00%	0.00%	-20.00%	
% males getting bonus	5.88%	5.31%	4.22%	8.99%	9.94%	3.47%	
% females getting bonus	0.90%	0.74%	0.64%	1.96%	2.09%	0.53%	

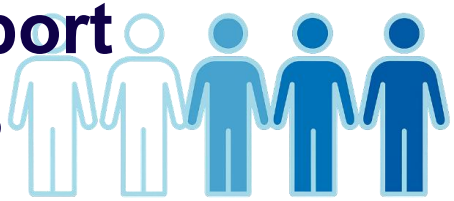
- The mean pay gap widened by 1.4% in 2025
- The median pay gap shifted in favour of men, now at 2.4%
- The mean bonus gap reduced by 7.5% in 2025
- The median bonus gap decreased by 20%
- The % of males receiving a bonus reduced to 3.5%
- The % of females receiving bonus reduced to 0.5%

In 2025, national changes to the consultant pay framework led to a significant reduction in the number of Consultants eligible for bonus payments, including adjustments to the structure and criteria for clinical excellence Awards. This has impacted the distribution of bonus pay across the workforce, and as such, direct comparisons with previous years should be approached with caution. In 2024 at STG, 618 consultants received a bonus, compared to 159 in 2025. At ESTH during 2024, 299 consultants received a bonus, compared to 92 in 2025.

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

gesh

Ethnicity Pay Gap Report



Snapshot Date: 31 March 2025

Features: ESR data on 31/03/2025 (extracted on 30 April 2025)
Published: TBC
By: Workforce Systems and Intelligence / Equality, Diversity and Inclusion

Ethnicity Pay Gap

Introduction

While public sector organisations are legally required to report and publish their gender pay gap annually under the Equality Act 2010 and Gender Pay Gap Information Regulations 2017, there is currently no mandatory requirement to report on the ethnicity pay gap.

Despite this, the St George's, Epsom and St Helier University Hospitals and Health Group (gesh) has chosen to examine pay disparities between employees who have declared their ethnicity using a snapshot data from **31 March 2025**. This voluntary analysis reflects our commitment to equity, transparency, and better understanding workforce experiences.

As of the snapshot date, the Group employed 18,147 staff, with 10,826 at St George's University Hospitals (STG) and 7,321 at Epsom and St Helier Hospitals (ESTH).

At STG, all staff excluding Medical and Very Senior Management (VSM) roles are on Agenda for Change (AfC) pay scales. At ESTH, in addition to Medical, VSM and AfC staff, 570 Estates and Facilities staff are employed on locally agreed pay frameworks. Non-Executive Directors have been excluded from this analysis due to the nature of their roles and impact on comparative averages.

What is the ethnicity pay gap?
The Ethnicity Pay Gap reflects differences in average hourly earnings between employees who have declared a disability and those who have not.

For instance, if staff with declared disabilities are underrepresented in higher-paid roles, or more frequently work in part-time or lower-banded positions, their average hourly earnings may be lower.

It is important to note that the Ethnicity Pay Gap is not the same as equal pay. Equal pay ensures that employees doing the same or similar jobs receive equal pay, regardless of disability. It remains unlawful to pay someone differently because of their disability status.

What do we have to report on?
Unlike the statutory requirements for Gender Pay Gap reporting, there is currently no legal obligation for public sector organisations to report on the Ethnicity Pay Gap. However, gesh has voluntarily undertaken this analysis, focusing on pay differences between staff who have declared their ethnicity as White and those who have declared a Black or Minority Ethnic (BME) background. This reflects our commitment to transparency, workforce equity, and a clearer understanding of staff experience across ethnic groups.

- The mean basic ethnicity pay gap
- The median basic ethnicity pay gap
- Proportion of White and BME staff in each pay quartile
- The mean bonus ethnicity pay gap
- The median bonus ethnicity pay gap
- Proportion of White and BME staff receiving a bonus payment

Who is included?
All staff who were employed across the gesh Group on full pay as of 31st March 2025, with the exception of Non-Executive Directors. Bank staff who worked a shift on the snapshot date are included, as are Consultant Additional Programmed Activities.

Excluded categories include:

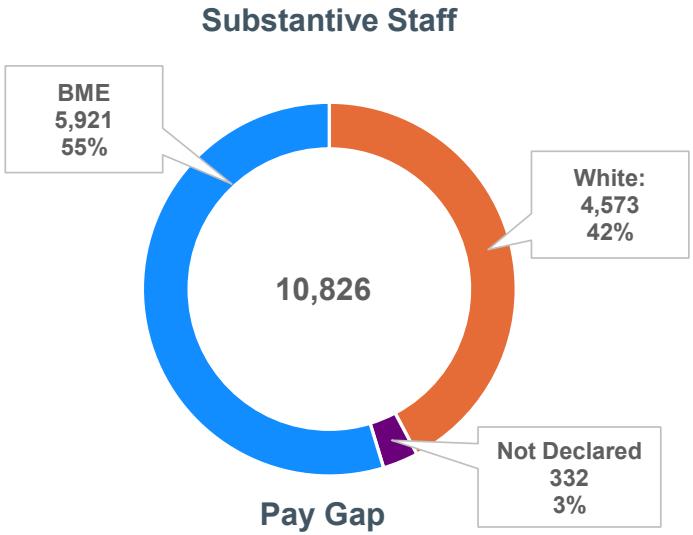
- Employees on half or nil pay due to absence or maternity leave
- Hosted staff (e.g. GP Trainees)
- Agency staff
- General overtime pay and expenses

What pay is covered?
The report covers both basic pay and bonus pay. Bonus pay is defined as any remuneration that is in the form of money, vouchers, securities or options and relates to profit sharing, productivity, performance, incentive or commission. This includes Clinical Excellence Awards and Distinction Awards. Recruitment & retention payments (RRPs) are only included if they are one-off payments at the start of recruitment. Ongoing RRPs are excluded. Workplace vouchers paid in addition to basic salary are included, unless provided via salary sacrifice arrangements. **For detailed information on how the pay gap is calculated please see Appendix A.**

Ethnicity Pay Gap

Site Overview

St George's University Hospital (STG)



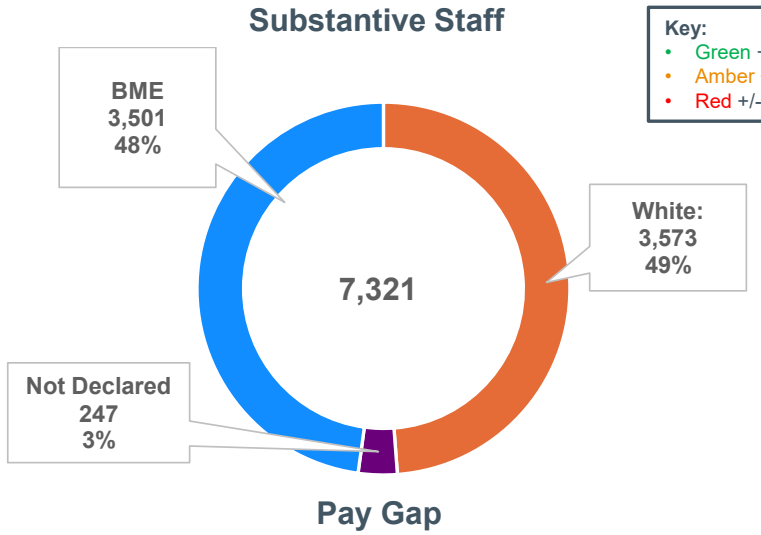
14.6%
Mean Pay Gap

↓ (-0.3% from 2024)

17.2%
Median Pay Gap

↓ (-0.3% from 2024)

Epsom and St Helier Hospital (ESTH)



-4.3%
Mean Pay Gap

↓ (-2.4% from 2024)

-4.2%
Median Pay Gap

↓ (-1.9% from 2024)

Ethnicity Pay Gap

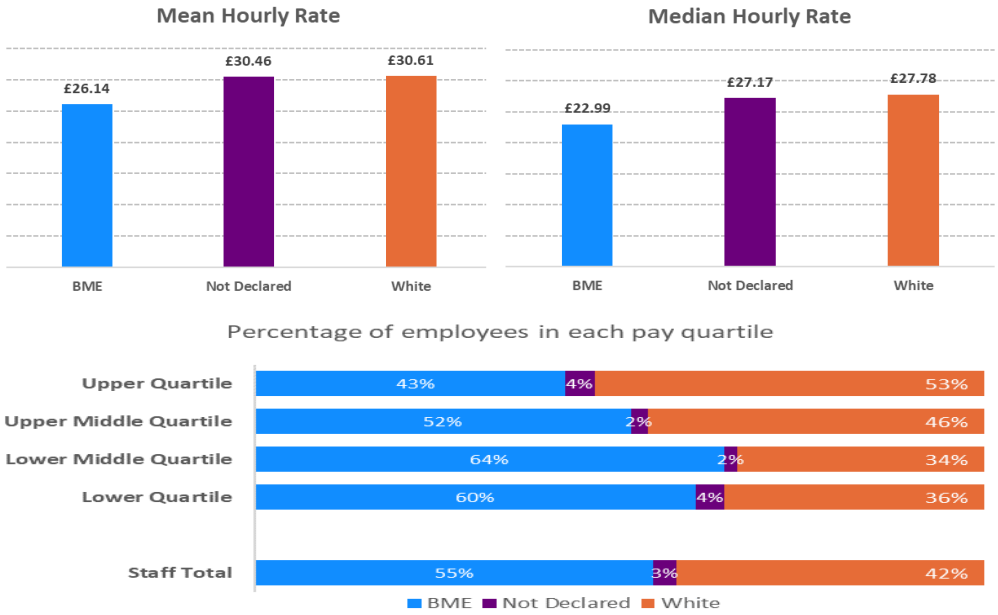
Basic Pay – Mean and Median Gap

Definitions of Pay Gap

The **Mean ethnicity pay gap**: The difference between the average hourly pay of all staff who identify as Black and Minority Ethnic (BME) and the average hourly pay of staff who identify as white.

The **Median ethnicity pay gap**: The difference between the hourly rate of the middle-paid BME staff member and the middle-paid white staff member, when each group is listed separately from highest to lowest paid.

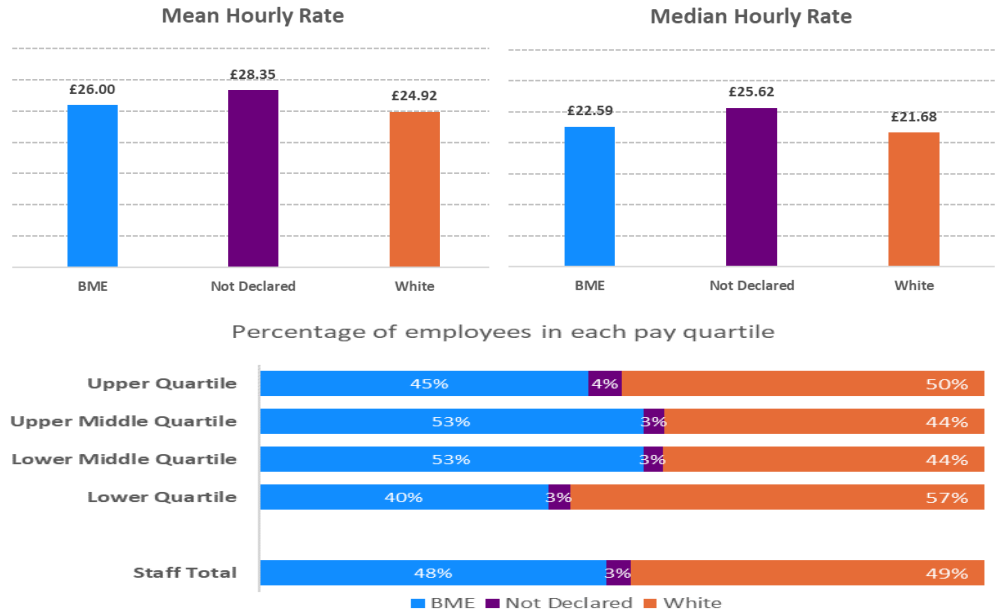
St George's University Hospital (STG)



On 31st March 2025 STG employed 10,826 staff – 5,921 (55%) BME staff, 4,573 (42%) white staff and 332 (3%) not declared. The mean hourly pay for BME staff was £4.47 lower than white staff, representing a pay gap of **14.6%** - a slight improvement from 14.9% the previous year. The median hourly rate was £4.79 lower for BME staff, resulting in a gap of **17.2%**, down from 17.5% last year.

For AfC (including VSM) staff, the average hourly rate for BME staff was £3.11 lower than white staff (**11.9%** pay gap), a decrease from 12.1% in the previous year. The median hourly rate for BME staff is £3.55 lower, resulting in a pay gap of **13.8%**, and an improvement from 15.4% last year.

Epsom and St Helier Hospital (ESTH)



On 31st March 2025 ESTH employed 7,321 staff – 3,501 (48%) BME staff, 3,573 (49%) white staff and 247 (3%) not declared. The mean hourly pay for BME staff was £1.08 higher than white staff, representing a pay gap of **-4.3%** - a further widening from -1.9% in the previous year. The median hourly rate was £0.91 higher for BME staff, resulting in a gap of **-4.2%**, down from -2.3% last year.

For AfC (including VSM) staff, the average hourly rate for BME staff was £0.42 lower than white staff (**1.8%** pay gap), an increase from 1.5% in the previous year. The median hourly rate for BME staff is £0.34 higher, resulting in a pay gap of **-1.6%**, and a decrease from 0% last year.

Ethnicity Pay Gap

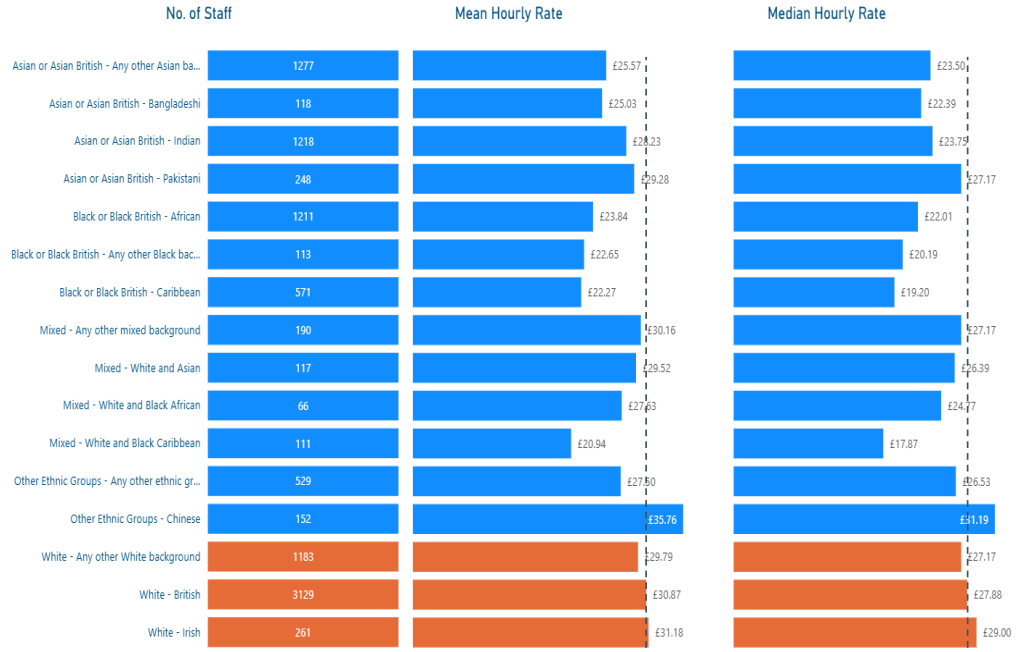
Basic Pay – Mean and Median Gap (Detail)

Definitions of Pay Gap

The **Mean ethnicity pay gap**: The difference between the average hourly pay of all staff who identify as Black and Minority Ethnic (BME) and the average hourly pay of staff who identify as white.

The **Median ethnicity pay gap**: The difference between the hourly rate of the middle-paid BME staff member and the middle-paid white staff member, when each group is listed separately from highest to lowest paid.

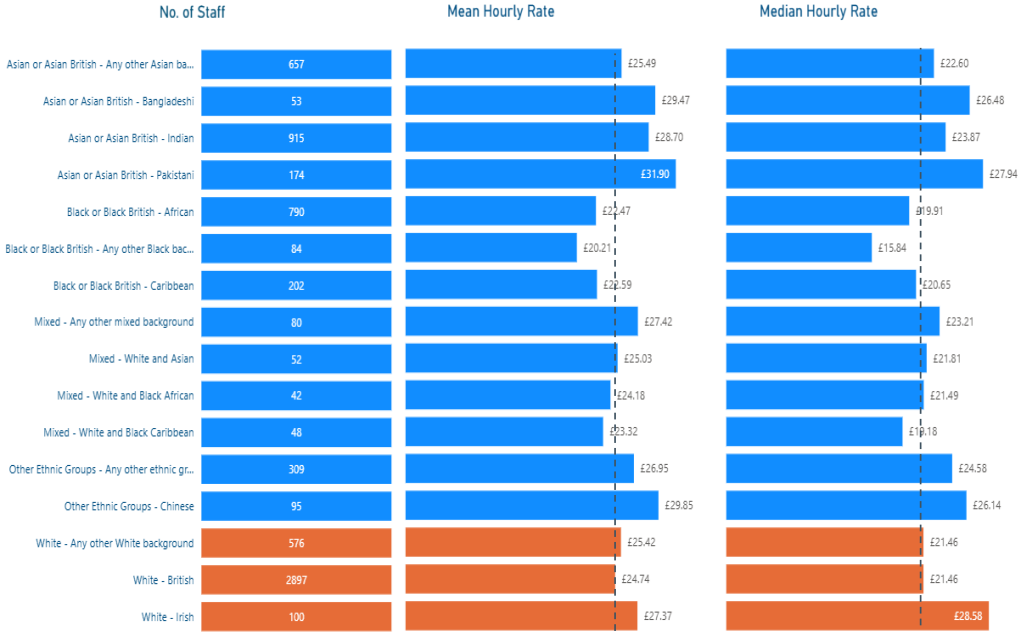
St George's University Hospital (STG)



STG employs 3,129 **White – British** staff, earning an average of **£30.87** per hour. This figure is higher than all other ethnic groups, except for **Chinese** staff, who earn **£4.89** more per hour, and **White – Irish** staff, whose average pay is **£0.31** higher.

The lowest average hourly rates were observed among **Mixed – White and Black Caribbean** staff (**£20.94**), **Black British – Caribbean staff** (**£22.27**), and **Any Other Black Background** staff (**£22.65**).

Epsom and St Helier Hospital (ESTH)



ESTH employs 2,897 **White – British** staff, earning an average of **£24.74 per hour**.

Across the workforce, all **Asian ethnic groups** saw a higher average hourly rate than **White – British** staff, both in terms of mean and median pay.

In contrast, **Black** staff are earning less than **White – British** colleagues, with **Black or Black British – Caribbean** earning **£20.59** per hour and **Black or Black British – African** earning **£22.47** per hour.

Ethnicity Pay Gap

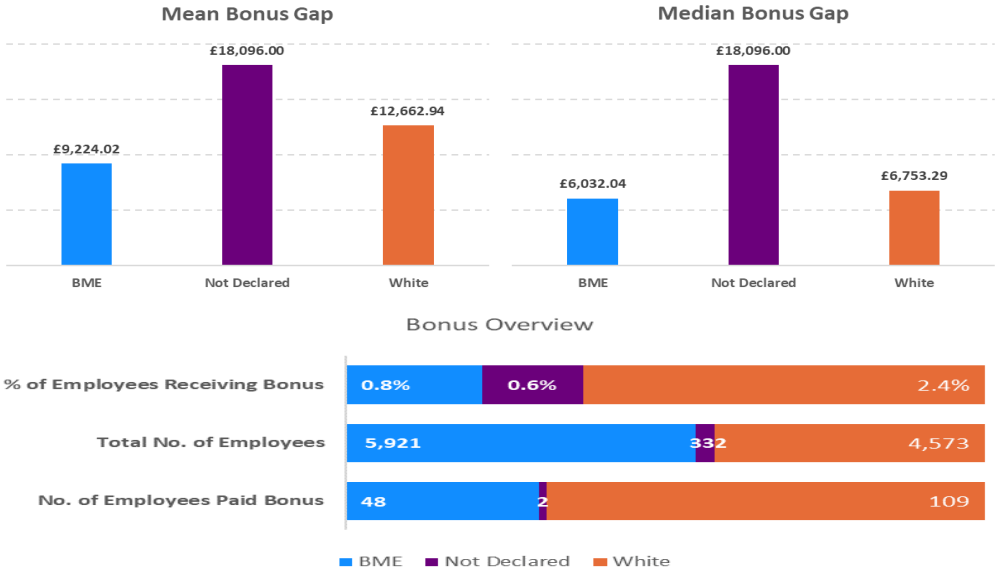
Bonus Pay – Mean and Median Gap

Definitions of Bonus Pay Gap

The **Mean ethnicity bonus gap**: The difference between the average bonus paid to all staff who identify as Black and Minority Ethnic (BME), and the average bonus paid to those who identify as white.

The **Median ethnicity bonus gap**: The difference between the bonus received by the middle-paid BME staff member and the middle-paid white staff member, when each group is ordered separately from highest to lowest bonus.

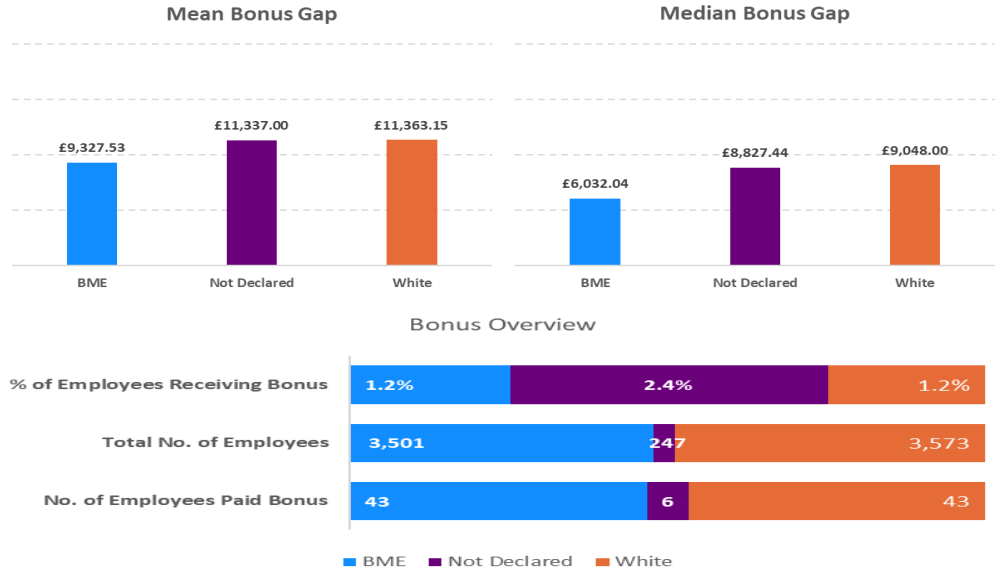
St George's University Hospital (STG)



A total of 159 staff received a bonus payment during this reporting period, all of whom were Consultants. Of these, 48 were BME (representing 0.8% of the BME workforce), 109 were white (representing 2.4% of the white workforce) and 2 had not declared (representing 0.6% of the not declared workforce).

The mean bonus pay for BME staff was £3,438.92 lower than white staff, resulting in a **27.2%** gap - up from 21.8% in 2024. The median bonus gap was £721.25 (resulting in a **10.7%** gap). Mean and median bonus gap widened significantly. In 2024, 618 staff received a bonus – 230 BME, 351 white and 37 not declared.

Epsom and St Helier Hospital (ESTH)



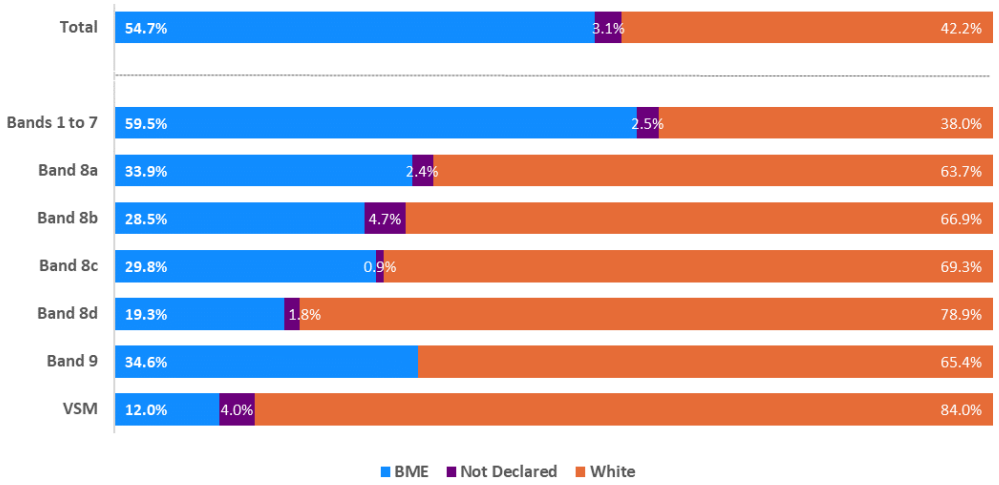
A total of 92 staff received a bonus payment during this reporting period, all of whom were Consultants. Of these, 43 were BME (representing 1.2% of the BME workforce), 43 were white (representing 1.2% of the white workforce) and 6 had not declared (representing 2.4% of the not declared workforce).

The mean bonus pay for BME staff was £2,035.62 lower than white staff, resulting in a **17.9%** gap - down from 24.8% in 2024. The median bonus gap was £3,015.96 (resulting in a **33.3%** gap). Mean bonus gap decreased, while the median increased. In 2024, 299 staff received a bonus – 158 BME, 121 white and 20 not declared.

Ethnicity Pay Gap

Spotlight on AfC (and local contracts)

St George's University Hospital (STG)

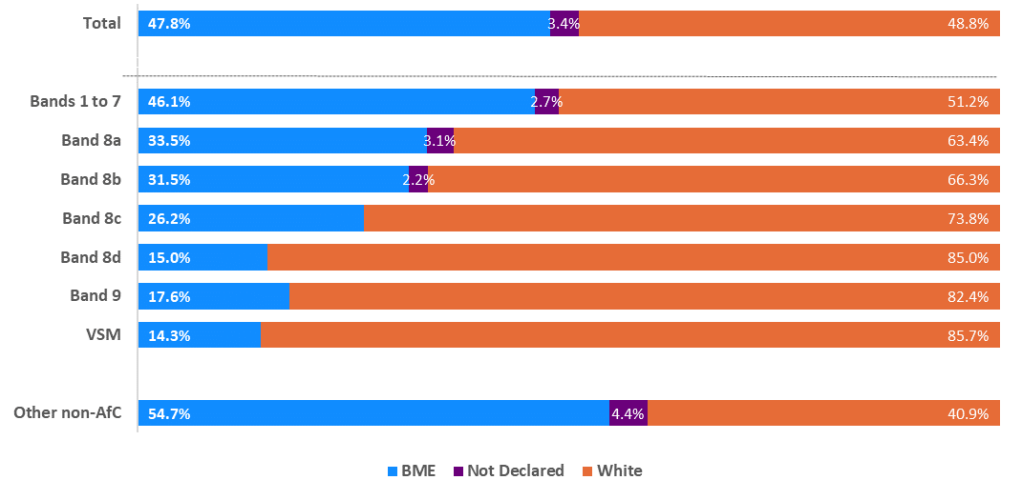


BME staff represent 55% of the overall workforce. Representation is broadly aligned with this figure across bands 4 and 6, ranging between 52% and 58%. Over-representation is observed in bands 2, 3 and 5, with BME staff accounting for 59% or more. The highest proportions of BME staff are seen in band 5 (71.1%) and band 2 (67.9%). Overall, BME staff was represented by 59.5% of the workforce across bands 1 to 7.

Lower representation is evident in senior grades. VSM roles show the lowest proportion of BME staff at 12.0%, followed by band 8d at 19.3% and band 8b at 28.5%.

Rates of 'Not disclosed' were highest in band 4 at 4.8% and band 8b at 4.7%.

Epsom and St Helier Hospital (ESTH)



BME staff represent 48% of the overall workforce. Over-representation is observed in bands 2 and 5, as well as among staff on local contracts in facilities, where BME representation reaches 52% or higher. The highest proportions of BME staff were seen in band 5 (66.5%) and band 2 (56.7%). Overall, 46.1% of staff in bands 1 to 7 are from a BME background.

Lower representation is evident in senior grades. BME staff account for 14.3% of the workforce at VSM level, 15.0% in band 8d, and 17.6% in band 9.

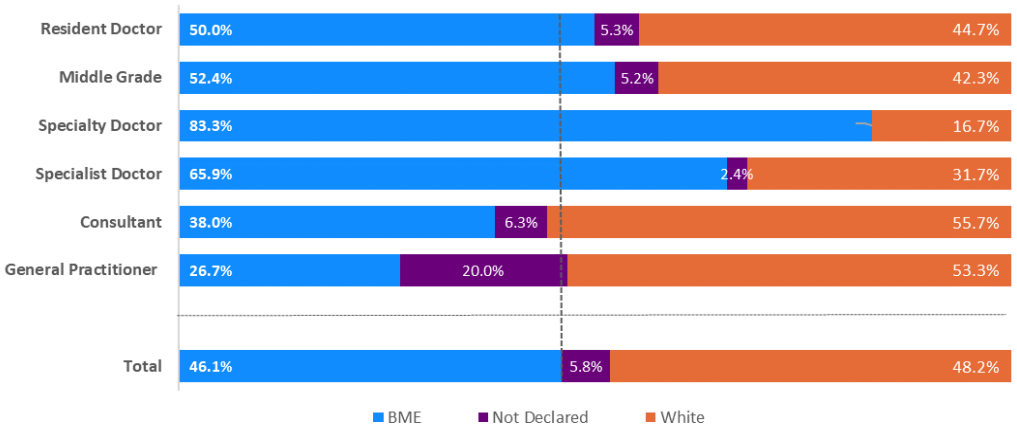
Rates of 'Not disclosed' ethnicity were highest in band 4 and band 7, both at 3.5%.

Ethnicity Pay Gap

Spotlight on Medical Staff

gesh

St George's University Hospital (STG)



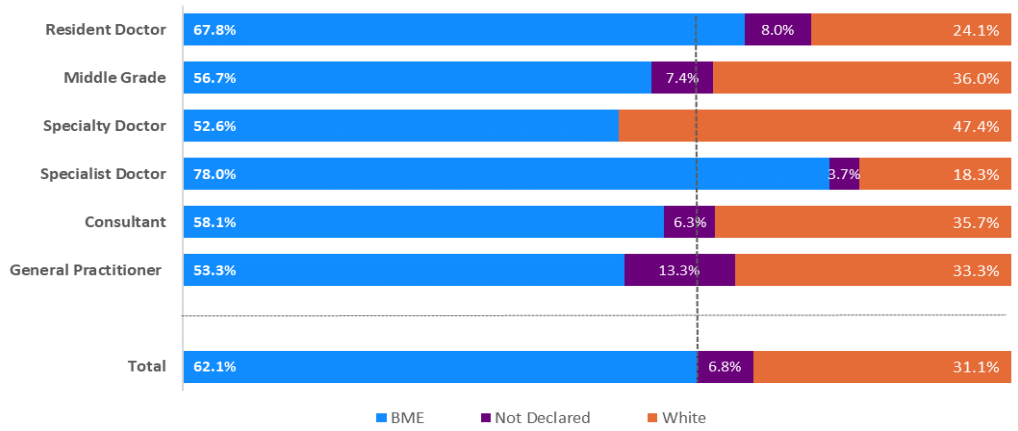
The Medical Staff group includes all 'Doctor in Training' through to 'Consultant' roles.

Within this group, 46.1% of staff identified as Black and Minority Ethnic (BME), 48.2% as white, and 5.8% did not declare their ethnicity.

The mean hourly pay for BME staff was £4.91 lower than for white staff, resulting in a 9.9% pay gap, down from 10.5% last year. The median pay gap stood at £9.59 in favour of white staff (18.6%), also a reduction from 19.5% in 2024.

Focusing on Consultants, BME staff earned £2.53 less per hour on average than their white counterparts - a 3.9% gap, down from 4.3% in the previous year.

Epsom and St Helier Hospital (ESTH)



The Medical Staff group includes all 'Doctor in Training' through to 'Consultant' roles.

Within this group, 62.1% of staff identified as Black and Minority Ethnic (BME), 31.1% as white, and 6.8% did not declare their ethnicity.

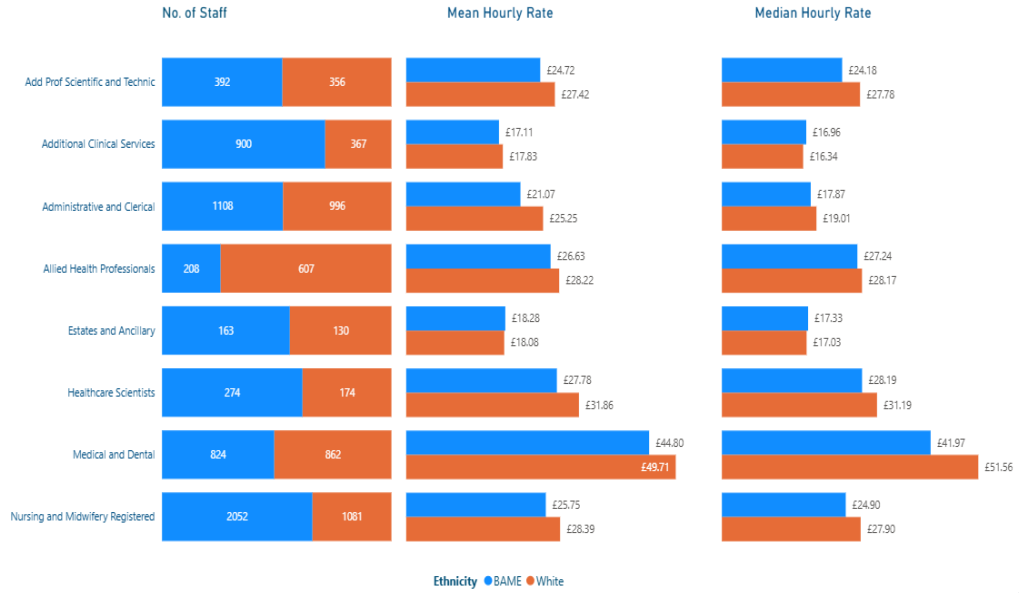
The mean hourly pay for BME staff was £4.58 lower than for white staff, resulting in a 9.2% pay gap, down from 12.5% last year. The median pay gap stood at £4.74 in favour of white staff (10.1%), also a reduction from 13.5% in 2024.

Focusing on Consultants, BME staff earned £4.33 less per hour on average than their white counterparts - a 6.4% gap, up from 5.3% in the previous year.

Ethnicity Pay Gap

Spotlight on Staff Group (excluding Medical and Dental)

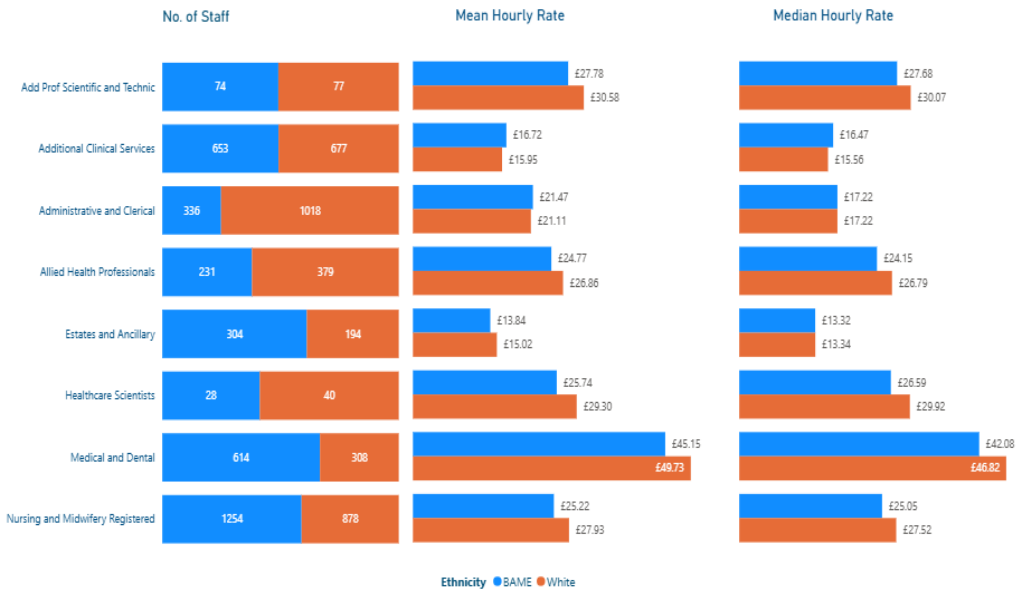
St George's University Hospital (STG)



The largest pay gap in favour of white staff was seen within Admin and Clerical roles, with a **mean gap of 16.5%** (down from 17.4% in 2024) and a **median gap of 6.0%** (up from 2.9% in 2024). Healthcare Scientists followed, with a **mean gap of 12.8%**, then Add Prof Scientific and Technic (**9.8%**), Qualified Nursing staff (**9.3%**), Allied Health Professionals (**5.6%**) and Additional Clinical Services (**4.0%**).

In contrast, pay gaps in favour of BME staff was seen within Estates and Ancillary staff, with a **mean gap of -1.1%** and **median gap of -1.8%**.

Epsom and St Helier Hospital (ESTH)



The largest pay gap in favour of white staff was seen within Healthcare Scientists, with a **mean gap of 12.2%** (down from 13.6% in 2024) and a **median gap of 11.1%** (down from 11.4% in 2024). Qualified Nursing staff followed, with a **mean gap of 9.7%**, then Add Prof Scientific and technic (**9.2%**), Estates and Ancillary (**7.8%**) and Allied Health Professionals (**7.8%**).

In contrast, pay gaps in favour of BME staff was seen within Additional Clinical Services staff, with a **mean gap of -4.8%** and **median gap of -5.8%**, followed by Admin and Clerical with a **mean gap of -1.7%** and a **median gap of 0%**.

Ethnicity Pay Gap

Site Trend 2024 - 2025

St George's University Hospital (STG)

	2024	2025
Mean Pay Gap	14.90%	14.60%
Median Pay Gap	17.50%	17.20%
Mean Bonus Pay Gap	21.80%	27.20%
Median Bonus Pay Gap	0.00%	10.70%
% white staff getting bonus	7.81%	2.38%
% BME getting bonus	4.16%	0.81%

- The mean pay gap decreased by 0.3% in 2025
- The median pay gap decreased by 0.3% in 2025
- The mean bonus gap increased to 27.2%
- The median bonus gap has significantly increased to 10.7%
- The % of white staff receiving a bonus decreased by 5.4%.in 2025
- The % of BME staff receiving bonus decreased by 3.4% in 2025

Unlike gender pay gap, we have two years of ethnicity pay gap data.

Epsom and St Helier Hospital (ESTH)

	2024	2025
Mean Pay Gap	-1.90%	-4.30%
Median Pay Gap	-2.30%	-4.20%
Mean Bonus Pay Gap	24.80%	17.90%
Median Bonus Pay Gap	0.00%	33.30%
% white staff getting bonus	3.29%	1.20%
% BME getting bonus	4.82%	1.23%

- The mean pay gap widened by 2.4% in 2025 and is in favour of BME staff
- The median pay gap widened by 1.9% in 2025 and is favour of BME staff
- The mean bonus gap decreased to 17.9%
- The median bonus gap has significantly increased to 33.3%
- The % of white staff receiving a bonus decreased by 2.1%.in 2025
- The % of BME staff receiving bonus decreased by 3.6% in 2025

Unlike gender pay gap, we have two years of ethnicity pay gap data.

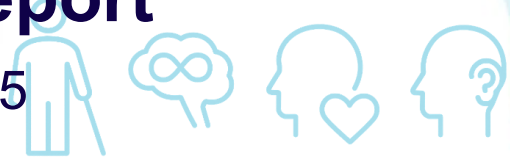
In 2025, national changes to the consultant pay framework led to a significant reduction in the number of Consultants eligible for bonus payments, including adjustments to the structure and criteria for clinical excellence Awards. This has impacted the distribution of bonus pay across the workforce, and as such, direct comparisons with previous years should be approached with caution. In 2024 at STG, 618 consultants received a bonus, compared to 159 in 2025. At ESTH during 2024, 299 consultants received a bonus, compared to 92 in 2025.

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

gesh

Disability Pay Gap Report

Snapshot Date: 31 March 2025



Features: ESR data on 31/03/2025 (extracted on 30 April 2025)
Published: TBC
By: Workforce Systems and Intelligence / Equality, Diversity and Inclusion

Disability Pay Gap

Introduction

While public sector organisations are legally required to report and publish their gender pay gap annually under the Equality Act 2010 and Gender Pay Gap Information Regulations 2017, there is currently no mandatory requirement to report on the disability pay gap.

Despite this, the St George's, Epsom and St Helier University Hospitals and Health Group (gesh) has chosen to examine pay disparities between employees who have declared a disability and those who have not, using snapshot data from **31 March 2025**. This voluntary analysis reflects our commitment to equity, transparency, and better understanding workforce experiences.

As of the snapshot date, the Group employed 18,147 staff, with 10,826 at St George's University Hospitals (STG) and 7,321 at Epsom and St Helier Hospitals (ESTH).

At STG, all staff excluding Medical and Very Senior Management (VSM) roles are on Agenda for Change (AfC) pay scales. At ESTH, in addition to Medical, VSM and AfC staff, 570 Estates and Facilities staff are employed on locally agreed pay frameworks. Non-Executive Directors have been excluded from this analysis due to the nature of their roles and impact on comparative averages.

What is the disability pay gap?
The Disability Pay Gap reflects the difference in average hourly earnings between employees who have declared a disability and those who have not across the organisation.

For example, if staff with declared disabilities are underrepresented in higher-paid roles or work more frequently in part-time or lower-banded positions, the average hourly earnings of disabled staff may be lower than those of non-disabled staff.

It is important to note that the Disability Pay Gap is not the same as equal pay. Equal pay relates to ensuring that employees receive equal pay for the same or similar jobs, or for work of equal value, regardless of disability. It remains unlawful to pay employees differently because of disability status.

What do we have to report on?
Unlike the statutory requirements for Gender Pay Gap reporting, there is currently no legal requirement to report on the Disability Pay Gap. However, gesh has chosen to undertake this analysis voluntarily as part of our commitment to workforce equity and transparency. In line with gender pay gap methodology, we have reported:

- The mean basic disability pay gap
- The median basic disability pay gap
- The proportion of disabled and non-disabled staff within each pay quartile band
- The mean bonus disability pay gap
- The median bonus disability pay gap
- The proportion of disabled and non-disabled staff receiving a bonus payment

***Note**: bonus pay information has been excluded due small group.*

Who is included?
All staff who were employed across the gesh Group on full pay as of 31st March 2025, with the exception of Non-Executive Directors. Bank staff who worked a shift on the snapshot date are included, as are Consultant Additional Programmed Activities.

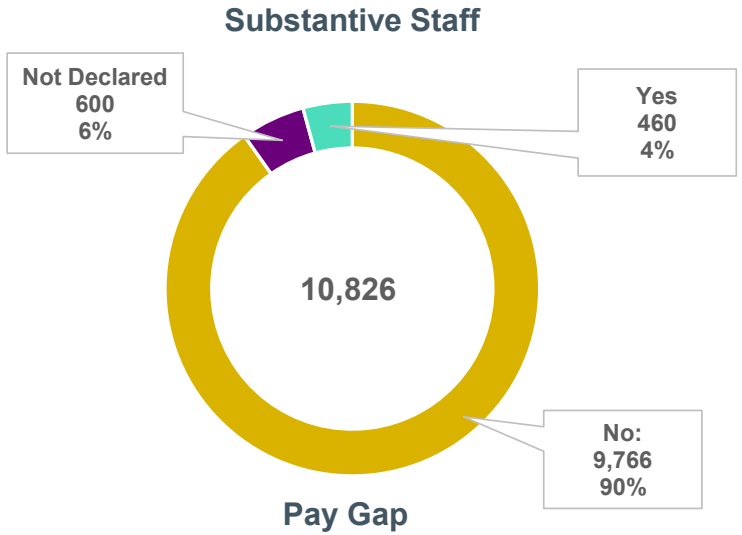
Excluded categories include:
- Employees on half or nil pay due to absence or maternity leave
- Hosted staff (e.g. GP Trainees)
- Agency staff
- General overtime pay and expenses

What pay is covered?
The report covers both basic pay and bonus pay. Bonus pay is defined as any remuneration that is in the form of money, vouchers, securities or options and relates to profit sharing, productivity, performance, incentive or commission. This includes Clinical Excellence Awards and Distinction Awards. Recruitment & retention payments (RRPs) are only included if they are one-off payments at the start of recruitment. Ongoing RRPs are excluded. Workplace vouchers paid in addition to basic salary are included, unless provided via salary sacrifice arrangements. **For detailed information on how the pay gap is calculated please see Appendix A.**

Disability Pay Gap

Site Overview

St George's University Hospital (STG)



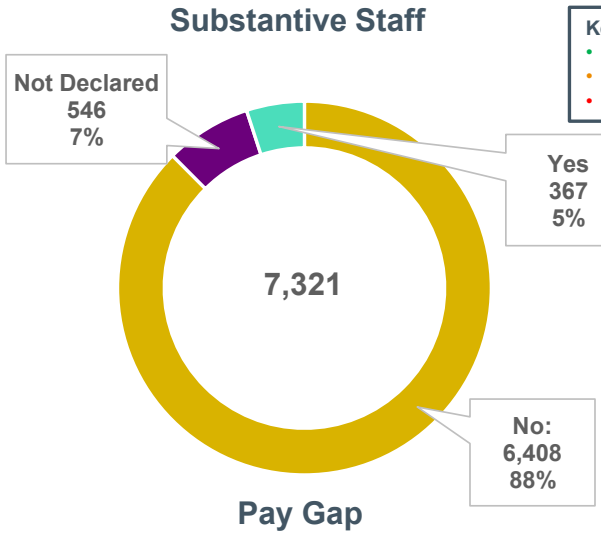
8.2%
Mean Pay Gap

↓ (-2.0% from 2024)

3.8%
Median Pay Gap

↓ (-2.6% from 2024)

Epsom and St Helier Hospital (ESTH)



Key:
- Green +/- 0-3%
- Amber +/-3-5%
- Red +/- 5% & above

7.9%
Mean Pay Gap

↓ (-0.7% from 2024)

2.5%
Median Pay Gap

↑ (+1.7% from 2024)

Disability Pay Gap

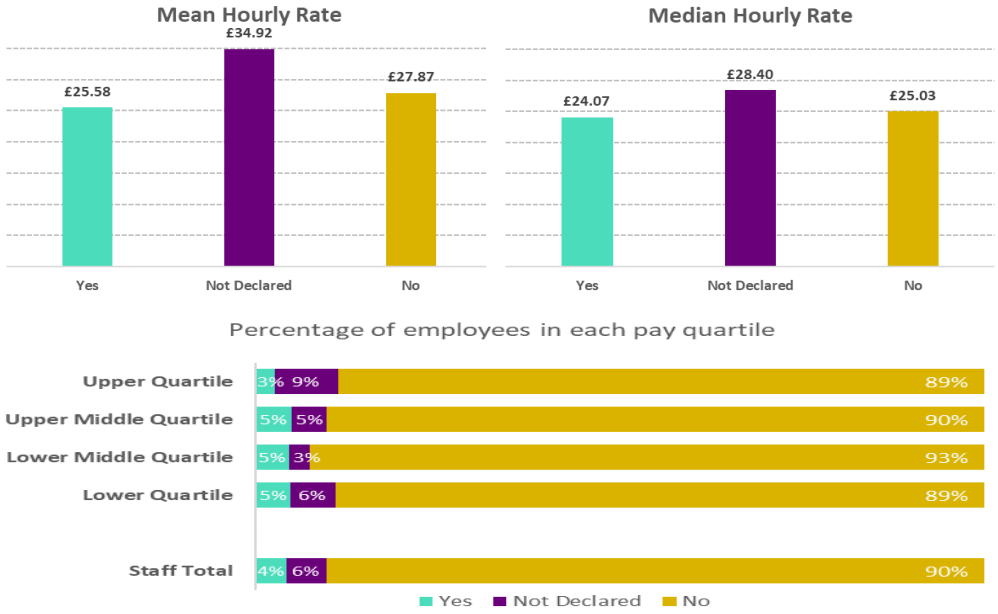
Basic Pay – Mean and Median Gap

Definitions of Pay Gap

The **mean pay gap** is the difference between the average pay of all non-disabled employees and the average pay of all disabled employees.

The **median pay gap** is the difference between the pay of the middle non-disabled and middle disabled, when all non-disabled employees and then all disabled employees are listed from the highest to the lowest paid.

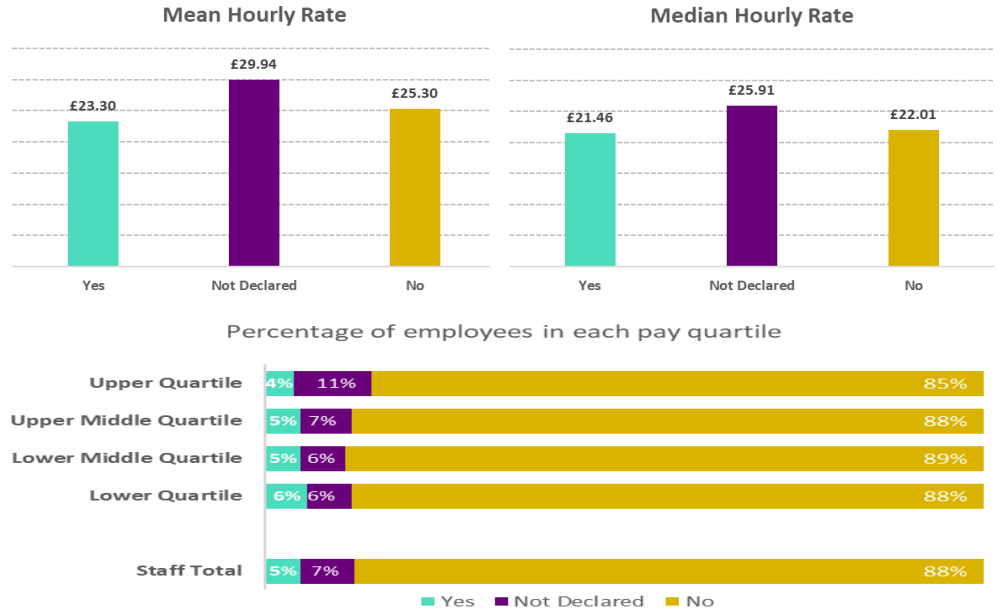
St George's University Hospital (STG)



On 31st March 2025 STG employed 10,826 staff – 9,766 (90%) were non-disabled, 460 (4%) were disabled and 600 (6%) not declared. The mean hourly pay for disabled staff was £2.29 lower than non-disabled, which is a gap of **8.2%** (a decrease from 10.2% in the previous year). Disabled median rate was £0.96 lower than non-disabled, which is a gap of **3.8%** (a decrease from 6.4% in the previous year).

For AfC (including VSM) staff, average hourly rate of disabled staff was £0.18 lower than non-disabled (**0.7%** pay gap), down from 4.7% last year. The median hourly rate for disabled and non-disabled staff is £22.91. resulting in a pay gap of **0.0%**, and an improvement from 1.0% last year.

Epsom and St Helier Hospital (ESTH)



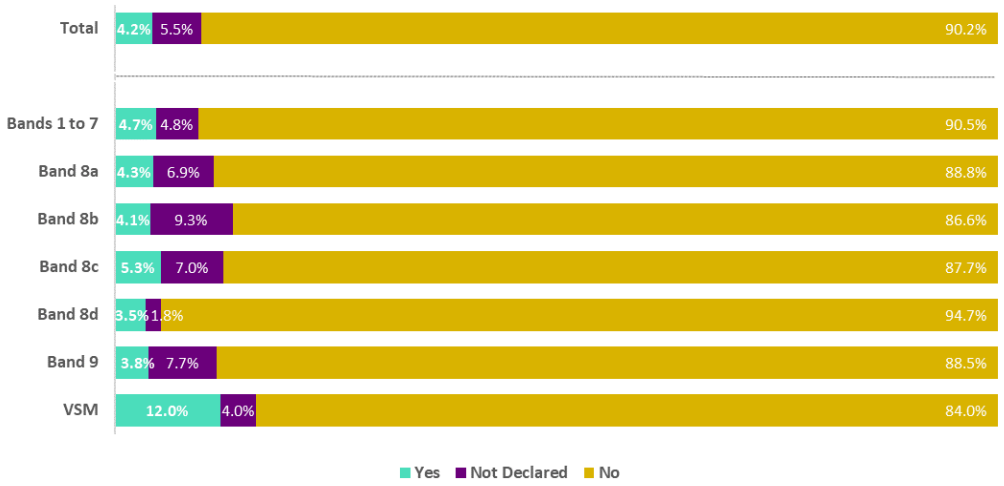
On 31st March 2025 ESTH employed 7,321 staff – 6,408 (88%) were non-disabled, 367 (5%) were disabled and 546 (7%) not declared. The mean hourly pay for disabled staff was £2.00 lower than non-disabled, which is a gap of **7.9%** (a decrease from 8.6% in the previous year). Disabled median rate was £0.55 lower than non-disabled, which is a gap of **2.5%** (an increase from 0.8% in the previous year).

For AfC (including VSM) staff, the average hourly rate for disabled staff was £0.17 lower than for non-disabled staff (**0.7%** pay gap), a decrease from 1.3% in the previous year. The median hourly rate for disabled and non-disabled staff is £21.46, resulting in a pay gap of **0.0%** (same as last year).

Disability Pay Gap

Spotlight on AfC (and local contracts)

St George's University Hospital (STG)

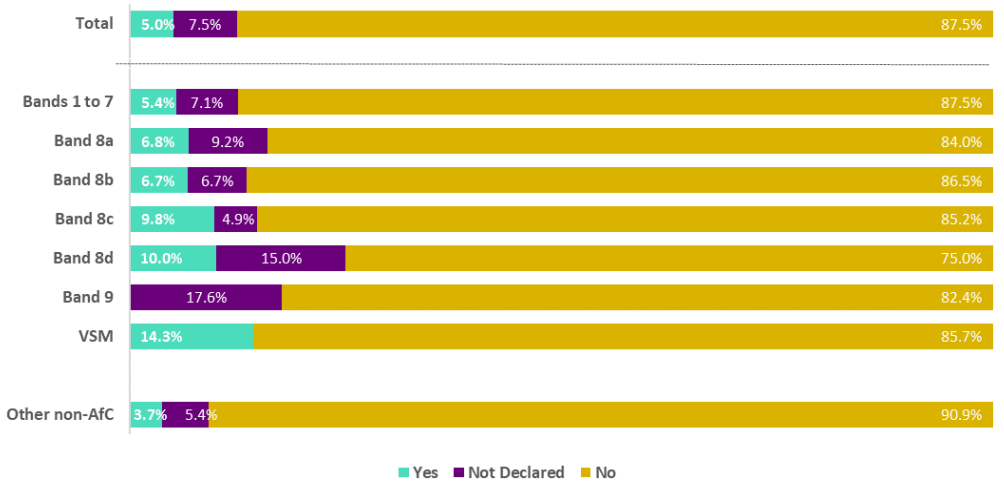


Disabled staff represent **4%** of the overall workforce. Representation is broadly aligned with this figure across bands **2, 4, 5, 8a, 8b, 8d and 9** (ranging from **3.5% and 4.5%**). Over-representation is seen at bands **7, 8c and VSM**, with disabled staff accounting for **5% or more**.

The highest disability declaration was found at **VSM (12%)** and **band 8c (5.26%)**.

However, **low overall declaration rates** make robust pay gap analysis challenging, highlighting the need for ongoing awareness and engagement. Bands 8b saw the highest not declared rate at **9.3%**.

Epsom and St Helier Hospital (ESTH)



Disabled staff represent **5%** of the overall workforce. Representation is broadly consistent across bands **5 and 7** (ranging from **4.5% to 5.5%**), with **over-representation** in bands **3, 4, 8a to 8d and VSM**, where disabled staff account for **6% or more**.

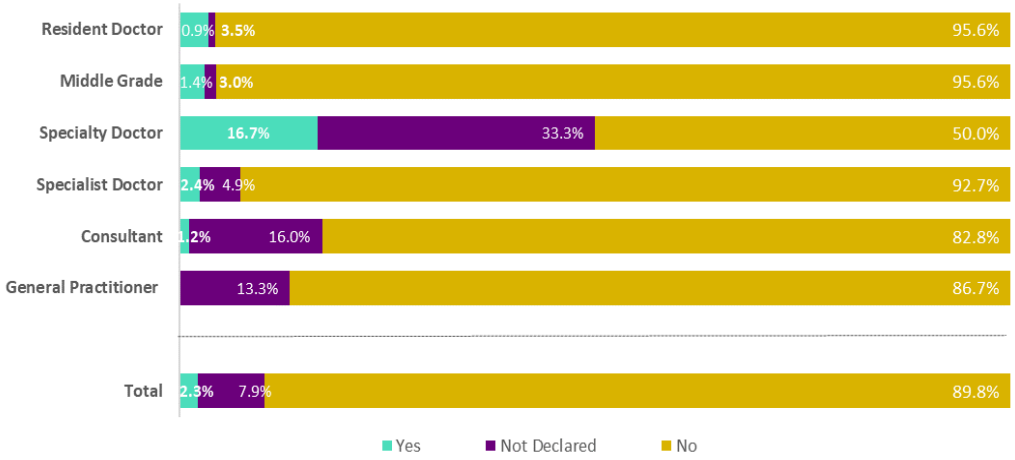
The highest disability declaration rates were at **VSM (14.3%)** and **band 8d (10.0%)**.

However, **low declaration volumes overall** continue to challenge pay gap analysis, reinforcing the need for greater staff awareness and engagement. Notably, **bands 8d (15.0%)** and **band 9 (17.6%)** had the highest proportions of staff with undeclared disability status.

Disability Pay Gap

Spotlight on Medical Staff

St George's University Hospital (STG)



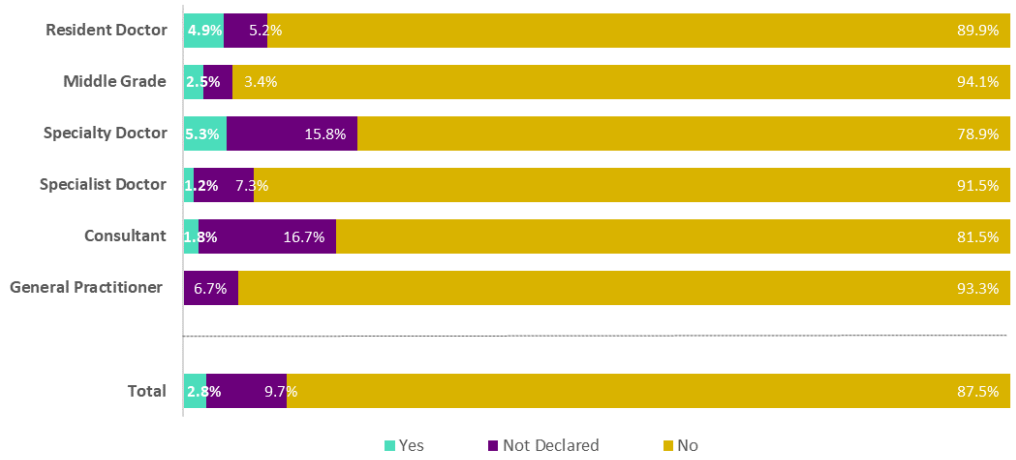
The Medical Staff group includes all 'Doctor in Training' through to 'Consultant' roles.

Within this group, **2.3%** of staff declared a disability, **7.9%** did not declare, and **89.8%** were non-disabled.

The **mean hourly pay gap** between disabled and non-disabled staff is **£6.03** in favour of non-disabled staff (a **13.2%** gap) and is same as last year. The **median gap** is **£3.81**, or a pay gap of **9.0%**, also a decrease from **17.2%** in 2024.

Among **Consultants**, disabled staff earned **£2.68** per hour less on average than non-disabled colleagues - a **4.3%** gap, up from **0.9%** last year.

Epsom and St Helier Hospital (ESTH)



The Medical Staff group includes all 'Doctor in Training' through to 'Consultant' roles.

Within this group, **2.8%** of staff declared a disability, **9.7%** did not declare, and **87.5%** were non-disabled.

The **mean hourly pay gap** between disabled and non-disabled staff is **£8.87** in favour of non-disabled staff (a **19.5%** gap) and is a slight decrease from 19.8% from 2024. The **median gap** is **£10.44**, or a pay gap of **24.8%**, also a decrease from **28.3%** in 2024.

Among **Consultants**, disabled staff earned **£0.98** less per hour on average - a **1.5%** gap, compared to a reversed gap of **-1.6%** in 2024.

Disability Pay Gap

Spotlight on Staff Group (excluding Medical and Dental)

St George's University Hospital (STG)

The largest pay gap in favour of non-disabled staff was seen within Estates and Ancillary roles, with a **mean gap of 12.3%** (up from 11.9% in 2024) and a **median gap of 13.2%** (down from 13.3% in 2024). Allied Health Professionals followed, with a **mean gap of 9.1%.** Smaller mean pay gaps were reported in Add Prof Scientific and technic (**2.2%**) and Additional Clinical Services (**0.2%**).

In contrast, pay gaps in favour of disabled staff was seen within Qualified Nursing staff, with a **mean gap of -1.2%** and **median gap of -3.8%**. Admin and clerical also showed a small gap in favour of disabled staff (**-0.6% mean gap**) and Healthcare Scientists (**-0.6% mean gap**).

Epsom and St Helier Hospital (ESTH)

The largest pay gap in favour of non-disabled staff was seen within Admin and Clerical, with a **mean gap of 9.1%** (down from 9.4% in 2024) and a **median gap of 7.7%** (no change to 2024). Other mean pay gaps were reported in Allied Health Professions (**7.8%**) Add Prof Scientific and technic (**2.9%**) and Additional Clinical Services (**0.6%**).

In contrast, pay gaps in favour of disabled staff was seen within Healthcare Scientists, with a **mean gap of -18.6%** and **median gap of -15.5%**. Qualified Nursing staff also saw a small gap in favour of disabled staff (**-6.9% mean gap**) and Estates and Ancillary (**-1.5% mean gap**).

Disability Pay Gap

Site Trend 2024 - 2025

St George's University Hospital (STG)

	2024	2025
Mean Pay Gap	10.20%	8.20%
Median Pay Gap	6.40%	3.80%
Mean Bonus Pay Gap	5.00%	41.20%
Median Bonus Pay Gap	8.80%	0.00%
% non disabled getting bonus	5.17%	0.99%
% disabled getting bonus	1.06%	0.22%

- The mean pay gap decreased by 2.0% in 2025
- The median pay gap decreased by 2.6% in 2025
- The mean bonus gap has significantly increased in 2025
- The median bonus gap has decreased to 0.0% in 2025
- The % of non-disabled staff receiving a bonus decreased by 4.2%.in 2025
- The % of disabled staff receiving bonus decreased to 0.2%.

Unlike gender pay gap, we have two years of ethnicity pay gap data.

Epsom and St Helier Hospital (ESTH)

	2024	2025
Mean Pay Gap	8.60%	7.90%
Median Pay Gap	0.80%	2.50%
Mean Bonus Pay Gap	39.50%	100.00%
Median Bonus Pay Gap	0.00%	100.00%
% non disabled getting bonus	3.54%	0.95%
% disabled getting bonus	0.83%	0.00%

- The mean pay gap decreased by 0.7% in 2025
- The median pay gap increased by 1.7% in 2025
- The mean bonus gap increased to 100% due to no disabled staff receiving a bonus
- The median bonus gap increased to 100% due to no disabled staff receiving a bonus
- The % of non-disabled staff receiving a bonus decreased to 1.0%
- The % of disabled staff receiving bonus decreased to 0%

Unlike gender pay gap, we have two years of ethnicity pay gap data.

In 2025, national changes to the consultant pay framework led to a significant reduction in the number of Consultants eligible for bonus payments, including adjustments to the structure and criteria for clinical excellence Awards. This has impacted the distribution of bonus pay across the workforce, and as such, direct comparisons with previous years should be approached with caution. In 2024 at STG, 618 consultants received a bonus, compared to 159 in 2025. At ESTH during 2024, 299 consultants received a bonus, compared to 92 in 2025.

Appendix: A

Calculating the Pay Gap

To calculate the pay gap, we first determine the average hourly pay for all valid employees within the month of March 2025. For each employee, the total pay - including basic salary, high cost allowance, any extra duties etc. – are totalled, and then divide by the number of hours worked that month. This gives an average hourly rate. Note: The figures in this appendix are an **example dataset** and related to gender (but also applicable to ethnicity and disability calculations) to show the calculations, they are not the figures for a specific reporting period.

Calculating the '**mean**' (i.e. average) hourly pay for all male employees and all female employees:

- Total the average hourly pay for each gender and then divide this figure by the number of employees in each group.
- A sample of 14 employees is shown below to assist with understanding these calculations:

For each employee their total monthly pay for March is calculated and then divided by the hours worked to determine an average hourly pay.

To get the mean hourly pay for the two genders all the average hourly rates are added together and then divided by the number of employees (in this case, 7):

- Female: (11.87 + 12.14 + 13.85 + 16.73 + 22.52 + 23.97 + 25.7) / 7 = £18.11
- Male: (13.35 + 18.48 + 19.68 + 24.09 + 33.31 + 52.73 + 52.99) / 7 = £30.66

To calculate the Agenda for Change (AfC) staff only, medical staff must be removed before the calculation. In this example there are only male medical staff (indicated by an asterisk * in the table), and so for just AfC male staff the calculation is (13.35 + 18.48 + 19.68) / 3 = £17.17.

To get the mean pay gap the calculation is the difference between the male and female hourly rates divided by the male hourly rate:

- 30.66 – 18.11 = 12.55
- 12.55 / 30.66 = 0.4093, which is 40.93%

For AfC only the calculation would be:

- 17.17 – 18.11 = -0.94
- -0.94 / 17.17 = -0.055, which is -5.48%. A minus value indicates that the pay gap favours female.

Gender	Employee	Basic Pay	High Cost Allowance	Additional	Total	Hours worked	Average Hourly Pay
Female	Training Nurse Associate	£1,567.75	£366.67		£1,934.42	162.95	£11.87
	Administrator	£1,288.80	£293.33		£1,582.13	130.36	£12.14
	HCA - Acute Medicine	£676.66	£168.67	£193.11	£1,038.44	74.96	£13.85
	Staff Nurse - Critical Care	£2,271.67	£454.33		£2,726.00	162.95	£16.73
	Research Nurse	£3,105.58	£564.75		£3,670.33	162.95	£22.52
	Receptionist	£3,341.00	£564.75		£3,905.75	162.95	£23.97
	Senior Staff Nurse - Critical Care	£3,105.58	£564.75	£518.03	£4,188.36	162.95	£25.70
Male	Theatre HCA	£1,585.00	£366.67	£224.34	£2,176.01	162.95	£13.35
	Staff Nurse - Acute Medicine	£2,509.33	£501.87	£55.27	£3,066.47	165.95	£18.48
	Anaesthetic Nurse	£2,509.33	£501.87	£235.53	£3,246.73	164.95	£19.68
	Specialty Registrar – Dermatology*	£4,006.25		£180.17	£4,186.42	173.81	£24.09
	Specialty Registrar - A&E*	£4,006.83		£1,782.90	£5,789.73	173.81	£33.31
	Consultant – Radiology*	£8,477.92		£685.84	£9,163.76	173.8	£52.73
	Consultant – Anaesthetics*	£8,477.92		£731.40	£9,209.32	173.8	£52.99

Outstanding care every time

Appendix: A

Calculating the Pay Gap

To calculate the GPG we first determine the average hourly pay for all valid employees within the month of March 2025. For each employee, the total pay - including basic salary, high cost allowance, any extra duties etc. – are totalled, and then divided by the number of hours worked that month. This gives an average hourly rate. Note: The figures in this appendix are an **example dataset** and related to gender (but also applicable to ethnicity and disability calculations) to show the calculations, they are not the figures for a specific reporting period.

Calculating the '**median**' (i.e. middle point) hourly pay for all male employees and all female employees:

- Rank the hourly pay rate of each employee, from smallest to largest, again separated by gender, and take the middle point hourly pay in the ranking. This is your 'median' value.
- In the given example the median hourly rate for both female and male staff is highlighted below:

The calculation for the pay gap remains the same:

- 24.09 – 16.73 = 7.36
- 7.36 / 24.09 = 0.3055, which is 30.55%

Excluding medical staff there is again no change in the female median value, but the median hourly rate for male staff is £18.48:

- 18.48 – 16.73 = 1.75
- 1.75 / 18.48 = 0.094, which is 9.47%

Gender	Employee	Basic Pay	High Cost Allowance	Additional	Total	Hours worked	Average Hourly Pay
Female	Training Nurse Associate	£1,567.75	£366.67		£1,934.42	162.95	£11.87
	Administrator	£1,288.80	£293.33		£1,582.13	130.36	£12.14
	HCA - Acute Medicine	£676.66	£168.67	£193.11	£1,038.44	74.96	£13.85
	Staff Nurse - Critical Care	£2,271.67	£454.33		£2,726.00	162.95	£16.73
	Research Nurse	£3,105.58	£564.75		£3,670.33	162.95	£22.52
	Receptionist	£3,341.00	£564.75		£3,905.75	162.95	£23.97
	Senior Staff Nurse - Critical Care	£3,105.58	£564.75	£518.03	£4,188.36	162.95	£25.70
Male	Theatre HCA	£1,585.00	£366.67	£224.34	£2,176.01	162.95	£13.35
	Staff Nurse - Acute Medicine	£2,509.33	£501.87	£55.27	£3,066.47	165.95	£18.48
	Anaesthetic Nurse	£2,509.33	£501.87	£235.53	£3,246.73	164.95	£19.68
	Specialty Registrar - Dermatology	£4,006.25		£180.17	£4,186.42	173.81	£24.09
	Specialty Registrar - A&E	£4,006.83		£1,782.90	£5,789.73	173.81	£33.31
	Consultant - Radiology	£8,477.92		£685.84	£9,163.76	173.8	£52.73
	Consultant - Anaesthetics	£8,477.92		£731.40	£9,209.32	173.8	£52.99

Outstanding care every time

Group Board Meeting (Public)

Meeting in Public on Thursday, 05 March 2026

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

Executive Summary

This report sets out the key issues considered by the Infrastructure Committees at their meetings on 23 January 2026 (Estates & Facilities focus) and 20 February 2026 (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 and discussed a written update from GCOFIE on the key developments including Capital Bids (extensive work was ongoing to secure funds via the Estate Safety Fund and NHS Standards Fund), Epsom Car Park (positive progress was reported on Capital Departmental Expenditure Limit and cash requests), and ongoing legal discussions with St Kilda's and Legal & General.
2. **ESTH Estate and Facilities Update (Fire and Water Safety)**
   The Committees reviewed both fire and water safety updates. The agreed assurance level for the Fire safety was Limited Assurance given the two active fire notices. The Committees recommended that a confidential paper regarding the E Block decant strategy and staff engagement should be presented to the private Board at a future meeting.
3. **Cyber Security**
   The Committees reviewed the report which set out the work underway to develop a cybersecurity strategy, including a focus on the Group's approach to scenario-based resilience testing and supply chain risk management. The Committees noted that the Cyber Security Strategy was not optional but an essential organisational safeguard to protect patients, maintain service continuity and meet statutory obligations.

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 January and February 2026.

Committee Assurance	
Committee	Infrastructure 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

See section 4.5 - Digital Risk Management Update

CQC Theme

☐ Safe	☐ Effective	☐ Caring	☐ Responsive	☒ Well Led

NHS system oversight framework

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

Financial implications

Set out in the paper.

Legal and / or Regulatory implications

Set out in the paper.

Equality, diversity and inclusion implications

N/A

Environmental sustainability implications

N/A

Infrastructure Committees Report
Group Board, 05 March 2026

1.0 Purpose of paper

1.1 This report sets out the key issues considered by the Infrastructure Committees' meetings on 23 January 2026 and 20 February 2026 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 23 January 2026 and 20 February 2026, the Committees considered the following items of business:

23 January 2026 (Estates & Facilities focus)	20 February 2026 (IT focus)
• Group Chief Officer - Facilities, Infrastructure & Environment Update • ESTH Water Safety • ESTH Fire Safety Update • SGUH Estate and Facilities Update • PACS Update	• Digital Delivery Update • Cyber Security • Digital Risk Management Update • Digital Priorities 2026/27 • Infrastructure Committees: Digital forward look • Access to Information by Staff Working in London Community Settings • Committee Effectiveness 2025/26

2.2 The Committees were quorate on 23 January 2026 and 20 February 2026. 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 and discussed a written update from the Group Chief Officer Facilities, Infrastructure and Environment (GCOFIE) on the following key developments:

- Capital Bids: Extensive work was ongoing to secure funds via the Estate Safety Fund and NHS Standards Fund. Further clarification was awaited from NHSE, but it is likely that the Estate Safety Fund would be oversubscribed.
- Epsom Car Park: Positive progress was reported on CDEL (Capital Departmental Expenditure Limit) and cash requests, though written confirmation was pending. Legal discussions with St Kilda's and Legal & General were ongoing.
- ITU Update: Contractor Vanguard had shortened the delivery programme, with practical completion now expected in May 2026 and patient treatment likely by July/August 2026.

- Property Interests: GCOFIE proposed a comprehensive review of the Group's property interests and leases.

3.2 ESTH Fire Safety Update

The Committees reviewed the report that and noted that the engagement with Surrey Fire and Rescue was positive. They appeared receptive to realistic timelines for estates work. The ongoing risks around Housekeeping remained a challenge in clinical areas. Efforts were focused on ensuring escape routes remained clear. GCOFIE added that work was moving at a reasonable pace and that it was treated as a high priority within the capital plan, though it must be balanced against the needs of an operational hospital. The Committees noted the report and agreed on a Limited Assurance rating given the two active fire notices.

3.3 ESTH Water Safety Update

The Committees received the water safety update and noted that, while current filters provided short-term safety, the pipework required replacement. The plan was to begin planning for the decant and closure of E Block in January 2027 to facilitate a long-term solution. The Committees recommended that a confidential paper regarding the E Block decant strategy and staff engagement should be presented to the private Board at a future meeting.

3.4 Committee Effectiveness 2025/26

The Committee effectiveness survey 2025/26 found that the Committee was operating reasonably effectively (with an equal split between those who regarded the Committee as operating very effectively or somewhat effectively). A number of strengths and areas of good practice were identified including having a dedicated Committee to consider infrastructure issues, the role of the Committee in promoting greater understanding of key infrastructure risks and the quality of discussions at the Committee. Areas for improvement included the scope to take a more integrated approach to infrastructure across estates and digital, the quality of papers and a suggestion to consider introducing visits across the estates to help promote greater real world awareness of estates challenges.

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 Digital Delivery Update

The Committees received and noted the key updates including action to build strong digital foundations (departmental restructure, substantive CDIO recruitment, changes to operating model, and development of a capital plan for IT infrastructure from 26/27 onwards). Pursuing digital transformation in the priority areas was supported by the Board at its December 2025 discussion on digital strategy (including transforming our staff's experience of the EPR via innovation like ambient voice technology, building a digital front door to our services for patients and building a digital front door to corporate services by aligning digital platforms across gesh.

4.3 Cyber Security Update

The Committees reviewed the report which set out the work underway to develop a cybersecurity strategy, including a focus on the Group's approach to scenario-based resilience testing and supply chain risk management. The Committees noted that the Cyber Security Strategy was not optional but an essential organisational safeguard to protect patients, maintain service continuity and meet statutory obligations. To address this gap, the IT team,

supported by a preferred partner will produce the cyber strategy and tactical plan, improve risk management and introduce maturity assessments.

4.4 SGUH Estate and Facilities Update

The Committees noted the report which outlined the latest updates from the Estates, Facilities and Medical Physics and Clinical Engineering teams, with a focus on Estates and Engineering compliance for St George's Hospital. The level of assurance overall was rated as Reasonable Assurance at this time for the SGH areas of the gesh E&F group**.** The Premises Assurance Model (PAM) had been committed for 2025/26, and this had seen improvements in most areas as reported in September 2025 to the Committee. The Division continued to support the cost improvement programme, but this remained a challenge. The business planning and budget setting for 2026/27 was in progress.

5.0 Other issues considered by the Committees

5.1 Digital Forward Look

The Committees noted 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 Picture Archiving and Communication System (PACS) Project Update

The Committees noted the update on the SWL Picture Archiving and Communication System (PACS) Programme. The report focused on the progress made since the previous report and outlined the details of the agreement on the clinical scope for go live and the status of key programme components required to support a formal restart.

5.3 Digital Risk Management Update

The Committees noted the update on IT-related risks on the corporate risk register. The 3 extreme risks for each site were being finalised, relating to Data Centre Failure, Core Network Infrastructure Failure and Cybersecurity Attack. The revised risks would be brought to the Risk and Assurance Group on 23 February 2026 for approval. Whilst all risks on the register were dynamic/subject to ongoing review, it was likely that the Cybersecurity risk in particular would need further review as we continued to develop our cybersecurity strategy.

5.4 Access to Information by Staff Working in London Community Settings

A recent report commissioned by NHS London and produced by the South London HIN (Health Innovation Network) on information access by staff working in community settings had highlighted significant barriers that could impact patient and staff safety, workforce productivity, and the quality of care. These challenges also risk creating inefficiencies across the wider health and care system, affecting integration and continuity of services. The London region highlighted a range of actions for providers to take, and asked providers to submit a response to the region – including assurance that the Board is sighted/content. The London region requested a response by 26 February 2026, which was being drafted by the team.

5.5 Digital Priorities 2026/27

The Committees reviewed the draft priorities ahead of a final version being developed in the coming weeks and requested that the digital priorities be aligned with the group transformation portfolio and with the recently submitted financial plan for 2026/27.

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 January and February 2026.