Group Board

Agenda

Meeting in Public on Friday, 08 May 2026, 12:30 – 15:50

Whitehall Lecture Theatre, Education Block, St Helier Hospital, Wrythe Lane, Sutton SM5 1AA

Feedback from Board visits					
Time	**Item**	**Title**	**Presenter**	**Purpose**	**Format**
12:30	-	Feedback from visits to various parts of the site	Board members	-	Verbal

Introductory items					
Time	**Item**	**Title**	**Presenter**	**Purpose**	**Format**
13:00	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
13:05	1.5	Feedback from Inclusion Board	Inclusion Board Members	Discuss	Verbal
13:20	1.6	Group Chief Executive Officer's Report	GCEO	Review	Report

Quality and Safety					
Time	**Item**	**Title**	**Presenter**	**Purpose**	**Format**
13:30	2.1	Quality Committees Report	Committee Chair	Assure	Report
13:40	2.3	Maternity Services Report	GCNO	Assure	Report
13:55	2.5	Quality Governance Improvement Plan	GCMO / GCNO	Assure	Report
14:05	-	*Break*			

Finance, Performance and Audit					
Time	**Item**	**Title**	**Presenter**	**Purpose**	**Format**
14:25	3.1	Finance and Performance Committees Report	Committee Chair	Assure	Report
	3.2	Finance Report – Year End 2025/26	GCFO	Review	Report
14:35	3.3	Integrated Quality and Performance Report	GDCEO	Review	Report
14:45	3.4	Audit and Risk Committees Report	Committee Chair	Assure	Report

People					
Time	**Item**	**Title**	**Presenter**	**Purpose**	**Format**
14:55	4.1	People Committees Report	Committee Chair	Assure	Report
15:05	4.2	NHS Staff Survey 2025 Report	GCPO	Review	Report

People					
Time	**Item**	**Title**	**Presenter**	**Purpose**	**Format**
15:20	4.3	Freedom to Speak Up Report	GCCAO / FTSUG	Review	Report

Items for Noting					
Time	**Item**	**Title**	**Presenter**	**Purpose**	**Format**
-	5.1	Fit and Proper Persons Annual Compliance Report	GCCAO	Assure	Report

Closing items					
Time	**Item**	**Title**	**Presenter**	**Purpose**	**Format**
15:35	6.1	New Risks and Issues Identified	Chair	Note	Verbal
	6.2	Reflections on the Meeting	Chair	Note	Verbal
	6.3	Questions from members of the public and Governors of St George's*	Chair		Verbal
	6.4	Any Other Business	All	Note	Verbal
15:50	-	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	Group Chair	Chair
Matthew Shaw	Group Chief Executive Officer	GCEO
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
James Blythe	Managing Director – ESTH	MD-ESTH
Elaine Clancy	Interim Group Chief Nursing Officer	IGCNO
Pankaj Davé	Non-Executive Director - ESTH/ SGUH	PD
Richard Jennings	Group Chief Medical Officer	GCMO
Stephen Jones*^	Group Chief Corporate Affairs Officer	GCCAO
Yin Jones	Non-Executive Director – ESTH/SGUH	YJ
Khadir Meer^	Non-Executive Director – SGUH	KM
Andrew Murray	Non-Executive Director – ESTH/SGUH	AM
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
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
Ralph Michell	Group Chief Transformation Officer	GCTO
Anna Macarthur	Group Chief Communications Officer	GCCO
Apologies		
Michael Pantlin*^	Group Deputy Chief Executive Officer	GDCEO
Phil Wilbraham	Associate Non-Executive Director – ESTH	PW
Observers		
Yvette Boamah	Inclusion Board Member	YB
Amol Joshi	Inclusion Board Member	AJ
Yasmin Mullick	Inclusion Board Member	YM

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, 05 March 2026, 11:30 – 14.50

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

PRESENT		
Mark Lowcock	Group Chair	Chair
James Blythe	Interim Group Chief Executive Officer	IGCEO
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
Pankaj Davé	Non-Executive Director – SGUH & ESTH	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^	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
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
IN ATTENDANCE		
Kelly Brown	Senior Corporate Governance Manager	SCGM
Stephen Friend	Consultant Physiotherapist in Major Trauma	CPMT
Stephanie Sweeney	Group Director of Quality and Safety Governance	GDQSG
APOLOGIES		
Elaine Clancy	Interim Group Chief Nursing Officer	IGCNO
Thirza Sawtell*	Managing Director – Integrated Care	MD-IC
Phil Wilbraham*	Associate Non-Executive Director – ESTH	PW
OBSERVERS		
Anna Macarthur	Group Chief Communications Officer	GCCO

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

FEEDBACK FROM WARD VISITS

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

- Endoscopy (GCMO,MD-SGUH and PD): Board members observed a high-quality clinical environment with a well-maintained estate and a strong, positive culture. Staff were welcoming, engaged and clearly committed to patient care, with effective multidisciplinary working across roles. The Board noted the scale and productivity of the service, including high volumes of procedures, and was impressed by the professionalism and training of staff, particularly healthcare assistants. Patient safety processes appeared well embedded, with staff demonstrating a clear understanding of risks. However, the Board also noted the need for more timely replacement of equipment, further development of digital processes, and opportunities to increase capacity through workforce and service planning.
- South West Pathology (GDCEO, KM, BS): Board members observed a highly complex, large-scale diagnostic service serving a wide population across the system. The Board noted the critical role of pathology in supporting healthcare delivery and the significant progress made in integrating services and standardising processes across organisations. There was clear evidence of innovation, particularly in relation to automation and digital transformation, supported by a strong culture of continuous improvement. At the same time, the Board identified opportunities to further standardise processes, particularly in areas such as phlebotomy, and to continue progress on workforce integration and contractual alignment. Members also noted the potential to maximise the benefits of ongoing digital transformation.
- Paul Calvert Theatres (IGCEO, GCFIEO, AM, YJ): Board members observed a well-led and cohesive team delivering care in a busy and complex environment. There was a strong sense of team culture, with good organisation and clear processes in place. The Board noted effective leadership, strong multidisciplinary working, and the use of structured learning processes, including regular sessions to review performance and share learning. The team demonstrated strong operational coordination, particularly in managing both planned and emergency work. However, the Board noted limitations in current digital systems, which required reliance on manual workarounds for scheduling, and identified opportunities to improve procurement and supply chain efficiency, particularly in relation to equipment and implants.
- General Intensive Care Unit (GCCO, MD-ESTH, LP): Board members observed a highly committed and engaged workforce, with strong team cohesion and a clear focus on patient care. Staff were open and articulate in describing both strengths and challenges within the service. The Board noted strong retention and a sense of pride among staff, as well as the importance of psychological support for patients recovering from trauma. While collaboration between teams was strong, Board members also identified a number of challenges, including limitations in IT systems leading to continued reliance on paper processes, delays in patient step-down affecting flow and experience, and the absence of dedicated psychological support for patients despite clear need. The current estate was also noted to be constrained, with improvements anticipated through the planned move to a new ICU facility.
- Frederick Hewitt & Pinckney Wards (GCPO, NA, GCCAO): Members observed the complexity of caring for a diverse group of patients with varying needs, including those requiring long stays while awaiting community support. While there were positive developments, such as improved security response and more effective triage, the Board noted ongoing challenges including staffing pressures, extended patient stays, and the impact on both staff wellbeing and patient experience. Issues relating to the availability of clinical supplies and equipment were also raised, alongside the need for continued focus on staff support and retention.
- Ceaser Hawkins and Gray Wards (Chair, GDQSG, IGCFO): Board members observed a high-performing ward with strong leadership, good morale and effective teamworking. There was clear evidence of a positive team culture and a focus on continuous improvement, supported by

	structured approaches such as staff huddles and locally led initiatives. The Board noted strong operational performance and organisation, alongside a high level of staff engagement. However, challenges were identified in managing boarding patients, including the use of corridor space during the day, and in dealing with incidents of violence and aggression, although these were reported to be well managed with strong organisational support. The Board also noted emerging concerns regarding the impact of changes to visa requirements on parts of the workforce, particularly healthcare assistants, and the need to assess the potential scale and impact of this issue across the Group. This would be followed up by the Executive.

1.0	INTRODUCTORY ITEMS
1.1	**Welcome, introductions and apologies**
	The Chair welcomed members to the meeting and noted the apologies as set out above.
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 8 January 2026 were approved as a true and accurate record.
1.4	**Action Log and Matters Arising**
	The Board reviewed the action log. • GB26.01.08/01: The Board briefing on quality governance improvement had been held on 2 February 2026. The Board agreed to close this action. • GB26.01.08/03: A Board session to discuss equality, diversity and inclusion had been arranged for 2 April 2026. On this basis, the Board agreed to close this action. All remaining actions were noted as not yet due.
1.5	**Group Chief Executive's Officer (GCEO) Report**
	The Board received the IGCEO report and discussed a number of key issues. • Corridor Care: The Board noted the increasing national focus on eliminating corridor care, following attendance by the IGCEO and senior leaders at an NHS England summit for the most challenged Trusts. The Board was advised that there is a strong expectation across the system that corridor care should be eliminated as soon as possible. The Board noted that action plans were being developed for both Trusts, drawing on existing transformation work and focusing on improving patient flow into, through and out of hospital. It was emphasised that addressing corridor care would require a combination of operational discipline, consistent leadership and system-wide working. The Board supported the development of these plans and requested that progress be reported through future Integrated Quality and Performance Reports. • Inclusion Board: The Board noted the launch of the Inclusion Board, a new initiative designed to strengthen inclusive leadership and ensure that a wider range of staff perspectives inform Board-level discussions. The Board was advised that the programme had attracted strong interest and would provide participants with exposure to governance, strategy and Board decision-making. The Board welcomed the initiative as a positive step in supporting staff engagement and inclusion.

	• National Maternity Investigation: The Board noted the publication of the national neonatal investigation interim report. While the report did not specifically focus on services at either Trust, the findings highlighted system-wide challenges in maternity care, including issues relating to staffing, culture and inequalities in outcomes. The Board discussed the implications of the report and noted that demand for maternity services was becoming more complex, despite a reduction in overall birth rates and that there were persistent challenges in addressing health inequalities, particularly for women from disadvantaged backgrounds. The Board emphasised the importance of continuing to strengthen local maternity services, embed learning from national reviews, and maintain a sustained focus on improvement across both Trusts. • Staff Wellbeing and International Context: The Board noted the impact of ongoing global events, particularly in the Middle East, on staff wellbeing. The IGCEO highlighted that many colleagues had personal connections to affected regions and may be experiencing distress or disruption. The Board noted that support was available through line management, occupational health and counselling services, and mental health first aiders. The Board emphasised the importance of ensuring that staff were supported appropriately during periods of external uncertainty, and recognised the value of maintaining a clear sense of purpose and support within the workplace. The Board **noted** the report and the updates provided, and supported the continued focus on operational improvement, staff engagement and delivery of the Group's strategic priorities.
2.0	**STRATEGY**
2.1	**Five Year Narrative Plan 2026/27 – 2030/31**
	The Board received the report, which detailed the five-year plan narrative, including the priorities which are to permeate the group in 2026/27 and the transformation portfolio. The Board noted that the plan provided a clear articulation of the Group's strategic direction, including transformation, integration of services and increased use of technology. Members emphasised the importance of ensuring that the strategy was clearly communicated and understood across the organisation, translating high-level strategic objectives into practical actions at service level, and developing clear metrics and feedback mechanisms to assess whether the strategy was being effectively implemented. The Board also recognised that effective delivery would require engagement beyond the Executive team, with a focus on visible leadership and communication across all levels of the organisation. The Board **noted** the 5-year plan narrative as submitted to NHS England following review and agreement by the Group Board in February 2026.
3.0	**QUALITY AND SAFETY**
3.1	**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 January and February 2026. The Committee Chair highlighted a number of key areas of focus: In relation to Quality Impact Assessments (QIA), the Committees reviewed both the winter plan QIA and those relating to cost improvement programmes. The Committees were satisfied that appropriate mitigations were in place for the winter plan, although noted that the review had been undertaken late in the process. It was agreed that, in future, QIAs should be reviewed earlier in the year to provide more prospective assurance. The QIA process for cost improvement programmes was considered to be robust, with clear evidence of both approved and rejected schemes and the rationale for decisions.

	The Committees also reviewed progress against quality priorities and noted a mixed position. While progress had been made in areas such as pressure ulcers and falls, delivery in other areas, including delirium assessment and VTE, had been more limited. The Committees emphasised the importance of setting realistic and deliverable priorities for 2026/27 and requested that draft priorities for the coming year be brought forward for review. In relation to maternity services, the Committees noted ongoing progress and confirmed that both Trusts had successfully achieved compliance with all 10 Safety Actions within the CNST Maternity Incentive Scheme. This submission had been subject to detailed scrutiny by the Committees and reviewed with the Integrated Care Board. The Board welcomed the report and noted the strengthened assurance provided in relation to the QIA process, particularly for cost improvement programmes. Members discussed the mixed delivery of quality priorities, emphasising the need to ensure that priorities were both ambitious and achievable, and that there was sufficient focus on delivery as well as planning. The Board also noted the importance of ensuring that QIA processes were applied early and consistently and maintaining a strong focus on patient safety and quality outcomes alongside financial and operational priorities. The Board welcomed the progress in maternity services, while recognising the need for continued focus and assurance in this area. The Board **noted** the report and areas requiring strengthened assurance.
3.2	**Maternity Services Report**
	The Board received the Maternity Services Report, which provided an update on performance, risks and improvement activity across both Trusts. The Board noted that both SGUH and ESTH were compliant with all 10 Safety Actions within the CNST Maternity Incentive Scheme, following review and approval by the Quality Committees under delegated authority. The report also highlighted evidence of ongoing improvement activity across the services. The Board acknowledged the progress made and the strength of the evidence presented within the report. However, members emphasised that significant risks remained, and that continued focus was required to ensure that improvements were sustained and embedded. The Board discussed the need for continued assurance in relation to independent review and oversight, noting that, while there is no formal requirement for “fresh eyes” review, Non-Executive Directors would welcome greater visibility of how this was achieved in practice. It was agreed that the detail of how such assurance could be provided should be considered further through the Quality Committees. The Board also reflected on the wider context of maternity services nationally, noting that demand was becoming increasingly complex, despite a reduction in overall birth rates, and that there were ongoing challenges in addressing health inequalities and variation in outcomes. The Board emphasised the importance of maintaining a sustained focus on quality improvement and patient safety, ensuring that lessons from both local experience and national reviews were actively embedded, and providing continued assurance that risks were being effectively mitigated. The Board **noted** the report, recognising the progress made while emphasising the need for continued focus on risk mitigation, assurance and sustained improvement in maternity services.
4.0	**FINANCE AND PERFORMANCE**
4.1	**Finance and Performance Committees Report**

	The Board received the report from the Finance and Performance Committees, summarising key issues and areas of assurance from meetings held in January and February 2026. The Committee Chair highlighted that there was increasing confidence in delivery of the year-end financial position, although this remained supported by a degree of non-recurrent measures. The Committees also noted the successful submission of a compliant Medium-Term Financial Plan, reflecting the requirements set by NHS England. The Board was advised that: • The financial position continued to be subject to delivery risk, particularly in relation to the development and delivery of cost improvement programmes • There were ongoing challenges in contract alignment with commissioners, which may impact income assumptions • Progress was being made in strengthening financial oversight and governance. The Board welcomed the progress made in improving financial performance and acknowledged the significant effort required to reach the current position. Members noted that while confidence in year-end delivery had improved, the position remained dependent on non-recurrent actions. Members also noted the need to maintain focus on developing sustainable efficiency plans. The Board emphasised the importance of ensuring that cost improvement programmes were fully developed and deliverable and of maintaining strong alignment between financial and operational performance. The Board recognised the ongoing delivery risk and **noted** the report.
4.2	**Finance Report – Month 10**
	The Board received the Finance Report for Month 10. The IGCFO advised that both Trusts remained on plan at Month 10, with the current forecast indicating delivery of the agreed financial position at year-end. The Board noted, however, that this position continued to rely on significant deficit support funding, and that the underlying financial position of both Trusts remained materially challenged. The Board **noted** the Month 10 financial position and the associated risks.
4.3	**Integrated Quality and Performance Report (IQPR)**
	The Board received the Integrated Quality and Performance Report. The Board noted that: • SGUH had made significant progress in reducing long waiting times, resulting in the Trust exiting NHS England Tier 1 oversight for elective performance • ESTH remained in Tier 1 for elective recovery and Tier 2 for urgent and emergency care performance, reflecting ongoing operational challenges The Board further noted that: • RTT recovery actions had delivered improvement across both Trusts • At ESTH, targeted actions are in place to eliminate 65-week waits, reduce 52-week waits to 1% or less, and improve overall performance against operational targets The Board welcomed the progress made at SGUH, recognising the significant effort required to exit Tier 1 oversight. Members noted that, despite this progress, performance pressures remained across both Trusts. Members further noted that ESTH continued to face sustained operational challenges, particularly in elective and urgent care performance.

	The Board emphasised the importance of maintaining focus on delivery of recovery plans, ensuring that improvements were sustained over time, and continuing to support ESTH in addressing its performance challenges. The Board **noted** the report, welcoming progress made while recognising the need for continued focus on performance improvement across both Trusts.
4.4	**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 February 2026: • External Audit and year-end: Work on the annual external audits at both Trusts had commenced, with the Committee reviewing the external audit plans and fees 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 noted concern regarding the number of management actions arising from previous internal audit reviews which remained overdue. Wider themes from internal audit would be considered and a systematic organisational response would be developed. • 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. Work was ongoing to improve the consistency and quality of risk articulation, controls and assurance. 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. • 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, were appended to the Committee's report for approval by the Board. The Board discussed the report and noted that: • While progress has been made in delivery of the internal audit programme, a number of management actions remain overdue, which had the potential to impact the overall level of assurance at year-end. This highlighted the need to strengthen Executive ownership and timely delivery of audit actions, and to ensure that agreed improvements were implemented in practice. • In relation to risk, the Board welcomed progress in refreshing and aligning Corporate Risk Registers, and noted the further work being undertaken to embed the Group-wide risk management framework. • In considering the proposed changes to financial limits, the Board noted that while increases are justified by the scale and complexity of the organisation, there was a need to balance this with maintaining appropriate financial oversight and control, to avoid any reduction in scrutiny.

	The Board: • **Noted** the report of the Audit and Risk Committee • **Approved** the changes to the Financial Limits in the Scheme of Reservation and Delegation of Powers
5.0	**PEOPLE**
5.1	**People Committees Report**
	The Board received the report from the People Committees, setting out the key issues and areas of assurance from recent meetings. The Board noted the following key updates: • Progress in implementing the People Function Target Operating Model (TOM), including the introduction of a single front door for digital HR services and phased implementation of the new model • Development of a refreshed approach to performance and development, moving away from annual appraisal processes towards continuous conversations and leadership development • Plans to introduce a three-tier management development programme, building on a successful pilot The Board welcomed the progress made and discussed the importance of ensuring that the People Function transformation delivered simpler, more effective processes, particularly for line managers and staff. The Board also underscored the importance of embedding the new approach to performance and development in a way that was valued by staff and supported continuous improvement, rather than becoming a compliance exercise. Members also noted that further detail would be required to understand how the new operating model would be implemented in practice and measured for impact. Board members also emphasised that it would be important to maintain a clear focus on staff experience and engagement, particularly during periods of wider organisational change. The Board **noted** the report.
5.2	**Pay Gap Report**
	The Board received the Pay Gap Report, which set out the Group's position in relation to gender, ethnicity and disability pay gaps based on data as at 31 March 2025. The report highlighted that, while there had been some areas of improvement, significant inequalities remained across all three measures. It was emphasised that the data reflected underlying workforce composition and progression patterns, rather than pay differences for equivalent roles, and that addressing these gaps would require sustained and targeted action over time. The Board noted that: • Across both Trusts, women represented the majority of the workforce, but men continued to earn more on average, with a widening gender pay gap in both organisations • At SGUH, the ethnicity pay gap remained significant, although there had been a slight improvement year-on-year • At ESTH, the ethnicity pay gap continued to favour BAME staff and had widened further • Disabled staff remained under-represented and continued to earn less on average than non-disabled staff, although there has been some improvement in the mean gap

	The Board discussed the findings and emphasised that: • The focus should be on understanding the underlying drivers of the pay gaps, rather than seeking to explain or justify the headline figures • Action should be targeted at improving equality of opportunity, particularly in relation to progression and access to senior roles Members noted that: • Pay gap data reflected structural issues within the workforce, including representation at different grades • Addressing these gaps would require sustained action over time, including improvements in recruitment, development and retention. The Board noted the report, noting that rather than trying to explain or justify the data, it would be more beneficial to commission analysis to understand the factors which drive the gender pay gap and work to mitigate these, such as ensuring there are equal opportunities for progression. The Board **approved** the report for publication to the Trusts' websites.
6.0	**INFRASTRUCTURE**
6.1	**Infrastructure Committees Report**
	The Board received the report from the Infrastructure Committees, which summarised key matters considered across estates, facilities and digital infrastructure. The report highlighted the scale of ongoing transformation activity, including progress in service integration, digital development and infrastructure improvement, alongside the operational challenges associated with delivering these changes across a complex estate. The Board noted the breadth of activity across infrastructure services and the importance of ensuring that digital and estate developments were aligned to clinical and operational priorities and that infrastructure programmes were delivered in a way that supported service transformation and improved patient outcomes. Members also noted that there were opportunities to learn from areas of strong performance, including highly effective and innovative services observed during Board visits. Board members also noted that continued focus was required on standardisation, efficiency and use of technology, particularly where variation in processes limited the ability to scale improvements. The Board emphasised the importance of maintaining oversight of delivery risks and dependencies, particularly in relation to digital programmes and workforce capacity. It also underscored the need to ensure that infrastructure investment supported the long-term strategic direction of the Group. The Board **noted** the report.
7.0	**CLOSING ITEMS**
7.1	**New Risks and Issues Identified**
	No new risks were identified.
7.2	**Reflections on meeting**
	The IGCEO gave his reflection on the meeting.

	The Board noted that there was an increasing sense of triangulation across discussions, with Non-Executive Directors drawing on wider insight from engagement across the organisation and using this to inform challenge and scrutiny of Executive reports. Members reflected that a number of issues discussed during the meeting were incremental and operational in nature, rather than focused on strategic priorities. It was noted that this reflected the current demands on the organisation, but also highlighted the importance of maintaining sufficient focus on longer-term transformation and strategic direction. The IGCEO advised that the Executive Team was actively considering how to ensure that sufficient time and capacity was created to focus on strategic priorities, including transformation, while continuing to manage operational pressures.
7.3	**Questions from members of the public and Governors of St George's**
	The Chair noted that a number of questions had been received members of the public: • *Samuel Chadwick had submitted a question about the Federated Data Platform.* *Question: My question today is concerned with the supplier of the Federated Data Platform (FDP). Is Palantir's well-reported record of collaborating with ICE in the USA, and IDF in Gaza, consistent with the publicly stated values of St George's and St Helier's (especially those of being professional, responsible and respectful)? In light of recent evidence surrounding Palantir, will the GESH Trust reconsider its decision to adopt Palantir as the supplier of the FDP* Answer: The GDCEO advised that the federated data platform was a national programme which was led, procured and contracted centrally by NHS England. Decisions regarding adopting the provider of FDP, including Palantir, were therefore made at a national level rather than by individual Trusts. However, each Trust did undertake its own information governance review before adopting elements of the FDP, including ensuring any use of the FDP complied fully with UK data protection legislation and NHS information governance standards. The FDP did not provide Palantir access to patient identifiable data, data remains under control solely of the NHS and is used to support direct care, operational management within strict safeguards set up by the law. • *Suzanne Loftus had written to the Board to raise concerns about an environmental noise issue affecting residents in the Woodcote area, adjacent to Epsom Hospital.* Answer: The GCFIEO committed to undertake a noise assessment, noting he would be in direct contact with the correspondent to provide feedback as a result of the assessment. • *Marion Parkes, member of the public, submitted a number of questions regarding the Picture Archiving and Communication System (PACS):* *Q1: As the MyOrb contract, promoted by the Acute Provider Collaborative (APC) has been referred to the NHS Fraud Agency, is it not now appropriate to also refer the Optum PACS contract to this Agency as it too, was based on an unseen system that did not exist?* Answer: The contract for the delivery of the South West London enterprise PACS remains in place and has been subject to extensive Board-led oversight. The IGCEO as the accountable Officer has been significantly involved in this over the past few months and does not believe there is any cause to suspect fraud. However, any individual can make a referral to the NHS Counter Fraud authority, should they suspect fraud. *Q2: Can you confirm that the leadership of the APC that led these disastrous and expensive contracts is still in place and leading on any discussions with this Supplier?* Answer: There is a dedicated South West London team working with Optum, with regular Programme Board and Chief Executive input. The IGCEO and two other executives met

	with the clinical radiology teams to discuss their input into the next phase of the work to ensure the system which is implemented is safe and effective.
7.4	**Patient Story**
	The Board received a patient story from the Pan London Rapid Access Acute Rehabilitation (RAAR) service, describing the rehabilitation journey of a patient following a serious traumatic injury sustained in a motorcycle accident. The presentation set out how the patient had required highly complex, multi-disciplinary care following admission, and demonstrated the role of the RAAR service in providing early, intensive rehabilitation within the acute hospital setting. The Board heard that access to on-site neuro-rehabilitation services at SGUH had enabled timely intervention, supporting both the patient's physical recovery and their longer-term rehabilitation outcomes. The Board noted that the case illustrated the importance of coordinated multidisciplinary working, including input from medical, nursing, therapy and support teams. Members heard how close collaboration between teams enabled a personalised and responsive care plan, tailored to the patient's changing needs throughout their recovery. A key theme highlighted was the importance of psychological support alongside physical rehabilitation. The Board noted that trauma patients could experience significant psychological impact, including long-term effects such as post-traumatic stress, and that access to specialist psychological input was critical to achieving holistic recovery. The Board also discussed the wider impact of the RAAR service, noting that: • Early access to rehabilitation could support improved patient outcomes and independence • The service contributed to reduced length of stay and improved patient flow within the hospital • Integrated rehabilitation models demonstrated the benefits of co-located specialist services and system collaboration across London Members further reflected on opportunities to build on this model, including: • Strengthening links with external organisations and charities, particularly in relation to prevention and post-discharge support • Considering how similar approaches could be extended or replicated across other pathways The Board recognised the commitment and professionalism of the teams involved in delivering this care and the positive impact on patient outcomes. The Board requested that their thanks be conveyed to both the clinical team and the patient for sharing their experience.
CLOSE	
The meeting closed at 14.40pm.	

Group Board (Public) - 8 May 2026

Action Log

ACTION REFERENCE	MEETING DATE	ITEM NO.	ITEM	ACTION	WHEN	WHO	UPDATE	STATUS
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	Verbal Update to be provided at the meeting	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 Friday, 08 May 2026

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

Executive Summary

This report provides an overview of the key issues across the St George's, Epsom and St Helier University Hospitals and Health Group, and offers some reflections on my first month in post as Group Chief Executive Officer.

Action required by Group Board

The Group Board is asked to note the report.

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

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

Group Chief Executive Officer's Report

Group Board, 08 May 2026

1.0 Purpose of paper

1.1 I am delighted to introduce my first report to the gesh Board as Group Chief Executive Officer, having started in post on 7 April 2026. This report provides an overview of the key issues across the St George's, Epsom and St Helier University Hospitals and Health Group. It also offers some personal reflections on my first month in post and the teams and departments I've had the opportunity to meet and listen to.

2.0 Group Updates

Interstitial Lung Disease

2.1 At our public Board in November 2024, the executive team spoke openly about the care of patients with Interstitial Lung Disease (ILD) who were not treated correctly by an individual respiratory consultant at St Helier. At that time, we had already stopped this doctor working for us and referred them to the GMC. All patients with ILD treated by this doctor since 2019 had been reviewed by a specialist team to ensure they were on the right treatment plan.

2.2 We have now received the independent Royal College of Physicians' report commissioned by the Trust in 2024, which examines the care provided to a sample of 28 patients with ILD. We have taken action to make the service safe, and we have acted on all the RCP's recommendations.

2.3 We will publish the RCP report's findings in full and will be completely transparent about the measures we have taken and any further learning at the earliest opportunity.

2.4 Before we do this, it is important that we first contact the patients and families affected and share the RCP's findings, and discharge statutory Duty of Candour in cases where the RCP identified harm. We will make sure they all have the opportunity to meet with us and discuss anything they want to.

2.5 Because of the findings in the report, we now plan to use the RCP's approach to review the care previously given to all ILD patients from 2019. We are writing to patients and families to explain this, and to invite them to discuss any concerns they may have. It is important we do this before publishing the report.

2.6 We want to be completely open with all ILD patients and families about the impact this may have had. Whist we are confident that all our ILD patients now are having the right care, the RCP reviewed a sample of 28 ILD patients, rather than all ILD patients, from 2019.We now need to contact all ILD patients. This will take time, but it is important we get it right for the patients and their families and they hear from us before the report is published.

Capital funding for St Helier Emergency Department refurbishment

2.7 We have recently had confirmation from NHS England that we have secured £55m of capital funding over the next four years to support the refurbishment of the Emergency Department at St Helier Hospital. The funding, which has been approved through the NHS Estates Safety Fund and national investment programmes supporting recovery towards NHS constitutional waiting

time standards, represents a significant milestone for both the Trust and the local community. It provides a major opportunity to modernise one of the busiest and most operationally challenged areas of the estate and to create an Emergency Department that is better aligned to current and future demand.

2.8 The investment comes at a critical time for the site. The current Emergency Department infrastructure was not designed for the volume and complexity of patients now attending the service, resulting in sustained pressure on clinical space, patient flow and staff working conditions. The redevelopment will enable the Trust to address longstanding estate constraints, reduce overcrowding and corridor care, improve patient privacy and dignity, and create safer and more appropriate environments for patients with mental health, frailty and complex care needs. Alongside improving operational resilience and supporting better performance against national standards, the scheme will also significantly improve staff experience by providing a more modern, functional and supportive working environment for frontline teams. Collectively, this investment will support the delivery of safer, higher-quality and more compassionate care for patients across South West London.

2.9 We now move into the next phase of programme development and delivery, working closely with NHS England and system partners to finalise the detailed business case, design development and enabling works programme. Early preparatory work will focus on ensuring the scheme can progress at pace while maintaining safe and effective services throughout construction. The redevelopment provides an opportunity to reshape emergency care at St Helier, creating a modern, fit-for-purpose environment that better supports patients, staff and operational resilience for the future.

Renal Development Programme

2.10 The Group continues to work with the New Hospital Programme and system partners to progress the Renal Development Programme, which remains a strategically important capital scheme for the organisation. We are working with the NHP to explore options for commencement of works in 2026/27 to enable the new build to be operational by 2030. The proposal would restart the renal build programme at St George's, bringing together renal services across the group into a single specialist centre. Planning approval and detailed design work have already been completed, with the Trust continuing to pursue the funding required to move the scheme into construction.

2.11 The scheme would significantly improve patient care by co-locating specialist renal, transplant and acute services on one site, reducing variation in care and improving access to specialist expertise. It would also provide modern inpatient, dialysis, outpatient and same day emergency care facilities, while enabling renal services to move out of some of the poorest-quality estate at St Helier. The programme remains an important enabler for the wider clinical and estates transformation across the group and a key long-term investment in the sustainability of services across South West London.

NHS Staff Survey 2025

2.12 The 2025 NHS Staff Survey, the results of which were published in March, shows that staff engagement across both Trusts remains above the national average, reflecting the continued commitment of colleagues to delivering high-quality patient care. However, the results also highlight significant challenges in staff experience, morale and organisational culture. Both Trusts scored below national averages in learning and development, flexible working, recognition and morale, with Epsom & St Helier ranked 13th and St George's ranked 17th out of 17 London Acute and Community Trusts overall based on overall performance against the People Promise themes.

2.13 Staff feedback identified concerns around workload, burnout, inconsistent leadership behaviours, bullying and discrimination, alongside frustrations with outdated IT systems, estates issues and lack of staff facilities. The survey also highlighted inequalities in experience for Disabled and Black, Asian and Minority Ethnic colleagues, particularly relating to harassment, career progression and reasonable adjustments. These findings align with the Care Quality Commission's Well Led inspection findings at St George's, particularly in relation to the need to strengthen how staff feedback is used to inform cultural improvement.

2.14 The findings reinforce the critical link between staff experience, organisational culture and the delivery of outstanding patient care. In response, the Group is prioritising a focused programme of work to: (i) strengthen leadership capability and consistency; (ii) promoting the behaviours we want to see, with a particular focus on civility, kindness and psychological safety, and tackling inappropriate behaviours; (iii) improving equality, diversity and inclusion through improved equity in recruitment, progression and experience, improved leadership accountability, and reducing inequity in workforce outcomes; and (iv) focusing on staff recognition and celebration, scaling up our approach to staff recognition, and increasing visibility and inclusivity of recognition across our Group.

2.15 Local action plans are being developed across divisions and services to ensure staff survey feedback results in meaningful change at team level. Managers are expected to lead regular "Conversations that Matter", including team meetings, huddles and career conversations, while focusing on two to three locally agreed improvement priorities linked to leadership, behaviours, inclusion and recognition. HR Business Partner-led working groups are supporting teams to analyse their results, develop targeted action plans and improve engagement, with additional support being provided to 20 low-scoring services across both Trusts through named leadership sponsors, facilitated engagement sessions and increased leadership visibility. Teams are also being encouraged to adopt a clear "You Said, We Did" approach to demonstrate how staff feedback is shaping local improvements.

Tackling violence and aggression against staff

2.16 The Staff Survey highlighted the significant impact that violence, aggression, harassment and abusive behaviour can have on staff experience, wellbeing and morale. Colleagues described concerns relating to bullying, psychological safety and inappropriate behaviours from both patients and visitors, reinforcing the importance of ensuring staff feel safe, supported and respected at work. In response to this and similar feedback in previous surveys, the organisation is strengthening its approach to violence prevention and reduction as part of the wider work to improve staff experience and organisational culture.

2.17 In June, the Group will launch a new Violence Prevention and Reduction Policy, providing a single, group-wide framework for preventing, managing and responding to violence, aggression, harassment and abuse directed towards staff. The policy reinforces the organisation's zero-tolerance approach to intentional violence, hate crime and sexual harassment, while also strengthening support available to colleagues before, during and after incidents. This includes clearer escalation processes, enhanced staff support and wellbeing provision, improved security and police liaison arrangements, strengthened training and risk assessment processes, and a more consistent approach to sanctions and exclusions where appropriate. The policy reflects the Group's commitment to creating safer working environments and ensuring colleagues feel protected and supported in delivering high-quality patient care.

The future of the gesh Group

2.18 Following consideration by the Group Board earlier this year, the Strategic Case for the merger of St George's University Hospitals NHS Foundation Trust and Epsom & St Helier University Hospitals NHS Trust has now been submitted to NHS England. Discussions with NHS England are progressing positively and the Group is now working towards a proposed merger date of April 2028, in less than two years' time. The merger would represent the next step in the evolution of the gesh Group, building on four years of successful collaboration through the existing Group model. Subject to further engagement with NHS England, the Group will now begin developing a Full Business Case over the coming months to support the next stage of the process.

2.19 The proposed merger is intended to support better outcomes for patients, staff and the wider health system by enabling faster and deeper integration across services, reducing duplication and improving the use of shared resources. A single organisation would help accelerate clinical collaboration, reduce unwarranted variation in care, support more joined-up patient pathways and strengthen the long-term sustainability of services across South West London and Surrey. For staff, the merger would create greater opportunities for career development, research, workforce flexibility and shared ways of working across a larger organisation. Importantly, there are no immediate changes planned to local services as a result of the merger, with the priority throughout remaining the delivery of safe, high-quality care for local communities.

CQC Inspections

2.20 Epsom and St Helier Hospitals NHS Trust underwent a series of CQC service inspections in December 2025 and the Trust has recently received the draft reports as part of the factual accuracy checking process. The final reports are expected to be published by the CQC in the near future. In addition, the Trust will undergo a CQC Well-Led inspection between 12–14 May 2026.

2.21 Alongside this, the Group continues to take forward a comprehensive programme of improvement work in response to the CQC findings at St George's, including both the service-level inspections and Well-Led review, which identified a number of areas requiring improvement. This work remains a key organisational priority, with a strong focus on strengthening quality, leadership, operational performance, culture and staff experience across the Group.

3.0 My first month as Group Chief Executive

3.1 Since joining gesh on 7 April, I have spent much of my first month listening to colleagues, visiting teams and services across our sites, and building my understanding of both the opportunities and challenges facing the Group. I deliberately wanted to begin where it matters most – alongside frontline teams delivering care. My first day was spent in the Emergency Department at St Helier Hospital, speaking directly with colleagues about their experiences, the pressures they face, what is working well and where they feel we need to improve. Starting in one of our busiest frontline environments reinforced for me both the scale of demand facing our services and the extraordinary commitment, compassion and professionalism shown by staff every day.

3.2 Over the following weeks, I have continued to spend time across our hospitals and community services to gain a broader understanding of the organisation and the communities we serve. At St George's, I visited a range of children's and women's services, including paediatric

intensive care, neonatal intensive care, Jungle Ward, paediatric day surgery, Fredrick Hewitt Ward and maternity services. These visits provided an opportunity to hear directly from teams about the challenges they face, the innovations they are leading, and the areas where they are particularly proud of the care they provide. I was also able to spend time with Facilities and Estates colleagues, including visiting the Energy Centre and key infrastructure areas, which highlighted the critical work that often happens behind the scenes to keep our hospitals running safely and effectively.

3.3 I have also visited Queen Mary's Hospital and Surrey Downs Health and Care, meeting colleagues working across inpatient wards, imaging, urology, endoscopy and community-based services. Spending time with the Surrey Downs Home First teams was particularly valuable in understanding how integrated care models are supporting people to remain independent and receive care closer to home. Across all of these visits, I have been struck by the depth of expertise, teamwork and pride colleagues have in the services they provide, as well as the openness with which staff have shared both their concerns and ideas for improvement.

3.4 Alongside these visits, I have also started wider conversations with staff and stakeholders about the future direction of the Group, including our ambitions around quality improvement, workforce culture, digital innovation and reducing health inequalities. Through the "Ask Mat Anything" initiative and my first Executive Question Time session, I have been keen to encourage open and transparent dialogue with colleagues and to begin building relationships across the organisation. I have been particularly encouraged by the strong appetite across gesh to continue improving care for our patients while creating a more supportive, inclusive and sustainable environment for staff. My first month has reinforced my belief that the Group has enormous potential, built on the commitment and talent of our people, and I look forward to continuing these conversations in the months ahead.

4.0 Events, Appointments and Our Staff

Appointments and Events

4.1 I am pleased to note the appointment of Dr Sijo Francis as the new Site Chief Medical Officer at St George's from June 2026, succeeding Dr Luci Etheridge following her appointment as a Registrant Council Member at the General Medical Council. Sijo brings extensive clinical and leadership experience to the role and is highly regarded for his collaborative leadership style and commitment to high-quality patient care, staff engagement and professional development. I would also like to recognise the outstanding contribution Luci has made during her time as Site Chief Medical Officer, providing compassionate and visible leadership through a number of challenging periods, and I am delighted that she will continue her clinical work at St George's alongside her new national responsibilities.

4.2 As part of celebrating our staff and recognising their contribution to our patients and communities, on Friday 15 May we are holding our gesh25 long service awards. These awards recognise colleagues from across our hospitals and community services who have served in the NHS for 25 years. Generously supported by our hospital charities, the event is part of how we are responding to feedback in the Staff Survey about the importance of valuing our people and saying thank you for the difference they make – and I look forward to celebrating with them.

Thank you to James Blythe

4.3 I would also like to thank James Blythe for his leadership and commitment to gesh over the last four years, including his six months as Interim Group Chief Executive Officer prior to my arrival. During that time, James provided steady and compassionate leadership through a period of significant operational challenge and organisational change, while continuing to drive improvement across the Group. Alongside his role as Managing Director at Epsom and St Helier, he has made an enormous contribution to the development of the gesh Group and to supporting colleagues to deliver safe, effective and compassionate care for our patients and communities. On behalf of the Board and colleagues across the organisation, I would like to thank James for his dedication and wish him every success in his new role as Chief Executive of Royal Berkshire NHS Foundation Trust.

5.0 Recommendations

5.1 The Group Board is asked to note the report.

Group Board Meeting (Public)

Meeting on Friday, 08 May 2026

Agenda Item	2.1	
Report Title	**Quality Committees Report**	
Executive Lead(s)	Richard Jennings, Group Chief Medical Officer Elaine Clancy, Interim Group Chief Nursing Officer	
Report Author(s)	Andrew Murray, Non-Executive Director	
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 March and April 2026 and the matters the Committees wish to bring to the attention of the Group Board. These include:

1. Quality Governance Improvement Plan: Committee members reviewed the Quality Governance Improvement Plan and suggested various areas for development including the need to develop a clear narrative on why and what the Quality Governance Improvement plan aims to achieve, which can be used with staff; a better description on how culture around quality and reporting will be addressed; a clearer description of how we will measure progress and what we can expect to see delivered in the next 6 months
2. Quality Priorities: Committees members reviewed the Proposed Quality Priorities for 2026/27, agreeing that the progress against implementing these priorities will be reviewed throughout the year.
3. Maternity Services Report: Members discussed a proposed change in approach to maternity governance and reporting now that the maternity leadership team has been fully recruited to. This approach includes establishing a Maternity Board to discuss the various statutory maternity reports in-depth, allowing only the key issues to be escalated upwards to the Quality Committees and Group Board.
4. Interstitial Lung Disease at ESTH - RCP Invited Review update: Committees members noted that the Trust has received the final Royal College of Physicians (RCP) Invited Review report on 24 March 2026, noting that the recommendations in the report have been accepted and have been being acted upon. Further information is included in the Group Chief Executive Officer's Report

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 March and April 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, 08 May 2026

1.0 Purpose of paper

1.1 This report sets out the key issues considered by the Quality Committees at its meetings in March and April 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 26 March 2026 and the 30 April 2026 the Committees considered the following items of business:

26 March 2026 – Focus Session	30 April 2026 – Focus Session
• Quality Governance Improvement Plan • Quality Priorities 2026/27 • Interstitial Lung Disease: Report from the Royal College of Physicians Invited Review	• Maternity Services Report • Patient Safety Incident Report • Interstitial Lung Disease at ESTH -RCP Invited Review update. • Quality Management System Report • SWL Pathology – FIT Testing • Integrated Quality Performance Report: Focus on Quality and Safety Metrics

2.2 The Committees was quorate at both meetings.

3.0 26 March 2026 – Key Issues for Escalation to Group Board

3.1 <u>Quality Governance Improvement Plan</u>

3.1.1 The report was introduced to the Committees, detailing the work which was taking place to strengthen the gesh Group's Quality and Safety Governance. Members noted that there hasn't been as much progress in its implementation as was initially anticipated, due to various factors, including senior leadership changes. Additionally, external regulatory and independent organisations perspectives, including the St George's CQC Well-Led Report in October 2025, and the draft Report of the Royal College of Physicians Invited review of Interstitial Lung Disease at St Helier have highlighted additional areas requiring focus.

3.1.2 The Committees recognised that the proposals within the improvement plan represented a large programme of change over the next 6 to 12 months. It was emphasised that divisions need to be clear on their roles in creating the workplans to aide in the implementation of the improvement plan.

3.1.3 Committees members agreed it would be beneficial to seek assurance on the proposed Quality Management System and requested that a report was presented at the next Committees to provide an understanding of the mechanics of this.

3.2 Quality Priorities 2026/27

3.2.1 The Committees received the report, which detailed the agreed quality priorities for 2026/27. These priorities were developed and agreed through discussion with Site Leadership Teams and key stakeholders across the Group. The priorities have also been informed by learning from the 2025/26 programme, including where improvement has been achieved, where progress has been slower than planned, and where further work remains necessary but is best taken forward through targeted local oversight rather than as a continuing Group-wide priority.

3.2.2 The Priorities for 2026/27 are:

- VTE prevention: risk assessment and learning from hospital acquired thrombosis
- Safety for Interventional Procedures
- Corridor Care
- Martha's Rule
- Quality and Safety Clinical Governance

3.2.3 Members reiterated the importance of successfully managing the Quality Priorities across the upcoming year, agreeing that an update be presented to the Committees on a quarterly basis.

3.3 Interstitial Lung Disease: Report from the Royal College of Physicians Invited Review

3.3.1 The report presented the Quality Committees with an update on the Lung Disease (ILD) at ESTH – Royal College of Physicians (RCP) Invited Review.

3.3.2 The invited review report from the RCP made a series of recommendations in the draft report sent to the GCMO for factual accuracy. This was in line with the immediate feedback received and it was acknowledged that they were highly likely to reflect the recommendations which will be within the final report. Following review of the 23 recommendations made, significant progress has been made by the department with the majority either completed or partially completed.

3.3.3 Committees members noted the report, noting that this is an ongoing situation and a further update would be provided at the next meeting.

4.0 30 April 2026 – Key Issues for Escalation to the Group Board

4.1 Maternity Services Report

4.1.1 Committees members reviewed the report, which included a note on the key achievements within the reporting period, such as:

- Midwifery senior leadership team now fully recruited to. Substantive Director of Midwifery at St Georges commenced in February and Group Chief Midwifery in March 2026
- 14 Band 5 midwives commenced at St Georges
- Consistent utilisation of Birth Centre at St Heliers (around 16%)
- Second theatre opened at Epsom

4.1.2 The Committees Chair noted that historically it has been challenging to have a clear understanding of the maternity reports, in part due to the volume of information which is required to be reviewed by the Committees, as per NHS Resolutions guidance. It was agreed that as the midwifery leadership team has now been fully recruited to, it is the ideal time to review how this information is presented to the Committees. It was advised that establishing a Maternity Board will create a space for all the required maternity reports to be reviewed in-depth whilst gaining assurance from maternity colleagues that there are appropriate plans and mitigations in place regarding managing the maternity services. The decision can then be

made in this forum as to what information from those statutory reports should be highlighted to the Quality Committees and Group Board, with the view to create a more focused repot which ensures there is appropriate Board-level oversight and assurance on the key maternity issues and risks. All statutory reports will be available in a reading room should Board members require them.

4.1.3 The Committees agreed that **limited assurance** could be taken on the Maternity Services update, noting that this rating would likely improve once the new approach to maternity reporting is implemented.

5.0 30 April 2026 – Key issues to which the Committees received assurance

5.1 Patient Safety Incident Report

5.1.1 The Committees welcomed the news that each site continues to embed and strengthen use of PSIRF, through governance forums and staff engagement. Mandatory training compliance (Level 1 of the National Syllabus) remains high and exceeds the target in all but one area. However, there remain some difficulties with overall capacity for initiating and completing learning responses and the shift to improvement.

5.1.2 Committees members noted the report referred to resourcing issues with regards to completing open patient safety incident investigations. Assurance was provided that more colleagues are now trained in undertaking these investigations. All divisional safety leads have also now been appointed, all of whom can support the completion of the investigations.

5.1.3 Committees members agreed that **reasonable assurance** can be taken that there are appropriate mitigations in place to manage Patient Safety Incident Investigations, noting that a deeper discussion on never events will be held at the May meeting.

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

5.2.1 Committees members noted that the Trust has received the final Royal College of Physicians (RCP) Invited Review report on 24 March 2026, noting that the recommendations in the report have been accepted and acted upon. The team is currently ensuring that the findings of the RCP in relation to the care given to individual patients is shared with those patients and families, and that Statutory Duty of Candour is fulfilled where applicable. The full report will be published and discussed at the Group Board in public when patients and families have been appropriately communicated with.

5.3 Quality Management System Report

5.3.1 Committees members reviewed the report, noting that over the past year, gesh Group has advanced its commitment to fostering a continuous improvement culture. Through the Group Transformation Portfolio, executives have committed to the development and implementation of a gesh Quality Management System (QMS).

5.3.2 Members welcomed the introduction of a Quality Management System and agreed that meaningful frontline engagement would be crucial to developing a system teams find effective and to ensuring its success. Committees members noted that at present the QMS majored on Quality Improvement but emphasised that a clear approach to control, assurance and planning was needed to further improve quality management across the group.

5.4 SWL Pathology – FIT Testing

5.4.1 A report was presented detailing that a patient safety incident was identified on 4 March 2026 involving the misreporting of Faecal Immunochemical Test (FIT) results for symptomatic

patients across South West London and Surrey Downs. Due to a calibration error following a system change, results between 27 December 2025 and 4 March 2026 were reported in incorrect units, inflating values by a factor of five and leading to false positives.

5.4.2 All affected results have since been corrected, impacted patients identified, and steps taken to prevent unnecessary procedures. Corrective actions include recalibration of equipment, enhanced quality control measures, staff retraining, and notification of regulatory bodies. A total of 17 NHS organisations had patients referred and a total of 281 GP practices have registered patients impacted by this incident

5.4.3 Committees members agreed that from an assurance stand point, the response to this particular issue was reassuring, with the report articulating the mitigations in place to manage and respond to this issue well.

5.4.4 Committees members discussed how the governance works for Pathology with regards to it being a shared service across South-West London. It was advised that there is a Partnership Board which is the forum for discussing all South West London Pathology matters, along with coordinating the communication of any identified issues with stakeholders. Committees members agreed that the governance could be strengthened to ensure that there is appropriate oversight on the performance of SWL Pathology on a regular basis, and it was agreed that executives would discuss this further and propose how the governance structure could be improved.

5.5 Committee Annual Report and Terms of Reference

5.5.1 Committees members noted the annual report which summarised how the Committees fulfilled its duties and responsibilities as outlined in its established terms of reference. Members also reviewed the proposed Terms of Reference for 2026/27, agreeing that listing explicitly what areas of quality governance the committees should focus on will be helpful, as this can be regularly reviewed in-year to ensure the Committee is fulfilling its duties.

5.5.2 Committees members noted that the draft forward planner for 2026/27 is being finalised and will be presented to the Committees in May 2026 for approval.

6.0 Recommendations

6.1 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 March and April 2026.

Quality Committees

Annual Report 2025/26

1 April 2025 – 31 March 2026

Contents

Quality Committees Annual Report 2025/26

1. Introduction

Since the formation of the St George's, Epsom and St Helier University Hospitals and Health Group, a number of Board Committees have met as Committees-in-Common across the Group. Since April 2022, this has included the Quality Committees, People Committees, Finance and Performance Committees and Remuneration Committees of the two Trusts, with the Infrastructure and Audit and Risk Committees also operating as Committees-in-Common since October 2023 and May 2024 respectively.

This report sets out a high level overview of the work of the Quality Committees in 2025/26. It provides an integrated report on the key matters considered by the Committees, and highlights issues that were considered which related solely to either St George's or Epsom and St Helier. The purpose of this report is not to provide a detailed account of all matters considered by the Committees but to give an overview of how the Committees have discharged their responsibilities as set out in their terms of reference over the past year.

2. Committee purpose and duties

The Quality Committees of the two Trusts have adopted common terms of reference in order to ensure that there is consistency of purpose and duties across the two Committees. The Committees' purpose and duties are set out in the terms of reference agreed by the Trust Board's in May 2022 respectively. Minor amendments have been made to the original Terms of Reference on annual basis since 2022.

2.1 Purpose

The purpose of each Committee is to provide assurance to its parent Board on the quality of care provided to the Trust's patients, specifically in relation to patient safety, clinical governance and clinical effectiveness and patient experience, as summarised below:

- Ensuring that the Trust has in place appropriate quality and clinical governance systems, processes and controls in place to achieve consistently high-quality care and to meet the Trust's legal and regulatory obligations.
- Identifying and reviewing themes and trends in key quality indicators, seeking assurance that appropriate action is being taken to respond to and learn from these.
- Seeking assurance that key risks relating to quality of care, as included on the Board Assurance Framework and the Corporate Risk Register, are being effectively managed and mitigated.
- Oversight of the implementation of strategies and other frameworks. Review progress against the Trust's quality and safety strategy, quality priorities and any quality improvement plans.

3. Membership and attendance

3.1 Members and attendees

During the reporting period (April 2025 to March 2026), the following were members or regular attendees of the Quality Committees-in-Common:

St George's Quality Committee			
Name	**Role**	**Designation**	**Period**
Andrew Murray	Member	Committee Co-Chair - Non-Executive Director	1 April 2025 – 31 March 2026
Leonie Penna	Member	Committee Co-Chair, Non-Executive Member	1 October 2025 – 31 March 2026 (Co-Chair from 1 December 2025)
Yin Jones	Member	Associate Non-Executive Director	1 April 2025 – 31 March 2026
Peter Kane	Member	Non-Executive Director	1 April 2025 – 30 September 2025
Natalie Armstrong	Member	Non-Executive Director	1 April 2025 – 31 March 2026
Khadir Meer	Member	Associate Non-Executive Director	30 July 2025 – 31 March 2026
Richard Jennings	Member	Group Chief Medical Officer	1 April 2025 – 31 March 2026
Arlene Wellman	Member	Group Chief Nursing Officer	1 April 2025 – 14 September 2025
Elaine Clancy	Member	Interim Group Chief Nursing Officer	15 September 2025 – 31 March 2026
Kate Slemeck	Member	Managing Director – St George's	1 April 2025 – 31 March 2026
Luci Etheridge	Attendee	Site Chief Medical Officer	1 April 2025 – 31 March 2026
Stephanie Sweeney	Attendee	Group Director of Quality and Safety Governance	1 April 2025 – 31 March 2026
Alison Benincasa	Attendee	Group Director of Compliance	1 April 2025 – 31 March 2026
Stephen Jones	Attendee	Group Chief Corporate Affairs Officer	1 April 2025 – 31 March 2026
Nicola Shopland	Attendee	Site Chief Nursing Officer	1 April 2025 – 31 March 2026

Epsom & St Helier Quality Committee			
Name	**Role**	**Designation**	**Period**
Andrew Murray	Member	Committee Chair, Non-Executive Director	1 April 2025 – 31 March 2026
Leonie Penna	Member	Committee Co-Chair, Associate Non-Executive Member	1 October 2025 – 31 March 2026 (Co-Chair from 1 December 2025)
Peter Kane	Member	Non-Executive Director	1 April 2025 – 30 September 2025
Natalie Armstrong	Member	Non-Executive Director	1 April 2025 – 31 March 2026
Richard Jennings	Member	Group Chief Medical Officer	1 April 2025 – 31 March 2026
Arlene Wellman	Member	Group Chief Nursing Officer	1 April 2025 – 14 September 2025
Elaine Clancy	Member	Interim Group Chief Nursing Officer	15 September 2025 – 31 March 2026
James Blythe	Member	Managing Director – Epsom & St Helier	1 April 2025– 20 September 2025
Alex Shaw	Member	Interim Managing Director – Epsom & St Helier	21 September 2025 – 31 March 2026
Thirza Sawtell	Member	Managing Director – Integrated Care	1 April 2025 – 31 March 2026
Rebecca Suckling	Attendee	Site Chief Medical Officer -ESTH	1 April 2025 – 31 March 2026
Theresa Matthews	Attendee	Site Chief Nursing Officer - ESTH	1 April 2025 – 31 March 2026
Alison Benincasa	Attendee	Group Director of Compliance	1 April 2025 – 31 March 2026
Stephen Jones	Attendee	Group Chief Corporate Affairs Officer	1 April 2025 – 31 March 2026
Simon Littlefield	Attendee	Site Chief Nursing Officer – Integrated Care	1 April 2025 – 31 March 2026

Members of the St George's University Hospitals NHS Foundation Trust Council of Governors also regularly attended to observe meetings of the Quality Committees during the period.

3.2 Committee meeting attendance

Under the Committees arrangements, the Quality Committee of each Trust was required to be quorate. The quorum for each Quality Committee was a minimum of four Committee members, including two Non-Executive Directors and two Executive Directors.

The Committee held a total of 12 meetings during the reporting period and the attendance of members and regular attendees as defined in the Terms of Reference are set out below. All meetings of the Committees were quorate for both Trusts.

Attendance			
Name	**Role**	**Trust**	**Attendance**
Andrew Murray **	Committee Chair	SGUH	12/12
Leonie Penna	Committee Co-Chair	Both	5/6
Peter Kane	Member	ESTH	6/6
Yin Jones	Member	SGUH	6/12
Natalie Armstrong	Member	Both	6/12
Khadir Meer	Member	SGUH	6/8
Richard Jennings	Member	Both	12/12
Arlene Wellman	Member	Both	6/6
Elaine Clancy	Member	Both	6/6
James Blythe	Member	ESTH	4/6
Alex Shaw	Member	ESTH	6/6
Kate Slemeck	Member	SGUH	12/12
Thirza Sawtell*	Member	ESTH/IC	0/12

**Thirza Sawtell was represented by Simon Littlefield at the majority of the meetings of the Committee.*

In addition to the above, the Group Chair, Group Chief Executive Officer and Group Deputy Chief Executive Officer regularly attended meetings of the Quality Committees during the reporting period.

The following members of the St George's Council of Governors observed meetings of the Quality Committees-in-Common also during this period:

SGUH Governors observing		
Name	**Role**	**Attendance**
John Hallmark	Public Governor Wandsworth	
Cllr Judy Gasser	Appointed Governor, Wandsworth Council	
Georgina Sims	Appointed Governor, Kingston University	
Sarah Forester	Governor Healthwatch Wandwsworth	
Alfredo Benedicto	Appointed Governor, Merton Healthwatch	
Huon Snelgrove	Staff Governor SGUH	
Chelliah Lohendran	Public Governor, Merton	
Dympna Foran	Staff Governor, Nursing and Midwifery	
Jackie Parker	Public Governor, Wandsworth	

Representatives of South West London Integrated Care Board, June Okochi and Justin Roper, also attended meetings of the Committee throughout the year.

4. Committee activity and focus

4.1 Overview of the Committees' work

During 2025/26, the Quality Committees undertook a broad programme of work to support the Group Board in its oversight of quality, safety and patient experience. The Committees undertook scrutiny of clinical quality and safety, bringing together performance reporting, deep dives into priority areas, and review of improvement programmes across both Trusts.

The scope of the Committee's work encompassed a wide range of quality domains, including patient safety and incident management and learning, maternity services, delivery of the Group's quality priorities, safeguarding, infection prevention and control, medicines management, and wider quality governance arrangements. This was supported by regular review of the Integrated Quality and Performance Report, thematic deep dives, and consideration of internal and external assurance sources, including regulatory feedback, audits and national standards.

A significant component of the Committee's work during the year involved examining the effectiveness of the Group's quality and safety governance framework itself. This included scrutiny of how issues were identified and escalated, the quality and reliability of data presented to support decision-making, and the extent to which improvement plans were clearly articulated, monitored and delivered. In several areas, the Committee focused not only on the issues being reported, but also on the robustness of the systems used to provide assurance.

Alongside this, the Committee maintained close oversight of a number of priority areas where risks to quality and safety were known or emerging. These included maternity services, the quality and safety implications of emergency department pressures, patient safety incidents and never events, falls prevention, venous thromboembolism (VTE), and delirium. The Committee also reviewed a range of established assurance areas, such as infection prevention and control, safeguarding and medicines management, where more mature governance arrangements were generally in place.

Throughout the year, the Committee's work was characterised by a combination of routine assurance, targeted scrutiny and escalation of concerns to the Group Board where appropriate. The Committee made use of focus sessions and deep dives to explore areas of risk in greater detail, and frequently requested further information or revised reporting where it considered that the material presented did not provide sufficient clarity or confidence.

4.2 Quality and Safety Governance

Quality and safety governance remained a central focus of the Committee's work during 2025/26. This focus was shaped by the findings of the two-part external quality governance reviews undertaken between 2023 and 2025, which identified a number of areas requiring strengthening across the Group's quality governance framework. It was reinforced by concerns arising from the Care Quality Commission (CQC) inspection of St George's maternity services in March 2023, and subsequent service-level inspections, which highlighted issues relating to oversight, assurance and the consistency of quality governance arrangements.

As a result, the Committee maintained close oversight of the development and implementation of a new Group-wide quality and safety governance improvement programme. This included reviewing proposals for revised governance structures, seeking clarity on roles and accountabilities, and examining how assurance flows from ward to Board.

Through this work, the Committee identified ongoing variability in the maturity of governance arrangements across the Group. While some services demonstrated well-established systems of oversight and assurance, others showed inconsistency in governance processes, including differences in how performance was monitored, how risks were articulated, and how improvement actions were tracked.

A recurring theme in the Committee's discussions was the quality and reliability of information presented to support assurance. In several areas, reports lacked sufficient clarity, consistency or depth to enable the Committee to form a clear view of risk and mitigation. This included challenges in data validation, benchmarking, and the alignment between narrative reporting and quantitative performance data. As a result, the Committee requested further work to strengthen reporting, improve data quality and provide clearer trajectories for improvement.

The Committee also recognised that governance is not solely a structural issue, but is closely linked to organisational culture and behaviours. In some areas, concerns were raised regarding whether issues were being identified and escalated in a sufficiently open and proactive manner, and whether quality governance processes were supporting a "problem-sensing" approach rather than one focused on assurance seeking.

Overall, while progress was made in developing a more coherent and structured governance framework, the Committee's work during the year highlighted that the effectiveness of quality and safety governance remained variable, and that further work is required to ensure that governance systems consistently provide reliable, timely and actionable assurance to the Board.

The Committee will have a major focus on the implementation, embedding and impact of the quality and safety governance improvement plan during 2026/27.

4.3 Patient Safety Incident Response Framework

The Committee maintained sustained oversight of patient safety throughout 2025/26, with a particular focus on the management of incidents, the embedding of the Patient Safety Incident Response Framework (PSIRF), and the extent to which learning from incidents was translated into improvement.

Across the year, the Committee received regular updates on patient safety incidents and noted that the organisation was making progress in embedding PSIRF as the primary framework for responding to incidents. This included strengthening governance processes, increasing engagement with clinical teams, and developing approaches to identifying and escalating themes arising from investigations. The Committee recognised that this represents a significant shift from previous approaches and requires time to become fully embedded across all services.

At the same time, the Committee's scrutiny consistently highlighted challenges in the consistency and pace of implementation. These included delays in completing investigations, variability in the quality of learning responses, and the need to ensure that learning was systematically translated into sustained improvement. In February 2026, the Committee also considered an internal audit of PSIRF at Epsom and St Helier, which reinforced these observations by identifying that, while key elements of the framework were in place, further work was required to ensure consistent application and full embedding of the approach in practice.

A particular and recurring concern for the Committee was the occurrence of Never Events during the year, with wrong site surgery and retained foreign objects being recurrent issues and the majority of Never Events relating to surgery and dermatology. While individual incidents were subject to investigation and action planning, the Committee consistently concluded that it could only take limited assurance in relation to the prevention of Never Events, despite being able to take reasonable assurance on the overall patient safety framework.

The continued incidence of these events led the Committee to question the extent to which learning from previous incidents had been fully embedded and whether preventative actions were being applied consistently across services. The Committee emphasised that Never Events should not become normalised within the Group and required further work to strengthen safety controls, improve oversight, and ensure that learning was identified, shared, and translated into sustained changes in practice.

Throughout the year, the Committee sought greater clarity on how themes from incidents were being monitored at a system level, and how assurance could be provided that actions taken were resulting in sustained risk reduction. Patient safety, and in particular the prevention of serious and avoidable harm, remained an area of continued focus and scrutiny.

4.4 Maternity Services

A key focus for the Committees during 2025/26 was maternity services across both Trusts, reflecting the scale of regulatory concern and the importance of sustained improvement in safety and quality. The Committees undertook detailed and ongoing scrutiny of maternity performance, monitoring a comprehensive range of indicators to assess the quality and safety of services. This included perinatal quality surveillance measures, performance against national maternity metrics, and delivery of the safety actions within the Maternity Incentive Scheme (MIS).

The Committees received quarterly reports in line with the requirements of the Maternity and Perinatal Incentive Scheme and the Perinatal Quality Surveillance Model (PQSM). These reports provided a structured overview of performance, including monthly indicators, emerging risks, significant incidents, and areas of progress. They also incorporated mandated data from the NHS England Perinatal Quality Oversight Model, alongside detailed updates on compliance with the Clinical Negligence Scheme for Trusts (CNST) safety actions and associated Board assurance requirements.

Throughout the year, the Committees maintained close oversight of the Trusts' response to issues identified through CQC inspections, including the delivery of action plans and progress against regulatory "must do" requirements. This scrutiny extended beyond monitoring completion of actions to assessing whether improvements were being delivered at pace, embedded in practice, and resulting in measurable improvements in safety and quality.

The Committees regularly challenged the quality and clarity of reporting, sought assurance on areas of risk, and requested further detail where progress or impact was not sufficiently evidenced. Particular attention was given to consistency of delivery across both Trusts and the sustainability of improvements over time.

In February 2026, the Committees received delegated authority from the Group Board to approve the CNST submission on its behalf. Following detailed review, the Committees were assured that both ESTH and SGUH were in a position to declare full compliance with all ten safety actions for MIS Year 7. This represented an important milestone; however, the Committees emphasised the need to ensure that compliance was sustained and translated into demonstrable and lasting improvements in clinical practice and patient outcomes.

4.5 Emergency department safety and quality

The Committee maintained oversight of quality and safety within Urgent and Emergency Care (UEC) services during 2025/26, recognising the sustained operational pressures within Group's three Emergency Departments and the associated risks to patient safety and experience.

The Committee received regular updates through the Integrated Quality and Performance Report and specific deep dives during the year, including detailed review following the CQC inspection at SGUH, which identified concerns in relation to safety within the Emergency Department. In response, the Committee supported enhanced scrutiny of ED services, including oversight of actions to address regulatory requirements and improve safety and governance processes.

Through this work, the Committee noted improvements in some areas, including triage processes and local governance arrangements. The Committee was able to take assurance that actions were in place to address the issues identified and that risks were understood and being actively managed. However, the Committee also recognised that underlying pressures relating to demand, flow and capacity continued to impact performance, including waiting times, overcrowding and corridor care. These pressures required ongoing organisational focus and were considered in the context of wider system challenges affecting patient flow.

Overall, the Committee's oversight reflected a position in which there was evidence of targeted improvement and strengthened oversight, alongside continued operational pressures which required ongoing scrutiny. The Committee will continue its focus on this in 2026/27.

4.6 Quality priorities

The Committee maintained oversight of the Group's quality priorities throughout 2025/26, including pressure ulcer prevention, venous thromboembolism (VTE) risk assessment, falls prevention, delirium assessment, emergency department flow, and maternity safety. These priorities were intended to focus organisational effort on areas of highest risk and support measurable improvement in patient outcomes.

The Committee received regular updates, including quarterly reports on progress, trajectories and areas requiring further attention. This enabled tracking of improvements in some areas, such as reductions in pressure ulcer harm and elements of falls prevention, alongside continued underperformance in areas such as VTE compliance and emergency department flow.

A consistent theme was variability in performance and delivery, both across priorities and between sites. In several areas, progress was not on the expected trajectory, and the Committee sought greater clarity on the effectiveness and pace of improvement actions.

The Committee also identified challenges in the quality and consistency of reporting, including limitations in data quality, benchmarking and the articulation of risk and mitigation. This was particularly evident in relation to delirium, where the Committee concluded that the information presented did not provide a sufficient basis for assurance and requested further work to improve reporting and clarity of improvement plans.

The Committee emphasised the importance of setting realistic, deliverable priorities supported by clear metrics and robust governance, and sought assurance that improvements were being embedded in practice.

In this context, the Committee also reviewed the proposed quality priorities for 2026/27, emphasising the need for a more focused and achievable set of priorities, aligned to areas of greatest risk and organisational capacity to deliver. The Committee supported the development of a refined set of priorities, with an expectation that these would be underpinned by clearer trajectories, improved data quality, and stronger governance arrangements.

Overall, while progress was evident in some areas, delivery of the quality priorities remained variable, requiring strengthened oversight, improved data quality and clearer demonstration of sustained improvement.

4.7 Clinical audit and effectiveness

The Committee considered clinical effectiveness and clinical audit primarily through its review of wider quality reports, including compliance with national standards, CQC requirements, and internal and external audit findings. This included areas such as NICE compliance, regulatory actions, and audit activity embedded within service-level reporting.

Through this work, the Committee was able to take assurance in specific areas where audit and compliance processes were well established. However, its discussions also highlighted variability in the consistency and maturity of audit processes across services, including differences in how findings were reported, acted upon and embedded in practice.

The Committee emphasised the importance of strengthening the link between audit, clinical effectiveness and quality improvement, and sought greater clarity on how learning from audit activity was translated into sustained improvement. This remained an area where further development was required to ensure that audit activity consistently supported robust assurance and improvement.

4.8 Interstitial Lung Disease

The Committee received regular updates on Interstitial Lung Disease (ILD) at ESTH following the concerns raised by staff and the commencement of an external review (As reported to the Group Board in public in November 2024). The Committee received updates on the progress of the external review by the Royal College of Physicians, the Trust's response, and the discharge of statutory Duty of Candour in cases where the RCP review identifies harm. The Committee noted the importance of fully understanding the findings of the review and ensuring that any required actions are clearly defined and implemented. The Committee will continue to maintain oversight of this area to ensure that learning is embedded and improvements are sustained.

4.9 Quality and Safety risks on the Group Board Assurance Framework

The Committee maintained oversight of the quality and safety risks on the Group Board Assurance Framework (BAF), considering updates on relevant strategic risks and reviewing and recommending to the Board associated assurance ratings.

Through this work, the Committee considered whether risk ratings remained appropriate and whether the level of assurance reflected the position described in supporting reports. This included, where necessary, recommending changes to assurance ratings or seeking clarification where further evidence was required.

The Committee noted that, in a number of instances, no changes to risk scores or assurance ratings were proposed, and supported this position where it was consistent with the information presented. It also considered the alignment between BAF risks and issues

identified through its wider work programme, including quality priorities and governance concerns.

The Committee will be reviewing the quality and safety risks on the revised Group Board Assurance Framework in 2026/27 on a quarterly basis, alongside regular oversight of the principal operational quality and safety risks on the two Trusts' Corporate Risk Registers.

5. Committee Effectiveness

In line with good governance practice, the Committee undertook its annual effectiveness review in February 2026, based on feedback from Committee members, Executive colleagues and regular attendees. Overall, the Committee was assessed as operating reasonably effectively, with the majority of respondents rating it as very or extremely effective .

Areas of good practice identified included:

- Effective chairing of meetings, enabling business to be delivered within time while supporting constructive and open discussion
- High quality of discussion and challenge, with a clear focus on quality, safety, risk and assurance
- Oversight of a broad range of quality and safety issues, with appropriate depth of scrutiny
- Well-organised meetings and strong support from the secretariat
- Usefulness of key reports, particularly the Key Issues report, in supporting discussion and oversight
- An open and collaborative environment that enables probing questions and meaningful debate

Areas identified for further development included:

- Variable quality and timeliness of papers, with a need for more concise reporting and clearer articulation of assurance and key issues
- Strengthening forward planning and agenda discipline to reduce late changes and deferred items
- Greater focus on key quality and safety metrics, particularly within the Integrated Quality and Performance Report
- Improving how progress against quality priorities is tracked and reported throughout the year
- Reviewing the effectiveness of alternating formal meetings and focus sessions, given the breadth of the Committee's responsibilities
- Enhancing triangulation, including stronger linkage with frontline services and other committees

These findings are being used to inform the Committee's work programme for 2026/27, including updates to the terms of reference, forward plan and reporting approach, with a focus on strengthening the quality of information and supporting robust and consistent assurance to the Board.

6. Committee Forward Plan and Terms of Reference

The Terms of Reference have been comprehensively reviewed to strengthen the Committee's ability to provide clear, evidence-based assurance to the Board on the quality and safety of

care, in line with best practice and the *Insightful Board* guidance from NHS England. The revised Terms clarify the Committee's role across four key areas: oversight of quality governance systems, scrutiny of risks to patient safety and quality, assessment of performance and outcomes using triangulated intelligence, and evaluation of whether learning is leading to sustained improvement across the organisation and wider Group. This provides a clearer and more structured basis for the Committee's work and decision-making.

The review also places greater emphasis on safety culture, continuous improvement and the effective sharing of learning across the Group, alongside clearer expectations around the quality, focus and purpose of reporting to the Committee. Collectively, these changes are intended to sharpen the Committee's focus on insight and impact, reduce duplication and ambiguity, and enhance the Board's confidence that it is receiving robust and meaningful assurance on the quality of care.

7. Conclusion

Over the course of 2025/26, the Committee was able to provide the Board with assurance across a broad range of quality and safety domains, supported by regular reporting, deep dives and targeted scrutiny of areas of risk. In a number of areas—particularly those with more established governance arrangements, such as infection prevention and control, medicines management and elements of the patient safety framework—the Committee was able to take reasonable assurance that appropriate controls were in place and broadly operating as intended. The Committee also saw evidence of progress in some areas, including maternity services and aspects of the quality priorities, supported by structured improvement activity.

However, the level of assurance was not consistent across all areas. In several key domains, including delivery of quality priorities, safeguarding, and specific patient safety risks such as never events, the Committee was only able to take limited assurance, reflecting variability in performance, delivery and the effectiveness of controls. In addition, there were instances where the Committee was unable to take assurance, most notably in relation to delirium, due to weaknesses in data quality, reporting and the absence of a clear improvement narrative .

Overall, the Committee's ability to take assurance was closely linked to the maturity and consistency of quality and safety governance, including the reliability of data and the clarity of reporting. While progress was evident in a number of areas, the Committee concluded that further work is required to strengthen governance, improve the quality of information and ensure that improvement activity is consistently translated into demonstrable and sustained improvements in patient care.

Quality Committee

Terms of Reference

1. Name

The Committee shall be known as the “Quality Committee”.

2. Authority

The Quality and Safety Committee is constituted as a committee of the Board of Directors and is authorised by the Board to:

- Request any information required from any member of staff
- Require attendance of any employee or officer
- Commission deep dives or reviews into areas of concern
- Obtain independent professional advice where required

3. Purpose

The purpose of the Committee is to provide the Board with robust, evidence-based assurance that the Trust delivers safe, effective, high-quality and patient-centred care, and that there is a culture of continuous learning and improvement across the organisation and the wider Group. The Committee will focus on the effectiveness of quality governance systems, the identification and management of risks to quality, the use of triangulated intelligence to understand performance and variation, and the extent to which learning leads to sustained improvement, including the effective sharing of learning across the Group. The Committee provides assurance and challenge; it does not undertake operational management.

The Committee will oversee all aspects of quality of care, including:

- Patient safety
- Clinical effectiveness
- Patient experience
- Safety culture and staff experience insofar as it impacts patient safety, quality of care and organisational learning
- Safeguarding and statutory quality duties
- Health inequalities in access, experience and outcomes
- The contribution of research and innovation to quality of care, including the adoption and spread of innovation across the Group

4. Responsibilities

4.1 Quality Governance Framework

The Committee will:

- Seek assurance that effective quality governance structures, systems and processes are in place and operating consistently

- Ensure there is a clear line of sight from ward to Board, including escalation routes for concerns
- Review the effectiveness of governance arrangements at site and service level
- Ensure that roles, accountabilities and reporting arrangements are clearly defined and understood
- Ensure that clear and consistent reporting routes are in place and operating effectively
- Seek assurance that there are effective mechanisms for sharing learning and best practice across the Group, and that these are embedded in governance processes

4.2 Patient Safety and Learning

The Committee will:

- Review and seek assurance on patient safety performance, including key risks, trends and variation
- Receive a regular patient safety report, setting out a summary of incidents, themes, learning and impact
- Seek assurance on the implementation of the Patient Safety Incident Response Framework (PSIRF)
- Seek assurance that learning from patient safety incidents, complaints and mortality reviews is:
    - systematically identified
    - Shared effectively within and across organisations in the Group
    - Embedded into practice
- Review whether actions taken lead to sustained improvement in safety outcomes across sites and services
- Receive assurance on high-risk areas (e.g. maternity, safeguarding) using a risk-based approach

4.3 Clinical Effectiveness and Outcomes

The Committee will:

- Seek assurance on the clinical effectiveness of services, including outcomes and variation
- Review key findings from:
    - Clinical audit programmes
    - Benchmarking and external comparisons
- Ensure that learning from audit and outcomes data is:
    - Translated into improvement
    - Shared and adopted across the Group where relevant

4.4 Patient Experience and Engagement

The Committee will:

- Seek assurance that patient experience is systematically captured, triangulated and acted upon
- Receive a regular patient experience report, including key themes, risks and learning
- Review intelligence from:
    - Complaints and compliments
    - Patient surveys (including Friends and Family Test)
    - Patient stories and engagement activity
- Ensure that learning from patient feedback is:

  - Used to drive improvement
  - Shared across services and organisations to improve care more widely

4.5 Safety Culture

The Committee will:

- Seek assurance on the culture of safety, openness and learning as it relates to the delivery of safe, high-quality care
- Review indicators relevant to quality and patient safety, including:
  - Staff confidence to raise concerns (e.g. Freedom to Speak Up)
  - Incident reporting rates and patterns
  - Safety-related themes from staff survey results
- Assess whether staff feel able to raise concerns about patient safety and quality, and whether these concerns are responded to effectively and lead to improvement
- Seek assurance that the organisation demonstrates a just and learning culture in response to safety incidents and concerns
- Ensure that learning arising from staff insight and safety concerns is used to improve care and shared across teams, sites and the wider Group

4.6 Health Inequalities

The Committee will:

- Seek assurance that the Trust is addressing inequalities in access, experience and outcomes
- Review data where available to identify variation across patient groups
- Monitor progress against strategic objectives relating to health inequalities
- Seek assurance that learning on reducing inequalities is shared and applied across the Group

4.7 Continuous Improvement

The Committee will:

- Seek assurance that the Trust has:
  - Sufficient capacity and capability for quality improvement
  - Effective frameworks and methodologies for improvement
- Review whether improvement activity is delivering measurable and sustained change
- Seek assurance that improvement learning is spread and adopted across the organisation and Group, avoiding isolated or localised change

4.8 Research and Innovation

The Committee will:

- Seek assurance that research and innovation activity contributes to improved patient outcomes, safety and experience
- Review how evidence, best practice and innovation are adopted and spread across the organisation and the wider Group
- Seek assurance that participation in research supports high-quality care and improved clinical outcomes
- Ensure alignment between research, innovation and the Trust's quality priorities and improvement objectives

4.9 Risk and Assurance

3

The Committee will:

- Review quality and safety risks within:
  - the Board Assurance Framework
  - the Corporate Risk Register
- Seek assurance that risks are:
  - Appropriately identified
  - Adequately controlled
- Identify and escalate gaps in assurance to the Board
- Consider whether risks and learning have implications beyond individual services or sites, and ensure these are addressed at Group level

4.10 External Oversight and Compliance

The Committee will:

- Seek assurance that the Trust meets regulatory requirements, including those of the Care Quality Commission
- Review findings from:
  - External inspections
  - Independent reviews
  - National benchmarking
- Oversee progress against Quality Account priorities and improvement plans
- Ensure that learning from external reviews is:
  - Acted upon
  - Shared across the organisation and Group where relevant

4.11 Integration with Other Committees

The Committee will:

- Work with the Finance and Performance Committee to ensure quality and performance are considered together
- Work with the Audit and Risk Committee to ensure alignment between risk, control and assurance
- Avoid duplication and ensure clarity of committee responsibilities
- Ensure that learning and risks are appropriately escalated and shared across committees and at Group level

5. Membership and Attendance

5.1 Membership

The Committee shall comprise:

- Minimum of four Non-Executive Directors (including two co-chairs)
- Group Chief Medical Officer
- Group Chief Nursing Officer
- Managing Director(s)

5.2 Co-Chairing Arrangements

The Committee will be jointly chaired by two Non-Executive Directors, with the chai typically alternative between meetings. One co-chair will be designated to report formally to the Board following each meeting.

5.3 Regular Attendees

The following are expected to attend but will not be counted towards quoracy.

- Site Chief Medical Officer
- Site Chief Nursing Officer
- Group Chief Midwifery Officer *(where maternity is on the agenda)*
- Group Director of Quality and Safety Governance
- Group Chief Corporate Affairs Officer

Other directors and staff may attend meetings with the prior permission of the joint Chairs.

An attendance register will be held for each meeting and an annual register of attendance will be set out in the Trust's Annual Report.

All members and attendees named above are expected to attend every meeting with a minimum attendance of 75% over the course of a financial year.

7. Quorum

The quorum for any meeting of the Quality and Safety Committee shall be a minimum of four members of the Committee including:

- At least two Non-Executive Directors
- At least two Executive Directors

Non-quorate meetings: Non-quorate meetings may go ahead unless the Chair decides not to proceed. Any decision made by the non-quorate meeting must however be formally reviewed and ratified at the subsequent quorate meeting or the Board.

8. Accountability and Reporting Arrangements

The Committee is accountable to the Trust Board. Under the Group Board arrangements, the Quality and Safety Committee, acting as part of a Group-wide Committees-in-Common, will report to the Group Board. This will include:

- Submitting an exception report after each meeting, clearly identifying:
  - Areas of concern
  - Areas of limited or no assurance
  - Key risks requiring escalation
- Highlighting areas where assurance is strong
- Highlighting themes, learning and improvement opportunities requiring action or adoption at Group level

- Escalating issues requiring Board attention
- Contributing to Group Committee-in-Common arrangements where applicable

In addition, the Committee will submit an annual report to the Group Board setting out how it has operated to fulfil role as set out in these terms of reference over the past year.

9. Meeting Format and Frequency

The Committee will meet monthly. Additional meetings may be called by the Chair as necessary, who may also cancel or rearrange meetings in exceptional circumstances.

10. Declarations of Interest

All members of the Committee must declare any actual or potential conflicts of interest. These will be recorded in the minutes.

Anyone with a relevant or material interest in a matter under consideration may be excluded from the meeting for the duration of the relevant item.

11. Meeting Arrangements and Secretariat

The Group Chief Corporate Affairs Officer will ensure secretarial support is provided for the Quality Committee. This will include the following;

- Preparing a forward plan for the Committee.
- Calling for, collating and distributing meeting papers.
- Taking accurate minutes.
- Producing an action log and chasing completion of actions.

The agenda for the meeting will be agreed in advance with the Committee Chair, based on the forward plan and in conjunction with the executive lead.

All papers and reports to be presented at the Committee must be approved by the relevant executive director.

The agenda and the supporting papers for the meeting will be circulated not less than five working days before the meeting.

12. Review of Committee effectiveness and Review of Terms of Reference

The Committee will:

- Undertake an annual review of the Committee's effectiveness
- Review these Terms of Reference annually
- Recommend changes to the Board for approval

Document Control

Profile	
Document name	Quality and Safety Committee Terms of Reference
Version	2.1
Executive Sponsor	Group Chief Medical Officer and Group Chief Nursing Officer
Author	Group Chief Corporate Affairs Officer
Approval	
Date of Committee approval	
Date of Trust Board approval	
Date for next review	April 2027

Group Board Meeting (Public)

Meeting on Friday, 08 May 2026

Agenda Item	2.2	
Report Title	**Maternity Quarterly report – PQOM, CNST, PMRT**	
Executive Lead(s)	Elaine Clancy, Interim Group Chief Nursing Officer	
Report Author(s)	Michelle Cudjoe Group CMO Contributors: Annabelle Keegan, Director of Midwifery and Gynaecology Nursing Laura Rowe, Lead Midwife for Clinical Governance and Risk Fiona Walkinshaw, Deputy Director of Midwifery	
Previously considered by	Quality Committees	30 April 2026
Purpose	**For Approval / Decision**	

Executive Summary

Purpose

This report is submitted to provide oversight of maternity service across GESH and escalate for review as required. It contains current metrics aligned to the Perinatal Quality Oversight Monitoring (PQOM) tool within the appendices, a CNST summary noting the changes expected to be contained within CNST Year 8 and a Moss Safety Critical check. The individual Trust papers cover a reporting period of December 2025- Feb 2026.

Of note, the MOSS safety signal occurred in March and although this fell outside of the reporting period, it has been included in line with the national requirement to include the review of any signal at the next Board or sub-committee.

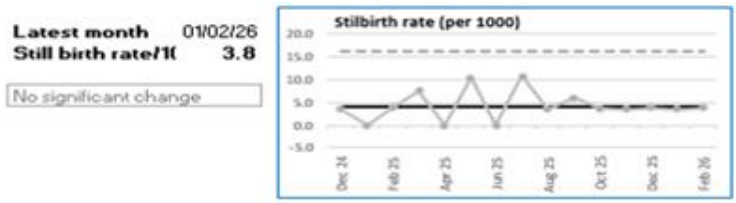
Key Achievements / Highlights

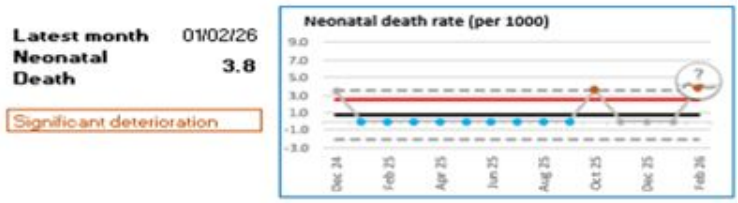
- Midwifery senior leadership team now fully recruited to. Substantive Director of Midwifery at St Georges commenced in February and Group Chief Midwifery in March 2026
- 14 Band 5 midwives commenced at St Georges
- Consistent utilisation of Birth Centre at St Heliers (around 16%)
- Second theatre opened at Epsom

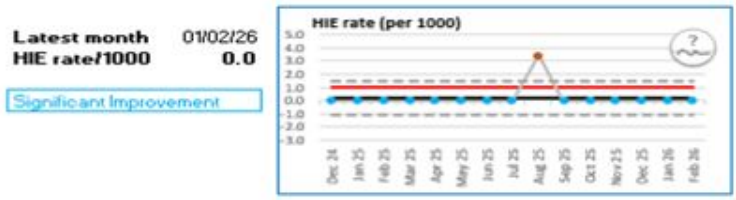
Maternity Outcomes

The following graphs demonstrate the current position in relation to key maternity outcomes across the group.

ESTH


Latest month 01/02/26
Still birth rate/1(3.8
No significant change
Stillbirth rate (per 1000)


Latest month 01/02/26
Neonatal Death 3.8
Significant deterioration
Neonatal death rate (per 1000)

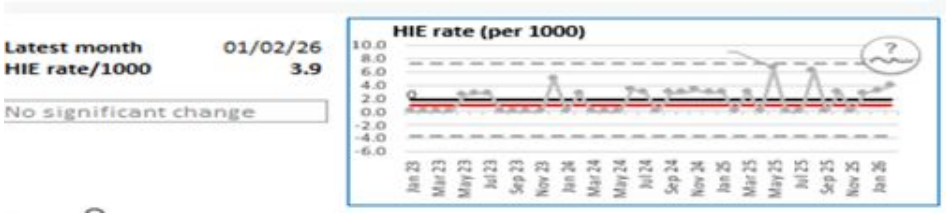

Latest month 01/02/26
HIE rate/1000 0.0
Significant Improvement
HIE rate (per 1000)


Variation
Assurance

St Georges


Latest month 01/02/26
Still birth rate/1000 0.0
No significant change
Stillbirth rate (per 1000)


Latest month 01/02/26
Neonatal Death rate/1000 11.7
No significant change
Neonatal death rate (per 1000)


Latest month 01/02/26
HIE rate/1000 3.9
No significant change
HIE rate (per 1000)

Although there is evidence presented within both PQOM reports of progress and improvement across the services (see appendices) there remains some key areas of risk that need to be highlighted to the Board from across the group.

Key risks and issues for escalation

ESTH

1. **STAN monitoring and storage of CTG issues:** Issues relating to the storage of fetal monitoring records was identified in January 2025 and escalated to the supplier, Neoventa. SWL fetal monitoring midwives and DoM's, including CNIO and IT, have met with Neoventa on 9th March to discuss the issues currently identified. As ESTH does not use Omniview, it relies on direct uploading of CTG records from the STAN machine to the patient record. The number of identified lost CTG's found from September to date is 25, with no known number previous to this. Strengthening of current mitigation is now in place to ensure safe storage of CTG's. The mitigation includes manual weekly download onto a USB then direct uploading into the patient record. Neoventa supported an upgrade to the software in March which has failed with responsibility for further upgrades now linking with EME department who have been in attendance at the discussions.
   Next steps: Awaiting further upgrade to test on a single machine at STH: ESTH site MDT meeting to review options
   It remains on the risk register at '15 - Extreme'

2. **Home Birth service**
   ESTH continues to provide a home birth service although this is currently limited in scope. A consultation to provide second on-call from the community teams commences on the 27th April and Staffside have been kept fully informed. The aim is to provide a safe service that delivers care by midwifery staff who are skilled in out-of-hospital birth settings. There is a national working group to review standards for homebirth which will inform the service when available, anticipated to be June 2026.

St Georges

CQC published report from October 2024 inspection

Safe - rated inadequate. Action planning has taken place across the service and improvements have been made. There remain some areas of concern where further work continues to ensure sustainability:

- Medicine management
  - Maternity Medicines Working Group is commencing in April to provide ward level scrutiny of medicine management and accountability for actions.
  - Team working to ensure all medications no longer required are discontinued.
  - Missed doses monitored by ward in-charge
  - Pharmacy planning roll-out of care Compass
  - Triangulation of patient feedback, complaints, datix to identify potential areas of improvement.
- Daily safety check compliance

- Ward leads overseeing daily safety checks to ensure that these have been carried out.
- Although improvement has been seen, work continues to provide assurance that this practice is fully embedded within Delivery Suite. Delivery Suite Matron following- up with individuals.

All actions are included within the Maternity Integrated Action Plan and evidence of improvement is presented to the Evidence Assurance panel.

2. Risk updates

iClip issues update (slide 7):
Since the implementation of iClip Pro at SGUH in February 2025, several challenges have arisen post-implementation. Some of these are build issues that were not appropriately acted on and some are issues that have been identified since the system has been in use. A risk assessment was completed in 25th September 2025 and regular updates have been presented to the Divisional Governance Meetings. This was added to the Maternity Risk Register as Extreme. Risks are mainly linked to the following areas and mitigations are in place as described in slide 9:

- Full data migration did not take place at Go-Live, meaning staff must view the old system alongside iClip during patient care – currently there is work ongoing to transfer data across with 1400 records still to migrate
- Lack of mandatory fields causing data quality issues, which impacts among other aspects, the accurate and full reporting of the Maternity Services Data Set (MSDS). Manual
- MEWS scoring not being scored electronically requiring a work round as it automatically defaults to NEWS.
- 100 IT tickets were submitted with identified issues which have been reviewed in a meeting led by the DDO – these tickets have now been reduced, merged and priority graded with 15 considered as high priority.

MEWS Update (see slide 9)
Cerner and IT have worked on a fix for the MEWS error, and this will be added to the Live system Mid-April for this to be tested. Superusers are being trained to support staff to test and feedback on whether this is a successful fix.

AWARE

- There are two cases from St Georges awaiting inquest dates this links to incidents which occurred in 2024 and 2025. An aggregate review of the cluster of deaths that occurred in 2025 is being undertaken.
- Obstetric training at St Georges is currently below the specified target. Midwifery training is just below 90% and is linked to 14 new midwives who started in Jan 2026. All staff have since been booked onto relevant training. The ESTH data for Jan and Feb 26 training for Trainee and Staff grade Obstetricians was reduced due to issues linking the booked study day with rosters. This has now been rectified, and all required training has been rostered correctly to improve the position.
- Saving Babies Lives Care Bundle Version 3: This is currently partially compliant across the group. Although there was enough progress noted for this to be rated compliant for CNST further progress is required, and work will continue to focus on these areas.
- Synthesis of incidents reported from each Trust identifies that PPH is one of the top 5 incidents reported in the quarter and as a result it is a priority clinical theme within each PSIRF plan. A

GESH Peer Review and Learning collaborative is being launched on the 8th May and will provide an opportunity for shared learning.

- Year 8 MIS has been launched. The focus is on outcomes and less on process giving some flexibility in relation to how compliance can be achieved. Local staff have been booked to attend the official launch of the Year 8 standards on 23rd April. Sign off of CNST evidence will be the sole responsibility of the Trust Board. Some new areas introduced which will require work at pace to achieve compliance across the group.

ALERT

ESTH

MOSS Signal: The Maternity Outcomes Signal System (MOSS) was introduced in November 2025 by NHS England in response to the East Kent Reading the signals report (2022). The reported recommended the development of a safety signal system capable of monitoring routinely collected Maternity and Neonatal outcomes to detect potential declines in safe care in a timely way, by generating signals at provider level. Signals do not necessarily mean a service is unsafe but must prompt a service-led critical safety check to provide early insights into potential intrapartum care safety issues enabling rapid intervention to reduce potential future harm.

MOSS objectives are to:

- be sensitive and specific to services that deliver intrapartum care by using the term outcome measure of stillbirth and neonatal death (up to 28 days), and from 2026 hypoxic ischaemic encephalopathy (HIE) cases, that have a high potential of causation from care and service deliver issues and a low potential of causation from clinical conditions
- Identify unusual near-real time changes in outcome trends that may indicate declining intrapartum safety
- Prompt a critical safety check led by the local perinatal leadership team to assess the safety of operational processes on the labour ward, review priorities and plan early interventions.
- support rapid escalation through the Trust Board, ICB, regional and national teams through the Perinatal Quality Oversight Model (PQOM)
- support a positive safety culture
- improve outcomes

St Helier is the hospital site that has triggered the Level 1 MOSS signal. MOSS review ESTH against a baseline with an Amber signal triggered when there is a doubling; for the time period under review, the baseline was 1 case meaning on reaching 2 cases in the time period this signal was triggered. Of note, the baseline changes due to the cumulative nature of the review system. Further details of cases reviewed and the critical response noted in appendix 3. An audit of surgical documentation gaps will be undertaken with an action plan to reduce these, reported in the Q2 2026. Of note these gaps did not contribute to the outcome and there is a failsafe within midwifery documentation.

Actions: Critical safety check accepted by ESTH SLT and Elaine Clancy, Group Chief Nurse and submitted to ICB and Regional teams as required on 10th April 2026.

CMO has arranged a workshop for all key stakeholders in relation to the use of MOSS

Action required by Group Board
The Board is asked to: a. Confirm assurance

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

Appendices	
Appendix No.	**Appendix Name**
Appendix 1	PQOM report ESTH and PQOM St Georges
Appendix 2	CNST update
Appendix 3	MOSS Critical Safety Check

Implications

Group Strategic Objectives

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

Risks

STAN and fetal monitoring concerns

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

ESTH: Achieved 10/10 Safety Actions in MIS Yr 7

Legal and / or Regulatory implications

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. An EDI working group is in place with membership including MNVP

representation – this group acts as the overarching oversight group for EDI work including review of national health inequalities data and local dashboard information. 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
None noted

Group Board Meeting (Public)

Meeting on Friday, 08 May 2026

Agenda Item	2.2	
Report Title	**ESTH Maternity MOSS Signal**	
Executive Lead(s)	Elaine Clancy, Interim Group Chief Nursing Officer	
Report Author(s)	Michelle Cudjoe Group CMO Safety Checklist Contributors: Annabelle Keegan, Director of Midwifery and Gynaecology Nursing Laura Rowe, Lead Midwife for Clinical Governance and Risk	
Previously considered by	Quality Committees	08 May 2026
Purpose	**For Assurance**	

Executive Summary

1.0 Purpose

This safety checklist is submitted to provide assurance in relation to a recent Level 1 Maternity Outcomes Signal System (MOSS) signal at St Helier Hospital.

Background

The Maternity Outcomes Signal System (MOSS) was introduced in November 2025 by NHS England in response to the East Kent Reading the signals report (2022). The report recommended the development of a safety signal system capable of monitoring routinely collected Maternity and Neonatal outcomes to detect potential declines in safe care in a timely way, by generating signals at provider level. Signals do not necessarily mean a service is unsafe but must prompt a service-led critical safety check to provide early insights into potential intrapartum care safety issues enabling rapid intervention to reduce potential future harm.
The checklist provides a structured, standardised approach to reviewing key safety indicators, including workforce, acuity, clinical outcomes and escalation triggers. The aim is to:

- Prompt a critical safety check led by the local perinatal leadership team to assess the safety of operational processes on the labour ward, review priorities and plan early interventions.
- Support rapid escalation through the Trust Board, ICB, regional and national teams through the Perinatal Quality Oversight Model (PQOM)
- Support a positive safety culture
- Improve outcomes

St Helier is the hospital site that triggered the Level 1 MOSS signal. MOSS review ESTH against a baseline with an Amber signal triggered when there is a doubling; for the time period under review, the baseline was 1 case meaning that on reaching 2 cases in the time period this was seen as doubling and a signal was triggered. Of note, the baseline changes due to the cumulative nature of the review system. Further details of the cases reviewed, and the critical response is contained within the safety checklist

The review showed no commonalities in the two cases. Once action that was non causal was identified as a part of the review process and an action plan has been put in place to resolve this. An audit of surgical documentation gaps will be undertaken with an action plan to reduce recurrence. This will be reported in the Q2 2026.These gaps did not contribute to the outcome and there is a failsafe within midwifery documentation.

Actions: Critical safety check accepted by ESTH SLT and Elaine Clancy, Group Chief Nurse and submitted to ICB and Regional teams as required on 10th April 2026.

CMO has arranged a workshop for all key stakeholders in relation to the use of MOSS planned for the 8th June 2026

Action required by Group Board

The Board is asked to:

a. Confirm assurance

Committee Assurance

Committee	Quality Committees
Level of Assurance	Choose an item.

Appendices

Appendix No.	Appendix Name
Appendix 1	PQOM report ESTH and PQOM St Georges
Appendix 2	CNST update
Appendix 3	MOSS Critical Safety Check

Implications

Group Strategic Objectives

☒ Collaboration & Partnerships

☒ Right care, right place, right time

☒ Affordable Services, fit for the future

☒ Empowered, engaged staff

Risks

STAN and fetal monitoring concerns				
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

ESTH: Achieved 10/10 Safety Actions in MIS Yr 7

Legal and / or Regulatory implications

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. An EDI working group is in place with membership including MNVP representation – this group acts as the overarching oversight group for EDI work including review of national health inequalities data and local dashboard information.

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

None noted

Maternity & Neonatal Trust Board Safety Report

St. George's University Hospital

Board report
Presented by Perinatal Leadership team
April 2026

Executive Summary

In 2020, NHSE implemented the Perinatal Quality Surveillance Model. As part of this, in partnership with their LMNS and Regional Maternity Team, local Maternity Units are required to report on a defined set of agreed measures, including as a minimum those defined by NHSE and the LMNS.

In August 2025, the model was revised and re-named the Perinatal Quality Oversight Model. As a requirement of the Maternity and Neonatal Incentive Scheme (Safety Action 9), these defined measures should be shared with the Trust Board (or delegated sub-committee) quarterly.

These slides report on the agreed Perinatal Quality Oversight Model measures in line with the requirements of the LMNS and NHSE.

Data measures – perinatal quality oversight tool (2025/26)

Slide No.	Metric	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Notes
	1. Findings of review of all perinatal deaths using the real time data monitoring tool	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	
	2. Findings of review of all cases eligible for referral to MNSI	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	
	2a. The number of patient safety incidents logged and what actions are being taken	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	
	2b. Training compliance for all staff groups in maternity, related to the core competency framework and wider job essential training	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	
	2c. Minimum safe staffing in maternity services to include obstetric cover on the delivery suite, gaps in rotas and midwife minimum safe staffing planned cover versus actual prospectively	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	
	3. Service user voice feedback - themes	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	
	4. Staff feedback from frontline champion and walk-abouts - themes	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	
	5. MNSI/NHSR/CQC or other organisation with a concern or request for action made directly with Trust	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	
	6. Coroner Reg 28 made directly to Trust	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	
	7. Progress in achievement of CNST 10 safety actions	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	
	8. Proportion of midwives responding with ‘Agree’ or ‘Strongly Agree’ on whether they would recommend their trust as a place to work or receive treatment										Reported annually			*52.1 %*
	9. Proportion of speciality trainees in Obstetrics & Gynaecology responding with ‘Excellent’ or ‘Good’ on how they would rate the quality of clinical supervision out of hours										Reported annually			*%*

Maternity Overview

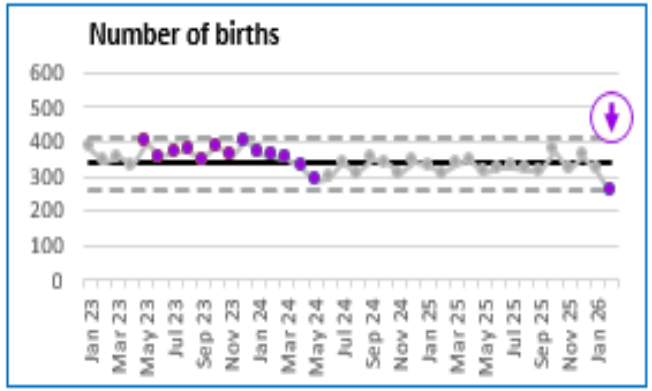
Patient Safety Data is reviewed and reported monthly at Divisional IQPR for CWDT.

PQOM slide

Delivery numbers are reviewed monthly. Although there was a drop in numbers from November 2023 the delivery activity had remained steady over the last 12months a further drop in February 2026.

Latest month	01/02/26
Number of births	256

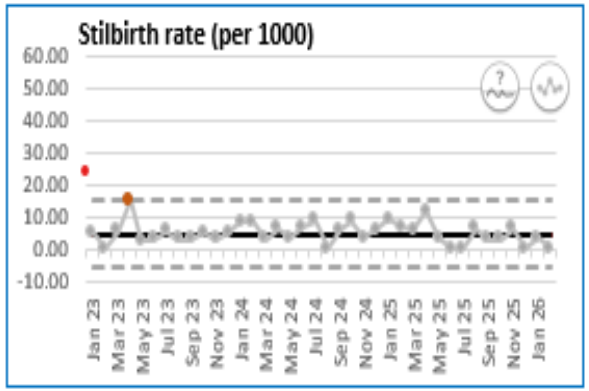
Significant reduction



Still birth rate has remained low and has had no significant change over the reporting quarter. Cases are reviewed through datix, PMRT and MNSI depending on gestation.

Latest month	01/02/26
Still birth rate/1000	0.0

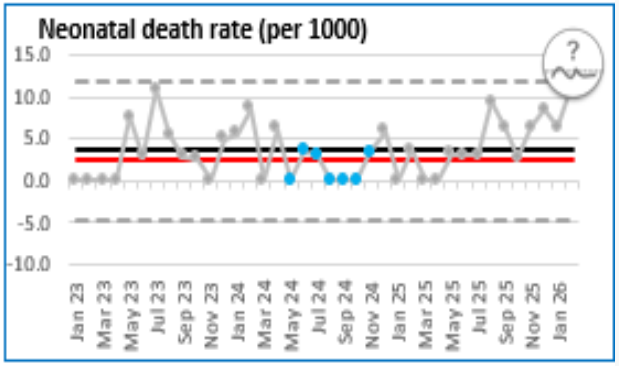
No significant change



Neonatal death rates have increased and NNU have carried out analysis into the increased death rate that was noted n 2024 MBRRACE-UK. This was presented with discussion at MGM on 20th April 2026.

Latest month	01/02/26
Neonatal Death rate/1000	11.7

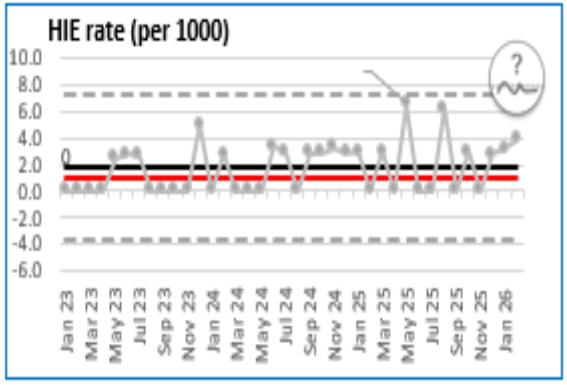
No significant change



HIE rates have increased over the last quarter with 3 cooling cases for this period. All are being reviewed through MNSI and awaiting full report. No immediate care issues have been identified.

Latest month	01/02/26
HIE rate/1000	3.9

No significant change



Maternity Overview

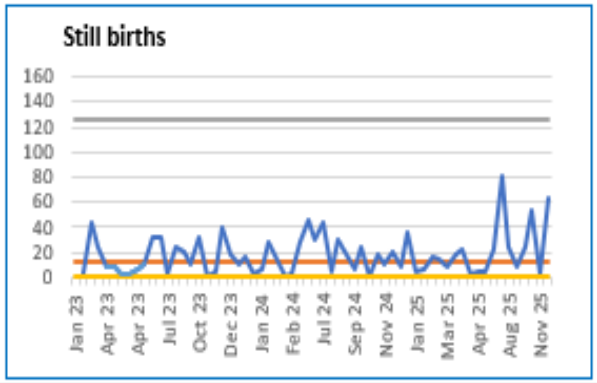
PQOM slide

No stillbirths recorded for February. Last SB data on chart is January.

Date of last stillbirth 29/01/26

Average days between stillbirths 13.0

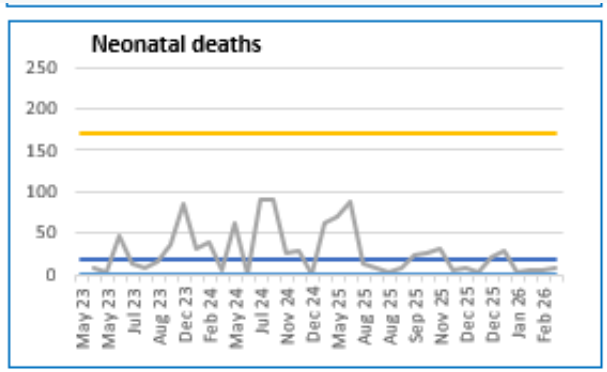
No significant change



Date of last neonatal death 16/02/26

Average days between deaths 17.7

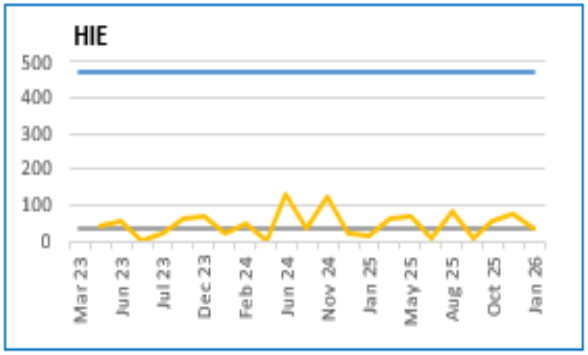
No significant change



Date of last HIE 19/01/26

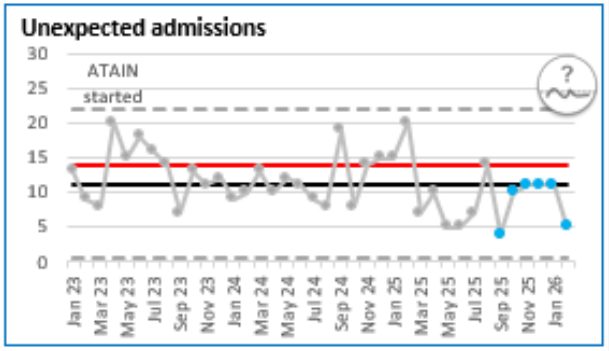
Average days between HIE 35.2

No significant change



Latest month Unexpected admissions to NNU ATAIN 01/02/26 5.0

Significant Improvement



5

Maternity Overview

PQOM slide

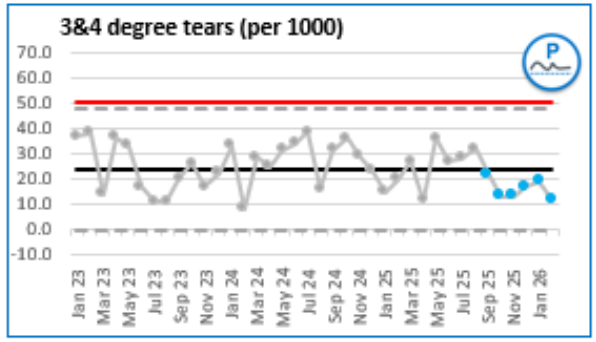
Ongoing OASI perineal protection training is being delivered to all levels of medical and midwifery staff. Overall, this has seen a reduction in 3rd & 4th degree tears and this training continues.

There are a number of actions in place (described in previous quality report) to reduce overall PPH rates after SGUH was highlighted as an outlier with higher than expected PPH rates. The unit is a PAS centre but recognised the PPH rate was still higher than expected and has delivered a number of successful initiatives to lower this .However, there has been an increase in February and this is being review to identify if there is a reason for this. All PPH's over 1500mls are reviewed as moderate cases.

Latest month 01/02/26

3&4 degree tears (per 1000) 12.0

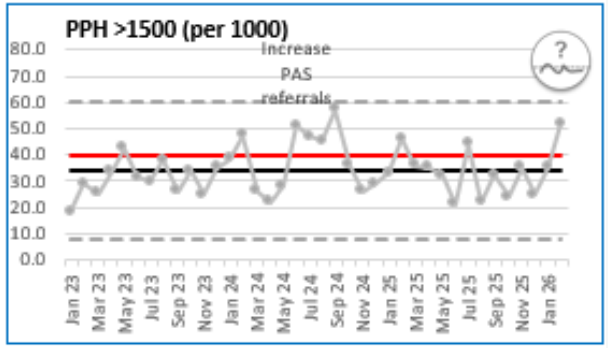
Significant Improvement



Latest month 01/02/26

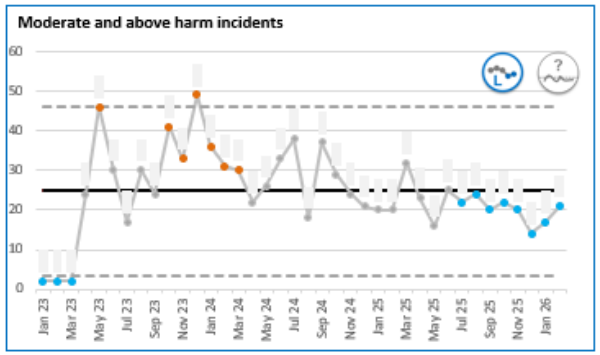
PPH >1500 (per 1000) 51.8

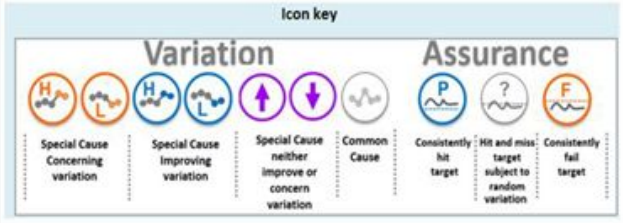
No significant change



Moderate and above harm incidents

No significant change





All datix incidents are reviewed each morning to ensure correct harm grading is in place. There has been a positive improvement in the reduction of the number of moderate and above incidents.

6

Perinatal Mortality Reporting Compliance

Report period & compliance	Summary
October 2025 – December 2025 **Full compliance with Safety Action 1 standards**	Total of 9 cases discussed • 9 cases reported to MBRRACE-UK (4 late fetal losses/stillbirths, 1 neonatal death) within 7 days • 7 cases met CNST criteria, and all reviews were started within 2 months. 7 cases were completed and published within the 6-month period. • 5 cases booked at another trust had a joint PMRT review External panel member present for 100% cases reviewed In two neonatal deaths the panel felt there were issues in care which may have made a difference to the outcome for the mother following the death of her baby. Actions identified are included in the local PMRT plan. In one neonatal death the review group found issues which they considered were likely to have made a difference to the outcome of the baby. The PMRT review has been superseded by a PSII investigation.

The introduction of the Submit a Perinatal Event Notification (SPEN) portal supports timely reporting as multiple reporting systems, including MBBRACE, have been amalgamated. Additionally extra funds have been received to support additional hours in support of PMRT. In November 2025 there was an increase in the PMRT Midwife lead's hours from 15 to 30 hours. In addition, administrative support for the neonatal team is also in place. A tracker was introduced to support timely reporting of cases, and since these actions have been taken there have been no further breaches.

Maternity Investigation Scheme (MIS) have been satisfied by these mitigations and with no further breaches are assured that reliable processes are in place. As such they have declared the Trust fully compliant with MIS Year 7 Safety Action One.

Perinatal Mortality Rate - December 2025- February 2026

Report ID	Status	Born at	Died at	Date of death	Type of death	Gestation	NNU	Baby's ethnicity
101375	Complete	Croydon University Hospital	St George's Hospital	09-Dec-25	Neonatal death	23	Yes	Other
101561	Open	St Peter's Hospital	St George's Hospital	29-Dec-25	Neonatal death	24	Yes	Other
101814	Complete	St George's Hospital	St George's Hospital	27-Jan-26	Neonatal death	32	Yes	Missing or declined
102215	Open	St George's Hospital	St George's Hospital	28-Jan-26	Neonatal death	23	No	White
102325	Complete	St George's Hospital	St George's Hospital	29-Jan-26	Stillbirth	27	No	Black or Black British
102310	Open	St George's Hospital	St George's Hospital	13-Feb-26	Neonatal death	26	Yes	Asian or Asian British
102493	Complete	St George's Hospital	St George's Hospital	16-Feb-26	Neonatal death	25	No	Asian or Asian British
102518	Open	St George's Hospital	St George's Hospital	18-Feb-26	Neonatal death	40	No	Black or Black British

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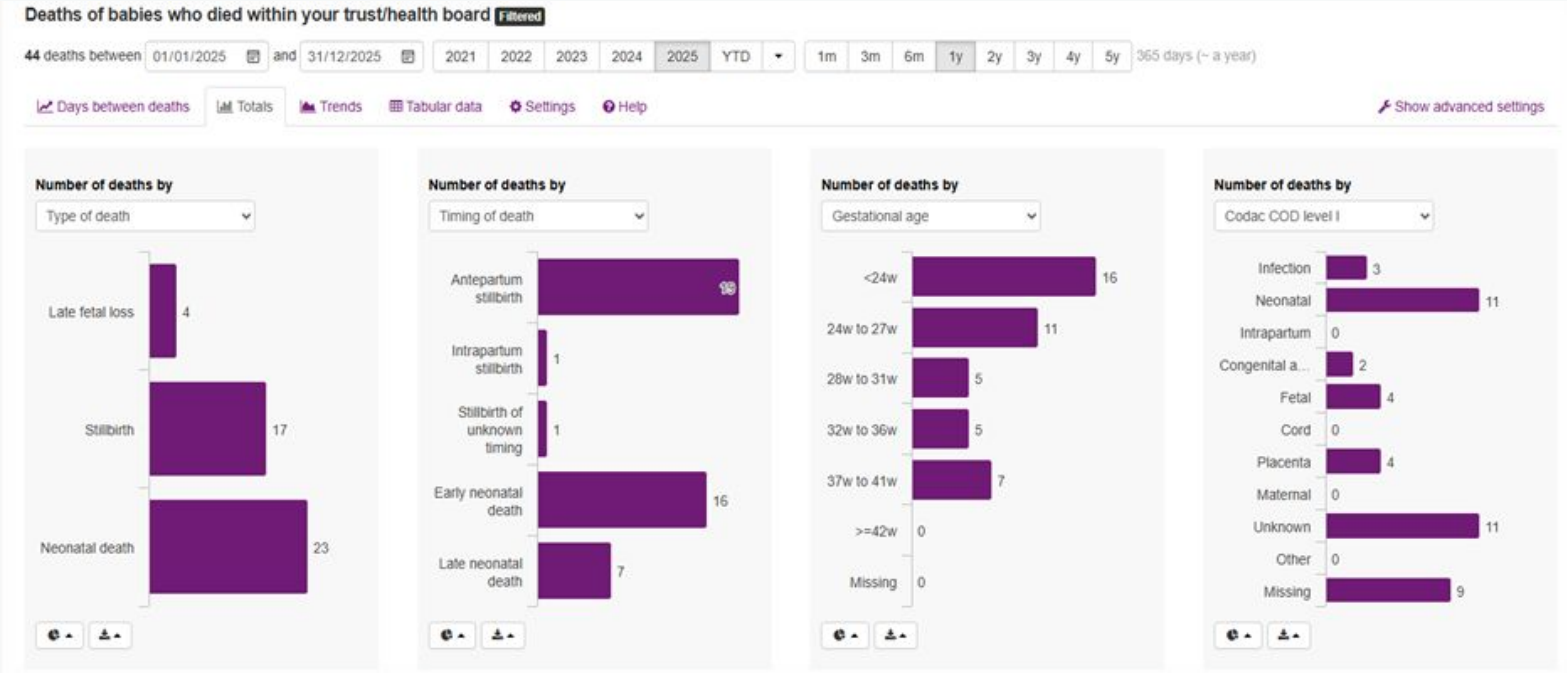
Perinatal Mortality
(MBRRACE- UK Perinatal Mortality Report 12month overview 2025)



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Perinatal Mortality- (MBRRACE- UK Perinatal Mortality Report)

MBRRACE-UK Mortality Rates are reported for babies born within SGUH at 24 completed weeks gestational age or later, excluding terminations of pregnancy. The stabilised & adjusted mortality rate provides a more reliable estimate of the underlying mortality rate, accounting for mother's age, socio-economic deprivation, baby's sex and ethnicity, multiplicity, and (for neonatal deaths only) gestational age at birth. While it is not possible to adjust for all potential risk factors, these measures do provide an important insight into the perinatal mortality for births within SGH Trust in 2024

MBRRACE-UK Perinatal Mortality Report for **2024** has shown that SGUH are up to 5% higher or up to 5% lower for stillbirths, and 5% higher for neonatal deaths in the comparator group. Although stillbirths has remained the same from 2022 and 2023 reports, neonatal deaths have increased in 2024.

On going 2025 monitoring of mortality rates and actions

Type of Death	Number 2025	Number 2024
Stillbirth	17	21
Neonatal	23	12
Extended Perinatal	40	33

There is an increase in the Neonatal death rate noted over 2025. The highest number are in the < 24weeks to 27-week gestation group

Action

NNU have carried out analysis into the increased death rate that was noted in 2024 MBRRACE-UK and has continued over 2025. This was presented with discussion at MGM on 20th April 2026.

Maternity and Newborn Safety Investigation Programme

Investigation progress update

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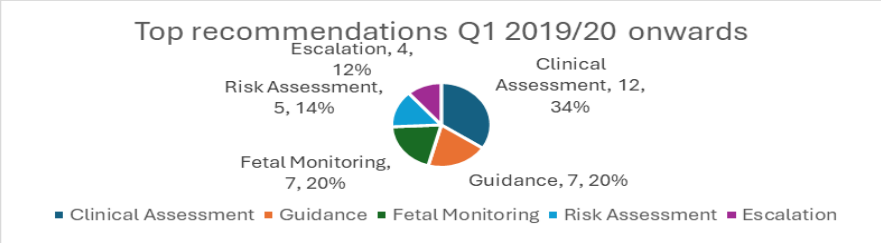

7 open cases with MNSI

Case Number	Date	Referral Criteria	Case Status
MI-040236/DW223760	03/03/2025	Maternal Death	Completed: Awaiting sign off action plan CIRG
MI-045016/DW231772	04/08/2025	HIE/Cooled	Completed: Awaiting sign off action plan CIRG. NND March Coroners case
MI-045290/DW232189	12/08/2025	HIE/Cooled	Completed: Awaiting sign off action plan CIRG
MI-047572/DW234674	05/10/2025	HIE/Cooled	Draft report returned to MNSI
MI-051101/DW238587	17/12/2025	HIE/Cooled	Staff interviewed Draft report in process
MI-052127/DW240139	19/01/2026	HIE/Cooled	Staff interviews commenced
MI-053158/DW241380	11/02/2026	Maternal death	Awaiting Staff interviews
MI-053269/DW241577	13/02/2026	HIE/Cooled	Awaiting staff interviews

Maternity and Newborn Safety Investigation Programme (MNSI)

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Learning from MNSI Investigations

Theme	Issue	Actions	Responsible (role)	By when
Fragmented care of pregnant patients in ED	Consistent Guidelines between ED and Maternity.	Implementation of joint ED/maternity Guidelines working group.	ED Governance lead/Obstetric Labour ward Lead	Completed
Coordinating care for patients with multiple comorbidities and health inequalities	Coordinating care around individual needs of those with multiple complexities and most at risk of inequitable outcomes	Implement personalised care plans including use of the Benefits, Risks, Alternatives, Information and Nothing (BRAIN) patient decision making acronym and the RCM Maternity Disadvantage Assessment Tool.	Intrapartum Consultant Midwife and Delivery Suite Matron	June 2026

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Maternity and Neonatal Patient Safety Incidents (PSII)

Maternity Patient Safety Incidents during the period Dec 2025- Feb 2026

Datix No.	Incident Category	Outcome/Learning/Actions	Responsible (role)	By when
DW217579	Moderate	30 Week IUD: Draft report with family for sign off	Consultant Obstetrician	April 2026
DW234095	Extreme	24 NND: Draft report for presentation at DIRG 08/04/2026	Consultant Obstetrician	May 2026
DW235557	Moderate	Retained Placenta	External Chair to be appointed by Division	June 2026
DW236973	High	PPH and Hysterectomy/Staff interviews	Consultant obstetrician	June 2026

Review of NHS Resolution Scorecard

A quarterly review of Trust's claims scorecard alongside incident and complaint data should be discussed by the maternity, neonatal and Trust Board level safety champions at a Trust level (Board or directorate) quality meeting.

SGH Claims Scorecard September - November 2025

September
Top injuries by volume:
- Scalp wound(1)
- Brain damage (3)
- Facial Palsy

October
Top causes by volume:
- Death of Twins (1)
- Failure to monitor(1)

November
Top causes by volume:
- Baby born in poor condition(1)
- Failure to recognise (1)
- Baby born in poor condition now diagnosed cerebral palsy(1)

Complaints September October and November 2025 (9 complaints)

Care during labour and birth (no clear themes) (2)
Safeguarding/referral to Mental health Services (1)
Communication (6)

December, January and February (moderate and above harm outcomes)

5 top Categories
- PPH (14)
- 3rd degree tears (9)
- Delayed care staffing (5)
- Baby admission to NNU/readmission (4)
- Still birth/Neonatal death (all cases including late miscarriages (2

Themes September October and November 2025

- Themes of HIE for Claims are also undergoing MNSI investigations and all go through the PMRT Process

Learning December, January and February 2025/6

- When categorising the need for emergency caesarean, clearly document and communicate which category is required to the MDT and prioritise accordingly.
- Please remember to consider TXA for women undergoing instrumental delivery in the room. The anaesthetic team have been advised to administer TXA for instrumentals done in theatre.
- If a patient is declining active 3rd stage with risk factors for PPH, please ensure this has been escalated to the MDT
- If you are worried about a patient and feel the plan of care is not appropriate or that your concerns aren't being listened to, please escalate your concerns.

Key Actions in progress

Review of the homebirth service/2nd on-call	End Feb 2026	
Thematic review of 14 cases including stillbirth, neonatal deaths and maternal deaths commencing.	End April 2026	
Quality Improvement plan and cultural improvement plan in progress	Paused	

Incident themes (PSIRF)

The majority of incidents reported in Maternity Services fall under the Category Patient Labour and Maternity. Therefore, the incidents included for December, January and February are under that subcategory.

Top 5 Incidents December 2025

- Staffing levels unsafe and inadequate (35)
- PPH (6)
- 3rd Degree Tear (4)
- Born before arrival (4)
- Closure of maternity unit to labour and maternity (3)

This indicates a relatively stable position over time and further information is included on the Outcomes Dashboard (slides 4-6). Detailed information is provided monthly to the Trust PSIR Panel via the specialty's DIRG Report.

Top 5 Incidents January 2026

- Staffing Levels unsafe and inadequate (14)
- PPH (7)
- Delay to act on adverse test/image results (4)
- Shoulder dystocia (3)
- Unexpected ADM to NNU (2)

Top 5 incidents February 2026

- PPH (11)
- Staffing Levels unsafe and inadequate (6)
- Delay of clinical assessment/diagnosis (4)
- Unexpected ADM to NNU (3)
- 3rd Degree Tear (2)

Maternity Outcomes Safety Signals System (MOSS)

- Introduction of the Maternity Outcomes Signal System (MOSS) from **Wednesday 26th November**. The Maternity Outcomes Signal System (MOSS) is a critical safety signal system being developed by NHS England in response to the first recommendation in the "**Reading the Signals**" report on East Kent. It is identified in the **10 Year Health Plan** for England with the commitment that MOSS will be in place across trusts from November 2025.
- MOSS uses near real-time data to identify potential safety concerns in maternity services. It will monitor term stillbirths, neonatal deaths and brain injuries prompting a rapid response.
- Signals prompt a rapid, service-led 'critical safety check' to determine if any safety issues exist that need addressing. It follows similar tools that have successfully improved outcomes in, for example, children's cardiac services and paediatric intensive care.
- Outcomes data is presented at Trust site level and refreshes daily with a short lag of 2-3 days for events. Signals prompt a locally-led critical safety check.
- MOSS is not a performance management or outlier tool, and signals do not necessarily mean that a service is unsafe – carrying out the MOSS critical safety check will determine this.
- To date SGUH has not triggered any signals on MOSS for either stillbirth or neonatal death.

Maternity Outcomes Signals – Cumulative sum (CUSUM)

This chart produces 'signals' of potential safety issues in maternity care arising during labour and birth using term stillbirths and term neonatal deaths up to 28 days.

The maternity unit's perinatal leadership team should carry out a critical safety check when any signal arises to make sure care on the labour ward is safe. Further guidance on this is available in the MOSS Standard Operating Procedures.

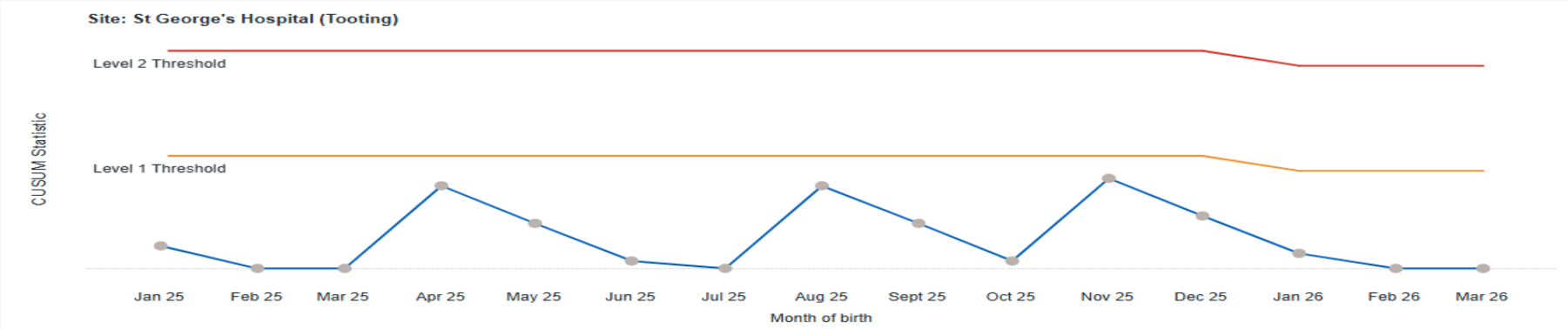

Table of Events - Trust: St George's University Hospitals NHS Foundation Trust

Date of term birth	Events (term only)	Site name
26 Nov 25	1 Term Stillbirth(s)	St George's Hospital (Tooting)
23 Nov 25	1 Term Stillbirth(s)	St George's Hospital (Tooting)
15 Aug 25	1 Term Neonatal Death(s)	St George's Hospital (Tooting)
05 Aug 25	1 Term Stillbirth(s)	St George's Hospital (Tooting)
21 Apr 25	1 Term Stillbirth(s)	St George's Hospital (Tooting)
17 Apr 25	1 Term Stillbirth(s)	St George's Hospital (Tooting)
25 Jan 25	1 Term Stillbirth(s)	St George's Hospital (Tooting)

Patient Safety Incidents

Summary of incidents reported:	
Date Range	01.12.2025-31.12.2025
Total no of Incidents (Maternity and Obstetrics)	146
No harm	119
Low harm	13
Moderate Harm	12
High Harm	2
Extreme Harm	0
Cases reported to MBRRACE for PMRT	6
Cases reported to MNSI	1
PSII reported on StEIS	0
Incident type (Top 3)	Patient Labour/Maternity (33) Patient Access, Appointment, Admission, Transfer, Discharge, Referral (16) Patient Clinical Assessment/diagnosis (15)

Summary of incidents reported:	
Date Range	01.01.2026-31.01.2026
Total no of Incidents (Maternity and Obstetrics)	95
No harm	95
Low harm	10
Moderate Harm	16
High Harm	1
Extreme Harm	0
Cases reported to MBRRACE for PMRT	2
Cases reported to MNSI	1
PSII reported on StEIS	2
Incident type (Top 3)	Patient Labour/Maternity (25) Patient Access, Appointment, Admission, Transfer, Discharge, Referral (21) Staffing Issues (19)

Summary of incidents reported:	
Date Range	01.02.2026-28.02.2026
Total no of Incidents (Maternity and Obstetrics)	82
No harm	56
Low harm	5
Moderate Harm	20
High Harm	0
Extreme Harm	1
Cases reported to MBRRACE for PMRT	4
Cases reported to MNSI	2
PSII reported on StEIS	2
Incident type (Top 3)	Patient Labour/Maternity (30) Patient - Clinical Assessment/diagnosis (Investigations, Images and Lab tests) (11) Patient Access, Appointment, Admission, Transfer, Discharge, Referral (10)

Moderate and above Harm Outcomes

In ***December 2025*** there were 14 incidents reported which resulted in moderate or above harm:

- ADM NNU cooled MNSI (1)
- ADM NNU (1)
- 3rd degree (4)
- Blood loss >1500mls (5)
- Blood loss >1500mls accreta (1)
- Delay in care midwifery staffing (2)

In ***January 2026***, there were 17 incidents reported as moderate or above harm:

- Neonatal death (1)
- Admission to NNU therapeutic cooling (1)
- Hyponatraemia (1)
- Convert to GA (1)
- 3rd Degree tear (2)
- Blood loss >1500mls (5)
- Blood loss >1500mls accreta (3)
- Delay in care midwifery staffing (3)

In ***February 2026*** there were 21 incidents reported as moderate and above harm;

- 3rd degree (3)
- Maternal Death MNSI (1)
- Blood loss >1500mls (7)
- Blood loss >1500mls accreta (2)
- Scalp/facial laceration (2)
- Neonatal death (1)
- Non attendance on escalation for outside dept review (1)
- Admission to NNU cooled MNSI (1)
- ADM ITU (2)
- Induction of labour breech presentation (1)

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Maternity Inquest’s

We currently have 3 open Maternity inquests.
No maternity inquests were held in the last quarter.

Identifier	Date of Death	Date Notified by Coroner	Summary	Inquest Date
	11/02/2026	Awaiting update	First pregnancy at 38 years of age, Black African ethnicity, BMI 27. Referred to maternal medicine team at booking for recurrent UTI and raised creatine. Seen in the joint obstetric and anaesthetic clinic plan for monthly MSU. Attended triage at 26+5 weeks with UTI symptoms and MSU which had grown ecoli. Discharged home with antibiotics. Attended DS triage two days later with pain and reduced fetal movements. Closed cervix and all observations were normal. Ten days later LAS called to say patient had collapsed at home, CPR commenced and then following HEMS arrival resuscitative hysterotomy was performed. Patient declared dead at scene, baby transferred to another Trust where died the next day.	TBC MNSI investigation underway
091/25	03/03/2025	22/05/2025	Admitted at 32+5weeks for control of raised blood pressure related to pre-eclampsia. Deteriorated and transferred to Delivery Suite. Patient became increasingly agitated and distressed. Decision was made to transfer to theatre.. While transferring onto theatre table, patient became unresponsive and had a seizure. MDT decision to cease resuscitation after >1 hour ALS and discussed with ICU teams - not candidate for mechanical circulatory support.	TBC MNSI investigation Complete
051/25	23/09/2024	26/03/2025	Booked with maternal medicine due to raised BMI and idiopathic intracranial hypertension and non-epileptic seizures. Seen in ED at 29weeks with H/O shortness of breath, chest pain and haemoptysis, prescribed antibiotics and admitted. Discharged 7days later. The ECHO was carried out as outpatient and showed evidence of pericardial effusion. Referred to cardiology and repeat echo in 4 weeks. Attended respiratory clinic, repeat chest X ray normal, with previous inflammatory shadows resolved. Admitted under the care of acute medicine due to an episode of confusion / non-epileptic absence during appointment and discharged next day following further assessments. Patient contacted by phone and reported no PET symptoms. Plan made to repeat urine sample a few days later. but Pt's sister called LAS to report she had been found unconscious in friends flat. LAS attended and she was declared dead at the scene. She was 32+4 weeks pregnant.	TBC MNSI investigation complete

Maternal death DW223760– Immediate actions

PQOM slide

Issue	Action	Responsible person and completion date
Communication between ED and maternity Maternity team not made aware of attendance to ED	Maternity moved to digital records on 8 February 2025. With maternity moved to digital records staff can now see and review medical records for birthing people who attend ED. Communication on this change will be sent by the Maternity Governance Team.	Mat Gov Team **Complete – 21/03/2025**
Daily inpatient review of antenatal patients Patient was not seen on ward round on 02.03.25	All obstetric staff have been reminded that all patients on antenatal ward must have a daily review.	Clinical Director **Complete - 14.3.25**
Resident doctor working in role outside of scope of practice **FY1 working in delivery suite triage and saw the patient on 27.02.25 and discharged her following discussion with senior registrar** There was lack of awareness among the general management team of the level of obstetric experience required to work in triage – which led to an FY1 being booked to cover a locum shift. It is not usual practice to have FY1 on delivery suite. On this occasion FY1 was doing a locum SHO shift.	Women's operational team advised by email that no SHO shifts on delivery suite triage can be filled by FY1.	Clinical Director **Complete - 13.3.25**
Role of obstetric registrar **Despite the midwife requesting review of the patient the doctors did not attend the patient on 4th floor**	Doctors on night shift (Senior registrar and 2 junior registrars) have had supportive meeting and given clear advice on their responsibilities to physically review patients if requested by a midwife. If unable to attend due to workload this needs to be escalated to senior registrar or consultant on call. Email to all resident doctors in women's services on responsibilities to review patients when requested by a midwife. Compliance measured via Datix reporting system.	Clinical Director **Complete -13.3.25**

Maternal death DW223760– Immediate actions

PQOM slide

Issue	Action	Responsible person and completion date
MEWS chart not available on iClip **Triggers for escalation from MEWS chart not available** With removal of paper MEWS chart the trigger list for escalation is not immediately available. This would have provided midwife with advice for who else she could contact	Posters of MEWS chart triggers and escalation made and displayed in all clinical areas of maternity and on BP monitors. MEWS Compliance is part of the audit cycle of business. The implementation of iClip PRO will impact on MEWS compliance in the initial phases, with improvement shown over time.	Mat Gov Team Complete -31.3.25
Distribution of midwifery staff **Lack of senior midwifery support on 4th Floor (antenatal, postnatal and Birth Centre)**	Pending review of the bleep holder role, the existing bleep holder (Band 7) to be based on 4th floor during out of hours (nights, weekends and BH). This will support junior midwives for clinical advice and support timely escalation to senior staff, e.g., anaesthetist and consultants Compliance measured via Datix reporting system.	Director of Midwifery Complete - 24.3.25
Knowledge gap **Doctors did not appreciate the significance of increased respiratory rate**	Labour ward lead, lead obstetric anaesthetist and HDU lead midwife to agree training programme for obstetricians and anaesthetists. Consideration to be given to half day teaching planned on annual basis. Need for training on deteriorating adults previously identified as an action from a previous Serious Incident and implemented in the last year. Training stats monitored monthly (see current training stats on slide 35) **March 2025** Trainees and staff grade obs – 83% Anaesthetic staff – 89% Obstetric Consultants – 89%	Clinical Director Complete - 30.04.25
Role of CCOT **Team did not escalate to CCOT in line with triggers on MEWS chart** Lack of understanding of role of CCOT	Obstetric anaesthetic lead, obstetric lead for HDU and Midwifery HDU lead to meet with CCOT lead to formulate plan for closer working. CCOT flow chart developed for maternity and distributed across clinical areas Arranged for CCOT to attend PROMPT training days to explain their role, what they can do to assist and when to call.	Clinical Director, HDU Lead Midwife Complete – 01-04-25

Risks – High and Extreme (10 and above)

PQOM slide

Ref no.	Risk Title	Current Risk Level	Rating	Risk Owner	Review Date	Update
2976	Meeting patients, mother and/or baby safety in line with regulatory safety standards	Extreme	16	Nicola Shopland	27/03/2026	86% of CQC action plan now completed and 2 Must Do's remain outstanding. Next Evidence Assurance panel arranged for end of April 2026 for these to be represented. Marked improvements with daily safety checking in all clinical areas. New DOM now in post and Group Chief Midwife due to start on 2026. The team will be taking this risk to Divisional Governance to discuss reducing this risk rating to 12.
3007	Data migration and iclip issues	Extreme	15	Fiona Walkinshaw	27/03/2026	Unable to move forward with data migration due to lack of staffing resource. Bi monthly meetings with the Director of Midwifery, Consultant Anaesthetist / iClipInterim Chief Clinical Informatics Officer and Chief Nurse for the digital portfolio. Review taken place to prioritise Heat requests and work commenced to make requested changes. These will be added following removal of IT freeze. MEWS fix has gone through testing phase and are currently preparing for test on Live platform from week of 6th April.
764	Infrastructure damage/sewerage flooding on the maternity unit	High	12	Fiona Walkinshaw	08/01/2026	Obstetric theatres 1 and 2 flooding in December which led to cancellation and delayed planned activity. No further flooding incidents noted since this date.
2175	Multiple Information Systems	High	12	Cheryl Stewart	09/01/2026	Data migration not completed, still in progress. New risk 3007 for data migration raised
2821	Diabetes team seeing 500+/year women with GDM in the same clinic for women with pre-existing diabetes	High	12	Fiona Walkinshaw	27/03/2026	Obstetric Consultant recruited to support GDM MDT clinic as per SBL element 6.
2985	Shortage of Staff within FMU Sonography service due to national shortage of highly specialised obstetric Sonographers	High	12	Cheryl Stewart	24/04/2026	Shortages continue with unsuccessful advertising of sonographer post for over 6 months. There is a Sonographer going on Maternity leave and the Lead Sonographer has left, recruitment is underway with minimal interest in this advertised post.
3053	Insufficient diabetes service provision due to staffing issues	High	12	Elaine Sheehan	27/03/2026	Recruitment of Consultant Obstetrician confirmed. The action for securing Obstetric registrar roster allocation 4 weekly has been completed. Maternity leave cover for team midwifery lead has commenced.
3096	Use of MEWs on iClip	High	12	Fiona Walkinshaw	27/02/2026	MEWS fix has been worked on and needs to be tested on live platform. Superusers identified to receive additional training, e-learning and crib sheets have been prepared to support staff. iClip support to go live week of 6th April. Staf to feedback if MEWS score is working and correct.
3098	Intrapartum risk assessments for iClip	High	12	Donna Dennis	03/04/2026	Discussion on the scope of implementing intrapartum risk assessment, fetal monitoring risk assessment and risk assessment for postpartum haemorrhage in paper format until the issues on iClip have been addressed.
3099	Vaginal birth after caesarean sections discussions	High	12	Donna Dennis	27/02/2026	There is no template on iClip to support the discussion and document the management plan for women who have had a previous caesarean section. Staff are free texting. Audit required on quality of documentation in accordance with RCOG
3100	Triage documentation	High	12	Fiona Walkinshaw	03/04/2026	IT to address issues on iClip and implement speculum examinations in the vaginal examination workflow. In addition to include antepartum haemorrhage, fetal heart rate and rhesus status.
3108	Partial compliance with the Saving Babies Lives Care Bundle Version 3	High	12	Donna Dennis	26/06/2026	The Maternity Services are partially compliant with the Saving Babies lives Care Bundle due to partial compliance with elements including smoking in pregnancy, fetal growth restriction, preterm birth and diabetes which may lead to issues with CNST compliance.
2023	Maternity Unit Security Risk	High	12	Cheryl Stewart	07/12/2025	Baby abduction drill has taken place. Discuss with Directorate Management team additional recourse to provide reception support for out of hours. Security is only provided 3 days per week.

Extreme Risk - 2976
Meeting patients, mother and/or baby safety in line with regulatory safety standards

CQC Must Do Actions 2024

13 Approved through GESH Evidence Assurance Panel
2 Require further supporting assurance

Must Do 11- Appraisals – noted ongoing improvement (85%) but not yet reached 90% compliance. *Outcome: To return in 3months*

Must Do 12 - Standard of documentation e.g. perineal repair, use of SBAR and MEOWS, sepsis risk assessment for babies, (not limited to these areas). Good evidence of work to embed audits but still areas that are not complaint and concerns continue regarding MEWS compliance.
Outcome: To continue work and bring back in 3months.

Next Evidence Assurance Panel: 30th April 2026

1. Safe staffing	2. Triage	3. Policies, guidelines and pathways
4. Fetal monitoring	5. Statutory mandatory training	6. Audit effectiveness
7. Medicines management	8. Incident management	9. Cleanliness, environment and equipment
10. Governance processes	11. Appraisal	12. Documentation
13. Safeguarding	14. Induction of labour	15. Bereavement documentation

Extreme Risk - 2976
Evidence to Support the Outstanding 2024 Section 29A condition, legal undertakings & remainder CQC Actions to be completed

Summary of Actions
31 key milestones to be achieved
29 now **GREEN**
2 remain **AMBER** – see details below

Key Areas of Focus

1. Maternity Triage
2. Standardisation approach to CTG
3. Medicines
4. Documentation
5. Equipment
6. Governance

CQC Amber Action	Final Outcome	Update Narrative	Action Update
Maternity Services Medicines	Medicines are readily available to the maternity unit and all patients are receiving their medicines as prescribed. All medicines are safety stored, managed and dispensed as per local guidance and medicines management policy.	Pharmacy undertaking process mapping on missed doses. Looking at the use of Care Compass in maternity Availability of medical team to discontinue no longer required prescriptions. Additional concerns regarding medicine management identified through CD and Medicine Audits and Datix.	Midwifery Team made aware of the importance of requesting discontinuation of medications on drug chart that are no longer required. **Action: Commencing Maternity Medication Committee in April 2026 to review all medication issues, datix's, audits and revisit CQC actions to ensure good oversight of medication management and identify areas for improvement**.
Maternity Services Emergency Equipment	Emergency trolley is robustly checked on each shift. This includes all emergency equipment checks e.g. resuscitaires	Matron observatory audit updated to include check on daily checks Audits built on RATE – clear wording for compliance Daily compliance checked on each shift by ward lead	Matron observatory audit taking place monthly in all clinical areas. Working with all teams to raise compliance rates. Matrons following up with staff when this is not taking place. Safety check compliance rates presented as CQC 'Must Do' action and returning to Evidence Assurance panel in April 2026 and aiming for final approval.

Extreme Risk - 3007

iClip issues and Data Migration

Main Issues Identified and actions

- **Data Migration** did not take place at time of Go-Live in February 2025, meaning staff must view the old system alongside iClip during patient care. New members of staff do not have access to E3 and cannot access previous records. There are currently there 1400 records that still require migration.
  Action: Ongoing issue as struggling to complete this task due to lack of staff available to carry out this work.
- **Lack of mandatory fields** in maternity iClip causing data quality issues, which impacts among other aspects, the accurate and full reporting of the Maternity Services Data Set (MSDS).
  Action: To achieve CNST requirements this data is updated manually where required.
- **MEWS scoring** not being scored electronically requiring a work round as it automatically defaults to NEWS.
  Action:
  1. Mitigation in place to enable staff to manually calculate the MEWS score and add this. Additional training has been provided by iClip training team which has been communicated to all staff to ensure everyone knows how to complete. Superusers have been identified and additional training is being rolled out to provide support in the clinical area.
  2. A fix of MEWS scoring error has been confirmed and requires testing on the Live System. Digital freeze has now been lifted and **testing due to commence 21st April 2026.**
- **ED not using MEWS for pregnant women** as they have not had training to access or use. This has been discussed with iClip team. When a patient is added on iClip as pregnant this will automatically default to MEWS.
  Action: Training will be rolled out following MEWS Cerner error fix.
- **IT system does not meet Maternity needs for patient safety and accurate staff documentation**. 100 IT tickets were submitted with identified issues which have been reviewed in a meeting led by the DDO – these tickets have now been reduced, merged and priority graded with 15 considered as high priority.
  Action: IT supporting maternity and have worked through identified issues. Need confirmation when these will be added to live system. Digital freeze now lifted.

iClip issues are graded as an Extreme Risk on the Maternity Risk Register and this is now being presented to be added to the Trust Risk Register.

PQOM slide

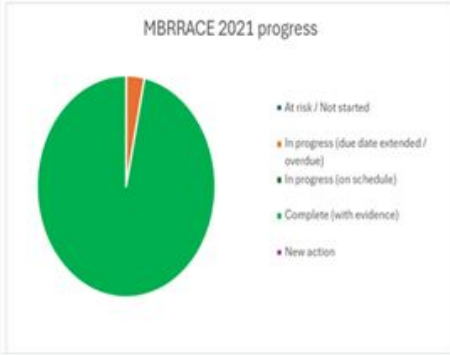
MSSP – Review and Reset Meeting and Actions

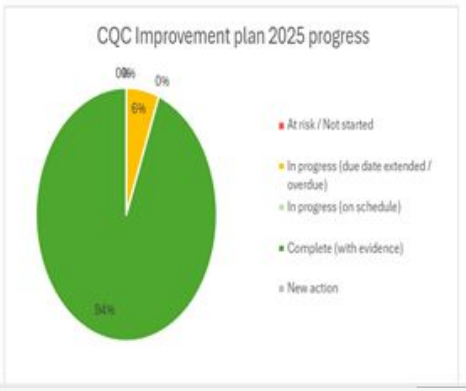
Action plan following reset meeting with MSSP on 8th August 2025			
Action	**Lead**	**Review Date**	**Update**
Review current de brief / birth afterthought service following feedback from the chaplaincy service	DDOM / CNO	05/09/2025	Review carried out of cases raised.
Review maternity workforce variance and specialist clinical midwifery roles	DOM	31/10/2025	Workforce reviewed and active recruitment underway.
Develop and sustain midwifery leadership	Div Tri	31/03/2026	Group Chief Midwife and DOM now in post
Ensure sustained progress on the externally commissioned Fetal Medicine Review with clear milestones and timely reporting	Div Tri	31/10/2025	
Monitor the effectiveness of current risk mitigation measures related to recording the MEWS chart, VTE score with a view to evaluate and embed a robust, compliant long-term solution that is reflective of maternity parameters	DOM, DDOM	31/12/2025	Mitigation in place for MEWS. Effectiveness monitored through Datix. However not sustainable and fix to go Live 21/04/26
Further Review and Reset to take place in three months to determine whether improvements are embedded and can be evidenced and whether there has been significant progress made in achieving the agreed exit criteria for the MSSP which would facilitate the trust moving to the sustainability phase of the programme and progress to exit from the MSSP.	SGH Maternity Senior Leadership, CNO	30/11/2025	

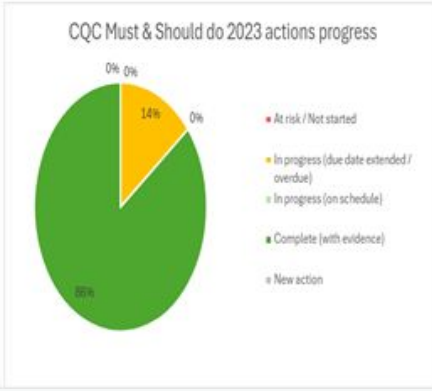
Integrated Unified Action Plan

PQOM slide

	Number closed	% Closed	Number open	% Open
Baby Falls	20	100%	0	0%
Transitional Care	14	100%	0	0%
SA3 Avoidable term admissions	9	100%	0	0%
MBRRACE 2020	9	100%	0	0%
MBRRACE 2021	29	97%	1	3%
Early notification scheme	7	100%	0	0%
MIS Year 6 actions	4	100%	0	0%
MIS Year 7 Actions	10	100%	0	0%
CQC Must dos 2023 inspection	18	86%	3	14%
CQC Immediate actions Jan 25	32	94%	2	6%
MSSP Actions	7	70%	3	30%
Safety Champions Actions	5	63%	3	38%
Total	164	93%	12	7%







See next slide for actions

Maternity Integrated Unified Action – Outstanding Actions

	Issue and Actions	Lead
MBRRACE-UK 2021	Triage – Implementation of BSOTS Not able to fully implement due to estate. Suggested plans have been proposed by Triage Lead. **Action**: funding submission sent to NHSE to enable building work which would improve area and increase clinical space by one additional room. Activity, staffing numbers and time to see patients is monitored and reported monthly.	Triage Lead
CQC 2023	31 key milestones – **29** now Green and **2** remain Amber 1. Medicines Management – Management of missed doses. **Action**: Working with teams to add reason for missed dose in electronic drug chart e.g. declined. Medication no longer required to be removed from charts. Implement Care Compass. 2. Safety Checks – Improvements in all areas, continue to monitor daily to ensure embedding of compliance. **Action**: Working to streamline how data is captured e.g. via QR code, following up with shift leads and individuals when not completed.	Matrons Pharmacy Matrons, DDOM
CQC 2024 MUST DO's	15 Must Do's – **12** approved and **2** remain partially approved. Evidence Assurance panel on 19th January approved Medicine Safety. Appraisals evidence was presented. Compliance is currently at 72% . Newly appointed DOM to introduce weekly PULSE (Performance Update and Local Service Evaluation) meetings with senior team weekly where performance will be monitored (other metrics /KPIS will be included)	DDOM

MatNeoist Update

- ***Review of implementation of BSOTS in Triage – although not able to fully implement improvements have been made with staffing and review times.***
- **Baby Abduction – Policy has been updated and abduction drill carried out earlier in the year and repeated on 26 Feb.2026 Action: Key findings shared with the team , plan to introduce CODE ORANGE .**
- ***Develop and sustain midwifery leadership – DoM commenced 9th February, Group CMO 30th March 2026 .***
- ***To support review of Community Service including Homebirth.***
- ***Review of maternity workforce variance and specialist clinical midwifery roles is taking place***

PQOM slide

Training compliance

Training compliance for all staff groups in maternity related to the core competency framework and wider job essential training. *Refer to training report for additional information*

Type of Training and % compliance	Staff Group	SGUH December 2025	SGUH January 2026	SGUH February 2026
PROMPT 90%	Midwifery Staff	93%	97%	92%
	Maternity Support Workers	95%	97%	100%
	Consultant Obstetricians	100%	100%	100%
	Trainee and Staff Grade Obstetricians	96%	94%	94%
	Anaesthetics	94%	100%	100%
	Junior Anaesthetists	83%	100%	100%
CTG Training 90%	Midwifery Staff	85%	86%	91%
	Consultant Obstetricians	95%	100%	100%
	Trainee and Staff Grade Obstetricians	96%	100%	100%
Essentials (CCF)	Midwifery Staff			86%
NLS (Newborn Life Support) 90%	Midwifery Staff	94%	96%	91%
NLS (Newborn Life Support) 90%	Neonatal Nursing Staff	90%	90%	94%
NLS (Newborn Life Support) 90%	Neonatal Medical Staff	100%	100%	100%

Mitigation: In essential training figures are low in Infant Feeding and Yearly Safeguarding

Action: 14 new Band 5 midwives commenced in January. All booked to attend mandatory training over first 3months. Permanent staff - Matrons reviewing to ensure all training is booked and attended.

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Mast Training

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- **Action:** Delivery Suite Band 7's and HDU Nurses who are outstanding for ILS have been identified and requested to book. Recording error for compliance as not 0% - this is being reviewed.
- Have discussed with Matron's to ensure all staff have booked BLS.
- Medical staff training data has been passed to Medical Leads to follow up with their team.

Non-Medical Staff

MAST Compliance

	Oct 25	Nov 25	Dec 25	Jan 26	Feb 26
Children and Women's Diagnostic and Therap..	92.06%	90.19%	91.51%	90.98%	90.64%
Ante Natal Clinic 712678	95.73%	92.98%	92.65%	95.00%	92.26%
Birthing Centre 712679	100.00%	100.00%	100.00%	100.00%	95.83%
Carmen Suite 712680	93.77%	91.73%	92.63%	93.09%	93.66%
Community Midwifery 712681	91.21%	89.58%	89.19%	90.63%	91.47%
Delivery Suite 712682	92.77%	91.59%	91.55%	90.32%	89.50%
Fetal Medicine Unit 712683	84.77%	84.80%	85.39%	91.22%	88.16%
Gwillim Ward 712684	94.34%	91.33%	93.44%	87.11%	87.29%
Maternal Medicine 712685	95.24%	95.06%	92.59%	92.50%	92.50%

	Oct 25	Nov 25	Dec 25	Jan 26	Feb 26
Conflict Resolution	94.92%	93.59%	94.25%	94.96%	94.63%
Dementia Awareness	98.31%	97.44%	98.67%	97.90%	98.35%
Equality, Diversity and Human Rights	91.95%	91.03%	91.59%	92.44%	92.15%
Fire Safety	94.07%	93.59%	94.69%	94.96%	94.63%
Health, Safety and Welfare	93.64%	92.74%	92.04%	92.44%	91.74%
Infection Prevention and Control Clinical	87.71%	85.90%	86.28%	87.39%	88.43%
Information Governance	88.98%	88.46%	88.94%	87.82%	86.36%
Moving and Handling	91.53%	91.88%	91.15%	90.34%	88.84%
Moving and Handling Patient	82.63%	75.40%	83.15%	84.29%	85.79%
Prevent - Basic Awareness Levels 1 - 2	85.00%	80.95%	90.91%	90.48%	86.36%
Prevent - Level 3	100.00%	97.65%	98.04%	95.85%	94.55%
Resuscitation ALS				83.33%	84.21%
Resuscitation BLS	78.35%	73.28%	77.68%	77.59%	78.99%
Resuscitation ILS	76.47%	76.47%	75.00%	0.00%	0.00%
Resuscitation Non Clinical	100.00%	100.00%	100.00%	100.00%	
Safeguarding Adults Level 2	90.99%	89.72%	92.38%	86.61%	87.93%
Safeguarding Children Level 2	80.00%	80.95%	86.36%	85.71%	81.82%
Safeguarding Children Level 3	97.18%	92.02%	94.12%	90.32%	87.73%
Grand Total	91.41%	89.39%	90.88%	90.23%	89.91%

Medical Staff
MAST Compliance

	Oct 25	Nov 25	Dec 25	Jan 26	Feb 26
Dementia Awareness	85.71%	90.48%	95.24%	93.44%	94.92%
Equality, Diversity and Human Rights	82.54%	85.71%	90.48%	90.16%	89.83%
Fire Safety	88.89%	92.06%	92.06%	90.16%	91.53%
Health, Safety and Welfare	77.78%	80.95%	85.71%	88.52%	89.83%
Infection Prevention and Control Clinical	76.19%	80.95%	79.37%	77.05%	74.58%
Information Governance	82.54%	87.30%	87.30%	88.52%	83.05%
Moving and Handling	79.37%	84.13%	85.71%	86.89%	88.14%
Moving and Handling Patient	85.71%	85.71%	100.00%	100.00%	100.00%
Prevent - Basic Awareness Levels 1 - 2	60.00%	68.57%	74.29%	69.70%	76.67%
Prevent - Level 3	78.57%	78.57%	82.76%	82.76%	82.76%
Resuscitation BLS	40.91%	45.45%	45.45%	50.00%	54.55%
Resuscitation ILS	41.46%	43.90%	51.22%	58.97%	59.46%
Safeguarding Adults Level 2	71.43%	68.42%	81.58%	80.56%	85.71%
Safeguarding Children Level 2	85.71%	91.18%	87.50%	83.33%	88.89%
Safeguarding Children Level 3	71.43%	72.41%	77.42%	77.42%	77.42%
Grand Total	75.86%	79.56%	82.69%	82.72%	83.52%

Safe Maternity staffing

Fill rates – planned versus actual

Midwifery

	December 2025						January 2026						February 2026					
Site /Area	Day			Night			Day			Night			Day			Night		
	Planned	Actual	%	Planned	Actual	%	Planned	Actual	%	Planned	Actual	%	Planned	Actual	%	Planned	Actual	%
Carmen Suite	776	526	68%	702	461	66%	741	677	90%	713	689	97%	705	348	49%	610	253	41%
Delivery Suite	5274	4274	81%	4967	4362	88%	5314	4523	85%	4991	4410	88%	4846	4010	83%	4492	3826	85%
Gwillim Ward	2318	2021	87%	1426	1257	88%	2,322	1,990	86%	1426	1385	97%	2135	1679	79%	943	842	89%

Midwifery Support Workers

	December 2025						January 2026						February 2026					
Site/ Area	Day			Night			Day			Night			Day			Night		
	Planned	Actual	%	Planned	Actual	%	Planned	Actual	%	Planned	Actual	%	Planned	Actual	%	Planned	Actual	%
Carmen Suite	364	341	94%	356.5	345	97%	0	0	0	0	0	0	361	240	66%	322	322	100 %
Delivery Suite	1060	984	93%	1058	1021	96%	1,075	924	86%	1,069	1,057	99%	953	865	90%	943	896	95%
Gwillim Ward	1145.5	987	86%	1070	1001	93%	1,205.5	828	69%	1,081	955	88%	1020	803	78%	943	842	89%

Mitigation: Daily escalation takes places x3 per 24hrs to establish escalation/mitigations as required.

Action: Staff moved to highest acuity areas where needed and if low staffing the Birth Centre (included within Carmen Suite) is closed to bring staff to DS. It is also closed when there is no staff allocated for the shift. Unusually low staff fill in Gwillim in February. This should improve now with X14 new Band 5 midwives in post. All vacant shifts are reviewed and go to Bank. If not filled activity is assessed and shifts sent out to agency as required.

Safe Neonatal staffing

Fill rates – planned versus actual

	December 2025						January 2026						February 2026					
Site /Area	Day			Night			Day			Night			Day			Night		
	Planned	Actual	%	Planned	Actual	%	Planned	Actual	%	Planned	Actual	%	Planned	Actual	%	Planned	Actual	%
NICU	5790	5800	100 %	5808	5811	100 %	5790	5800	100%	5808	5811	100%	5169	5189	100 %	5152	5152	100 %
SCBU	1861	1468	79%	1806	1338	74%	1981	1643	83%	1886	1543	78%	2437	1679	69%	2254	1577	70%

The SCBU staffing mitigation:

- Use very limited bank in SCBU (mainly used on NNU)
- Have an unregistered workforce of band 4 staff who work clinically (nursery nurses)
- Rotate staff between NNU and SCBU depending on the number of babies (In Dec, Jan, Feb there were cot spaces in SCBU which meant staff moved across to NNU to work in HDU)

Staffing Vacancy rates

Staff group	Vacancy rate
Midwifery	0.46%
Midwife Support workers	30.27%
Obstetric consultants	-5.96%
Resident doctors	7.23%
Neonatal Nurses	2.29%
ANNP	Not able to provide
Neonatology consultants	8.47%
Resident doctors	Not able to provide
Obstetric anaesthetists	Not able to provide
Resident doctors	Not able to provide
Sickness	% rate
Obstetrics – Long Term	3.05%
Short Term	2.76%

Midwifery Red flags, actions and mitigations

Midwives
New Starters
X15 Band 5 Midwife recruited and commenced in January.
X1 Band 8a Maternal medicine (Mat leave cover) commenced.

Recruitment
X3 Band 6 midwives – interviews taking place 27/03/26
X8 MSW's - Interviews continue
X1 Lead PMA – unsuccessful and continue to advertise

Sonographers – FMU
X2 Sonographers – continue to advertise
X1 Band 8a Lead sonographer – shortlisting

Obstetricians
Consultant presence extended to 08:00–22:00 daily with 2 consultant ward rounds.
Positive feedback from staff
3 tier 24hr rota now in place with SHO cover at night

Anaesthetists
100% compliance with 24/7 availability and supervision standards

Neonatal Staffing
- Medical: fully compliant with BAPM standards
- Nursing: QIS trained staff at 80% (QIS compliant)

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Operational team's challenges update

LTS Maternity Specialists
Head of Governance 1 WTE
Head of Safeguarding 0.8 WTE
ACP Diabates 1 WTE
Bereavement Midwife 1 WTE

Actions:

- Management support for staff currently off sick.
- Divisional Governance team assisting with complaints and incident management.

FMU Sonographer Vacancies
Concerns regarding lack of uptake for FMU sonographer posts. Maternity speciality training is required. Local hospitals appear to be offering enhanced payment due to challenges with recruitment.
Risk due to shortage of staff – potential that set timescale for women to receive screening may not be met as well as all other scans completed in line with set gestation.
Action: Recruitment continues. Some support from Clinical Fellows and Staff Bank. Discussions with Trust Imaging Lead – posts may be of more interest if rotational ultrasound offered rather than just obstetric.

Senior Leadership Update	Commenced
Director of Midwifery and Gynae Nursing	9th February 2026
Group gesh Chief Midwife	30th March 2026

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Obstetric staffing

We have recruited to Mat med clinical fellow post – 1 WTE.

Consultant attendance in line with RCOG

We have full 24hr emergency Consultant cover within Maternity

RCOG compliance of long-term locums

Any long-term Locums are former SGH staff members and RCOG compliant

Fundamentals of Care – Infection Control

Overall: 0 HAI reported.

Saving Lives Audit	Dec 25	Jan 26	Feb
Hand Hygiene	100	99.2	98.3
Cleaning & Decontamination	98.2	100	98.7

Cleaning & Decontamination for each area

Area	December 2025	January 2026	February 2026	Detail
Carmen - Antenatal	96.9	100	95.7	22 / 23
Carmen - Birth Centre	No data	No data	100	3 / 3
Delivery Suite	97.6	100	95.5	21 / 22
Gwillim Ward	100	100	100	25 / 25
Fetal Medicine Unit	No data	No data	100	
Fetal Medicine Unit (FMU)	100	100	100	

Actions:
Carmen Ward: Equipment to be cleaned away from clean items
Delivery Suite: PPE to be worn and disposed of correctly after use.
Feedback to teams on audit results and actions

Hand Hygiene results for each area

Area	December 2025	January 2026	February 2026	Detail
Carmen - Antenatal	100	98.6	100	54 / 54
Carmen - Birth Centre	No data	No data	90	18 / 20
Delivery Suite	100	100	100	21 / 21
Fetal Medicine Unit (FMU)	100	100	100	29 / 29
Gwillim Ward	100	100	100	23 / 23

Actions:
Carmen Birth Centre: feedback to staff members to ensure correct hand hygiene and bare below the elbows in the clinical areas.

Service User Feedback

Complaints
We received 10 formal complaints over the period December – February 2026. There are no clear themes, but issues identified include;

- Care during labour and birth (no clear themes)
- Communication
- Unhappy with Transitional Care Bay
- Appropriate use of translation services
- Cancelation of antenatal tests
- Communication and treatment from staff whilst receiving bad news in FMU

December – February positive feedback :

- ✓ Received excellent care from midwives both in delivery suite and postnatally. In delivery suite, Jack and Ilward were calming, reassuring and caring. As my birth did not go as plan both gave me the space to be upset and were considerate towards my feelings. The anaesthetic team were also wonderful especially when the epidural stopped working. They came promptly and discussed all options with me..
- ✓ My midwife Ella Defty and the other staff Charlie and the receptionist Denise saved my life. I was not registered to give birth there but I needed help and they came to my rescue. The birth was difficult and they were all amazing.
- ✓ I received such amazing care pre birth, during birth and post birth. I felt very lucky to be looked after the way I was, thankyou so much for

Friends and Family Test (FFT) Score

Save as Excel | Save as PDF | Print

Search:

Service	March	April	May	June	July	August	September	October	November	December	January	February	March
Antenatal Clinic	78	73	91	88	90	90	78	81	57	100	65	69	100
Carmen - Antenatal	100	100	100	100	100	100	100	No data	100	100	100	100	100
Carmen - Birth Centre	100	100	100	100	100	100	100	No data	No data	100	100	No data	100
Day Assessment Unit (DAU)	94	100	100	No data	100	98	97	95	100	100	No data	No data	No data
Delivery Suite	100	100	93	91	100	100	100	100	100	100	100	100	100
Fetal Medicine Unit	No data	No data	No data	No data	No data	No data	No data	No data	No data	No data	No data	No data	No data
Gwillim	97	93	86	90	100	93	96	100	88	80	100	83	50

Additional Service User feedback

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Compliments	Action and progress
The healthcare professional who completed the NIPE check on our newborn detected no red light reflex which subsequently led us to being seen by the neonatal team, a paediatric ophthalmologist and a referral to Moorfield Hospital all within two weeks of discharge. This early detection should hopefully allow our daughter the best chance of treatment of congenital cataracts.	Fed back positive comments at ward meetings.
I had a wonderful experience at Gwillim ward. The staff were incredibly supportive professional and compassionate throughout my stay. They made me feel comfortable and well cared for during my stay.	Fed back positive comments at ward meetings
Friends and Family test	**Action and progress**
Fantastic staff - everyone from catering staff to midwives were so wonderful and kind. Excellent clinical care delivered which is the most importance thing. The facilities were awful though- broken windows, showers that don't work etc	Discussed positive feedback with ward team. Working with facilities to improve showers and general upkeep of facilities within the ward area.
No water pressure in the showers, very difficult to wash	Facilities reviews taking place monthly. Bathroom and shower replacement has now been completed at bottom end of ward. Checking water pressure
Happy with the service and support. The area for improvement: the staff should ask patients in the ward to not speak loudly at night to respect other patients who want to have a rest	Discussed feedback at ward meetings. Looking at adding posters at bedside asking patients to use headphones and speak quietly overnight.
Complaints	**Action and progress**
Unhappy with baby being admitted to Transitional Care Bay as felt this was an Infection Control risk	Patient met with by ward Matron and TC lead. Reassurance to the parent and explained the reasoning of TC care.
Unhappy about conflicting scan results between FMU and private service. Lack of reassurance given by FMU consultant.	Confirmed results from FMU were correct and referred for genetic review. Apologies form Consultant but this was unfortunately bad news and was unable to provide the reassurance they wanted.
Unhappy that GTT test was stopped and rescheduled once it had been noted that the patient had not drunk all of the required glucose drink.	Apologies given for upset caused and explained the reasoning for this decision.

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Safety Champions meeting

Meeting Log and Walk About

Date	Role	Attendance
22/01/2026	Board Safety Champion	√
25/03/2026		√
22/01/2026	Board Safety champion	√
25/03/2026		√
22/01/2026	Perinatal Obstetric Lead	x
25/03/2026		√
22/01/2026	Perinatal Midwifery lead	√
25/03/2026		√
22/01/2026	Perinatal neonatal lead	√
25/03/2026		X
22/01/2026	Perinatal management lead	X
25/03/2026		X
22/01/2026	MNVP leads x2	√
25/03/2026		√

Safety Champions feedback

- A staff engagement events have taken place quarterly, last meeting 4th February 2026, where Safety Champion feedback and actions are shared. A full day Staff Engagement Day is planned for 12th May 2026. Safety
- Quarterly staff engagement events are embedded and have been in place throughout the CNST period.
- A separate Safety Champions Report is submitted to QCiC which includes details of all engagement events, visits and walk-arounds and actions taken in respect of any concerns raised. Main actions identified at SGUH include issues with iClip and MEWS computer connectivity on delivery suite, the need to improve staff changing facilities, recruitment.
- A recent walk-around at SGUH (March 2026) found the area to be clean, tidy and well-organised and the staff welcoming. Issues identified included issues with IT connectivity of computers on Delivery Suite and Birth Centre closure concerns.

Insights from service users and Maternity & Neonatal Voices Partnership Co-production

Recruitment to post update

There is now a Maternity Lead and Deputy, and Neonatal Lead and Deputy. This equates to **45hrs MNVP per month**.

Meetings and Activities

1. MNVP Meeting 05/02/2026, 26/02/2026

Actions reviewed and updated

Key areas of discussion –

Maternity Helpline proposed changes and potential closure of the Maternity Birth Centre.

Operational updates, Social Media

Presentation: Dr Hedley, Pregnancy vaccine studies on GBS & RSV

2. SWL MNVP Meeting 05/03/2026

3. MNVP Self Assessment Completion 23/03/2026

Meeting with SWL Maternity Service User Voices and Engagement Lead to support MNVP complete Self Assessment to support Job Planning.

4. Co-Production Work 29/01/2026, 13/03/2026

Attended Maternity Patient Survey Co-production Meetings, with aim to produce an action plan for improvement following 2025 patient feedback report

NHS

2025 Maternity Survey

Results for St George's University Hospitals NHS Foundation Trust

CareQuality Commission

Where service user experience is best

- ✓ **Care in the Ward:** Partner or someone else close to them being able to stay as much as they wanted
- ✓ **Postnatal Care: Care at home after birth:** Receiving help and advice from a midwife about feeding baby in the 4 weeks after birth
- ✓ **Postnatal Care: Care at home after birth:** Frequency of seeing or speaking to a midwife
- ✓ **Postnatal Care: Care at home after birth:** Being given information about physical recovery after birth
- ✓ **Triage: Assessment and Evaluation:** Feelings about the length of time they waited before being seen by a midwife

Where service user experience could improve

- o **Antenatal care: Antenatal check ups:** Midwives or doctor aware of medical history
- o **Care in the Ward:** Being able to get help from staff when needed
- o **Care in the Ward:** Delays to discharge on the day of leaving hospital
- o **Labour and Birth: Your labour and birth:** Being sent home when they were worried about themselves or their baby
- o **Postnatal Care: Care at home after birth:** Having confidence and trust in the midwife/midwifery team who they saw or spoke to after going home

These questions are calculated by comparing your trust's results to the national average. "Where service user experience is best": These are the five results for your trust that are highest compared with the national average. "Where service user experience could improve": These are the five results for your trust that are lowest compared with the national average.

This survey looked at the experiences of service users who gave birth at the trust in January and/or February 2025. Between April and July 2025, a questionnaire was sent to 302 recent service users who gave birth at St George's University Hospitals NHS Foundation Trust. Responses were received from 112 service users at this trust. If you have any questions about the survey and our results, please contact [NHS TRUST TO INSERT CONTACT DETAILS].

PQOM slide

Action plan – adherence to service specification NHS England » Service specification: neonatal critical care

Theme	Progress	Support requirements
CNST Safety Action 4 – Compliance with BAPM Nursing standards – 70% of staff to be QIS (Qualified in speciality).	**Achieved in September 2025** – QIS trained staff now **80%** -target has been achieved. This has been achieved via - New band 6 recruitment strategy in 2024 and JD/Person spec (externally recruited 10 band 6 staff since August 2024). Previously external recruitment into QIS posts has been low. - Maximise QIS course uptake – including 8 staff who have now completed the accelerated QIS courses started by the ODN in 2024. - Clear set trajectory to keep on track - Reduction in turnover.	• TNA requirements for QIS courses to be met • ODN to continue to support with the ANQIS courses • TRAC processes to meet service needs • Establishment reviews in line with BAPM standards
Safety Action 3- Transitional Care service	**Achieved – Full 24/7 TC service since March 2025**. - Staffing and rosters fully complaint - Band 7 lead nurse - Caring for NGT, IV's, NAS, 34 weeks and low BW, triplets and twins - - All staff competencies signed off - Staffing rotation plan between TC and NNU working well.	• Maternity collaboration and attendance at meetings • BFI reaccreditation assessment 22/23rd October 25. For further review. • Establishment review support

PQOM slide

Action plan – adherence to service specification NHS England » Service specification: neonatal critical care

Theme	Progress	Support requirements
Transitional Care Audit	**Compliant** – continued the audit that we registered 15th October 2024 titled Establishment of a BAPM compliant Transitional care service within St Georges. - Ongoing monthly TC meetings - SOP's and Guidelines in place and evolving with need - NEWTT2 - Audit ongoing and presented at clinical governance	• Continued attendance at TC meetings • Space to present at MGM

Saving Babies Lives v3.2- Q2 (Aug-Oct 2025) reviewed by SWL LMNS on 16/10/2025- Overall compliant with this Safety Action 6 (87%)

PQOM slide

Implementation Progress

Intervention Elements	Description	Element Progress Status (Self assessment)	% of Interventions Fully Implemented (Self assessment)	Element Progress Status (LMNS Validated)	% of Interventions Fully Implemented (LMNS Validated)
Element 1	Smoking in pregnancy	Partially implemented	90%	Partially implemented	90%
Element 2	Fetal growth restriction	Partially implemented	85%	Partially implemented	80%
Element 3	Reduced fetal movements	Fully implemented	100%	Fully implemented	100%
Element 4	Fetal monitoring in labour	Fully implemented	100%	Fully implemented	100%
Element 5	Preterm birth	Partially implemented	85%	Partially implemented	88%
Element 6	Diabetes	Partially implemented	83%	Partially implemented	83%
All Elements	TOTAL	Partially implemented	87%	Partially implemented	87%

See next slide for update of actions

Saving Babies Lives v3.2- Q1 (Aug- Oct 2025) reviewed by SWL LMNS on 16/10/2025- Overall compliant with this Safety Action 6 (87%)

PQOM slide

	Progress / Action	Responsible (role)	By when
EI 1: Smoking in pregnancy	Women setting quit dates. Working with teams to improve Co monitoring at 36 weeks. Communication to community midwives. All clinics have CO monitors. Have joined Quit Smoking Initiative with aim to improve quite rates (financial incentive for women)	Consultant Midwife (Public Health)	In progress (90%)
EI 2: Fetal growth	Deviation for NICE guidance. No routine fundal height measurements instead ASPRE screening carried out with aspirin and monitoring and delivery pathway for high-risk women. All women have growth scan at 36-weeks identification of SGA babies (3rd to 10th centile) is demonstrated as higher than standard set rates.	Lead Midwife FMU/DAU	In progress (80%)
EI 3: Reduced fetal movement	Fully compliant for the management of women reporting reduced fetal movements	Senior Midwife DAU	Completed 100%
EI 4: Fetal monitoring	Fully compliant for fetal monitoring standards.	Fetal Monitoring Lead Midwife	Completed 100%
EI 5: Pre-term births	Audit on maternal breast milk for pre-term babies non-compliant. NNU team working on further education to their team and maternity to prepare mothers who are going to deliver pre-term to collect colostrum. This is promoted and monitored through Perinatal Optimisation Pathway (POP) and is presented quarterly.	Neonatal Consultant	In progress (88%)
EI 6: diabetes in pregnancy	SGH to have a separate clinic for women with pre-existing diabetes. Team are working on this action – looking for venue.	Consultant Midwife (Maternal Medicine)	In progress (83%)

MIS Year 7 – Safety Action Plan Summary

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

Action No.	Maternity safety action	Action met? (Y/N)	Met	Not Met	Info	Check Response	Not filled in
1	Are you using the National Perinatal Mortality Review Tool to review and report perinatal deaths to the required standard?	Yes	7	0	0	0	0
2	Are you submitting data to the Maternity Services Data Set (MSDS) to the required standard?	Yes	2	0	0	0	0
3	Can you demonstrate that you have transitional care services in place to minimise separation of mothers and their babies?	Yes	5	0	0	0	0
4	Can you demonstrate an effective system of clinical workforce planning to the required standard?	Yes	11	0	1	0	0
5	Can you demonstrate an effective system of midwifery workforce planning to the required standard?	Yes	6	0	1	0	0
6	Can you demonstrate that you are on track to achieve compliance with all elements of the Saving Babies' Lives Care Bundle Version Three?	Yes	4	0	0	0	0
7	Listen to women, parents and families using maternity and neonatal services and coproduce services with users	Yes	4	0	0	0	0
8	Can you evidence the following 3 elements of local training plans and 'in-house', one day multi professional training?	Yes	21	0	0	0	0
9	Can you demonstrate that there are robust processes in place to provide assurance to the Board on maternity and neonatal safety and quality issues?	Yes	9	0	0	0	0
10	Have you reported 100% of qualifying cases to Healthcare Safety Investigation Branch (HSIB) (known as Maternity and Newborn Safety Investigations Special Health Authority (MNSI) from October 2023) and to NHS Resolution's Early Notification (EN) Scheme?	Yes	8	0	0	0	0

Following confirmation through the external verification process and discussion with our Collaborative Advisory Group (CAG), **I am writing to congratulate your organisation on meeting all 10 safety actions for Year 7 of MIS**.

15.0 Equality, Diversity and Inclusion

Maternity services continue to prioritise the delivery of equitable, person-centred care that is responsive to the diverse needs of women, birthing people, and families. Persistent disparities in maternity outcomes—linked to ethnicity, socioeconomic status, and other protected characteristics—are being actively monitored through regular data review to identify and address inequalities.

To improve access and support informed decision-making, the service is embedding culturally sensitive care planning, enhancing interpretation services, and engaging more effectively with local communities. Staff are consistently completing mandatory training in equality, diversity and inclusion, with emphasis on cultural competence and unconscious bias.

Inclusive workforce practices are also being promoted through staff networks and equitable opportunities for professional development. Collectively, these initiatives underpin the Trust's commitment to reducing health inequalities and ensuring all service users receive safe, respectful, and responsive maternity care.

15.0 Recommendation

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

a) Note the maternity service updates and the key risks and points for escalation

b) Consider any aspects where further assurance is required

They are also asked to record in the Trust Board minutes as requested to provide evidence for the maternity incentive scheme.

Group Board Meeting (Public)

Meeting on Friday, 08 May 2026

Agenda Item	2.3	
Report Title	**Quality Governance Improvement Plan Update**	
Executive Lead(s)	Richard Jennings, Group Chief Medical Officer Elaine Clancy, Group Chief Nursing Officer	
Report Author(s)	Stephanie Sweeney, Group Director of Quality and Safety Governance Anna Wickins, Senior Programme Manager, Corporate Medical Directorate	
Previously considered by	Choose an item.	Click or tap to enter a date.
Purpose	**For Noting**	

Executive Summary

The Group Executive and the Group Board have recognised the need to strengthen quality and safety governance across the Group in response to recent external reviews of quality governance and the findings of recent CQC inspections.

The way in which quality and safety information and assurance flows, from ward to Board and from Board to ward, has been recently been clarified, simplified and strengthened.

We are now building on these recent changes through the Quality Governance Improvement Plan, which was agreed at Quality Committee on 26 March 2026, and which focuses on specific improvements across our Group-wide governance standards and effectiveness - to be delivered over the next six months.

Over the past two years, a number of external reviews have highlighted opportunities to strengthen the Group's approach to quality and safety governance. These include reviews led by Dr Sally Herne (NHSE Improvement Director) and the Care Quality Commission Well-Led Review of St George's (October 2025). and the Royal College of Physicians review of Interstitial Lung Disease care at St Helier. In particular, feedback from the Care Quality Commission Key Lines of Enquiry (KLOEs) has emphasised the need to further strengthen quality governance in line with the Well-led, Safe, and Effective domains, ensuring systems are consistently applied, clearly understood, and demonstrably effective in identifying risk and driving improvement in an organisation that nurtures psychological safety and supports staff to speak up.

As the gesh Group has developed, we have continued to refine and strengthen how the Group operates and the governance that underpins it. In February 2025, we put in place a new Group Accountability Framework, which clarifies roles and responsibilities across the Group at Executive, Site and Divisional levels, and in March 2025 we introduced a new Group-wide Risk Management and Escalation Framework, which standardises and strengthens the Group's approach to risk identification and escalation. This framework also implemented the new Patient Safety Incident Response Framework (PSIRF).

Over the past two months, we have also reviewed and strengthened our Executive governance arrangements – strengthening how the Group Executive Committee oversees quality and safety across gesh, establishing a new framework for Executive oversight of Site performance and support through the introduction of new Executive-Site Development Forums, and creating a new Clinical Safety Action Group (replacing the former Executive sub-Group “Quality Group”). In addition, we have aligned Group-wide Quality Priorities from Board to Ward. These developments mean the organisation is now operating from a much stronger and aligned quality governance foundation, with clear appreciation of CQC expectations, particularly the Well-led domains covering leadership, governance, culture and learning.

The next phase focuses on embedding consistency, clarity and impact through a structured Quality and Safety Governance Improvement Programme. This programme is supported by a weekly Taskforce and overseen through a quarterly executive-led and multidisciplinary Steering Group which will maintain pace and oversight.

On 14 May, a standardised Group Governance Toolkit will be launched at the first meeting of the Group-wide Clinical Governance Community of Practice. The toolkit has been crafted in response to learning from observations, feedback from reviews, and in line with NHS best practice. For staff, this will translate into a more consistent and predictable governance experience:

- Clearer meeting structures,
- Standardised documentation,
- Improved access to meaningful clinical data, and
- Stronger alignment between local activity and Group priorities.

Critically, it will also strengthen the Well-led culture by embedding openness, learning and reflection, underpinned by psychological safety so that staff feel confident to speak up, escalate concerns, and challenge practice.

In practice, governance will feel simpler, more joined-up and more supportive. Clinical teams will be equipped with practical tools, training and the Community of Practice to build capability and share learning. Expectations will be clearer, duplication reduced, and good practice more easily spread across the organisation. Over time, this will enable teams to focus less on process and more on improving patient care, with stronger assurance that quality and safety risks are being identified, understood and acted upon consistently across the Group, and that governance is fully aligned with a Well-led organisation where leadership, culture, learning and improvement are visibly integrated into everyday practice.

Progress against implementation will be formally reviewed and reported to the Quality Committee within six months of the 14 May launch, with a structured assessment against baseline measures and clear identification of further required actions, as needed.

Action required by Group Board

The Board is asked to:

a. Note the completed and ongoing quality governance improvement work.
b. Consider if there are any additional actions that should be considered as part of this Group-wide programme.

Appendices	
Appendix No.	**Appendix Name**
Appendix 1	Quality and Safety Governance Architecture Diagram

Implications

Group Strategic Objectives

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

Risks

There is a risk that the Clinical Governance Improvement Programme is not delivered at the required pace or with sufficient consistency across the Group, due to competing priorities, capacity constraints and financial pressures. This could result in continued variation in the maturity of clinical governance arrangements, weaker assurance, and slower improvement in quality and patient safety. This risk is being mitigated through the establishment of clear leadership, defined delivery milestones, regular programme oversight, and ongoing review through the Taskforce, Steering Group and Committee reporting arrangements.

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

Quality & safety governance has some direct financial implications (e.g. CNST cost) and indirect ones

Legal and / or Regulatory implications

Quality & safety governance is central to our compliance with CQC and other regulatory requirements

Equality, diversity and inclusion implications

Strong quality & safety governance underpins key improvements to be made in health inequalities

Environmental sustainability implications

No direct implications

Quality Governance Improvement Plan

Group Board, 08 May 2026

1.0 Purpose of paper

1.1 This paper provides an update to the Board on the progress already made to strengthen Quality and Safety Governance across the Group, following a series of internal and external reviews. It also outlines the next phase of the Clinical Governance Improvement Programme, which is focused on embedding consistency, strengthening data-driven oversight, and delivering measurable improvements in quality and safety.

2.0 Background

2.1 Over the past two years, a number of external reviews have highlighted opportunities to strengthen the Group's approach to quality and safety governance. These include reviews led by Dr Sally Herne (NHSE Improvement Director), the CQC Well-Led Review (October 2025).

2.2 In particular, feedback from the Care Quality Commission has emphasised the need to strengthen governance arrangements in line with the Key Lines of Enquiry (KLOEs), particularly within the Well-Led, Safe, and Effective domains. This includes ensuring that governance systems are clearly understood, consistently applied, and demonstrably effective in identifying risks, driving improvement, and delivering high-quality care.

External reviews into specific safety concerns, such as the Royal College of Physicians (RCP) Invited Review of Interstitial Lung Disease (ILD) care at St Helier, have also indicated the need to improve early detection of issues, psychological safety for staff raising concerns and appropriately timely and effective organisational responses.

2.3 Collectively, these reviews identified common themes: the need for clearer, more outcome-focused governance; improved access to and use of clinical data; and greater consistency in governance arrangements across the organisation. Alongside this, the appointment of Health Equity Leads at both sites has further highlighted the importance of embedding a systematic approach to reducing health inequalities within governance and improvement activity.

2.4 These findings have informed a structured and organisation-wide programme of work to strengthen governance and align more closely with regulatory expectations.

3.0 Strengthening our Group Governance

3.1 When the Group was established in February 2022, we put in place a Group Operating Model, supported by a Group governance framework including the establishment of Site Leadership teams for each of the Sites within the Group, a Group Executive, the formation of Committees-in-Common, and the establishment of a Group Board. As we have developed as a Group, we have strengthened how the Group is governed to ensure that we have robust systems and processes in place to support the effective operation of the Group at every level.

- **Group Accountability Framework**: In February 2025, we established a new Group Accountability Framework, which defines roles and responsibilities and clear delineation of duties and accountabilities across the gesh Group. The Accountability Framework supports effective governance, risk management and assurance as well as

clarity of decision-making, and provides a framework for the Group to realise its strategic objectives and deliver strong performance. The Framework clarifies the respective roles of the Executive, Sites and Divisions and puts in place clear mechanisms to support delegation of responsibilities through each level of the Group and deliver robust accountability. While not yet fully embedded at every level of the organisation, the Framework provides clarity on what the Group is for, how it operates, and how its constituent parts interact in the delivery of high quality care for patients and communities.

- **Group-wide Risk Management and Escalation Framework:** As part of the harmonisation of standards across the Group, in March 2025, we introduced a new Group-wide risk management framework which harmonises and strengthens how risk is identified, escalated and managed across the Group. This new framework has provided clarity on roles and responsibilities in relation to risk management, and has helped to enhance the visibility of risk across the Group and is supporting a more dynamic and engaged approach to risk that is consistent across the Group.

- **Strengthened Executive governance structures:** In early 2026, we undertook a review of our Executive governance structures and have made wide-ranging changes which streamline and strengthen the operation of the Group Executive Committee and the management structures that feed into it. The Group Executive Committee now has a dedicated rhythm of meetings focusing on: risk and compliance; people and culture; quality and safety; and finance and performance. The governance architecture supporting the Executive has been streamlined and the establishment of new Executive-Site Development Forums provide a new and, when embedded fully, robust way of ensuring effective Executive assurance on Site delivery across quality and safety, operational performance, finance, and culture. Our revised high level governance structure is appended to this report.

i. These recent frameworks provide clarity in a way that is concise and intelligible, and this augments the emphasis on learning and systems that is supported by the adoption of the **Patient Safety Incident Response Framework (PSIRF)**. The appointment of a Group Director for Clinical Effectiveness and Mortality, and the uniting of the previously separate Site-based effectiveness and mortality teams, has also further strengthened leadership in this area.

4.0 Strengthening our Quality and Safety Governance

4.1 Strengthening Key Quality and Safety Governance Architecture

i. Building on these foundations, the governance structure for quality and safety has been streamlined to improve clarity and focus.

ii. ESTH and SGUH both have **Patient Safety & Quality Groups (PSQGs)** and it is in these groups that the core work of quality & safety governance is done at Site Leadership team level. The reaffirmation of the central importance of these groups, and the alignment of their working processes, underpins the deliberate shift back to the Site Leadership Teams of accountability and control of quality & safety issues.

iii. The Executive oversight and input is now provided through the new **Clinical Safety Action Group (CSAG)**, co-chaired by the Group Chief Nursing Officer and Group Chief Medical Officer. now provides a dedicated forum for oversight of the most significant quality and safety risks. This replaces and improves upon the previous

gesh Quality Group, in that the membership of CSAG is leaner and more senior, and detailed discussion will focus by exception on the priority issues for which Group-wide and Executive input can add most value. The CSAG will also have an explicit role in identifying learning from issues at one site for Group-wide learning and improvement. The CSAG will meet formally for the first time on 15 May 2026.

iv. CSAG brings together senior clinical leaders from across the Group and is explicitly action-focused, enabling rapid decision-making and coordinated improvement. A monthly report to the Group Executive Committee ensures that key risks and actions are visible at the highest level of the organisation.

v. The role of the **Group Executive Committee (GEC)** in relation to oversight of quality and safety has also been enhanced through the changes outlined above, with the Executive creating a dedicated and regular focus session on quality and safety. This new cycle started in April 2026, and will ensure that quality and safety received more structured and detailed oversight and assurance alongside finance, people and effectiveness.

vi. The Group Executive and the three Site Senior Leadership Teams now meet in regular **Site Development Forums**. These commenced in April 2026, and provide a regular opportunity for the Executive team to have oversight and assurance on quality and safety, but also to provide input and support on those issues that are most complex and high risk. This enables executives and senior leaders to focus their time on the most important issues by exception, whilst also maintaining regular oversight.

4.2 Aligning Quality Priorities from Board to Ward, and Ward to Board

i. Work has also been undertaken to strengthen organisational focus through the development of a small number of **Group Quality Priorities for 2026–27**. These priorities have been agreed collaboratively across Group, Site, and Divisional leadership and represent areas where coordinated action is expected to deliver the greatest impact.

ii. The Group Quality Priorities were discussed and confirmed at Quality Committee on 26 March 2026.

iii. Progress against these priorities is reported through Divisional governance structures and the Quality Committee, ensuring a clear line of sight from frontline delivery to Board assurance, aligning the focus of our quality and safety leaders and ensuring clear communication on the most pressing quality and safety improvement areas.

4.3 Embedding a Systematic Approach to Health Inequalities

i. A structured approach has been introduced to embed health inequalities improvement work within governance and improvement activity. The SGUH and ESTH Health Equity leads, in collaboration with gesh Business Intelligence, have developed a Health Equity Dashboard and a Health Equity Reporting toolkit for the use of Clinical Directorates and Divisions.

ii. The new Health Equity dashboard provides easy visibility of variation and inequity across access (e.g. Referral to Treatment waiting times), experience (e.g. outpatient Did Not Attend rates) and outcomes (e.g. readmissions, ED attendances (and enables directorates to identify and target a key area for improvement and to measure and report on impact. This includes improvements in ethnicity data quality, the development

of equity dashboards, and the establishment of a Group-wide programme overseen by a Steering Group.

iii. This initiative is being developed alongside the Health Inequalities Community of Practice and the ENGAGE Champions network, which support capability building across the organisation. These health equity improvement actions, and their impact, will be tracked through quarterly Divisional reporting and will form part of the regular health inequalities updates to the Quality Committee.

5.0 Progress of the gesh Quality and Safety Governance Improvement Programme

5.1 To deliver governance improvements consistently and at pace, a clear and disciplined programme structure has been established, building on updates previously reported to the Quality Committee.

5.2 Operational delivery is led through a weekly Quality and Safety Governance Taskforce, chaired by the Group Director of Quality and Safety Governance. This forum drives momentum, coordinates workstreams, and ensures grip on delivery. Strategic oversight is provided through a quarterly Steering Group, chaired by the Group Chief Nursing Officer and Group Chief Medical Officer, ensuring alignment with organisational priorities and regulatory expectations.

5.3 The Taskforce has undertaken a comprehensive review of governance arrangements across Divisions, Directorates and Wards, alongside incident reporting and escalation processes. This work, combined with active engagement with clinical and governance leads, has highlighted variation in practice and clear opportunities for standardisation and strengthening.

5.4 Drawing on these insights, and learning from external reviews, the Group will launch a standardised Group Governance Toolkit on 14 May for all clinical and governance leads across the Group. This marks a key transition from assessment to implementation.

5.5 The core components of the programme are:

- A systematic review of governance structures and standards across all levels of the organisation
- Rollout of the new Group-standardised Governance Toolkit to enable consistent, high-quality practice
- Implementation of agreed standards and best practice, supported by a Clinical Governance Community of Practice to build capability and share learning
- Strengthening clinical data quality, access and usability to support timely, informed decision-making
- Mapping and strengthening Multidisciplinary Team (MDT) governance, with clearer expectations, roles and assurance mechanisms
- Mapping and strengthening governance of Clinical Guidance across the organisation.

5.6 Following the 14 May launch, the focus will shift from the previous reviewing and design into embedding these standards in day-to-day practice. The Group Director of Quality and Safety Governance, supported by the Taskforce, will work closely with governance leads across the organisation to support adoption, provide training, and monitor implementation.

5.7 In practical terms, this will mean a step-change in how governance operates across the Group. Clinical teams will:

- Use standardised Group templates for Terms of Reference, agendas, minutes, action logs and forward plans
- Participate in regular Clinical Governance Community of Practice sessions for training, shared learning and rollout of new tools
- Apply consistent best practice in chairing meetings, fostering psychological safety, triangulating information, and using clinical data effectively

5.8 Standardised reporting templates, co-produced with clinical teams, will support Ward, Service and Divisional governance. These will:

- Embed high-quality clinical data
- Triangulate quantitative and qualitative intelligence
- Align reporting to Group Quality Priorities
- Incorporate local health inequalities priorities

5.9 Six months after the 14 May launch, a formal review will be undertaken to assess progress against the baseline. A report will be presented to the Quality Committee, evaluating the extent to which standards have been embedded and identifying further opportunities to strengthen quality and safety governance across the Group.

6.0 Recommendations

6.1 The Board is asked to:

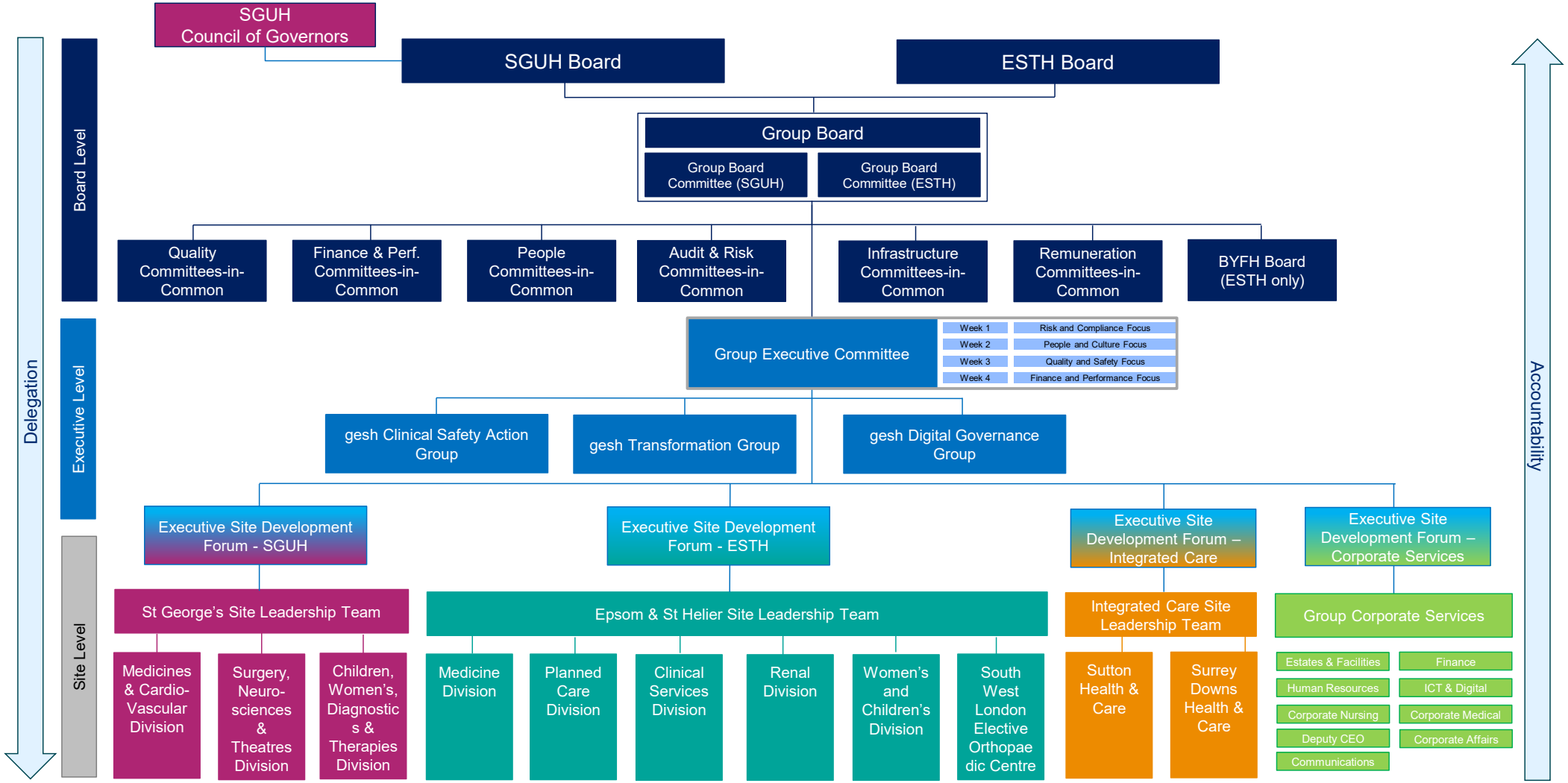
a. Note the completed and ongoing quality governance improvement work.

b. Consider if there are any additional actions that should be considered as part of this Group-wide programme.

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

High-level Group Governance Structure

gesh



Group Board

Meeting in Public on Friday, 08 May 2026

Agenda Item	3.1	
Report Title	**Report from Finance and Performance Committee**	
Executive Lead(s)	Lizzie Alabaster, IGCFO	
Report Author(s)	Bidesh Sarkar, Committee Chair	
Previously considered by	n/a	-
Purpose	**For Assurance**	

Executive Summary

This report sets out the key issues considered by the Finance and Performance Committee at its meetings in March and April (1st May) 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) Approve the Terms of reference appended to the paper
b) Note the approved Annual Report from the Committee
c) 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	N/A

Implications

Group Strategic Objectives

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

Risks

[Set out summary of risk and state link to Board Assurance Framework]

CQC Theme

☐ Safe	☒ Effective	☐ Caring	☐ Responsive	☐ Well Led

NHS system oversight framework

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

Financial implications

n/a

Legal and / or Regulatory implications

n/a

Equality, diversity and inclusion implications

n/a

Environmental sustainability implications

n/a

Finance and Performance Committee Report
Group Board, 08 May 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 March and April (1st May) 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 27th March and 1st May 2026, the Committee considered the following items of business:

27th March 2026	1st May 2026
PUBLIC MEETING • IGCFO/DCEO report • NOF meeting update • IQPR • Integrated Finance report M11 • Forecast update M11 • Productivity update • Medium Term Financial Plan • Strategic Business Case update	**PUBLIC MEETING** • IGCFO/DCEO report • NOF Q3 Update • IQPR • 2025/26 Financial Outturn* • Medium Term Financial Plan* • Capital Governance • Annual Report to Group Board* • Committee Terms of Reference*

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

2.2 The Committee was quorate for both meetings.

4.0 Sources of Assurance

4.1

a) Financial Outturn 25/26

The committee welcomed the draft accounts submission that reflected key capital and revenue metrics being delivered in 25/26. Whilst this was subject to external audit it reflects significant work from budget holders and finance teams to deliver a very challenging budget, and the committee also celebrated the movement in underlying financial performance.

b) Productivity update

The Committee noted this update in March.

c) Medium Term Financial plan

NHSE has accepted the plan submitted but with conditions noting the residual financial risk at the planning stage primarily related to efficiency delivery. As a result, efficiency scheme development and delivery will be subject to close monitoring with regular reporting to the regional team. The Committee reflected on progress with contractual alignment, financial risks, efficiency delivery and investment on transformation and operational targets in the April meeting. Financial risk relates to efficiency development and the key action agreed is to progress development.

d) Operational Performance

The Committee noted the good work going on across operational performance, with deep dives scheduled in for much of the coming financial year on individual areas. Emergency care was the primary focus on April's meeting, with good progress on the UTC model at ESTH highlighted.

e) Strategic Business Case/Capital update

The March committee updated on some of the key projects such as the Epsom Car Park acquisition. In April the committee reviewed a proposed governance framework for capital that was being implemented across the group.

f) Annual Report / Terms of Reference

The Committee **approved the report** and noted proposed changes to the Terms of Reference. It was suggested that the consideration given by the Committee to the 3 year element of the MTP should be better emphasised in the report. **The Committee recommended the updated Terms of Reference to the Group Board.**

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 March and April (1st May) 2026.

Finance and Performance Committees

Annual Report 2025/26

1 April 2025 – 31 March 2026

Contents

Finance and Performance Committees Annual Report 2025/26

1. Introduction

Since the formation of the St George's, Epsom and St Helier University Hospitals and Health Group, a number of Board Committees have met as Committees-in-Common across the Group. Since April 2022, this has included the People Committees, Quality Committees, Finance and Performance Committees and Remuneration Committees of the two Trusts, with the Infrastructure and Audit and Risk Committees also operating as Committees-in-Common since October 2023 and May 2024 respectively.

This report sets out a high-level overview of the work of the Finance and Performance Committee in 2025/26. It provides an integrated report on the key matters considered by the Committees, and also highlights issues that were considered which related solely to either St George's or Epsom and St Helier. The purpose of this report is not to provide a detailed account of all matters considered by the Committees but to give an overview of how the Committees have discharged their responsibilities as set out in their terms of reference over the past year.

Membership

2. Committee purpose and duties

The Finance and Performance Committees of the two Trusts have adopted identical terms of reference to ensure that there is consistency of purpose and duties across the two Committees. The Committees' purpose and duties are set out in the terms of reference agreed by the St George's and Epsom and St Helier Boards.

2.1 Purpose

The purpose of each Committee is to assist the Board in maximising the Trust's healthcare provision within available financial constraints by:

- Approving the annual financial plan and reviewing financial performance to ensure the Trust achieves its annual financial targets and uses public funds.
- Approving the annual operational plan and reviewing performance to ensure the Trust achieves its annual performance targets.
- Ensuring financial, workforce and operational plans triangulate.
- Reviewing and approving the investment in service development opportunities and approving tender proposals.
- Seeking assurance that key risks relating to finance, performance, as included on the Board Assurance Framework and the Corporate Risk Register, are being effectively managed and mitigated.
- Overseeing the implementation of strategies and other frameworks and risks to their delivery.

The full terms of reference, including proposed changes, are at Appendix 1.

3. Membership and attendance

3.1 Members and attendees

During the reporting period (April 2024 to February 2025), the following were members or regular attendees of the Committee:

St George's Finance Committee			
Name	**Role**	**Designation**	**Period**
Ann Beasley	Member	Committee Chair, Non-Executive Director	1 April 2025 – 12 October 2025
Bidesh Sarkar	Member	Committee Chair, Non-Executive Director	13 October 2025 – 31 March 2026
Peter Kane	Member	Non-Executive Director	1 April 2025 – 30 September 2025
Leonie Penna	Member	Non-Executive Director	1 October 2025 – 31 March 2026
Pankaj Dave	Member	Non-Executive Director	1 April 2025 – 30 September 2025
Claire Sunderland Hay	Member	Associate Non-Executive Director	1 April 2025 – 31 March 2026
Michael Pantlin	Member	Group Deputy Chief Executive Officer	1 April 2025 – 31 March 2026
Andrew Grimshaw	Member	Group Chief Finance Officer	1 April 2025 – 30 November 2025
Lizzie Alabaster	Member	Interim Group Chief Finance Officer	1 December 2025 – 31 March 2026
Richard Jennings	Member	Group Chief Medical Officer	1 April 2025 – 31 March 2026
Arlene Wellman	Member	Group Chief Nursing Officer	1 April 2025 – 31 August 2025
Elaine Clancy	Member	Interim Group Chief Nursing Officer	14 September 2025 – 31 March 2026
Kate Slemeck	Member	Managing Director – St George's	1 April 2025 – 31 March 2026
Victoria Smith	Attendee	Group Chief People Officer	1 April 2025 – 31 March 2026
Thirza Sawtell	Attendee	Group Executive Director of Integrated Care	1 April 2025 – 31 March 2026
Tara Argent	Attendee	Site Chief Operating Officer	1 April 2025 – 31 March 2026
Mark Bagnall	Attendee	Group Chief Infrastructure, Facilities & Environment Officer	1 April 2025 – 31 March 2026
Ed Nkrumah	Attendee	Group Director of Performance & PMO	1 April 2025 – 31 March 2026
Stephen Jones	Attendee	Group Chief Corporate Affairs Officer	1 April 2025 – 31 March 2026
Sarah Dixon	Attendee	NHSE SWL Regional Lead	1 October 2025 – 31 March 2026
Helen Jameson	Attendee	SWL Chief Financial Officer	1 April 2025 – 31 December 2026
Dinah McLannahan	Attendee	SWL Chief Financial Officer	1 January 2026 – 31 March 2026
Andy Stephens	Attendee	Site Director of Financial Strategy	1 April 2025 – 31 March 2026
George Harford	Attendee	Site Chief Financial Officer	1 April 2025 – 31 March 2026

Epsom & St Helier Finance Committee			
Name	**Role**	**Designation**	**Period**
Ann Beasley	Member	Committee Chair, Non-Executive Director	1 April 2025 – 12 October 2025
Bidesh Sarkar	Member	Committee Chair, Non-Executive Director	13 October 2025 – 31 March 2026

Epsom & St Helier Finance Committee			
Name	**Role**	**Designation**	**Period**
Peter Kane	Member	Non-Executive Director	1 April 2025 – 30 September 2025
Leonie Penna	Member	Non-Executive Director	1 October 2025 – 31 March 2026
Pankaj Dave	Member	Non-Executive Director	1 April 2025 – 30 September 2025
Phil Wilbraham	Member	Non-Executive Director	1 October 2025 – 31 March 2026
Michael Pantlin	Member	Group Deputy Chief Executive Officer	1 April 2025 – 31 March 2026
Andrew Grimshaw	Member	Group Chief Finance Officer	1 April 2025 – 30 November 2025
Lizzie Alabaster	Member	Interim Group Chief Finance Officer	1 December 2025 – 31 March 2026
Richard Jennings	Member	Group Chief Medical Officer	1 April 2025 – 31 March 2026
Arlene Wellman	Member	Group Chief Nursing Officer	1 April 2025 – 31 August 2025
Elaine Clancy	Member	Interim Group Chief Nursing Officer	14 September 2025 – 31 March 2026
James Blythe	Member	Managing Director – Epsom & St Helier	1 April 2025 – 18 September 2025
Alex Shaw	Member	Interim Managing Director – Epsom & St Helier	18 September 2025 - 31 March 2026
Thirza Sawtell	Member	Group Executive Director of Integrated Care	1 April 2025 – 31 March 2026
Victoria Smith	Attendee	Group Chief People Officer	1 April 2025 – 31 March 2026
Alex Shaw	Attendee	Site Chief Operating Officer	1 April 2025 – 31 August 2025
James Pavett-Downer	Attendee	Interim Site Chief Operations Officer	1 September 2025 - 31 March 2026
Mark Bagnall	Attendee	Group Chief Infrastructure, Facilities & Environment Officer	1 April 2025 – 31 March 2026
Ed Nkrumah	Attendee	Group Director of Performance & PMO	1 April 2025 – 31 March 2026
Stephen Jones	Attendee	Group Chief Corporate Affairs Officer	1 April 2025 – 31 March 2026
Sarah Dixon	Attendee	NHSE SWL Regional Lead	1 October 2025 – 31 March 2026
Helen Jameson	Attendee	SWL Chief Financial Officer	1 April 2025 – 31 December 2026
Dinah McLannahan	Attendee	SWL Chief Financial Officer	1 January 2026 – 31 March 2026
Lizzie Alabaster	Attendee	Site Chief Financial Officer	1 April 2025 – 30 November 2025
Rob Chidlow	Attendee	Site Chief Financial Officer	1 December 2025 – 31 March 2026

3.2 Committee meeting attendance

The quorum for each Committee meeting was a minimum of four Committee members, including two Non-Executive Directors and two Executive Directors.

The Committee held a total of 12 meetings during the reporting period and the attendance of members and regular attendees as defined in the Terms of Reference are set out below. All meetings of the Finance and Performance Committee were quorate for both Trusts.

Attendance			
Name	Role	Trust	Attendance
Ann Beasley	Committee Chair	Both	6/6
Bidesh Sarkar	Committee Chair	Both	6/6
Peter Kane	Member	Both	6/6
Leonie Penna	Member	Both	5/6
Pankaj Dave	Member	Both	6/6
Claire Sunderland Hay	Member	SGH	9/12
Phil Wilbraham	Member	ESTH	4/6
Michael Pantlin	Member	Both	11/12
Andrew Grimshaw	Member	Both	8/8
Lizzie Alabaster	Member	Both	4/4
Richard Jennings	Member	Both	11/12
Arlene Wellman	Member	Both	3/5
Elaine Clancy	Member	Both	0/7
Kate Slemeck	Member	SGUH	11/12
James Blythe	Member	ESTH	3/5
Alex Shaw	Member	ESTH	6/7
Thirza Sawtell	Member	Both	9/12
Vicky Smith	Attendee	Both	10/12
Mark Bagnall	Attendee	Both	5/12
Alex Shaw	Attendee	ESTH	1/5
James Pavett-Downer	Attendee	ESTH	5/7
Tara Argent	Attendee	SGUH	8/12
Stephen Jones	Attendee	Both	1/12
Andy Stephens	Attendee	SGUH	12/12
Alastair Haggart	Attendee	ESTH	12/12
Ed Nkrumah	Attendee	Both	12/12
Helen Jameson	Attendee	Both	4/9
Dinah McLannahan	Attendee	Both	0/3
George Harford	Attendee	SGUH	12/12
Lizzie Alabaster	Attendee	ESTH	6/8

In addition to the above, the Chair in Common, Group Chief Executive Officer regularly and attended meetings of the Finance Committees-in-Common during the reporting period. The Chairman attended 11 meetings and the Group Chief Executive Officer 8 meetings (between the two incumbents).

4. Committee activity and focus

4.1 Finance Performance, Oversight and Business Planning

The Committee received monthly updates on iterations of the Group financial plans for 2025/26 in the early part of the year, before turning attention to planning for 2026/27 in the autumn. Discussions focussed on the planning and delivery of Cost Improvement Plans (CIPs), both business as usual and transformational, as well the impact of industrial action, and exit run rates from the previous year. Both Trusts have operated in an extremely challenged financial context this year, and the Committee has sought assurance on the delivery of the 2025/26 plan and key risks to delivery, the delivery of agreed CIPs, and the

development of a credible 2026/27 financial plan within the context of the Group's development of a wider three-year Medium Term Plan.

In addition, greater emphasis was placed on contractual negotiation. As the Group heads into 2026/27 there will also be additional scrutiny on cash management, and capital expenditure.

The Committee now regularly receives updates on Group productivity following metrics published nationally, which comments on the validity of results obtained. As well as this, there is a quarterly update on costing and the performance against national benchmarks.

The Group delivered a financial for 2024/25 of £9.4m, (with SGH at (£4.3m) and ESTH at (£5.1m)), which was in line with the forecast agreed with SWL and NHSE. At the time of writing the Committee had agreed breakeven plans for 2026/27 subject to 7.5% CIP targets. 2025/26 forecasts are for a £4.9m surplus at SGUH and £0.8m deficit at ESTH following confirmation of additional Deficit Support Funding.

4.2 Financial Strategy and Management

As the year has progressed, the Committee has reviewed progress on the new ESTH Electronic Patient Record (EPR) which went live in May 2025. It has also recommended a new SWL Pathology GP Hub in Croydon, the acquisition of land related to the Epsom Car Park and a new ESTH Surgical Robot to Group Board during 2025/26.

The Committee receives bi-annual assurances from the refresh of financial policies, with further steps forward in coordinating these into Group policies. The Committee approved the updated SGUH Petty Cash, Business Expenses, Asset Valuation and Treasury Management policies in June 2025 and rolled forward several policies in January 2026. The updated Standing Financial Instructions for the group was ratified by the Group Board in March 2026.

The management of cash remains a key topic of discussion with PDC revenue drawdown a possibility in 2026/27. The Group is monitoring the impact of the 2026/27 plan and forecast for cashflow changes that may require the use of PDC drawdown.

Financial risk remained a crucial part of discussions during the year. The Committee agreed to recommend a score of 25 for both ESTH and SGUH under the strategic (BAF) risk 4 related to financial sustainability.

4.3 Procurement

On a quarterly basis throughout the year, the Committee received regular updates on Procurement progress, including updates on CIP plans, as well as the latest on breaches and waivers. The Committee recommended procurements for:

- SGH and ESTH Laundry and Linen Services
- SWL Pathology POCT services
- ESTH Tissue Typing
- SWL Pathology POCT Blood Glucose
- SGH NIPT service
- SWL Pathology Molecular Managed Service
- SGH Utilities
- SGH NEPT service

- South London Cardiology joint procurement
- ESTH Genmed contract
- ESTH Patient Ready Meals
- SGH Catering provision

4.4 Business Cases, Benefits Realisation and Return on Investment

The Committees received regular updates on major group business cases, including in this financial year including the ESTH Surgical Robot, Epsom Car Park, SWL PACS, EPR, Pathology GP Hub and Ambient Voice VT.

4.5 Operational Performance

Over the past year, the Finance and Performance Committees have strengthened their oversight of operational performance, ensuring that performance receives detailed scrutiny alongside the Group's financial performance. This is in the context of both Trusts entering NHS England's Tier 1 oversight for elective care performance and Epsom and St Helier entering Tier 2 oversight for urgent and emergency care in autumn 2026. The Committees have reviewed and sought assurance in relation to the delivery of key operational metrics, namely the Emergency Care Operating Standard, the suite of national Cancer targets, RTT performance (specifically the incomplete pathway %, number of 65 and 52 week waits) and Diagnostic performance. St George's successfully exited Tier 1 oversight in early 2026.

The Committee have also received assurance on the Operational risk associated with delivering these targets, especially following the impact of industrial action.

The Committees also regularly highlight areas of escalation as appropriate to the Group Board.

5. Committee Effectiveness

The Finance and Performance Committee conducted a review of its effectiveness towards the end of the reporting period, which sought the views of both members and regular attendees. Respondents felt that the Finance and Performance Committee was working well, with scope to make further improvements.

The review identified a number of areas of strength, including:

- The level of grip and interrogation of financial performance by the Committee, including understanding of key complex issues and challenge from Non-Executives;
- The ability of the Committee to balance its focus between in-year delivery and future planning;
- The effectiveness of the escalation of issues from the Committee to the Board;
- The input of external stakeholders, particularly South West London Integrated Care Board and NHS England;
- The improvements made in the duration of Committee meetings, which had been brought to a more manageable length in recent months.

A number of areas for further improvement were also identified:

- The need to streamline the volume of information presented to the Committee in order to ensure an appropriate balance between the detail required for the Committee to

discharge its responsibilities and the succinctness needed to deliver effective governance oversight, with the expectations of regulators;

- The scope to document the Committees' assurance on operational performance to the same level as its reporting of assurance on financial matters
- The challenges of balancing scrutiny at the Committee between finance and performance, both of which were challenged and required careful oversight;
- The opportunity for the Committee members to be better linked with the work of other Committees and colleagues at system level;
- The scope for newer NEDs on the Committee to challenge the financial information presented to the Committee.

6. Committee Forward Plan and Terms of Reference

The Committees' terms of reference have been reviewed in the context of the Committee annual effectiveness review and developments within the organisation and externally. Two minor sets of amendments are proposed: the first to reference the Committees' role in overseeing delivery of the Medium-Term Plan; and the second to make the Executive lead for the Committee a joint responsibility between the Group Chief Finance Officer (for finance issues) and the Group Deputy Chief Executive Officer (for operational performance issues). These amendments are set out in an appendix. Changes to the working practices of the Committee, such as taking operational performance first on the agenda and limiting the duration of the meetings do not require changes to the terms of reference.

A forward plan for the Committee has also been developed, which broadly reflects the Committees' plan for 2025/26.

7. Conclusion

The year 2025/26 was the fourth year in which the Finance and Performance Committees of the two Trusts worked together across the gesh Group, with a shared agenda and a common forward plan of business.

Overall, the Committees have worked hard to deliver against their responsibilities as set out in their terms of reference. The Committee effectiveness review demonstrated the value members and attendees attach to this new way of working and to the potential benefits of this approach. However, the experience of the fourth year of operation has also highlighted areas in which the Committees' ways of working will need to evolve in the year ahead to further strengthen its operation and effectiveness. These relate in particular to balancing the Committees' consideration of finance and performance in a more balanced way, as has been the case over recent months, and streamlining the volume of information presented to the Committees to support improved governance and assurance. The Committee's forward work plan for 2026/27 and review of agenda items and reporting arrangements to the Boards will help strengthen the operation of the Committees.

Finance and Performance Committee

Terms of Reference

1. Name

The Committee shall be known as the “Finance and Performance Committee”.

2. Establishment and Authority

The Committee is constituted as a committee of the Board of Directors and is authorised by the Board to:

i. Act within its terms of reference.
ii. Seek any information it requires, and all staff are required to cooperate with any request made by the Committee.
iii. Instruct professional advisors and request the attendance of individuals and authorities from outside the Trust with relevant experience and expertise if it considers this necessary or expedient to the carrying out of its functions.
iv. Obtain such internal information as is necessary and expedient to the fulfilment of its functions.

3. Purpose

The purpose of the Committee is to assist the Board in maximising the Group’s healthcare provision within available financial constraints by:

- Reviewing and approving the annual financial plan and seeking assurance on the delivery of the plan to ensure the Trust achieves its annual financial targets and uses public funds wisely.
- Approving the annual operational plans and reviewing performance to ensure each Trust achieves its annual performance targets.
- Ensuring financial, workforce and operational plans triangulate.
- Seeking assurance on the implementation and delivery of the 3 year Medium-Term Plan
- Reviewing and approving the investment in service development opportunities and approving tender proposals.
- Seeking assurance that key risks relating to finance and performance as included on the Group Board Assurance Framework and the Corporate Risk Register for each Trust, are being effectively managed and mitigated.
- Overseeing and providing assurance to the Group Board on progress in the delivery of the Group’s strategic objective of delivering affordable healthcare fit for the future, and the financial aspects of Group strategic initiatives.

1

4. Duties

The Committee's duties as delegated by the Trust Board, include:

Finance and Business Planning

- Assessing the timeliness and robustness of the annual business planning process.
- Reviewing and recommending the annual financial plan, including capital plan, for approval by the Board.
- Approving cost improvement and income plans and seeking assurances that any resulting service changes are safe and do not have an adverse effect on the quality of patient care.
- Approving returns and submissions on behalf of the Boards.
- Reviewing productivity, profitability and efficiency metrics.

Financial Strategy and Management

- Reviewing all aspects of financial performance against the annual financial plan in order to provide assurances to the Board.
- Reviewing and seeking assurance on the implementation and delivery of the financial elements of the 3 year Medium-Term Plan
- Approving policies in relation to cash management and ensuring they are effective.
- Reviewing arrangements for effective compliance and reporting in respect of loan covenants in place or other requirements relating to borrowed funds.
- Reviewing and seek assurance in relation to key risks related to the operation of the Trust's financial systems and processes and the delivery of the financial plan.

Procurement

- Overseeing the implementation of relevant procurement strategies.
- Approving the annual procurement plan and receiving progress reports on its implementation.
- Seeking assurance in respect of the effective operation and financial management of any collaborative activity hosted by the Trust.

Business Cases, Benefits Realisation and Return on Investment

- Reviewing and approving business cases, tenders and bids for new business opportunities and investment required in service developments in line with approved financial limits in the Scheme of Reservation and Delegation of Powers for the Trust, as appropriate.
- Considering any significant infrastructure investment prior to proposals being put to the Group Board for consideration/approval.
- Reviewing benefits realisation and return on investment of major projects.

Operational Performance

- Reviewing the operational performance of the Trust on a regular basis across the range of performance indicators within the Integrated Quality and Performance Report prior to consideration by the Group Board, including NHS Constitutional Standards.
- Scrutinising key indicators where performance is deteriorating and/or is off-trajectory and seeking assurance that appropriate actions are being taken to bring performance back to trajectory.
- Reviewing the Trust's performance against any other key metrics and performance indicators included in the NHS Oversight Framework and seeking assurance that appropriate actions are being taken to bring performance back to trajectory where applicable.
- Reviewing the development of the Trust's operational plan and other relevant regulatory submissions, including the winter plan, prior to submission to the Group Board for approval.
- Reviewing and seeking assurance on the implementation and delivery of the operational performance elements of the 3 year Medium-Term Plan
- Overseeing the Trust's arrangements for, and compliance with, national standards in relation to Emergency Preparedness Resilience and Response (EPRR), and reviewing the annual EPRR submission to NHS England and NHS Improvement.

General

- Referring any matter to any other Board Committee and responding to items referred to the Committee from other Board Committees and / or the Board.
- Obtaining assurance on the risks to delivery of the Trust's strategic and corporate objectives in relation to finance and performance, with a particular focus on issues that are cross-cutting or trust-wide, or specific issues which should be reviewed at the committee. This includes reviewing regularly relevant risks on the Corporate Risk Register and reviewing the entries on the Group Board Assurance Framework which relate to the scope of the Committee.
- Reviewing material findings arising from internal and external audit reports covering matters within the Committee's remit and seeking assurance that appropriate actions are taken in response, as requested by the Audit and Risk Committee.
- Seeking assurance that the Trust has in place appropriate policies that fall within the Committee's scope and approving relevant policies in line with the Scheme of Reservation and Delegation of Powers.
- Receiving and reviewing reports on significant concerns or adverse findings highlighted by regulators, peer review exercises, surveys and other external bodies in relation to areas under the remit of the Committee, and seeking assurance that appropriate action is being taken to address these.
- As required, reviewing any Trust strategies within the remit of the Committee prior to approval by the Board (if required) and monitor their implementation and progress.

5. Membership and Attendance

A non-executive director will be Chair of the Committee and in his/her absence, an individual will be nominated by the remaining members of the Committee to chair the meeting.

The Group Chief Finance Officer and the Group Deputy Chief Executive Officer are the executive leads for the Committee on finance and performance respectively.

The membership of the Committee comprises:

- Four Non-Executive Directors (including the Chair)
- Group Chief Finance Officer
- Group Deputy Chief Executive Officer
- Group Chief Nursing Officer / Group Chief Medical Officer
- Managing Director(s)

The following are expected to attend but will not be counted towards quoracy.

- Site Chief Finance Officer
- Site Chief Operating Officer

Other directors and staff may attend meetings with the prior permission of the Chair.

An attendance register will be held for each meeting and an annual register of attendance will be set out in the Trust's Annual Report.

All members and attendees named above are expected to attend every meeting with a minimum attendance of 75% over the course of a financial year.

6. Quorum

The quorum for any meeting of the Finance and Performance Committee shall be a minimum of four members of the Committee including:

- At least two non-executive directors
- At least two executive directors

Non-quorate meetings: Non-quorate meetings may go ahead unless the Chair decides not to proceed. Any decision made by a non-quorate meeting must however be formally reviewed and ratified at the subsequent quorate meeting or the Board.

7. Accountability and Reporting Arrangements

The Committee operates under the delegated authority of the Board of Directors and remains ultimately accountable at all times to the Trust Board of Directors.

Under the Group Board arrangements, the Finance and Performance Committee, acting as part of a Group-wide Finance and Performance Committees-in-Common, will report to the

Group Board on the meetings that have taken place since the last Group Board meeting. This will include:

- A list of all items considered by the Committee-in-Common during the relevant period
- Key issues for escalation to the Group Board
- Key issues on which the Committee-in-Common received assurance
- Other issues considered by the Committee-in-Common
- Review of risks assigned to the Committee-in-Common

8. Meeting Format and Frequency

The Committee will meet monthly and ahead of Group Board meetings so that a report to the Board can be provided and any advice on material matters given. Additional meetings may be called by the Chair as necessary, who may also cancel or rearrange meetings in exceptional circumstances.

9. Declarations of Interest

All members of the Committee and those in attendance must declare any actual or potential conflicts of interest. These will be recorded in the minutes.

Anyone with a relevant or material interest in a matter under consideration must be excluded from the meeting for the duration of the discussion.

The Board has approved the potential conflict relating to those members who hold in-common appointments across the St George's, Epsom and St Helier University Hospitals and Health Group, so this will not need to be declared at each meeting under normal circumstances.

10. Meeting Arrangements and Secretariat

The Group Chief Corporate Affairs Officer will ensure secretarial support is provided for the Finance and Performance Committee. This will include the following:

- Preparing a forward plan for the Committee.
- Calling for, collating and distributing meeting papers.
- Taking accurate minutes.
- Producing an action log and chasing completion of actions.

The agenda for the meeting will be agreed in advance with the Committee Chair, based on the forward plan and in conjunction with the executive lead.

All papers and reports to be presented at the Committee must be approved by the relevant executive director.

The agenda and the supporting papers for the meeting will be circulated not less than five working days before the meeting.

11. Review of Committee effectiveness and Review of Terms of Reference

The Committee shall undertake an annual review of effectiveness, the results of which will be considered by the Committee and will be presented, in summary, to the Group Board.

These Terms of Reference shall be subject to an annual review. Any changes to these Terms of Reference may only be made by the Group Board following review by the Committee.

Document Control

Profile	
Document name	Finance and Performance Committee Terms of Reference
Version	1.5
Executive Sponsors	Group Chief Finance Officer and Group Deputy Chief Executive Officer
Author	Group Chief Corporate Affairs Officer
Approval	
Date of Committee approval	30 May 2025
Date of Trust Board approval	3 July 2025
Date for next review	July 2026

Epsom and St Helier University Hospitals NHS Trust

St George's University Hospitals NHS Foundation Trust

Annual Cycle of Business for the Finance and Performance Committee 2026/27

All items below are joint agenda items unless stated

Theme		Action/Paper	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
		Month reported	(12)	(01)	(02)	(03)	(04)	(05)	(06)	(07)	(08)	(09)	(10)	(11)
Financial Planning and Investment	1	Medium Term plan update			X			X	X	X	X	X	X	X
	2	Capital planning	X			X			X			X		
	3	Big Projects update	X		X		X		X		X		X	
	4	Material Business Cases and Procurement awards as per the Scheme of Delegation in support of the Group Strategy (as & when required)	X	X	X	X	X	X	X	X	X	X	X	X
Operational	1	Integrated Quality and Performance Report and associated issues	X	X	X	X	X	X	X	X	X	X	X	X
	2	Deep dives on an area of operational risk with reference to financial impacts. Links between operational change and financial sustainability.	X	X	X	X	X	X	X	X	X	X	X	X
	3	Productivity update (including data quality)	X	X	X	X	X	X	X	X	X	X	X	X
Financial Performance	1	Review financial performance (integrated finance report to include SoCI, SoFP, Cashflow, Capital).	X	X	X	X	X	X	X	X	X	X	X	X
	2	Income and Expenditure Forecast.				X	X	X	X	X	X	X	X	X
	3	Costing, SLR and PLICs		X		X			X			X		
Group - BAF	1	Finance: Review of assurances around the financial control environment (**by exception, yellow for board review date**)	X	X	X	X	X	X	X	X	X	X	X	X
	2	Operational Risk (**by exception, yellow for board review date**)	X	X	X	X	X	X	X	X	X	X	X	X

FPC Agenda Planner 2026/27

Theme		Action/Paper	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
		Month reported	(12)	(01)	(02)	(03)	(04)	(05)	(06)	(07)	(08)	(09)	(10)	(11)
Financial Governance	1	Review Financial Policies					X					X		
	2	Self-assessment of the Committee's performance										X	X	
	3	Write annual committee report to the Trust Boards											X	
	4	Review Terms of Reference		X										
	5	Set Annual Workplan for the Committee											X	
Other associated issues	1	Procurement Report	~~X~~	X		X			X			X		
	2	SWLP Report		X			X			X			X	

Note: the GCFO will maintain a live version of the annual business cycle and present this to each meeting of the Committee.

Standing Items for All Committee Meetings

Opening Administration	Items at Every Meeting	Closing Administration
1. Apologies 2. Declarations of Interest 3. Minutes 4. Matters Arising & Action Log	1. Reports from other groups 2. Action Plans arising from Reviews or Investigations (as required) 3. Review of Risks Allocated to the Committee 4. Internal Audit Reports	1. Items for Escalation to Audit Committee 2. Forward Plan for Next Meeting 3. Reflection on Meeting 4. AOB

FPC Agenda Planner 2026/27

Group Board Meeting (Public)

Meeting on Friday, 08 May 2026

Agenda Item	3.2	
Report Title	**Financial Outturn 25-26**	
Executive Lead(s)	Lizzie Alabaster, Interim Group Chief Finance Officer	
Report Author(s)	GCFO, SCFOs	
Previously considered by	Finance and Performance Committees	01 May 2026
Purpose	**For Noting**	

Executive Summary

This update on the financial year end is brief and based on draft information as the Trusts complete year end processes ahead of submission and external audit.

The key financial for both trusts are achieve the revenue control total and achieving the capital delegated expenditure Limit (CDEL). Both trusts have reported they expect to meet these targets in the “Key Headline Metrics” and have confirmed this in the “Draft Accounts” submitted on 27th April 2026.

The key dates for the accounts are outlined below.

Work on the External Audit has commenced.

The position has been discussed at the Finance & Performance Committee on 1st May and reported to Audit Committee on the 6th May.

Action required by Group Board

The Board is asked to:

a. Note the update

Committee Assurance	
Committee	Group Executive Committee
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

[…]

CQC Theme

☐ Safe	☐ Effective	☐ Caring	☐ Responsive	☒ Well Led

NHS system oversight framework

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

Financial implications

[…]

Legal and / or Regulatory implications

[…]

Equality, diversity and inclusion implications

[…]

Environmental sustainability implications

[…]

gesh

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

Integrated Finance Report
Group Public Board

Date: 8 May 2026

2025/26 Outturn Executive summary

Timetable and submissions

- This update on the financial year end is brief and based on draft information as the Trusts complete year end processes ahead of submission and external audit.
- The key financial for both trusts are achieve the revenue control total and achieving the capital delegated expenditure Limit (CDEL). Both trusts have reported they expect to meet these targets in the “Key Headline Metrics” and have confirmed this in the “Draft Accounts” submitted on 27th April 2026.
- The key dates for the accounts are outlined below.
- Work on the External Audit has commenced.
- The position has been discussed at the Finance & Performance Committee on 1st May and reported to Audit Committee on the 6th May

Provider Timetable	Date	Status
Key headline metrics submitted	13 April 2026	Achieved both trusts
First submission unaudited accounts	27 April 2026	Achieved both trusts
Final Agreement of balances and full accounts	26 June 2026	On track both trusts

SGH Draft Year End 25/26

I&E, Cash, Capital

- The numbers included within this slide are based on the draft account submission 27th April. This shows performance against control totals, excluding items such as donated capital and impairments.

I/E	Plan £m	Actual £m	Variance £m
Income	1,358.9	1,385.3	26.4
Expenditure	(1,358.9)	(1,380.4)	(21.5)
Surplus / (Deficit)	-	4.9	4.9

Income and Expenditure Target

- The Trust is reporting a surplus of £4.9m at year end, which is favourable to plan following the confirmation of additional DSF monies as notified by NHSE.
- NHS England confirmed redistribution of any DSF foregone by systems that did not deliver their plans this year to those providers that did so, as long as those providers are part of a system that delivered plan and have also submitted a balanced plan for 2026/27. Because the funding from which the bonus will be paid was originally intended to fund system deficits, the money has to be flowed to the bottom line creating a surplus to make sure that the NHS overall meets its financial targets, and so cannot be spent but does strengthen the cash position.
- The actual position includes £45.1m deficit funding from SW London ICB against £40.2m in the plan.

Capital	CDEL Plan £m	Actual £m	Variance £m
Capital Spend	(73.6)	(43.6)	29.9

Capital Spend

- The Trust is reporting capital spend of £43.6m.
- The underspend of £29.9m is materially in line with the expected system position. SGH held an SWL unallocated pot which subsequently was redistributed later in the year.

Cash	24/25 Closing Cash £m	25/26 Closing Cash £m	Movement £m
Cash Balance	80.4	103.3	22.9

Cash

- The Trust ended the year with a cash balance of £103.3m which is £22.9m higher than the opening balance for the year. The trust received PDC for capital that will be paid out in 26/27. In addition, large revenue receipts were received in later months to support the I&E forecast without cash outflows to offset.

ESTH Draft Year End 25/26

I&E, Cash, Capital

- The numbers included within this slide are based on the draft account submission 27th April. This shows performance against control totals, excluding items such as donated capital and impairments.

I/E	Updated Budget £m	Actual £m	Variance £m
Income	762.6	808.1	45.5
Expenditure	(768.3)	(808.9)	(40.6)
Surplus / (Deficit)	(5.7)	(0.8)	4.9

Income and Expenditure Target

- The Trust is reporting a deficit of £0.8m at year end, which is £4.9m better than plan following the confirmation of additional DSF monies as notified by NHSE.
- NHS England confirmed redistribution of any DSF foregone by systems that did not deliver their plans this year to those providers that did so, as long as those providers are part of a system that delivered plan and have also submitted a balanced plan for 2026/27. Because the funding from which the bonus will be paid was originally intended to fund system deficits, the money has to be flowed to the bottom line creating a surplus to make sure that the NHS overall meets its financial targets, and so cannot be spent but does strengthen the cash position.
- The actual position includes £46.5m deficit funding from SW London ICB against £41.6m in the plan.

Capital	CDEL £m	Actual £m	Variance £m
Capital Spend	(24.7)	(43.6)	(18.9)

Capital Spend

- The Trust is reporting capital spend of £43.6m, £18.9m more than plan.
- Additional resources were received from SWL ICB late in the year to fund the purchase of land in Epsom which are not included in the CDEL plan position.

Cash	24/25 Closing Cash £m	25/26 Closing Cash £m	Movement £m
Cash Balance	52.2	51.0	(1.2)

Cash

- The Trust ended the year with a cash balance of £51.0m which is £1.2m less than the opening balance for the year.

Group Board

Meeting on Friday, 08 May 2026

Agenda Item	3.3	
Report Title	**Group Integrated Quality & Performance Report (IQPR)**	
Executive Lead(s)	Michael Pantlin, Group Deputy Chief Executive Officer	
Report Author(s)	Ed Nkrumah, Group Director of Performance & PMO	
Previously considered by	Choose an item.	Click or tap to enter a date.
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.

A proposed schedule of performance-related deep-dive topics for the Committee is included in this summary.

The executive summaries in the report highlight the successes achieved during the month, alongside the challenges affecting quality, safety, and operational performance for each Trust. An overview of the current assurance process and key messages on quality and performance is also provided below.

The report provides an overview of the NHS Oversight Framework assessments and rankings for Quarter 3 of 2025/26, published in March 2026. Both Trusts have maintained their Segment 3 status with marginal improvements in overall rankings relative to other acute Trusts, reflecting of performance improvements relative to the previous quarter or relative to other Trusts. Proposed changes to the Oversight Framework for 2026/27 are being considered by NHSE, with internal readiness assessments already underway. The IQPR will be updated to reflect revisions to the quality and performance domains through 2026/27.

NHSE is considering removing ESTH from elective performance tiering following confirmation that the Trust returned to plan in March 2026, achieving the RTT 18-week and 52-week targets of 65.5% and 1% respectively. Against the five exit criteria metrics agreed for UEC Tier 2, progress has been made in several areas, including implementation of the UTC First model and improved utilisation of SDEC capacity. However, further work is required to meet the agreed targets in full, including improvements in data quality.

Both Trusts exceeded the 77% national cancer 28-day Faster Diagnosis Standard. SGUH's 62-day cancer performance was 72.4%, reflecting demand and capacity pressures within thoracic services. Discussions with system partners (RMP and the ICB) are ongoing to identify sustainable solutions. ESTH delivered 80.8% against the 62-day standard, below target and plan, primarily due to pressures in gastrointestinal pathways, including endoscopy delays and anaesthetic workforce shortages. Lung cancer diagnosis is also impacted by external waits for navigational bronchoscopy and endobronchial ultrasound. A SWL FIT test incident resulted in

increased lower GI referrals, placing additional pressure on triage assessment clinic, outpatient and endoscopy capacity.

Children's services at Sutton Health and Care remain stretched, with 48.8% of children starting treatment within 18 weeks against the 78% ambition. Rising demand and increasing complexity continue to drive long waits, particularly in Speech and Language Therapy, where 105 children are waiting over 52 weeks. Harm reviews are ongoing, and a consolidated SWL-wide recovery plan is being developed with the ICB to support improvement.

In relation to Urgent and Emergency Care (UEC), performance remains challenged across gesh. In March 2026, SGUH achieved 78.2% ED 4-hour wait performance supported by Targeted operational actions implemented to strengthen front door flow and oversight. Performance at ESTH improved 75.1% from 74.1% in the previous month. Key drivers continue to be delayed access to inpatient beds and flow constraints. Actions are in place at site, group, and system level to deliver both short- and long-term, end-to-end transformational change to achieve sustainable improvements. The 2-hour urgent community response target continues to be met by Surrey Downs but missed at Sutton Health and Care with a performance of 66.5%, improvement work within the Home from Hospital model is underway to enhance productivity, efficiency, and performance.

Both Trusts continue to address core patient safety and clinical compliance challenges, including VTE risk assessment, delirium assessment, pressure ulcer prevention, and infection control. VTE risk assessment compliance has improved—SGUH 84.2% and ESTH 84.2%—with detailed action plans supporting progress toward the 95% national target. Delirium assessments within 24 hours for patients aged 65+ remain significantly below the 90% NICE standard, and both Trusts have initiated improvement plans in response.

ESTH reported a Never Event in March 2026, after a wrong implant was identified during a robotic-assisted total knee replacement, this was identified during final checks and corrected before wound closure. A SWARM learning response was undertaken resulting in a number of key actions. There were three Patient Safety Incident Investigations (PSIIs) declared at SGUH in March 2026 relating to a maternal death at home, an unexpected admission to the neonatal unit on Delivery Suite and an incident involving incorrect processing of samples in Medical Microbiology.

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 rate as measured by SHMI is as expected for both Trusts.

At SGUH, targets for timely acknowledgement of complaints were not met in March 2026 due to workforce constraints, which are being addressed through recruitment, recent increases in formal complaints received are being investigated and divisional themes will inform learning and mitigating actions.

Sickness absence levels remain high across gesh, adversely impacting performance, quality and efficiency. As a result, the Clinical Workforce Transformation programme is prioritising sickness absence reduction as a key workstream for mobilisation. Group Executive Committee will shortly be considering a proposed pilot project aimed at helping support hotspot areas to manage absences.

Action required by Finance and Performance Committee
The Committee is asked to note this paper.

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

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

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

March 2026

Outstanding Care, Together: Our strategy 2023 to 2028

Publication Date: 24th April 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): Mar26

	Actual	Plan	Trend
SGUH	10.2	8.4	normal variation
ESTH	11.1	10.9	normal variation

Reduce delays between planned & actual discharge (inc 0 delays) Feb 26

	Actual	Trend
SGUH	0.7 day	normal variation
ESTH	1.4 days	Improving trend

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

	Actual	Trend
Sutton	418	normal variation
Surrey	541	increasing trend

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

Deliver Financial Plan (month 12)

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

Improve (Implied) Productivity (YTD Nov 25)

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

Deliver CIP Target (month 12)

	YTD Delivery	Note
SGUH	£95.3m to date	Fully Delivered £42.8m NR compared to £21.0m plan
ESTH	£67.8m to date	Fully Delivered £31.4m NR compared to £20.5m plan

Improve Cash Position (month 12)

	Current balance and Cash stress expected based on current cash flow		
SGUH	£103.3m	£88.3m favourable	As per MTP
ESTH (M8)	£51m	£49m favourable	As per MTP

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

Improve VTE Performance: Mar 26

	Actual	Plan	Trend
SGUH	85.2%	95%	no significant change
ESTH	84.2%	95%	no significant change

Reduce RTT 52week waiters: Feb 26

	Actual	Plan	Trend
SGUH	1.07%	1.0%	improved
ESTH	1.11%	1.0%	improved

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

	Actual	Plan	Trend
SGUH	7.5%	13.5%	normal variation
ESTH	14.4%	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 2024	Actual 2025	Trend
SGUH	63.2%	59.5%	deteriorating
ESTH	61.5%	57.3%	deteriorating

Reduce Staff sickness absence rates: Mar 26

	Actual	Plan	Trend
SGUH	4.8%	4%	above average
ESTH	5.4%	4%	above average
Sutton	5.7%	4%	normal variation
Surrey	4.8%	4%	normal variation

2

Our Strategy & Medium-Term Plan Ambitions

C	A	R	E
Collaboration & Partnership: Become the most integrated health and care system in the NHS	**Affordable healthcare, fit for the future:** Break even financially	**Right care, right place, right time:** Waiting times in top quartile, lower than expected mortality, reducing harm	**Empowered, engaged staff: Position** gesh in the top five acute trusts in London for staff engagement

Board to Ward Priorities for 2026/27: Board Objectives

Work with other teams to reduce delays in patient journeys through our services: optimise admission avoidance services and reduce delayed discharges to top-quartile performance	**Live within our means, reducing our costs:** Deliver the Efficiency Programme	**Minimise risk of harm from delays in care:** Work towards eliminating Corridor Care	**Make this a place we'd recommend to work and receive care:** Position gesh in London's top five for staff experience and as a recommended place for care.

Supporting Metrics to be reported from Month 1

1. Average delays between planned and actual discharge (including zero delay admissions) 2. Proportion of Urgent Community Referrals responded to within 2 hours	4. Group wider efficiency plan by level of maturity (BAU and Transformation)	5. Corridor Care in Emergency Departments 6. RTT 52 week waits	7. Proportion of staff recommending gesh as a place to work 8. Proportion of staff recommending gesh as a place to receive care.

National Oversight Framework

Quarterly assessments, rankings and metric scores

Assessment Period: Q3 2025/26				SGUH Q1	SGUH Q2	SGUH Q3	ESTH Q1	ESTH Q2	ESTH Q3
			Trust Segment (adjusted)	3	3	3	3	3	3
			Ranking (Acute Trusts)	37/134	61/134	56/134	61/134	101/134	93/134
			Unadjusted Segment (pre finance override	1	2	2	3	3	3
			Overall Metric Score (breakdown below)	2.05	2.31	2.29	2.41	2.64	2.64
Domain	**No.**	**Metric**	**Data Period**	**Metric Scores**	**Metric Scores**	**Metric Scores**	**Metric Scores**	**Metric Scores**	**Metric Scores**
Access	1	RTT 18 weeks Performance	Sep-25	2.34	2.62	2.34	1.81	2.11	2.66
	2	RTT 18 weeks Performance vs Plan	Sep-25	1.00	1.00	1.00	1.12	3.17	3.65
	3	RTT 52 Weeks Performance	Sep-25	2.73	2.94	2.73	2.32	2.76	2.51
	4	Community Services - % waits over 52 Weeks	Sep-25	1.00	1.00	1.00	2.35	2.06	2.59
	5	Cancer - 28-Day Faster Diagnosis Standard	To Sep 2025	2.20	3.65	2.20	2.04	3.67	3.51
	6	Cancer - 62-Day Treatment Standard	To Sep 2025	1.00	2.15	1.00	1.00	1.00	1.00
	7	A&E 4-Hour Wait Standard	To Sep 2025	1.00	1.00	1.00	3.37	2.62	2.91
	8	A&E 12-Hour Waits (from arrival)	To Sep 2025	2.82	3.11	2.82	3.78	3.67	3.68
	9	Annual change in CYP accessing MH services	To Sep 2025	N/A	N/A	N/A	2.34	3.74	N/A
		Access to services domain score	**Q2-25/26**	1.76	2.18	1.76	2.22	2.75	2.81
Effectiveness & experience of care	10	Summary Hospital Level Mortality Indicator	R12 - Jun-25	2.00	2.00	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	1.74	Not Reported (DQ)	3.64	3.52
	12	CQC inpatient survey satisfaction rate	2023	2.00	2.00	2.00	2.00	2.00	2.00
	13	Urgent community response 2-hour performance	Q2-25/26	N/A	N/A	N/A	2.24	2.76	2.42
		Effectiveness and experience of care domain score	**Q2-25/26**	1.91	2.13	1.91	2.08	2.60	2.49
Patient Safety	14	NHS Staff Survey -raising concerns sub-score	2024	3.12	3.12	3.12	2.78	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	N/A	N/A
	16(a)	Rates of MRSA infections	R12 -Sep-25	2.37	2.33	2.37	2.63	2.60	3.01
	16(b)	Rates of C-Difficile infections	R12 -Sep-25	3.62	3.30	3.62	2.62	1.00	1.00
	16(c)	Rates of E-Coli infections	R12 -Sep-25	3.39	3.37	3.39	2.05	2.15	2.07
		Patient Safety to services domain score	**Q2-25/26**	3.12	3.06	3.12	2.62	2.35	2.40
People and workforce	17	Sickness absence rate	Q1 2025/26	1.72	1.60	1.72	2.44	2.68	2.54
	18	NHS Staff Survey engagement theme score	2024	2.38	2.38	2.38	2.20	2.20	2.20
		People and Workforce domain score	**Q2-25/26**	2.05	1.99	2.32	2.32	2.44	2.37
Finance and productivity	19	Planned surplus/deficit	2025/2026	4.00	4.00	4.00	4.00	4.00	4.00
	20	Variance year-to-date to financial plan	M6 2025	1.00	1.00	1.00	1.00	1.00	1.00
	21	Implied Productivity Level	M3 YTD 25/26	1.74	3.28	1.74	3.26	3.44	3.53
		Finance and productivity domain score	**Q2-25/26**	1.87	2.64	1.87	2.63	2.72	2.76

Executive Summary
Safe, High-Quality Care

St George's Hospital

- **Never Events:** No never events were declared at SGUH in March 2026
- **Patient Safety Incident Investigations (PSII) -** Three Patient Safety Incident Investigations (PSIIs) were declared at SGUH in March 2026, relating to a maternal death at home, an unexpected neonatal unit admission, and a microbiology sample processing error (SWL Pathology service). Investigations are underway. Findings and actions will be reported to the Patient Safety & Quality Group (PSQG).
- **VTE Risk Assessments:** The Trust delivered an improved assessment rate of 85.2%, although below the national ambition of 95%. Early indications are that improvement plans are having a impact.
- **Falls Prevention and Management:** In March 2026, there was one high, and two moderate harm falls. The high-harm fall was a fractured neck of femur. That patient has been discharged home. Of the moderate-harm falls, one involved a distal radius fracture. That patient has been discharged home. The second fall resulted in a subarachnoid haemorrhage which is being conservatively managed. All incidents have undergone Swarm reviews and were discussed at Divisional Incident Response Group (DIRG) meetings.
- **Pressure Ulcers:** In March 2026, eleven category 3 pressure ulcers were reported, of which, one was medical device related (MDR), related to a nasal cannula on Allingham ward. The pressure ulcer prevention action plan has been updated.
- **Delirium Assessments:** In March 2026, completion of assessment within 24 hours of admission for patients >65 years of age was 5.5%, up slightly from February (4.8%). Nursing delirium assessments were completed within 24 hours for 35.5% of cases.
- **Infection Prevention and Control:** Three *C. difficile* cases were reported in March 2026, bringing the total for 2025/26 to 51 – exceeding the annual threshold of 43 cases and a reduction compared to the 60 cases reported in 2024/25. Learning from case reviews are shared across teams, and a dedicated action plan remains in place.
- **Respiratory infections**: Influenza and COVID-19 are stable; no outbreaks reported in March 2026.
- **Complaints:** Targets for timely acknowledgement of complaints were not met in March 2026 due to workforce constraints, which are being addressed through recruitment. Data is being reviewed to understand the increase in the number of complaints received and origin (i.e. direct or via PALs).
- **Mortality:** SHMI mortality performance is as expected. Recent Same Day Emergency Care (SDEC) reporting changes (from 29 October 2025) are being monitored for impact on future SHMI results.
- **Stillbirths**: Rate of 3.56 for 2024 was broadly in line with the MBRRACE comparator average of 3.47. The higher rate in March 2026 reflects three individual cases and does not indicate an underlying trend.

Epsom & St Helier

- **Never Events:** A Never Event involving a wrong implant occurred at ESTH in March 2026. During a robotic-assisted total knee replacement, checks revealed that a Cruciate Retaining (CR) insert had been used instead of the planned Posterior Stabilised (PS) insert. The CR insert was replaced with a PS insert before wound closure. A SWARM learning response was agreed.
- **Patient Safety Incident Investigations (PSII) -** There were no PSIIs declared in March 2026
- **VTE Risk Assessments:** Rates remain below the 95% national ambition at 84.23% with plans in progress.
- **Falls Prevention and Management**: In March 2026, five falls resulting in harm were reported: a fractured C2 on B5; hip fractures in the Frailty Hub and StH ED; a fractured humerus in EGH ED; and a fractured femur on A5. Reviews have been completed in all areas. Targeted actions are being progressed within the Medicine Division, focusing on falls prevention for high-risk patients and improvements in post-fall management. Two staff study days have been scheduled to support this.
- **Pressure Ulcers:** Two category 3 pressure ulcer was acquired in March 2026. One in Britten ward and one is Mary Seacole. All other pressure ulcer categories remain within normal limits.
- **Delirium Assessments:** In March 2026, assessment rates within 24 hours of admission for patients >65 years of age remained the same (2.25%) as February 2026 (2.54%). Nursing delirium assessment within 24 hours was 39% up from 35% in February 2026. An improvement plan is in place.
- **Infection Prevention and Control:** Three cases of *C. difficile* were reported in March 2026, bringing the total for 2025/26 to 54—below the annual threshold of 63. This compares favourably to 2024/25, when the Trust exceeded the threshold, recording 75 cases against a target of 63. Learning from case reviews are shared across teams, and a dedicated action plan remains in place.
- **Water safety:** Issues continue to be monitored through the Water Safety Group and the associated action plan. The latest water sampling programme was conducted in the Women's Health Building in December 2025, targeting the NICU ward and Delivery Suite. The results indicate significant improvement in water safety, with successful elimination of Pseudomonas in NICU and reduced Legionella detection. Ongoing monitoring and follow-up sampling are recommended, particularly for the unsampled 2nd-floor section, to maintain a safe environment for patients and staff.
- **Complaints:** In March 2026, all complaints were acknowledged within 3 working days, and 87% responded to within 35 working days against the target of 85%.
- **Mortality:** Mortality rate, as measured by the Summary Hospital-level Mortality Indicator (SHMI), performance is as expected at both hospital sites, and continues to be closely monitored.
- **Stillbirths:** The higher rate in March 2026 relates to 3 stillbirths and does not indicate an underlying worsening trend.

Executive Summary

Operational Performance & Productivity

St George's Hospital

Successes

- Efforts to recover elective performance continue, with 65-week and 52-week waits showing improvement, while 18-week wait performance remains ahead of plan. Independent Sector capacity is being used effectively across General Surgery, Vascular, Cardiology and Gynaecology to treat long waiters.
- The proportion of patients waiting less than 18 weeks for a first appointment improved by 10%, reflecting the Trust's commitment to the National Q4 Sprint. More first appointments were delivered as a result. Actions are overseen by the Chief Operating Officer.
- The Cancer Faster Diagnosis Standard exceeded target with 84.4%, supported by backlog reduction within challenged areas. Lower GI performance also improved to 73.1%, although constrained by limited direct-to-test capacity and increased referrals following the FIT testing incident (December 2025– March 2026).
- Capped theatre utilisation remains top-quartile, nationally, with consecutive monthly improvement in day case rates following targeted Day Surgery Unit improvements.
- ED 4-hour performance exceeded target achieving 78.2%, supported by enhanced front-door capacity through additional streaming, Rapid Assessment Team presence at ambulance triage and UTC cover 24 hours in the last week of March 2026.

Challenges

- Cancer 62-day performance remained below target at 72.4%, with pressure driven by lung pathways, constrained thoracic theatre and diagnostic capacity. Short-term mitigation is in place, with sustainable solutions under development with the ICB.
- Although the Trust achieved the diagnostic standard in February 2026 (4.4%), performance in March 2026 is likely to be adversely affected by sickness absence and vacancies, impacting capacity across a number of modalities.
- Length of stay reduced to 10.2 days against a plan of 8.4 days. Several improvements were made in March 2026, including the launch of W-OPEL, expanded bridging services, acute medicine moving into business-as-usual, and completion of key reviews with outputs due in April 2026. These are aligned to the gesh-wide Non-Elective Transformation Programme.
- NHS England has introduced a standard definition of corridor care for national reporting. This is a count of ED patients who spend over 45 minutes receiving corridor care during a 24-hour period, from midnight to midnight. This includes patients treated, assessed, admitted, or transferred. Stakeholder communications and alignment with reporting and assurance, are now the focus.
- Expansion of Patient-Initiated Follow-Ups (PIFU) and the reduction of low-value follow-ups are key components of the SGUH productivity workstream within the gesh OP Transformation programme.

Epsom & St Helier

Successes

- Two cancer performance standards were achieved in February 2026: 28-Day Faster Diagnosis (87.9%); and 31-day decision-to-treat to treatment (100%).
- Theatre utilisation rates remained high at 81%. The Golden Patient initiative is improving start times, and work continues to standardise perioperative pathways via new screening and iClip pre-op assessment.
- RTT performance improved in February 2026 - the second consecutive month, after seven months of decline following EPR go-live. The Trust is forecast to deliver >65.5% by the end of March 2026.
- RTT >52-week and >65-week waits reduced again in February 2026, supported by external funding. The Trust is forecast to deliver <1% 52-week waits by the end of March 2026.
- Diagnostic performance improved again in February 2026, supported by recovery actions focused on increased activity, weekly validation and workforce management.

Challenges

- Cancer 62-day (Referral to treatment) performance standard was not met in February 2026 (80.8%). 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.
- 4-hour performance improved to 75.1% in March (from 74.1%) but remained below the 78% trajectory due to admitted-pathway pressures; non-admitted performance achieved 81%. Key actions have been implemented to support recovery including launch of ED–Medical Ambulatory Pathways, Review and revision of ED streaming and triage processes and Extension of 7-day front-door frailty service.
- Twelve-hour performance improved to 14.4% but remained below target, driven by challenges on the admitted pathway. Non-admitted performance was 8.7%.
- NHS England has introduced a standard definition of corridor care for national reporting. This is a count of ED patients who spend over 45 minutes receiving corridor care during a 24-hour period, from midnight-to-midnight. This includes patients treated, assessed, admitted, or transferred. Focused improvement continues at St Helier to further reduce corridor care numbers.
- Non-elective LOS reduced to 11.8 days in March 2026 but remains above the ambition. This month's performance is partly attributed to a targeted initiative to discharge the most complex patients, resulting in 19 discharges with a total 2,681 bed days.
- gesh wide NEL Transformation programme is in development with local ESTH 2026/27 UEC Transformation plan scoped to support National, Regional and Local priorities.

Executive Summary
Integrated Care

Quality & Safety

An increase in Category 3 pressure ulcers at both Sutton Health and Care (SHC) and Surrey Downs Health and Care (SDHC) reflects more consistent reporting. The complexity of 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.

A patient information video has been produced for patients and carers to support pressure ulcer prevention.

Sutton Health & Care (SHC) Specific

- Safety and infection control indicators: Reablement Unit re-opened – successfully monitored post 28-day infection. Local actions have been taken to improve hand/uniform hygiene as well as reporting.
- PSIRF SWARMS
    - Unexpected Death in Virtual Ward - A SWARM discussion identified that several services were involved in the patient's care and each team acted appropriately within their role. However, the system lacked clear coordination and ownership of the patient's overall care.
    - Staffing issues in Virtual impacting delivery - The primary issue was system design and visibility, not individual performance

Children's Therapy – dysphagia pathway system review –awaiting OFSTED & CQC report.

Surrey Downs Health & Care(SDHC) Specific

- Safety and control indicators - MRSA, *C. difficile and* E. coli are stable, with no significant issues reported in March 2026.
- One fall with moderate harm occurred- SWARM completed with lessons shared and actions from action plan being embedded in March.
- Undertaking a review of the podiatry service due to staffing challenges and capacity issues.

Operational Performance

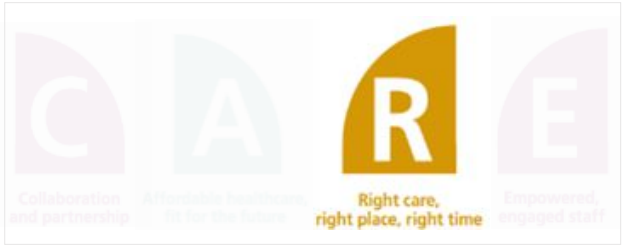
Sutton Health & Care (SHC)

- In March 2026 2-hour Urgent Community Response (UCR) performance was 66.5%, against a 70% target. Referrals are within normal range however there are variations especially out-of-hours with referrals peaking early evening, having an impact on capacity. As part of the Sutton Home from Hospital model, improvement work is underway which will ensure improvements to productivity and efficiency, with close down on mitigating actions to ensure the service is performing above target.
- Children's services waiting list remains high, with an improvement plan in place alongside a system health pathway review (GESH-Sutton Alliance Board-SHC). The waiting lists remain a challenge due to increased demand, driven predominantly by increasing complexity of need. The number of patients waiting over 52 increased to 105 at the end of March 2026 with 48.8% of children were waiting less than 18 weeks for treatment. Harm reviews continue to take place to ensure there is no harm to these children, with delayed waiting times.

Surrey Downs Health & Care (SDHC)

- Service continues to exceed the 2 –hour Urgent Community Response (UCR) target, achieving 82.8% in March 2026.
- Virtual ward occupancy rates exceeded target at 96.1% in March 2026. Work continues to expand Virtual Ward provision and ensure it remains a viable alternative to acute care.
- Waiting list performance remains strong; however, demand for services is increasing and there are staffing challenges in some specialist roles, such as Neuro Occupational Therapy.

Quality & Safety



Safe, High-Quality Care

Overview Dashboard

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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	Mar 26	1	0	0			N/A	Mar 26	1	1	0			N/A
Patient Safety Incident Investigations	Mar 26	2	3	0			N/A	Mar 26	1	0	0			N/A
Moderate and Severe Harm from Falls	Mar 26	3	3	2			N/A	Mar 26	0	5	1	H		N/A
Pressure Ulcers - Acquired Category 3	Mar 26	7	11	7			N/A	Mar 26	1	2	6	H		N/A
Pressure Ulcers - Acquired Category 4	Mar 26	1	0	0			N/A	Mar 26	0	0	0			N/A
Infection Control - Number of MRSA	Mar 26	0	0	0	L		3rd Quartile	Mar 26	0	0	0	L		3rd Quartile
Infection Control - Number of Cdiff - Hospital & Community	Mar 26	4	3	5			2nd Quartile	Mar 26	0	3	6			2nd Quartile
Infection Control - Number of E-Coli	Mar 26	7	12	9			Lowest Quartile	Mar 26	4	4	5			2nd Quartile
Delirium Assessment Compliance 65+	Mar 26	4.9%	5.5%	90.0%		F	N/A	Mar 26	2.5%	2.3%	90.0%		F	N/A
Delirium Assessment Nursing Compliance 65+	Mar 26	28.7%	35.5%	90.0%		F	N/A	Mar 26	34.0%	39.0%	90.0%		F	N/A
Delirium RDAR Compliance 65+	Mar 26	15.1%	13.2%	90.0%		F	N/A	Mar 26	15.8%	15.6%	90.0%		F	N/A
30-Day Emergency Readmission Rate	Feb 26	9.0%	8.0%	-	L		N/A	Apr 25	5.3%	5.7%	-		-	TBC
VTE Risk Assessment	Mar 26	82.8%	85.2%	95.0%		F	Lowest Quartile	Mar 26	83.3%	84.2%	95.0%	H	F	Lowest Quartile
Mortality - SHMI	Nov 25	0.89	0.90	-	L	-	As Expected	Nov 25	1.11	1.12	-	L	-	As Expected
% Births with 3rd or 4th degree tear	Mar 26	1.2%	2.2%	-	L	-	3.0%	Mar 26	3.6%	3.3%	-		-	2.7%
% Births Post Partum Haemorrhage >1.5 L	Mar 26	5.2%	2.2%	-		-	3.0%	Mar 26	3.0%	3.6%	-		-	3.2%
Stillbirths per 1,000 births	Mar 26	0.0	9.2	-		-	3.3	Mar 26	3.8	10.4	-		-	3.3
Neonatal deaths per 1,000 births	Mar 26	11.7	0.0	-		-	1.6	Mar 26	3.8	0.0	-		-	1.6
HIE (Hypoxic ischaemic encephalopathy) per 1,000 births	Mar 26	3.9	0.0	-		-	N/A	Mar 26	0.0	0.0	-	L	-	N/A

Safe, High-Quality Care, Patient Experience

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	Mar 26	85.2%	93.5%	85.0%			N/A
Complaints - Acknowledgement within 3 working days	Mar 26	85.5%	99.0%	100.0%			N/A
Number of complaints not completed within 6 months from date of receipt	Mar 26	2	1	0		F	N/A
Friends and Family Test - Inpatients Score	Mar 26	98.8%	91.8%	90.0%	L	P	Top Quartile
Friends and Family Test - Emergency Department Score	Mar 26	78.2%	78.6%	90.0%		F	2nd Quartile
Friends and Family Test - Outpatients Score	Mar 26	94.4%	94.7%	90.0%	H	P	3rd Quartile
Friends and Family Test - Maternity Score	Mar 26	100.0%	100.0%	90.0%			2nd Quartile
Friends and Family -Inpatient Response Rate	Mar 26	35.7%	31.6%	-		-	N/A
Friends and Family -Emergency Department Response Rate	Mar 26	9.7%	10.5%	-	L	-	N/A
Friends and Family - Outpatient Response Rate	Mar 26	9.8%	8.4%	-		-	N/A
Friends and Family - Maternity Response Rate	Mar 26	0.9%	2.1%	-	L	-	N/A

Epsom & St Helier

Latest month	Previous Month Measure	Measure	Target	Variation	Assurance	Benchmark
Mar 26	87.0%	90.0%	85.0%			N/A
Mar 26	100%	100%	100%	H		N/A
Mar 26	4	5	0	L	F	N/A
Mar 26	94.0%	95.0%	90.0%		P	3rd Quartile
Mar 26	77.5%	77.0%	90.0%		F	Lowest Quartile
Mar 26	91.0%	93.0%	90.0%		P	Top Quartile
Mar 26	94.7%	94.1%	90.0%			3rd Quartile
Mar 26	14.0%	12.0%	-		-	N/A
Mar 26	5.0%	4.0%	-		-	N/A
Mar 26	4.2%	4.5%	-	H	-	N/A
Mar 26	8.0%	6.0%	-		-	N/A

Sutton Healthcare

KPI	Latest month	Previous Month Measure	Latest Month Measure	Target	Variation	Assurance
Patient Safety Incidents Investigated	Mar 26	0	0	0		
Number of Falls with Harm (Moderate and Above)	Mar 26	0	0	-	L	-
Pressure Ulcers Category 3	Mar 26	10	11	-	H	-
Pressure Ulcers Category 4	Mar 26	2	2	0	H	
Infection Control - Number of MRSA	Mar 26	0	0	-	L	-
Infection Control - Number of Cdiff	Mar 26	0	0	-		-
Infection Control - Number of Ecoli	Mar 26	0	0	-	L	-
Community Friends and Family - Community Score	Mar 26	98.0%	92.6%	90.0%	H	
Community Friends and Family - Response Rate	Mar 26	2.1%	3.3%	-		-

Surrey Downs

Latest month	Previous Month Measure	Latest Month Measure	Target	Variation	Assurance
Mar 26	0	0	0		
Mar 26	0	0	-	L	-
Mar 26	8	9	-	H	-
Mar 26	0	1	0		
Mar 26	0	0	0	L	
Mar 26	0	0	-		-
Mar 26	0	0	-		-
Mar 26	96.0%	94.3%	90.0%	H	
Mar 26	32.0%	31.6%	-		-

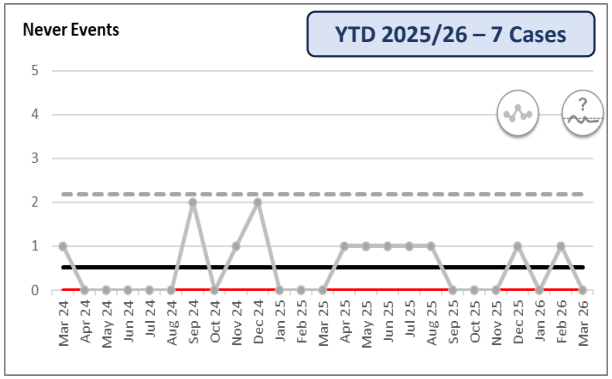
- Community FFT is a subset of Epsom and St Heliers FFT data.
- IC (Dorking and Molesey Hospitals – community do not have set national trajectories for HCAIs although all cases are reviewed and investigated)

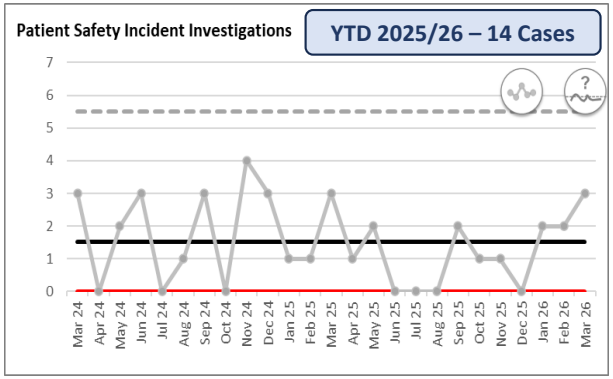
10

Safe, High-Quality Care

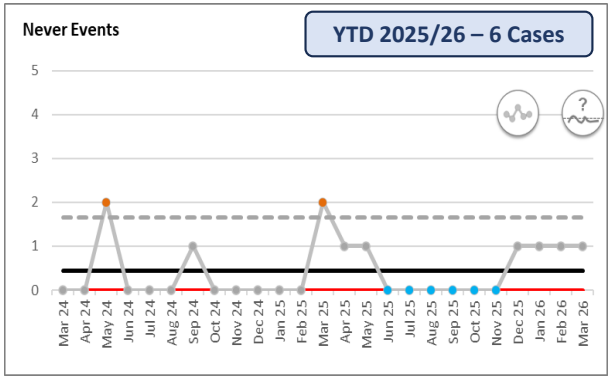
Exception Report | **SGUH** and **ESTH** - Incidents

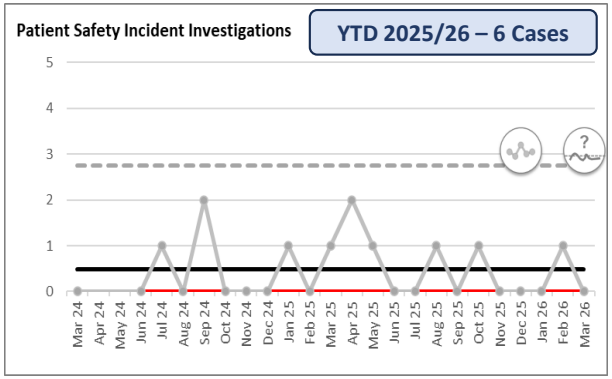
St George's





Epsom & St Helier





Summary and Actions:

SGUH

There were no Never Events declared at SGUH in March 2026.

Three Patient Safety Incident Investigations (PSIIs) were declared in the month.

- A maternal death in Maternity (patient's home) - An After Action Review (AAR) was undertaken following this incident. The case has since been accepted for investigation by the Maternity and Newborn Safety Investigations (MNSI) programme
- An unexpected admission to NNU on Delivery Suite - case accepted for investigation by the Maternity and Newborn Safety Investigations (MNSI) programme
- An incident involving incorrect processing of samples in Medical Microbiology led to the establishment of a FIT Score Incident Management Group. The response is being led by the SGUH / gesh Group, chaired by the Group Deputy Chief Executive Officer, with clinical and safety leadership by the Group Chief Medical Officer. Oversight of the investigation sits with St George's Central Incident Review Group (CIRG)

ESTH

A Never Event was declared at ESTH in March 2026 after a wrong implant was identified during a robotic-assisted total knee replacement. A Cruciate Retaining insert was implanted instead of the planned Posterior Stabilised prosthesis. This was identified during final checks and corrected before wound closure.

A SWARM learning response was undertaken resulting in a number of key actions:

- External interruptions to the surgeon operating should be minimised.
- Compatibility checks must be undertaken with full attention and focus, treating each check as a fresh verification to avoid confirmation bias or diffusion of responsibility
- Any workflow pause or deviation should prompt a brief team pause to verbally reconfirm key details before proceeding
- Investigate the possibility of H-Trac scanning system to identify incompatibility issues prior to opening the implants to the sterile field.

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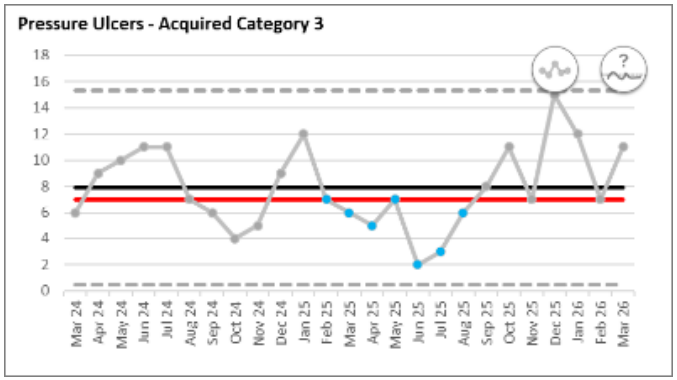
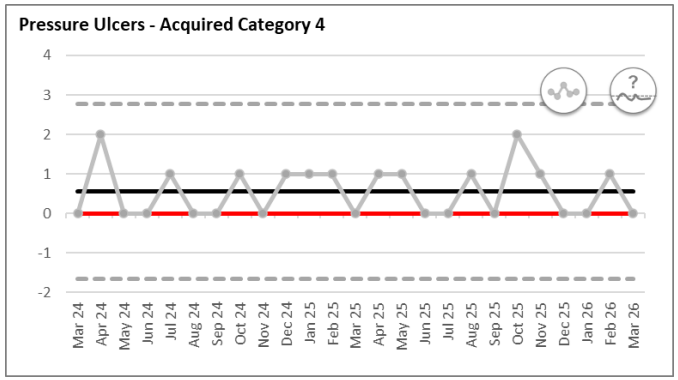
Safe, High-Quality Care

Exception Report | SGUH Pressure Ulcers - Category 3 & 4



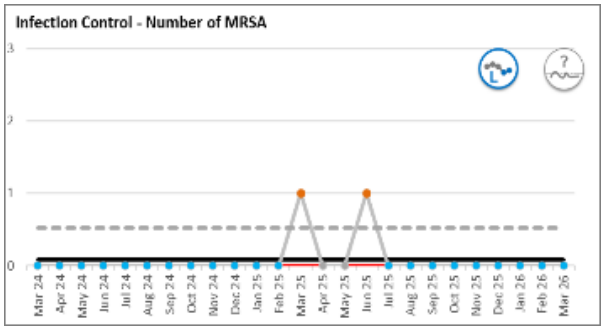


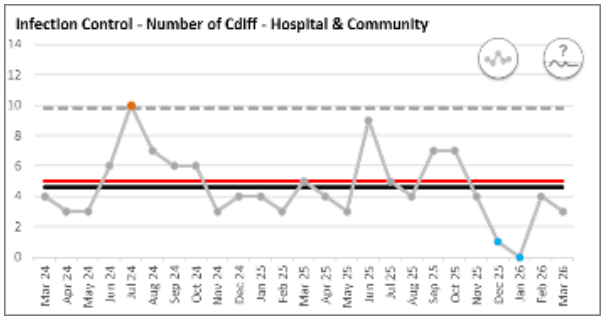
Site & Metric	Cause of variance/ non-compliance	Actions: Completed since last update, New, and Ongoing	Recovery Date
SGUH Pressure Ulcers Category 3: 11 cases in March 2026 Pressure Ulcers Category 4: No incidents occurred in March 2026 **Data Quality:** Sufficient for assurance	There were 11 category 3 pressure ulcers and no category 4 pressure ulcers in March 2026. One category 3 pressure ulcer was medical device related, linked to a nasal cannula. Most pressure ulcers occurred within the MedCard division (6). Most non-medical devise related pressure ulcers continue to be acquired on the patients' sacrum, spine and heals; a theme across the last four months. There are concerns regarding the efficiency 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 product was agreed after a trial and extensive testing in January 2026. ESTH have started to trial a mattress and will feedback to SGUH. • A trial of the dynamic high spec mattresses has commenced (usually used in ICU) for high-risk patients, instead of current hybrid Mattress with pump. This is due to complete by the end of April. • A meeting is planned to look at role out of the 'get-up, get dressed, get moving' initiative, across the MedCard division. • Feedback on the new pressure ulcer incident SWARM template, led by MedCard, has been positive. This is now being trialled Trust-wide. The pressure ulcer governance working group continues.	June 2026. Being reviewed at Site level

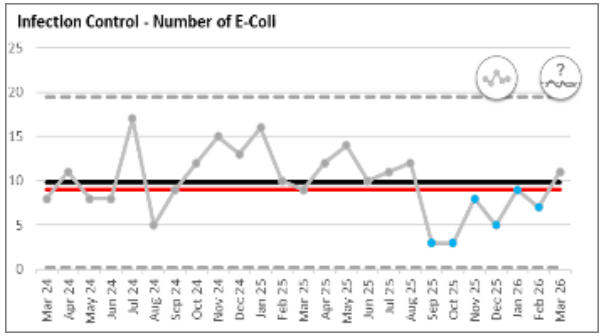
Safe, High-Quality Care

Exception Report | SGUH and ESTH - Infection Prevention and Control

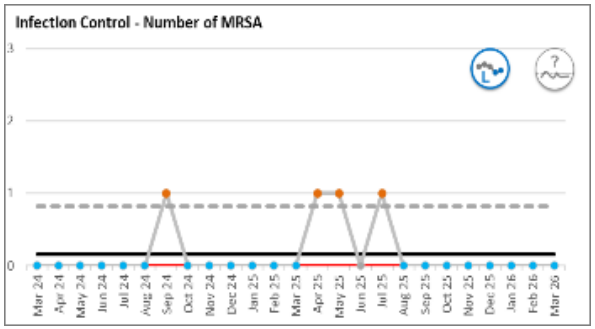
St George's

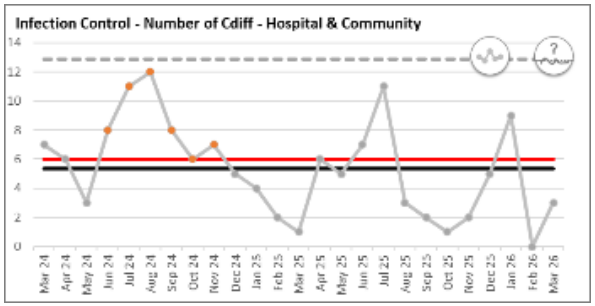


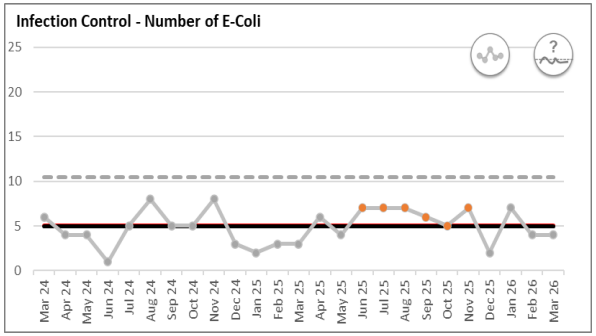




Epsom & St Helier







Summary with Cause of variance/ non-compliance

SGUH

SGUH	In-Month	YTD	Annual Threshold
MRSA	0	1	0
Cdiff	3	51	43
EColi	12	118	109

The Trust exceeded the infection thresholds set for 2025/26; however, fewer cases were reported compared with 2024/25.

- A group-wide C. difficile action plan has been implemented with divisional leads
- Multidisciplinary C. difficile ward rounds and learning reviews continue
- An enhanced environmental decontamination, post-discharge/transfer (HPV available) is in place
- Expanded C. difficile education takes place across key forums
- E. coli: A digital urinary catheter passport is in development for hospital and community use

ESTH

ESTH	In-Month	YTD	Annual Threshold
MRSA	0	3	0
Cdiff	3	54	63
EColi	4 *	66	57

* includes 1 Integrated Care case

ESTH ended the financial year with 54 C. difficiile cases, below the annual threshold of 63. However, it exceeded the E. coli threshold of 57, with a total of 66 cases.

- An overarching group C. difficile action plan was shared with divisional leads.
- Ongoing surveillance, early identification, and adherence to infection prevention and control (IPC) measures have contributed to keeping case numbers low.
- Continued vigilance is required to sustain this performance and further reduce the incidence of infection
- E. coli: The iClip team is supporting implementation of a digital urinary catheter passport to for hospital and community management and reviews.
- 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.

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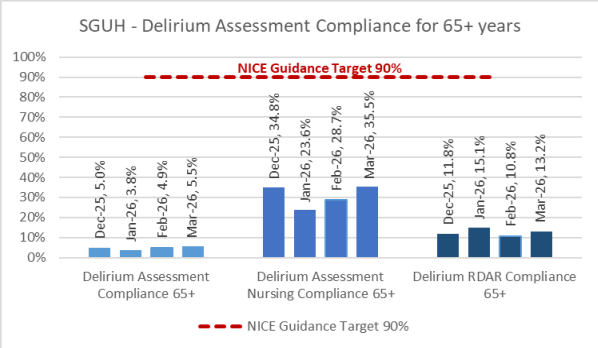
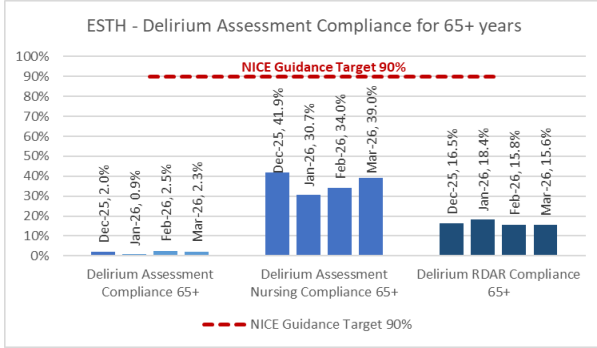
Safe, High-Quality Care

Exception Report | SGUH & ESTH Delirium Assessment for 65+ years of age

St George's



Epsom & St Helier



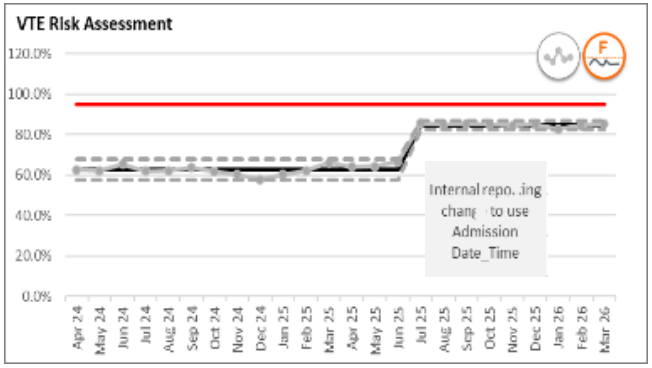
- Delirium assessment includes a validated tool 4AT (4 A's Test) to detect acute changes in attention, awareness, and cognition, often aided by collateral history and cognitive screening
- R.A.D.A.R. (Recognizing Acute Delirium as Part of Your Routine) is a quick, bedside screening tool for nurses to 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
SGUH: Delirium Assessment within 24 hrs – 5.5% Delirium Assessment Nursing within 24 hrs – 35.5% RADAR Compliance (Daily Ax) – 13.2 % **Data Quality** – sufficient for assurance	• In March 2026, 50.76% of eligible admitted patients were assessed for delirium using at least one of the assessment methods available on iCLIP. Completing assessments within 24 hours as per NICE guidance is not yet fully met. Completion did increase (4.87%) in March. • 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 in May 2026 • Increasing uptake of training for Care Groups where performance is low. • Risk Assessment reviewed with ESTH colleagues following feedback from frontline staff. Improvements were requested to increase useability. • Corporate Nursing will be meeting with the Dementia and Delirium nursing team	Aiming for 10% improvement per quarter; 15% Q1 2026/27 25% Q2 2026/27 35% Q3 2026/27 45% Q4 2026/27
ESTH: Delirium Assessment within 24 hrs – 2.3% Delirium Assessment Nursing within 24 hrs – 39.0% RADAR Compliance (Daily Ax) – 15.6% **Data Quality** – sufficient for assurance	• In March 2026, 68.67% of eligible admitted patients were assessed for delirium using at least one of the assessment methods available on iCLIP. 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 (CNS) has met with the Frailty consultants to discuss low compliance with 4AT especially amongst medical staff. • Plan is for education/training of doctors during induction/Grand Rounds. Doctors will also be reminded during consultant rounds. • Medical led audit planned in ED and acute medical areas for May/ June to engage staff and explore barriers to completion	

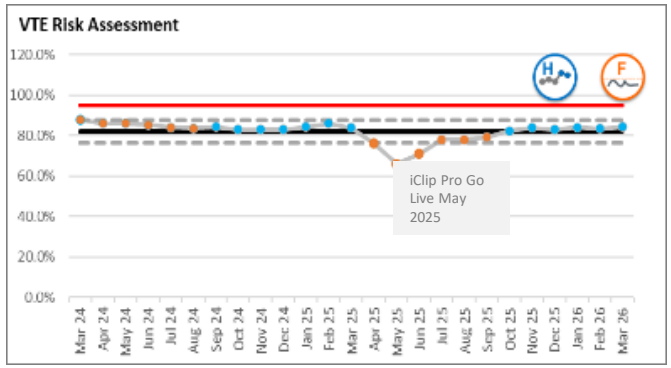
Safe, High-Quality Care

Exception Report | SGUH & ESTH VTE Risk Assessment

St George's



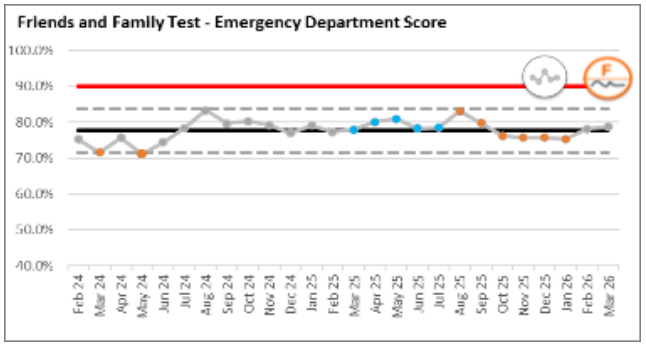
Epsom & St Helier

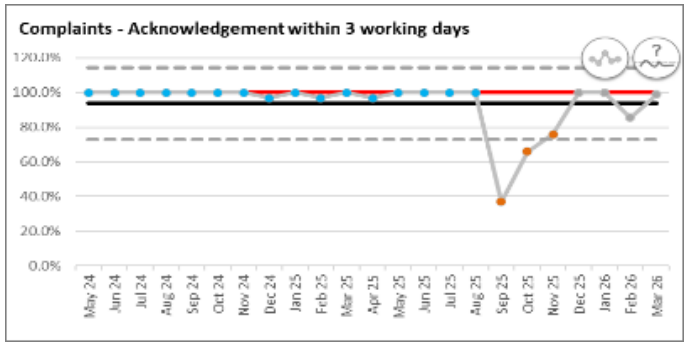


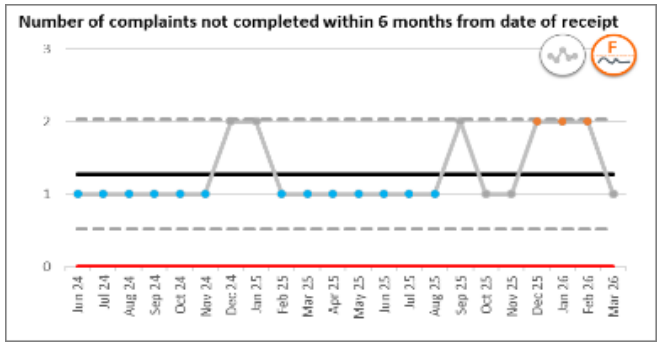
Site & Metric	Cause of variance/ non-compliance	Group Actions: Completed since last update, New, and Ongoing	Recovery Date
SGUH: VTE 85.2%. Not meeting target of 95% **Data Quality:** Sufficient for assurance	The Chief Medical Officers at gesh have reviewed the reporting logic for VTE assessments. The Trusts now records the *admission time* (when the patient is placed in a bed) instead of the Decision to Admit time.	• 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.	Trajectories under review
ESTH: VTE 84.2% Not meeting target of 95% **Data Quality:** Sufficient for assurance	Reporting at ESTH has been adversely affected by the implementation of the new EPR: • Incorrect coding of low-risk cohorts remains an issue. There is a plan to adapt SGUH process to low risk cohort patients with length of stay of less than 12 hours in specific patient groups (e.g ED, elective admissions). • ED to implement a new process where VTE becomes integrated into admission clerking of patients staying more than 12 hours.	• 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. • VTE champions form a multiprofessional group to boost assessment compliance. In ESTH, 10 new RN champions have been recruited and are expected to deliver a QI project aimed at improving VTE prevention practice. • ESTH to introduce a Thromboprophylaxis audit to all inpatients 16 years and above to assess appropriate prophylaxis prescribing. The audit will examine adherence to standards set out in the NICE guidelines NG89 and Royal College of Obstetricians and Gynaecologists RCOG 37a/37b.	Trajectories under review

Safe, High-Quality Care

Exception Report | SGUH Patient Experience (Satisfaction & Complaints)



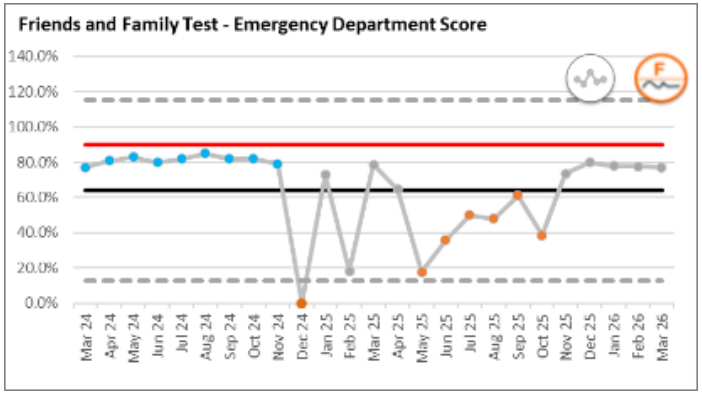


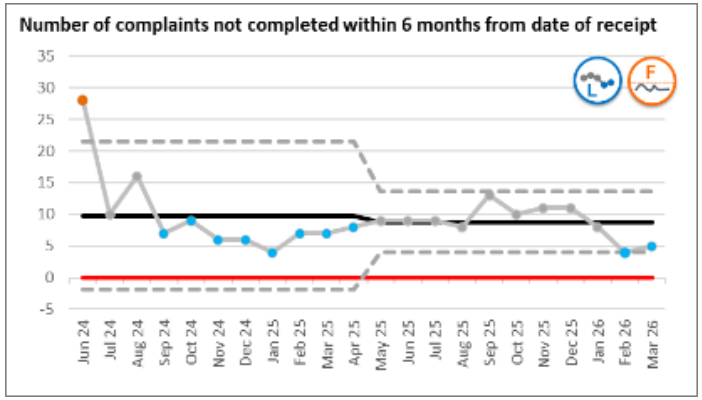


Site & Metric	Cause of variance/ non-compliance	Actions: Completed since last update, New, and Ongoing	Recovery Date
SGUH FFT ED Score 78.2% normal variation **Data Quality** – sufficient for assurance	• In March 2026, 79% of patients said they would recommend the department. This is similar to previous months. Scores have been reflective of ongoing challenges, such as, long waits and corridor care. There has been a decline in respondents completing the survey from 12,048 patients in February 2026 to 832 in March 2026.	• Patient feedback review and ongoing corridor care checks. • Standardised RN documentation; comfort packs for all patients. • Daily safety checks; RAT rota Mon–Fri for early senior review. • Digital check-in launched January 2025 for efficiency. • SDEC expansion: 10 new medical pathways; surgical streaming ongoing.	Ongoing
SGUH Complaints Acknowledged within 3 working days shows normal variation but not meeting target	• Staffing issues in September 2025 to January 2026 impacted complaint acknowledgements. Action plans have improved performance, with 99% of complaints acknowledged within 3 working days seen in March 2026 against a target of 100%	• Support is being given to complaints manager to provide cover during sickness, improving response rates. Weekly oversight meetings between SGUH Senior Nursing and Group Complaints teams. An action plan has been implemented to address staffing shortfalls and restore targets. Permanent recruitment successful to administrative role, recruitment approved for an additional Band 5 complaints officer.	May 2026
SGUH Complaint's not completed within 6 months of receipt now showing normal variation	• A small increase in complaints not completed within 6 months has arisen due to patient choice and meeting availability with the clinical teams. Increased long term sickness in the team has impacted response rates. In addition, there has been challenges with divisions getting complaints in on time.	• Complaints reviewed weekly with the Divisions to track progress and provide support / advice if necessary • Escalation to support delays and backlogs	June 2026

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
ESTH: FFT ED Score Normal variation and consistently failing target **Data Quality** – sufficient for assurance	The FFT contract at ESTH has concluded and transitioned to Gather, where the survey is accessible via posters, reaching a limited audience; however, 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, showing some variation, particularly in services where surveys are conducted via text.	• Work to improve response rates across both hospital sites is underway. • A review of messaging within ED about the survey, is planned. • Thematic and trend analysis is being carried out with respect to negative feedback. • The Medicine Division is committed to enhancing patient experience during periods of heightened emergency care demand. This is demonstrated 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.	July 2026 (response rate). Recovery date for scores under review
ESTH: Number of complaints not completed within 6 months of referral – not meeting target.	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. However, a positive reduction has now been seen and remains stable	• The accountability for responding to complaints is being reviewed with divisional teams to clarify roles and responsibilities. This work will inform training designed to improve the quality of complaint responses, by divisional teams. • A gesh group complaints policy and Standard Operating Procedure is in development • 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 – Acute Trusts

KPI	St George's Latest month	St George's Previous Month Measure	St George's Latest Month Measure	St George's Target	St George's Variation	St George's Assurance	St George's Benchmark	Epsom & St Helier Latest month	Epsom & St Helier Previous Month Measure	Epsom & St Helier Latest Month Measure	Epsom & St Helier Target	Epsom & St Helier Variation	Epsom & St Helier Assurance	Epsom & St Helier Benchmark
RTT - Waits over 65 weeks	Feb 26	8	14	0			2nd Quartile	Feb 26	21	20	0			Lowest Quartile
RTT - Percentage of waits over 52 weeks	Feb 26	1.35%	1.07%	1.00%			2nd Quartile	Feb 26	1.37%	1.11%	1.00%			2nd Quartile
RTT - Percentage of waits within 18 weeks	Feb 26	60.5%	62.2%	60.0%			2nd Quartile	Feb 26	61.5%	63.3%	65.4%			3rd Quartile
RTT - Percentage of waits within 18 weeks for first appointment	Feb 26	66.0%	76.6%	66.6%			3rd Quartile	Feb 26	75.0%	77.5%	81.3%			2nd Quartile
RTT- Waiting List – total children under 18	Feb 26	6399	6488	7715			-	Feb 26	7867	7760	6449			-
Cancer - 28 Day Faster Diagnosis Standard	Feb 26	79.0%	84.4%	82.7%			Top Quartile	Feb 26	81.7%	87.9%	86.8%			Top Quartile
Cancer 62 Day Referral to Treatment Standard	Feb 26	70.8%	72.4%	85.0%			2nd Quartile	Feb 26	82.7%	80.8%	86.6%			Top Quartile
Diagnostics - 6 Week Waits	Feb 26	4.3%	4.4%	5.0%			Top Quartile	Feb 26	11.2%	7.2%	5.0%			3rd Quartile
4 Hour Operating Standard	Mar 26	75.5%	78.2%	78.0%			2nd Quartile	Mar 26	74.1%	75.1%	78.0%			2nd Quartile
Over 12 Hours in ED from Arrival (%) Type 1	Mar 26	9.5%	7.5%	13.0%			2nd Quartile	Mar 26	15.2%	14.4%	13.5%			3rd Quartile
Emergency Department Corridor Care (Average Daily Count)	Mar 26	23	19	-		-	TBC	Mar 26	67	64	-			TBC
Ambulance average Handover Time (min)	Mar 26	00:24:24	00:24:24	00:24:00			TBC	Mar 26	00:23:55	00:22:56	00:22:00			TBC

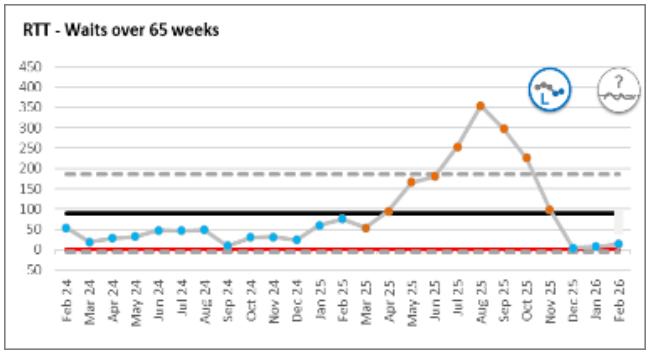
Targets based on Operating Plan end of year March 2026 position (trajectories in place)
Benchmark Position in arrears in line with model hospital publication dates

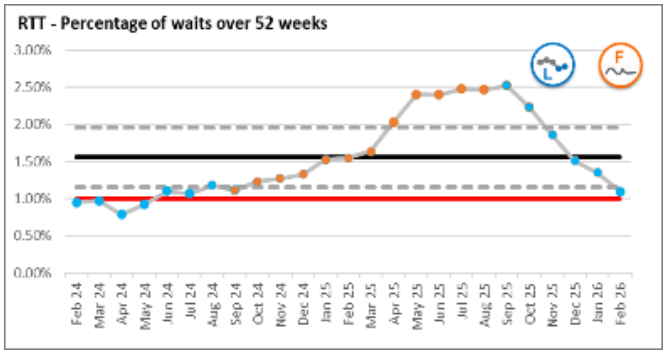
Operational Performance

Overview Dashboard – Integrated Care

	Sutton Healthcare						Surrey Downs					
KPI	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	Mar 26	68.5%	66.5%	70.0%			Mar 26	88.9%	82.8%	70.0%		
Virtual ward - Bed Occupancy	Mar 26	100.0%	87.1%	85.0%			Mar 26	86.7%	96.1%	80.0%		
Number of waits Adults >52wks	Mar 26	3	4	0			Mar 26	0	0	0		
Percentage of waits Adults <18wks	Mar 26	98.7%	98.7%	78.0%			Mar 26	96.5%	96.4%	78.0%		
Number of waits Children >52wks	Mar 26	83	105	0								
Percentage of waits Children <18wks	Mar 26	50.2%	48.8%	78.0%								

Operational Performance
Exception Report | SGUH Referral to Treatment RTT

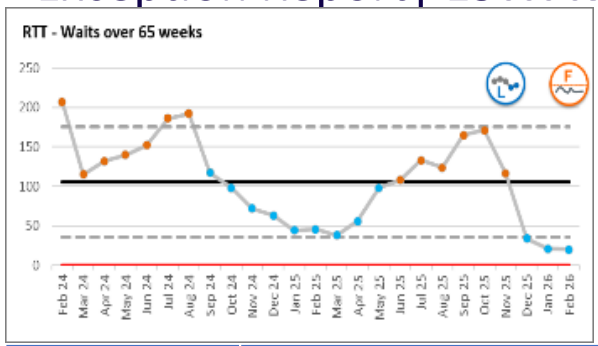


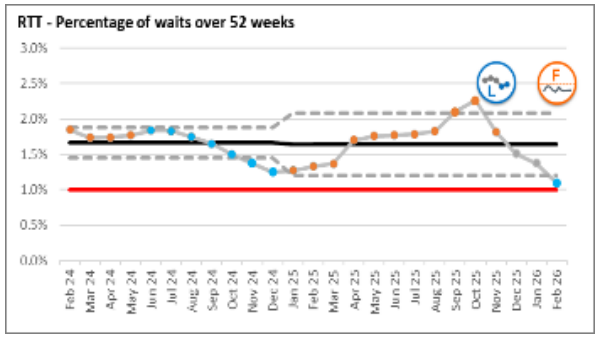


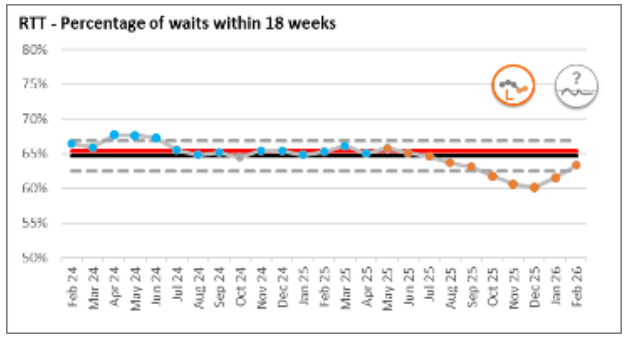
Site & Metric	Cause of variance/ non-compliance	Actions: Completed since last update, New, and Ongoing	Recovery Date
SGUH Waits over 65 weeks Waits over 52 weeks - reduction Special cause variation of an IMPROVING nature **Data Quality:** sufficient for assurance	**65 Week Waits** recovery has been seen in the reduction of +65 week waits. SGH remains close to the target level of zero. At the end of February 2026, 14 patients were waiting for treatment beyond 65 weeks (Neurosurgery 5, Vascular 4, Dermatology 2, Neurology 1, Diabetes 1, General Surgery 1) **52 Week Waits of the overall PTL** Performance continues to improve, with long waits falling to 1.07% by the end of February 2026, which ahead of trajectory to meet the March target of 1%. NHS England is assured by the progress seen against these metrics.	**Completed:** Specialist Weight Management and Neurosurgery have reduced their long waits through significant additional activity being carried out. These teams have worked hard to ensure the backlog of patients was cleared down, supporting the Trust-level recovery plan. Vascular Surgery have completed a targeted validation of longer waiting patients on the PTL, utilising available capacity to see and treat the backlog of patients in chronological order. **Ongoing/new:** • Weekly Tier One committee meetings continue to be held. These focus on eliminating 65 weeks, reducing 52 week waits to <1% of the overall PTL and improving RTT performance. • Specialties are now focusing on a forward view of activity plans and demand/capacity modelling for 2026/27 to ensure the long wait position continues to be reduced and RTT performance sustainably improves. • Outpatient Transformation Programme in place to support delivery of productivity opportunities to increase number of patients seen and embed digital improvements. • Divisions are developing additional activity requests which will support delivery of the RTT ask, to improve performance by 7%	52 week waits – March 2026 Multiple metrics - March 2026

Operational Performance

Exception Report| ESTH Referral to Treatment RTT





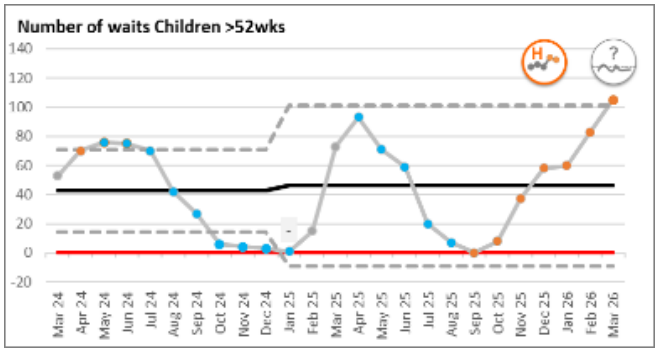


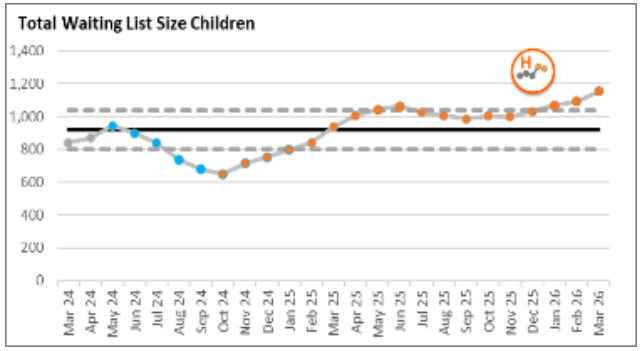
Site & Metric	Cause of variance/ non-compliance	Actions: Completed since last update, New, and Ongoing	Recovery Date
ESTH Proportion of waits over 52 weeks – above monthly trajectory of 0.93% Percentage within 18 weeks – below monthly trajectory of 65.43% Percentage waits for first appointment under 18 weeks – below monthly trajectory of 81.30% **Data Quality-** sufficient for assurance	• 52WW have continued to reduce since November 2025 and the downward trend is further reflected within the overall %, which was 1.11% at the end of February 2026. The highest volumes were in General Surgery (106), Gynaecology (97) and Trauma & Orthopaedics (71). • 65WW also reduced to 20 in February 2026. • RTT performance improved again from 61.53% in January 2026 to 63.30% in February 2026. • Percentage waits for first appointment under 18 weeks improved again from 75.2% in January 2026 to 77.5% in February 2026.	**Total PTL** -ESTH's PTL has been increasing since December 2025 (following a month-on-month reduction since September 2025), mainly driven by an iCLIP issue following the latest software release in December 2025. This has since been resolved and additional validation resource has started in March 2026 to support recovery from this issue and to expedite the reduction of other DQ within the cohort. **Long Waiters -52WW** - Recovery plans remain in place and ongoing for the most challenged specialties. • General Surgery: General Surgery continues to face challenges with workforce constraints and balancing demand for complex abdominal wall surgery, hot gallbladder referrals and long-waiting patients. Throughout February 2026, 12 extra theatre sessions were stood up to support the reduction of 52 and 65 week waits by the end of March 2026. Daily PTL meetings continue, alongside a weekly touchpoint with UGI consultants. A decrease in long waiters has been observed, reflecting the focus on improving the position. • 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. • Trauma & Orthopaedics: T&O continue to receive late drop in referrals from partner hospitals. SWLEOC are recruiting a part-time flexible Hip/Knee consultant to backfill empty theatre lists to help with RTT pressures. T&O Spinal Service under review to further improve pathways to combat long waiting times in clinic. Many 52WW's are within Hands (ESTH) and extra lists have been arranged to reduce high waits.	March 2026

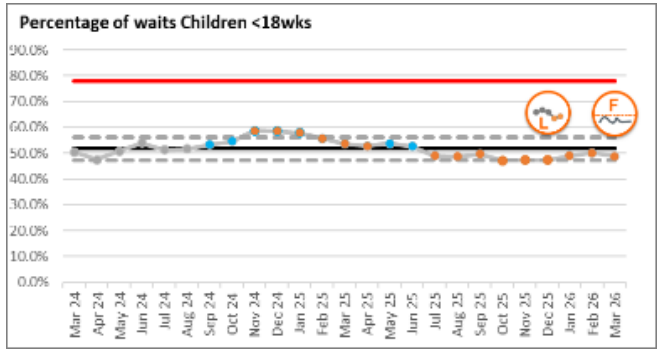
Operational Performance

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

Sutton Healthcare



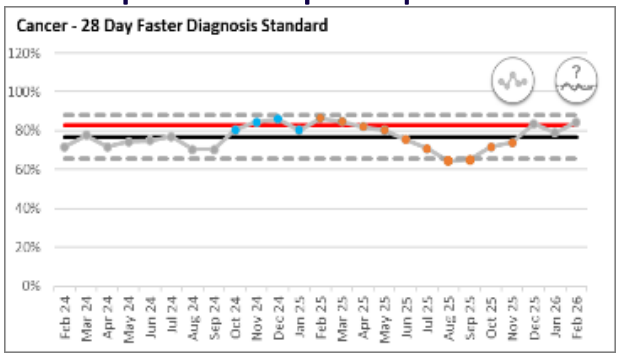


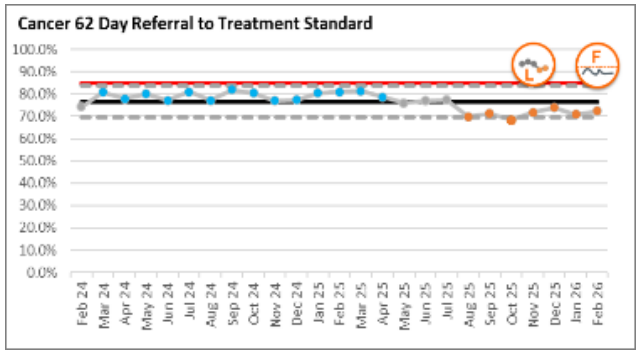


Site & Metric	Cause of variance/ non-compliance	Actions: Completed since last update, New, and Ongoing	Recovery Date	Data Quality
Sutton Health & Care waits over 52 weeks - % of waits within 18 weeks variation of a CONCERNING nature.	The overall children's services waiting list continues to increase, with the most recent data points exceeding the upper control limit, representing the highest waiting list size over a 24-month period and a continued signal of special-cause variation. Increases continue to impact long waits with the number of children waiting (SALT services) for more than 52 weeks rising to 105 at the end of March 2026. 52 weeks waiters for Children and Young People (CYP) have significantly increased nationally over the last 18 months. There is a consolidated action plan in development across South- West London. Waiting lists are challenged due to demand driven predominantly by increasing complexity of need. This has been highlighted on the risk register. At the end of March 2026, 48.8% of children were waiting less than 18 weeks for treatment. 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. To note – the overarching community waiting list performance for ESTH (Sutton and Surrey combined) exceeds the 2026/27 target of 78%.	• Harm reviews continue to take place to ensure there is no harm to children with longer waiting times. No concerns have been raised • Education, Health and Care Plans (EHCP) targets remain on track. • As part of improvement work alongside the SEND partnership forum (Sutton), and as part of the CQC-OFSTED review (LBS) with a particular focus on dysphagia, Sutton Place partners are working together to review and mitigate any concerns related to the health pathway: to include delays in development/ treatment, workforce capacity including vacancies and hard to fill specialist posts and modelling improvement. This is ongoing work alongside the ICB and DCO for Sutton.	TBC	Sufficient for assurance

Operational Performance

Exception Report| SGUH 28 day and 62 day Cancer Performance

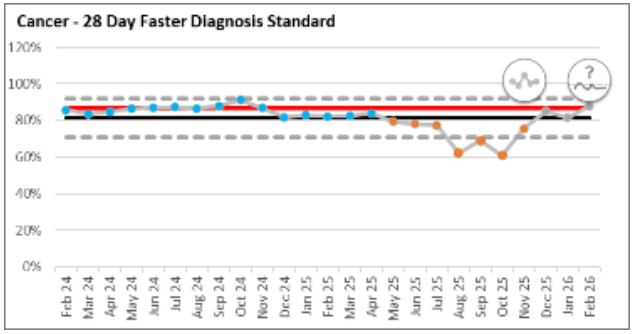


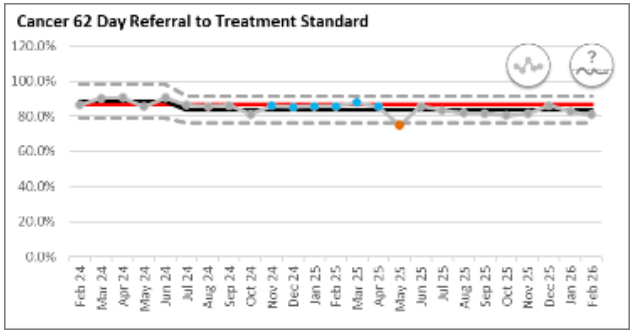


Site & Metric	Cause of variance/ non-compliance	Actions: Completed since last update, New, and Ongoing	Recovery Date
SGUH 28 Day – Normal variation 62 Day Special cause variation of a CONCERNING nature **Data Quality**: Sufficient for assurance	**28-Day FDS Standard:** February 2026 performance was 84.4%, improving from 79% in January 2026. Ten tumour sites were compliant overall. Lower GI performance has good overall improvement (73.11%), with some constraints in access to Direct to test slots. This was further impacted by a FIT testing incident resulting in an increase in referrals over 27 Dec 2025 to March 2026. **62-Day Standard:** February 2026 72.4% compared to 70.8% in January 2026: Performance is primarily driven by lung (22.9%), specifically thoracic services. This reflects ongoing theatre capacity constraints for thoracic surgery, resulting from increased demand associated with the national lung cancer screening programme, with the Trust receiving additional referrals from SWL, Surrey and Sussex. Diagnostic capacity, (navigational bronchoscopy), is also impacted.	**Lower GI** Short-term waiting list initiatives are planned to increase service capacity. Correction of FIT testing thresholds via SWL Path has reduced referral demand. **Dermatology** Ongoing pathway work is focused on regular image-review clinics, standardised letters, optimised imaging pathways and aligned job planning are improving triage, decision-making, discharge and capacity, while the Dermatology Summer Plan prepares services for seasonal demand. **Lung / Thoracic** • RMP are managing short-term pathway pressures via eight NHSE-funded weekly lists running until March 2026, with non-robotic cases diverted to Imperial due to limited robotic capacity • Group executives will hold further discussions with RMP and the ICB on options to address the demand and capacity imbalance on a sustainable basis. **Head & Neck and Maxillofacial** • Between January and March 2026, 12 additional RMP-funded clinics and biopsy lists are planned to expand diagnostic and treatment capacity. **Winter Resilience Funding** • A total of £55K RMP funding for January 2026 is supporting additional capacity across Maxillofacial, LGI, theatre activity (lung, urology, plastics), and Oncology.	Skin and FDS recovered. Thoracic recovery is dependent on theatre capacity.

Operational Performance

Exception Report| **ESTH 28 day and 62 day Cancer Performance**

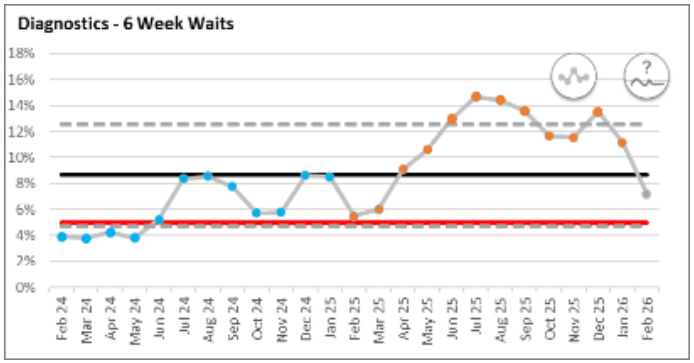




Site & Metric	Cause of variance/ non-compliance	Actions: Completed since last update, New, and Ongoing	Recovery Date
28 Day FDS **87.9 %** above the trajectory of 86.9% and the national target of 77% **62 Day Standard** **80.8%** below trajectory of 86.2% and national target of 85% **Data Quality:** Sufficient for assurance	**Gynaecology (74.3%):** FDS has improved compared to 64% in January 2026, there is restricted outpatient and general anaesthetic (GA) diagnostic capacity.	Weekly touchpoints support capacity planning and improvement, while monthly business meetings have shown improved clinic efficiency and reduced repeat diagnostics. An expression of interest for Widschwendter Initiative Diagnostics (WID) testing has also been submitted, with potential to further enhance the diagnostic pathway.	April 2026
	Lung (45.8%) - Delays to Navigational Bronchoscopy at Royal Brompton. **Lower GI (73.5%) –**Complex pathways requiring multiple investigations and support. **Upper GI(68.8%)-**Pathway management and delays to external diagnostics – EUS. **Urology(81.6%)-**Patient choice delays. **Haematology (81%) –**. Complex pathways ;patient requiring multiple investigations.	**Lung:** Navigational biopsy waiting times are expected to increase due to capacity constraints at Royal Brompton. Imperial and Barts are working to provide additional WLIs to help manage demand. An RMP SWL Lung Cancer Programme meeting has been established to support improvements in the lung diagnostic pathway. **Lower GI:** Increased referral volumes have caused diagnostic turnaround delays. To reduce waiting times, the endoscopy team is running weekend WLI lists and holding pathway meetings with the Clinical Lead and nursing team to improve management of complex diagnostics. A SWL FIT test incident led to an increase in LGI TWR referrals by putting additional pressure on Triage Assessment Clinic, outpatient and endoscopy capacity. **Upper GI:** Planned Care has successfully completed a business case, and a project plan is now being developed to establish an Endoscopic Ultrasound service at ESTH. This will help reduce current waiting times (currently around six weeks). Successfully implemented nurse led follow up clinics to request diagnostics for patients following Multidisciplinary Team discussions. **Urology:** Urology is experiencing significant delays related to patient choice, which is impacting cancer performance. This has been reviewed, and the team has been encouraged to highlight any delays early in the pathway to enable timely clinical review and potential early intervention.	

Operational Performance

Exception Report| ESTH Diagnostic Performance

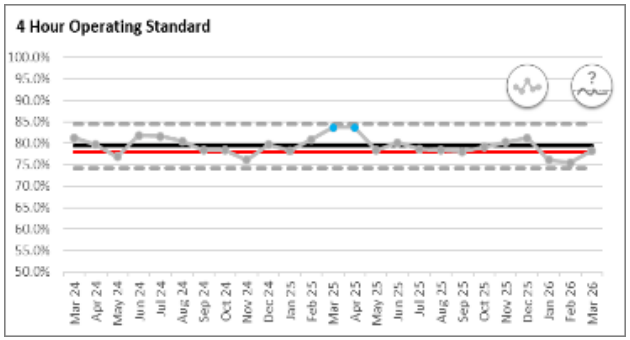


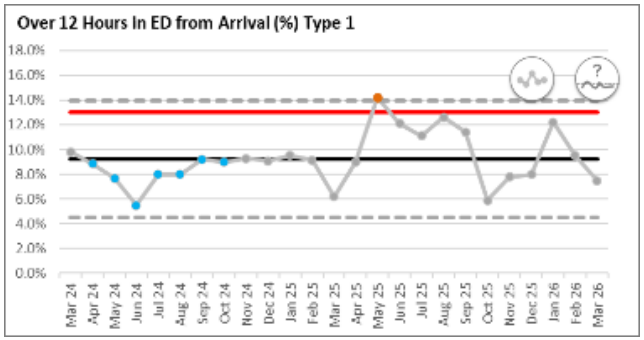
Modality	6 Week Breaches	>6 Week Performance
Colonoscopy	289	33.1%
Gastroscopy	191	24.7%
Cardiology - echocardiography	155	28.4%
Audiology - Audiology Assessments	142	19.3%
Flexi sigmoidoscopy	83	38.2%
Urodynamics - pressures & flows	77	33.0%
Cystoscopy	61	17.6%
Non-obstetric ultrasound	56	0.7%
Computed Tomography	41	2.4%
Magnetic Resonance Imaging	17	1.0%
DEXA Scan	11	2.1%
Neurophysiology - peripheral neurophysiology	0	0.0%

Site & Metric	Cause of variance/ non-compliance	Actions: Completed since last update, New, and Ongoing	Recovery Date
ESTH: 6Wk waits 7.2% not meeting national interim target of 5% **Data Quality:** February 2026 data still includes some data quality issues following EPR implementation, which are being addressed, mainly within OP modalities—Neuro-Phys, Urodynamics and Cystoscopy—and are likely to have a minimal overall impact on performance.	Diagnostic performance continued to improve in February 2026: 1,123 patients were waiting over six weeks for diagnostics (DM01), down from 1,651 in January 2026. Performance improved to 92.8% but remained below the 95% national interim target. The modalities with the highest volumes waiting >6 weeks at the end of February 2026 were • Endoscopy (563) resulting from reduced activity during the iClip Pro launch and issues with the new booking system • ECHO (155) data quality issues linked to the new EPR system remain under review • Audiology (142) inclusion of paediatric audiology in the reporting matrix and reduced activity after the iClip implementation Imaging modalities all remain above 95%.	• **Endoscopy:** An Endoscopy recovery plan is in place with 15 additional Saturday Waiting List Initiative sessions approved for 6 months from April 2026, supporting delivery of performance targets. We continue to experience a surge in TWR referrals (40% increase compared to 24/2025 levels, since January 2026), which is replicated across SWL. The reason for the increase has been identified and addressed regionally, but we have yet to see a local reduction in TWR referrals. • **Echos:** The number of breaches reduced significantly to 155 at the end of February 2026 compared to 457 at the end of January 2026, reflecting the planned increase in capacity. Weekly waiting list validation has been reinstated, although data quality issues linked to the new EPR system remain under review. Interviews for the substantive Band 7 post were successful. Agency staff to backfill still in place. Service recovery includes 22 additional clinics (220 echocardiograms) scheduled for March. • **Audiology:** Additional pressures include long-term sickness, recruitment challenges, and increased demand after neighbouring Trusts began rejecting referrals. Three new staff have been appointed and are expected to have a positive impact within the next three months. The service is currently running additional sessions to improve its DM01 position by the end of March 2026.	March 2026

Operational Performance

Exception Report| SGUH A&E Waits and Ambulance Handovers

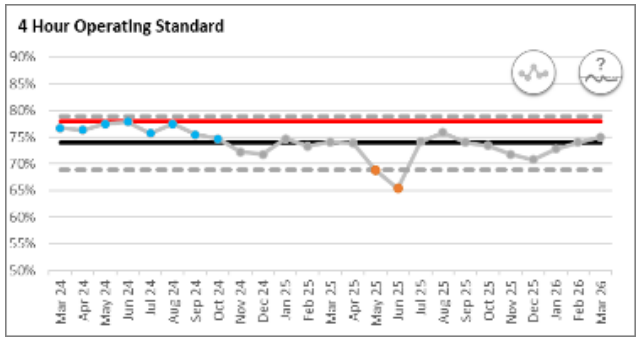


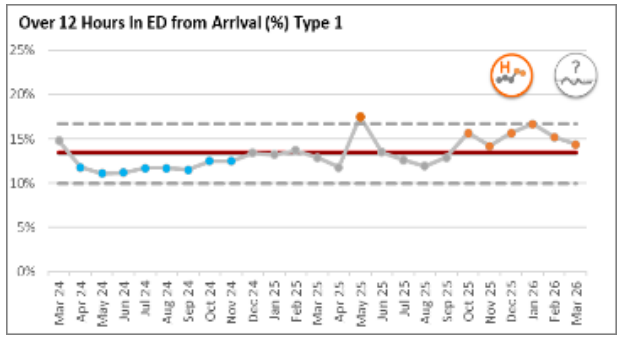


Site & Metric	Cause of variance/ non-compliance	Actions: Completed since last update, New, and Ongoing	Recovery Date
SGUH 4 Hour Target normal variation 12 Hour Waits – normal variation **Data Quality:** Sufficient for assurance. !2-Hr waits is sourced from NHSE ECDS reports	• March 2026 4-hour performance improved, achieving 78.2%. • March 2026 saw 2,595 ambulance conveyances, with 76% offloaded within 15 minutes. • Delay for inpatient beds significantly impacts department capacity resulting in longer waits for assessments and treatment decisions. Admitted patients waited, on average, 11 hours 45 minutes – an improvement of 92 minutes from the previous month. • Performance pressures are in line with other SWL acute providers. • A high volume of mental health patients are attending ED, with long waits for mental health beds.	• Direct access to Paediatric clinics for Urgent Treatment Centre (UTC) plastic patients. • Assessment/triage model updated to add resources at the front-door, including an extra streamer and a Rapid Assessment and Treatment (RAT) consultant at ambulance triage for timely handovers and redirection, in addition to: i. Emergency Practitioner, Advanced clinical practitioner and Physician associate providing cover Mon-Fri to ensure three at the front-door. ii. Appointment bookings for local GPs from streaming – reduction in availability in 2026, taking forward with Integrated Care Board • Confirmed focus on performance with daily oversight at Senior Leadership Team level. • UTC was kept open 24 hours for the final week of March 2026 to improve performance • New work to align ECDS and UEC data, in real time, has seen improvements made since March. Further improvements to be made with resource pulled from existing staffing.	

Operational Performance

Exception Report | ESTH A&E Waits and Ambulance Handovers

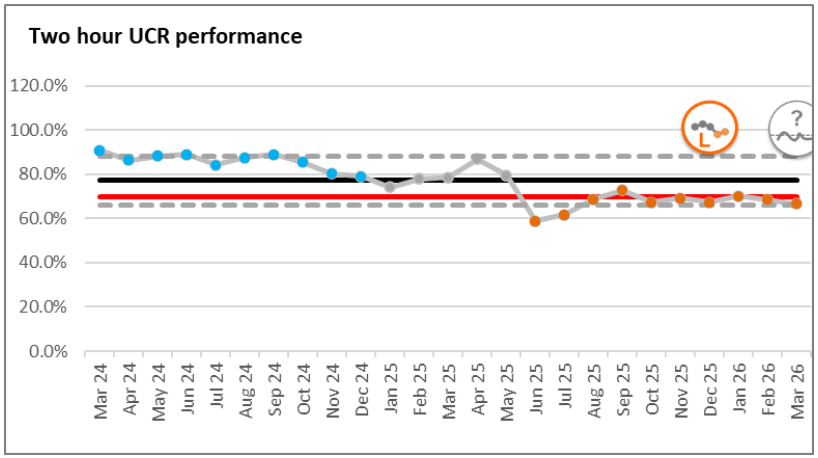


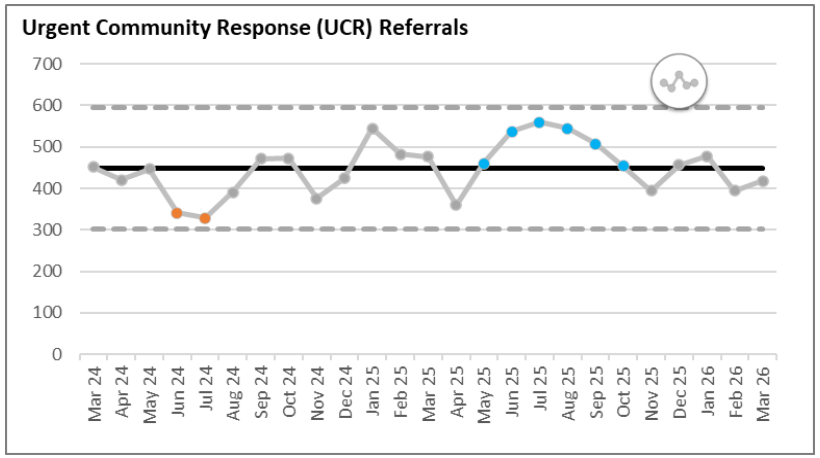


Site & Metric	Cause of variance/ non-compliance	Actions: Completed since last update, New, and Ongoing	Recovery Date
ESTH 4 Hr performance below trajectory of 75.5% ED Type 1 LOS>12 Hours - normal variation **Data Quality:** Sufficient for assurance	• ESTH 4-hour emergency department (ED) performance improved in March 2026 delivering 75.1% versus 74.1% in February 2026 albeit against an agreed trajectory of 78.0% performance. Failure to meet the trajectory was mainly due to adult patients requiring admission, with admitted performance at 24.9% versus 81.0% for non-admitted adults in March 2026. • 12-hour wait times for type 1 attendances improved to 14.4% in March 2026 from 15.2% in the previous month driven by high acuity and our admitted cohort limited bed availability affecting 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 the UEC pathway. Key actions implemented during the last month include: • The ESTH ED–Medical Ambulatory Pathways commenced a soft launch across both sites on 16 March 2026. The pathways are functioning well, enabling more appropriate patient streaming and triage. Patients are being seen by the correct specialty earlier, improving the overall ED journey. This has been supported by strong collaboration between the medical SDEC and ED teams, including rapid (<1-minute) Consultant-to-Consultant discussions. • Streaming and Triage processes reviewed and revised with changes implemented. • Test of proposed changes in ED streaming to increase UTC patients continued; includes ring-fencing SDEC capacity for patient assessment. • UTC First pathways updated pending implementation planned from 15 April 2026. • Extension of front-door frailty service to 7 days with added weekend consultant/SHO support continued supported by winter monies. • Ring-fencing 1 bed in the frailty hub to accommodate x3 chairs for ambulatory patients. • Decision to Admit (DTA) huddles introduced in Emergency Departments on both sites. • ED/ Radiology processes have been reviewed to include ED clinician accessibility and escort transfer • Weekly meetings continue with SWL pathology to support the reduction in delays of pathology sample waiting times. • March 2026 was supported by Additional staffing requirements to include an ED Middle Grade for Front Door Triage, an additional SDEC Middle Grade, an additional Band 6 Triage Nurse, an additional Band 5 Nurse for night shifts, an additional ED Porter providing 24/7 cover, and an additional AMU Porter from 09:00–11:00.	

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
Sutton Health Urgent Community Response within 2-Hrs – Target rate of > 70% not met **Data Quality:** Sufficient for assurance	• March 2026 2-hour response performance was 66.5%, against a 70% target. • Referrals are within normal range however there are variations especially out of hours with referrals peaking early evening, having an impact on capacity.	• As part of the Sutton Home from Hospital model, improvement work is underway which will ensure improvements to productivity and efficiency, with close-down on mitigating actions to ensure the service is performing above target.	TBC after detailed analysis which is in progress

Section 2.2:
Operational Productivity

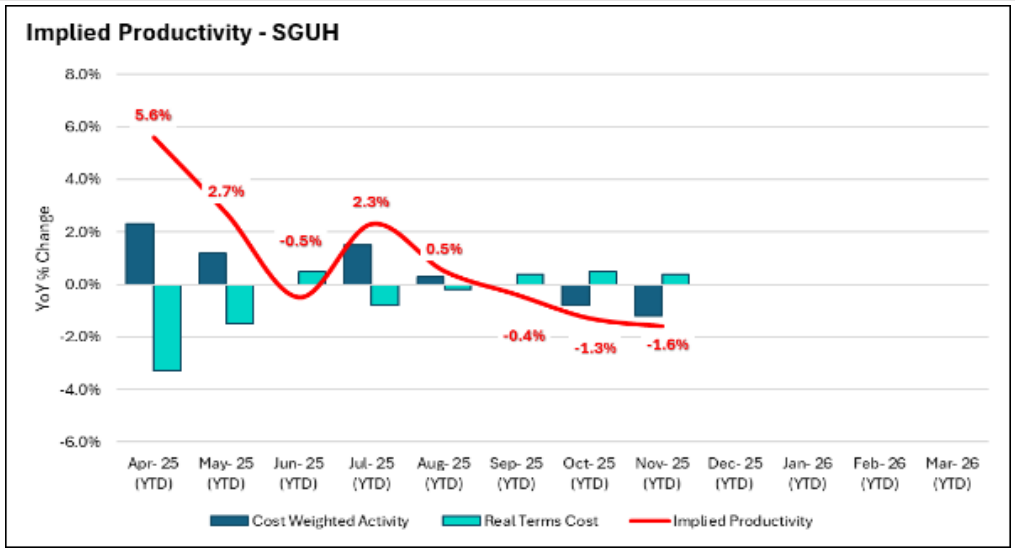
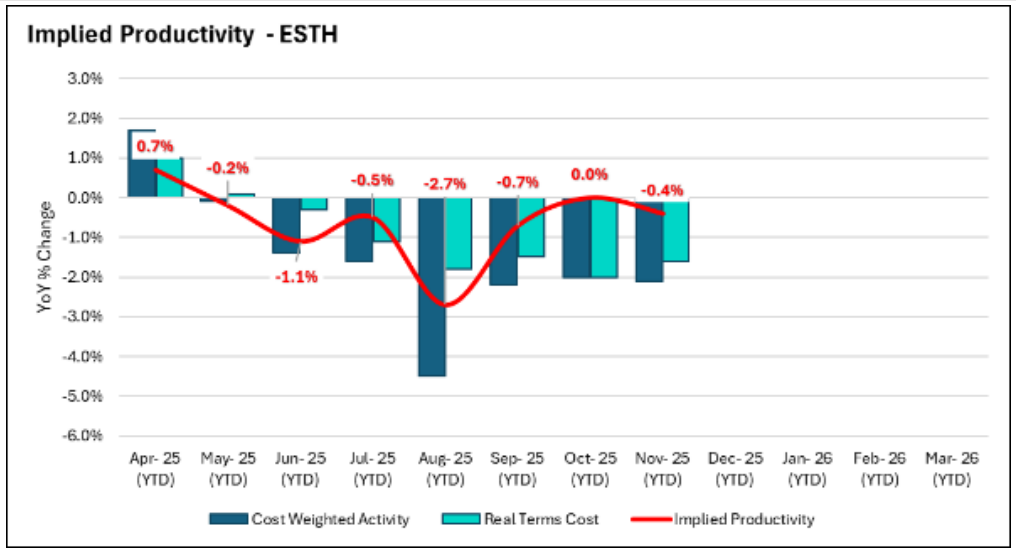
Operational Productivity

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	Nov 25	-1.3%	-1.6%	-	N/A	N/A	Lowest Quartile	Nov 25	0.0%	-0.4%	-	N/A	N/A	Lowest Quartile
Non Elective Length of Stay (SWL Methodology exc 0 days, exc <18 years)	Mar 26	10.8	10.2	8.4			N/A	Mar 26	12.1	11.8	10.9			N/A
Average days from Discharge Ready Date to date of discharge (inc 0 day delays)	Feb 26	0.7	0.7	-			2nd Quartile	Feb 26	1.5	1.4	-			Lowest Quartile
Theatre Utilisation (Capped)	Mar 26	85.6%	84.0%	85.0%			Top Quartile	Mar 26	80.8%	81.0%	85.0%			2nd Quartile
BADS All Daycase & Outpatient Procedures % of total procedures	Dec 25	81.8%	82.9%	83.6%			3rd Quartile	Dec 25	63.8%	66.6%	83.6%			Lowest Quartile
Outpatients Patient Initiatied Follow Up Rate (PIFU)	Mar 26	2.4%	2.6%	5.0%			Lowest Quartile	Mar 26	5.1%	4.6%	5.0%			2nd Quartile
Outpatients Missed Appointments (DNA Rate)	Mar 26	9.4%	10.6%	8.0%			Lowest Quartile	Mar 26	7.0%	7.0%	6.0%			3rd Quartile
First and Procedure Attendances as a proportion of Total Outpatients	Mar 26	54.3%	53.3%	49.0%			2nd Quartile	Mar 26	42.0%	45.7%	49.0%			Lowest Quartile

Operational Productivity – Implied Productivity

Outputs (cost-weighted activity) vs inputs (operating expenditure).

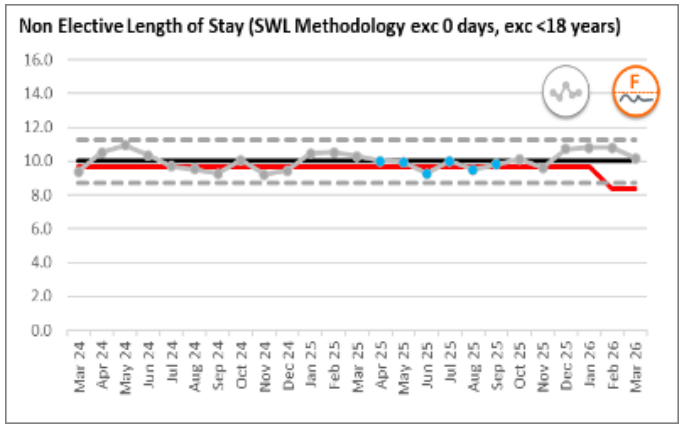
SGUH Summary	ESTH Summary
	
Productivity decreased by 1.6% in Month 8 YTD (2025/26) compared with the same period in the previous year, driven by a 0.4% increase in operating expenditure and a 1.2% reduction in cost-weighted activity. Cost weighted activity reductions are partly driven by under reporting of activity delivered which is being addressed.	Productivity decreased by -0.4% in Month 8 YTD (2025/26) compared with the same period in the previous year, driven by a 1.6% decrease in operating expenditure and a 2.1% reduction in cost-weighted activity. Activity data remains volatile following EPR implementation, resulting in significant month-on-month changes that are currently under review.

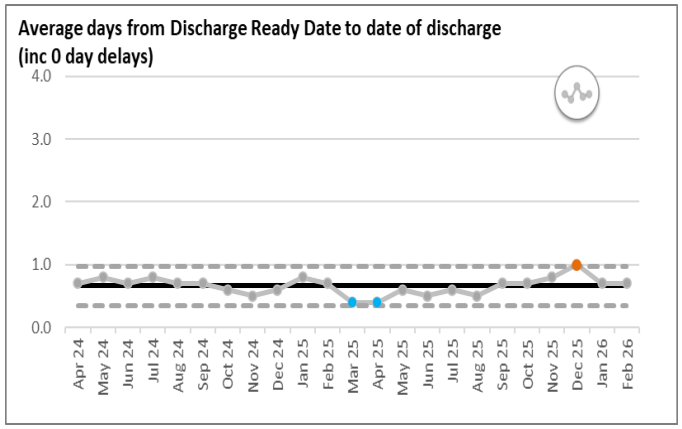
Data source: NHSE Official statistics portal, revised figures

Operational Productivity

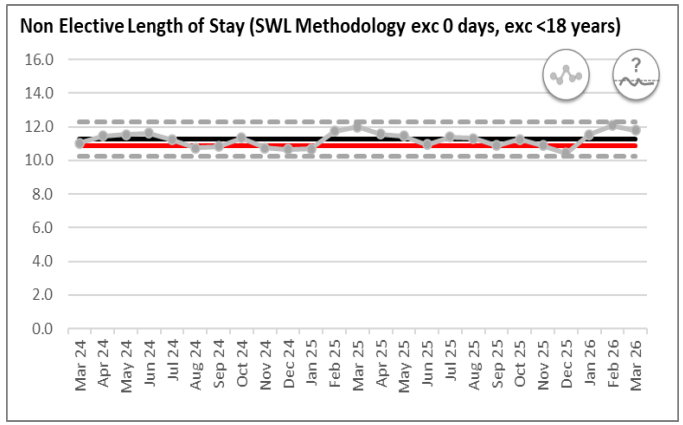
Bed utilisation

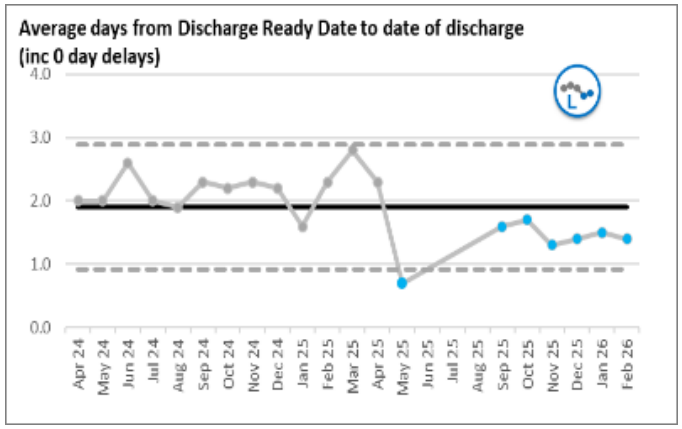
St George's





Epsom & St Helier





Analyses & Key actions

Group-wide

- Aligned to gesh-wide Non-Elective Transformation Programme

SGUH

- W-OPEL (Ward based Operational Pressures Escalation Levels) launched in March 2026, with *Action card workshops* planned for April 2026.
- Health funded bridging services expanded via winter funding in March 2026. Increased utilisation and will now monitor impact.
- Acute medicine: Developed an established workforce in MSDEC and supplementary to Majors B in ED. Celebrated the move from a pilot to BAU.
- Completed a *criteria to admit* audit mid-March. Results to be reviewed in April 2026.
- Completed the GIRFT *Alternative to ED* & *Frailty alternatives to ED* (A-ted & F-ted) in March 2026 – results in April 2026.

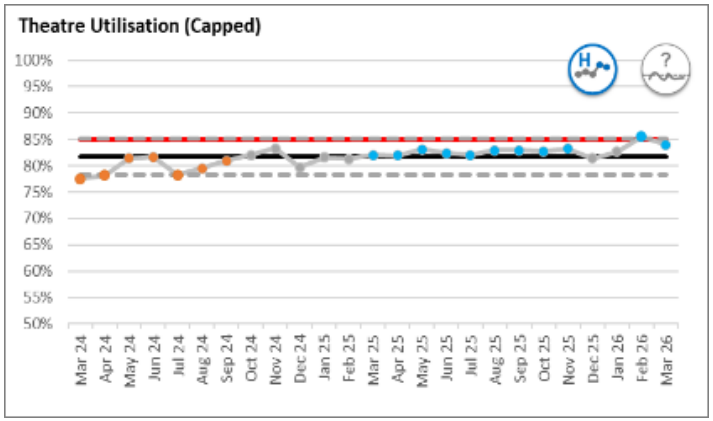
ESTH

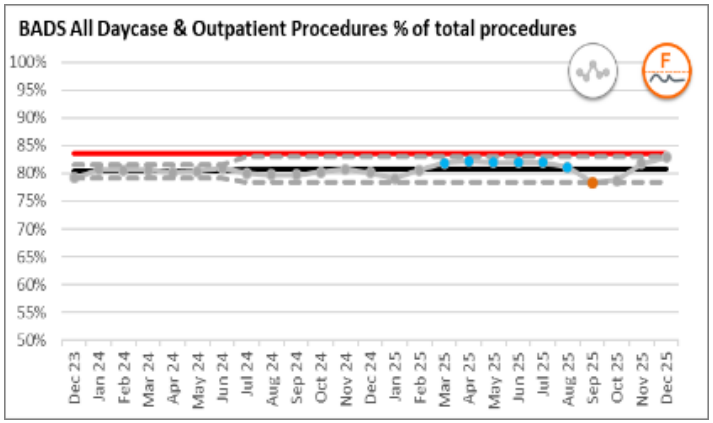
- Non-elective length of stay fell to 11.8 days in March 2026, reflecting a focused initiative to discharge complex patients, delivering 19 discharges and releasing 2,681 bed days, despite remaining above ambition.
- Average delay to discharge reduced to 1.4 days in the month of February 2026 from 1.5 days in the previous month.
- Discharge & Flow: Trust-wide rollout of standardised ward processes, ward LOS dashboard now live.
- Therapies and capacity-release models are fully live, including trusted assessor and acute-to-community interfaces, supported by a ring-fenced reablement bed, with further progression of D2A modelling
- Optimising Bed Base: Agreed SWIFT and AMU relocations and scope to improve elective and non-elective flow.
- Workforce -Acute Medicine self-rostering now live.

Operational Productivity

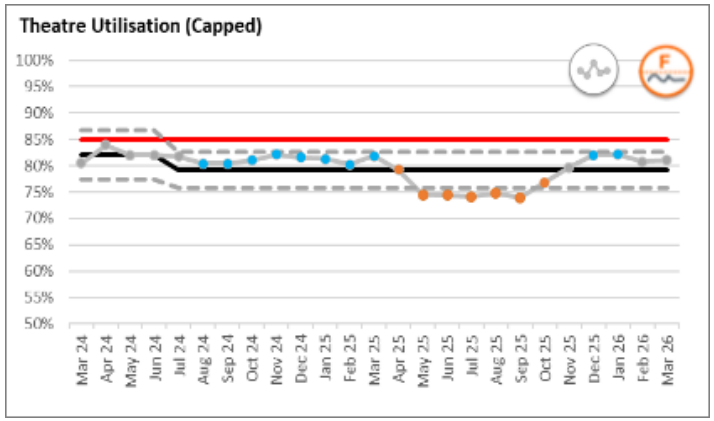
Theatre Utilisation

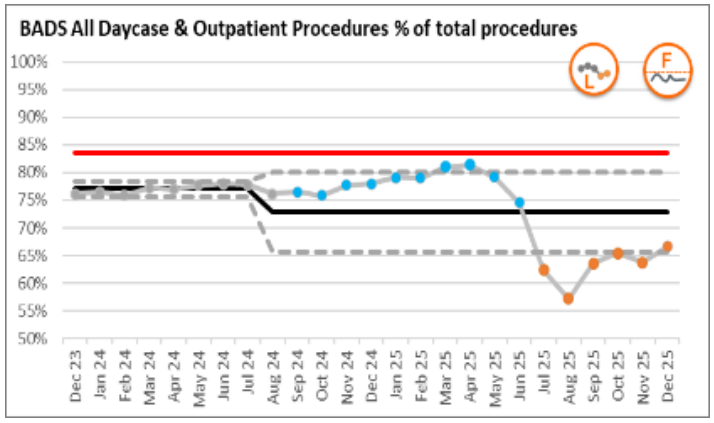
St George's





Epsom & St Helier





Analyses & Key actions

Group-wide

- A gesh-wide working group has been set up to deliver electronic Pre-Operative Assessment by March 2026.

SGUH

- Theatre allocation has been optimised through the introduction of structured weekly 6-4-2 meetings.
- A revised policy on same-day cancellations has been approved and is currently being implemented.
- Actions from the three-month Day Surgery Unit review are underway, including 7-day patient reminder calls and time-and-motion studies
- Planning is being strengthened to support more day-case procedures in line with GIRFT recommendations
- Targeted education is being delivered through protected teaching sessions to support the accurate recording of theatre timestamps.

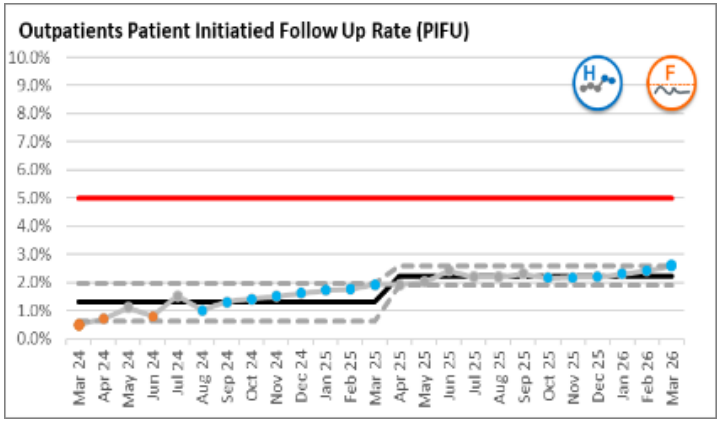
ESTH

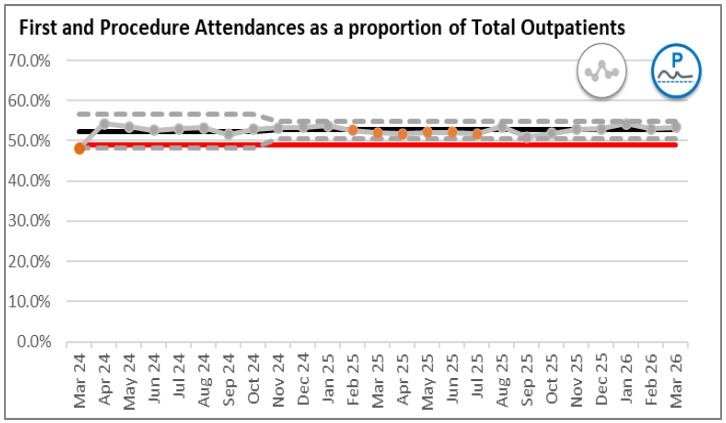
- The Golden Patient initiative, launched in February 2026, is being reviewed using performance data and staff feedback to assess its impact and improve theatre start times.
- On-The-Day Cancellations Task and Finish Group working with specialties to implement standby patient processes to improve theatre utilisation and reduce cancellations.
- A coding review is underway, supported by clinical champions, with a system issue affecting BADS outpatient procedure reporting identified and under review to improve national metric accuracy

Operational Productivity

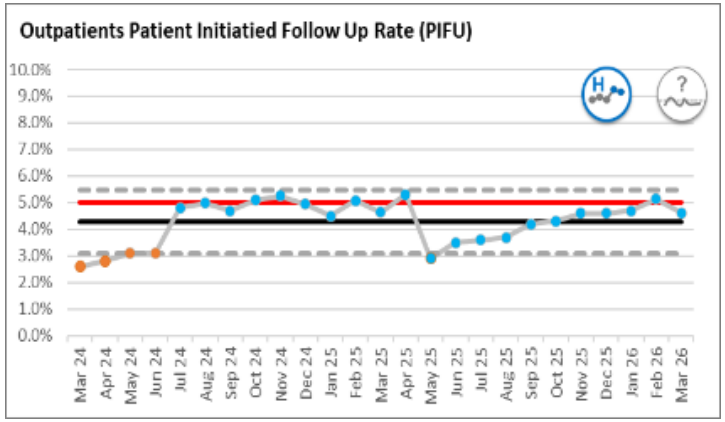
Outpatient Follow-ups

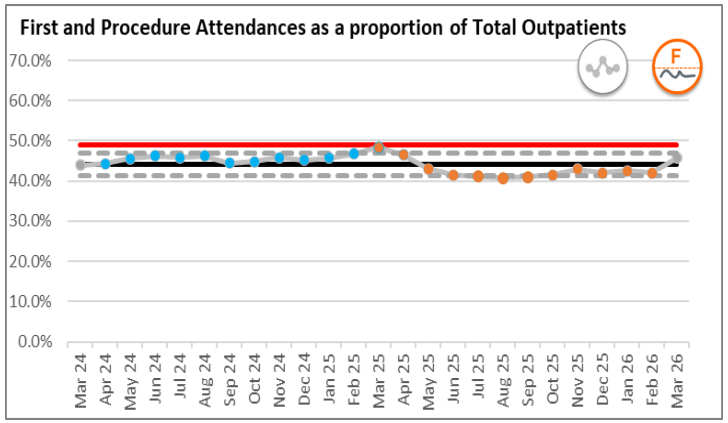
St George's





Epsom & St Helier





Analyses & Key actions

Group-wide

- Key element of the gesh-wide Outpatient Transformation programme. Both sites are working collaboratively on increasing PIFU uptake using a standard model.

SGUH

- PIFU expansion and reduction of low value follow ups a key component of SGH Productivity workstream in gesh OP Transformation programme
- 26k appointments (annual) where patient is not present have been identified and are artificially inflating the Trusts reported position. Discussions on-going and testing plan in place with a view to removing from SUS submission going forward.
- Work to commence to expand PIFU types used by Trust.
- Plan to embed PIFU into standard clinical pathways
- Wait list validation to expand and be automated

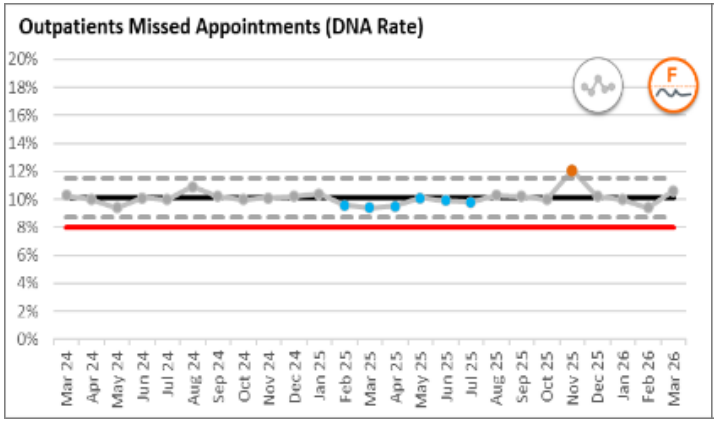
ESTH

- The PIFU rate decreased by a further 0.5% in March, likely reflecting reduced activity due to higher levels of leave, when PIFU is typically most utilised. A review is underway to identify specialties that have not yet recovered to pre-iClip PIFU levels; these will be the initial focus of this year's PIFU acceleration work.
- An appointment type has been identified, with support from SGUH, to test an ENT notes review in place of a first outpatient attendance, aiming to reduce outpatient appointments. Progress is currently subject to ICT delivery timelines, which have been escalated for resolution.

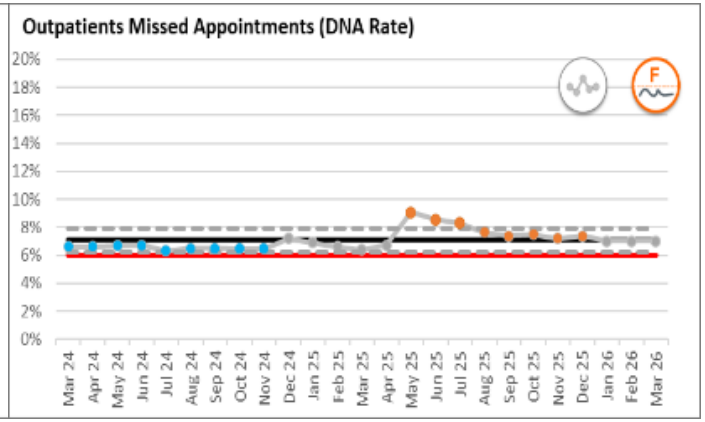
Operational Productivity

Outpatients – Missed Appointments (DNA Rates)

St George's



Epsom & St Helier



Analyses & Key actions

Group-wide

- Reduction in DNA rates is a key element of the gesh-wide Outpatient Transformation programme.

SGUH

- Improvements in patient portal are being tested to improve patient communication. A trial to change the timing of SMS reminders and to supplement further with automated call reminders is being planned.
- New functionality is being secured to deliver SMS-based digital letters (via Netcall) to supplement existing digital letters.
- Pilot underway in T&O to use vacant slot from short-notice patient cancellations for long waiting patients
- Plan to expand portal to encompass paediatrics is underway.
- Partial booking lightroll out to Urology, Plastics and T&O imminent.
- DNA rebooking process to change to reduce multiple DNAs.

ESTH

- The DNA Text Reminder Task & Finish Group has commenced work, including a baseline review to identify appointment types not currently configured. Operational teams have been asked to confirm requirements to address gaps in text message reminders.
- Reporting issues are being defined, and a communications pack is in development to outline current message content, timing, and address frequently asked questions.

Section 3:
Our People

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	Mar 26	5.2%	4.8%	4.0%			2nd Quartile
MAST	Mar 26	91.1%	91.1%	85.0%			Top Quartile
Vacancy Rate	Mar 26	5.3%	5.3%	10.0%			-
Appraisal Rate Medical	Mar 26	86.0%	88.0%	90.0%			-
Appraisal Rate Non Medical	Mar 26	75.6%	76.3%	90.0%			Top Quartile
Turnover (12-month)	Mar 26	9.1%	9.0%	13.0%			4th Quartile
Workforce WTE	Feb 26	10790	10841	10325			-
Percentage BAME staff band 8a and above	Mar 26	32.7%	32.6%	-		-	-

Epsom & St Helier

Latest month	Previous Month Measure	Measure	Target	Variation	Assurance	Benchmark
Mar 26	6.0%	5.5%	4.0%			3rd Quartile
Mar 26	88.5%	88.6%	85.0%			Top Quartile
Mar 26	10.5%	10.5%	10.0%			-
Mar 26	90.8%	93.2%	90.0%			-
Mar 26	80.8%	79.8%	90.0%			Top Quartile
Mar 26	8.8%	8.6%	12.0%			Lowest Quartile
Mar 26	7471.00	7623.00	7173.49			-
Mar 26	30.2%	30.5%	-		-	-

Sutton Healthcare

KPI	Latest month	Previous Month Measure	Latest Month Measure	Target	Variation	Assurance
Sickness Rate	Mar 26	7.5%	5.7%	4.0%		
MAST	Mar 26	92.2%	93.1%	85.0%		
Vacancy Rate	Mar 26	16.7%	14.5%	10.0%		
Appraisal Rate Medical	Mar 26	100.0%	100.0%	90.0%		
Appraisal Rate Non Medical	Mar 26	74.4%	81.7%	90.0%		
Turnover (12-Month)	Mar 26	9.1%	9.7%	12.0%		
Percentage BAME staff band 8a and above	Mar 26	24.5%	27.1%	-		-

Surrey Downs

Latest month	Previous Month Measure	Measure	Target	Variation	Assurance
Mar 26	5.4%	4.8%	4.0%		
Mar 26	93.4%	93.3%	85.0%		
Mar 26	10.7%	9.8%	10.0%		
Mar 26	100.0%	100.0%	90.0%		
Mar 26	84.8%	85.5%	90.0%		
Mar 26	10.4%	10.0%	12.0%		
Mar 26	11.1%	10.9%	-		-

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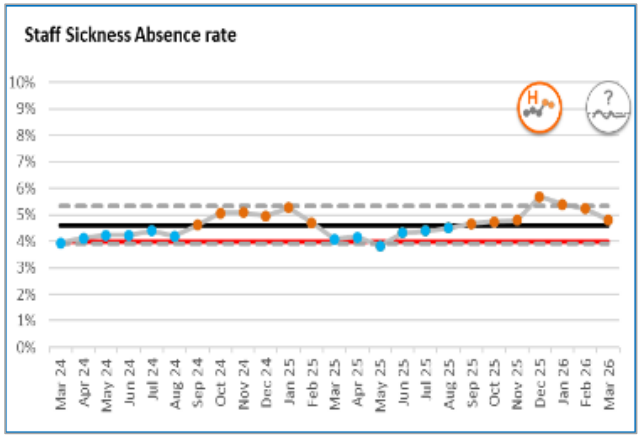
External report on Turnover from Model Hospital includes fixed term contracts, and Resident Doctors. The Trust excludes these in their reports and would explain discrepancies.

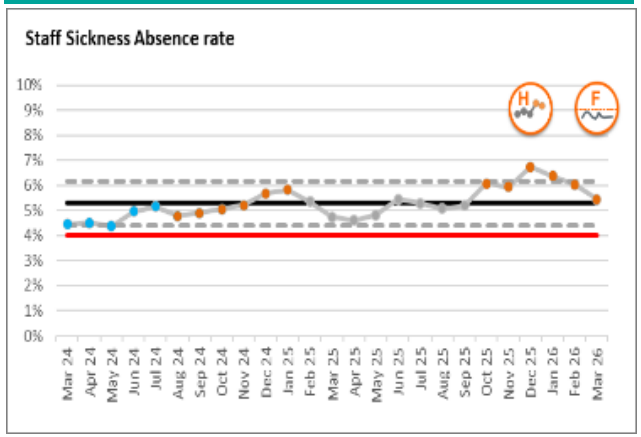
Our People

Exception Report| **Sickness Absence Rate**

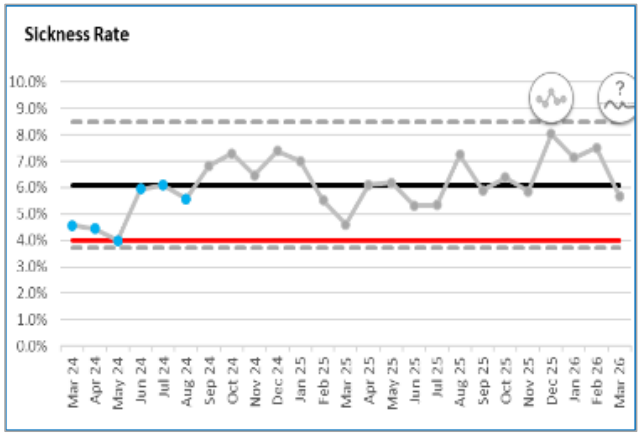
St George's



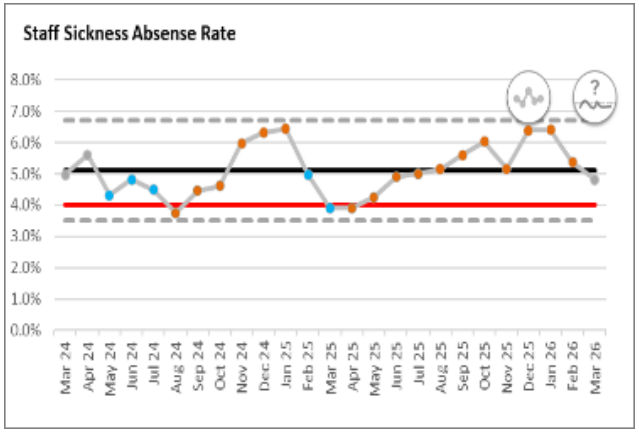
Epsom & St Helier



Sutton Healthcare



Surrey Downs



Analyses & Key actions

- Sickness absence levels remain high across gesh, adversely impacting performance, quality and efficiency.
- As a result, the Clinical Workforce Transformation programme is prioritising sickness absence reduction as a key workstream for mobilisation.
- Group Executive Committee will shortly be considering a proposed pilot project aimed at helping support hotspot areas to manage absences.

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	Mar 26	140	121	0			Lowest Quartile
Number of Complaints Received	Mar 26	88	165	-		-	N/A
Number of re-opened complaints in month	Mar 26	0	4	-		-	N/A
Parliamentary and Health Service Ombudsman (PHSO) Received	Mar 26	3	0	-		-	N/A
Parliamentary and Health Service Ombudsman (PHSO) Closed	Mar 26	0	0	-		-	N/A
RTT - Total Size Incomplete Waiting List	Feb 26	68049	68072	74003			3rd Quartile
Community Percentage of waits within 18 weeks	Jan 26	67.9%	71.0%	78.0%			TBC
Cancer 31 Day Decision To Treat to Treatment Standard	Feb 26	88.5%	93.0%	96.0%			2nd Quartile
On the Day Cancellations not re-booked within 28 days	Feb 26	4	3	0			2nd Quartile
Outpatient Advice & Guidance Rate per 100 First OPA	Dec 25	23.3	22.1	16.0			2nd Quartile
Emergency Department Attendances per day	Mar 26	432	429	-		-	N/A
Mental health delays 4 Hour Breaches	Mar 26	124	89	-		-	N/A
Length of stay > 21 days (super stranded)	Mar 26	162	147	-		-	3rd Quartile
Overnight G&A beds occupancy - Adults	Mar 26	96.6%	96.8%	96.0%			3rd Quartile
Number of patients not meeting criteria to reside (Daily Avg)	Mar 26	113	98	-		-	2nd Quartile

Epsom & St Helier

Latest month	Previous Month Measure	Latest Month Measure	Target	Variation	Assurance	Benchmark
Mar 26	29	40	0			Lowest Quartile
Mar 26	73	50	-		-	N/A
Mar 26	2	3	-		-	N/A
Mar 26	0	0	-		-	N/A
Mar 26	3	4	-		-	N/A
Feb 26	60088	60294	50386			3rd Quartile
					-	
Jan 26	99.0%	99.0%	96.0%			Top Quartile
Dec 25	0	2	0			Top Quartile
Dec 25	63.0	65.8	16.0			Top Quartile
Mar 26	433	453	-		-	N/A
Mar 26	218	221	-		-	N/A
Mar 26	174	173	-		-	Lowest Quartile
Mar 26	91.1%	92.9%	96.0%			2nd Quartile
Mar 26	191	199	-		-	3rd Quartile

Sutton Healthcare

KPI	Latest month	Previous Month Measure	Latest Month Measure	Target	Variation	Assurance
Urgent Community Response (UCR) Referrals	Mar 26	395	418	-		-
Virtual ward - Admissions	Mar 26	378	351	-		-
Virtual ward Length of Stay (Average)	Mar 26	7.3	7.6	-		-
Discharge to Assess- Pathway 0-3 Delays (Median Days)	Mar 26	5	4	-		-
Total number of adult patients on the waiting list	Mar 26	2339	2685	-		-
Total number of children patients on the waiting list	Mar 26	1093	1154	-		-
Total Number of Compliants Received	Mar 26	0	3	-		-

Surrey Downs

Latest month	Previous month measure	Latest month measure	Target	Variation	Assurance
Mar 26	561	541	-		-
Mar 26	274	263	-		-
Mar 26	7.8	7.9	-		-
Mar 26	2	1	-		-
Mar 26	5925	5959			-
Mar 26	3	0			-

Appendix 3 - Cancer Performance by Tumour Type

Overview Dashboard

28 Day Faster Diagnosis Standard

KPI	St George's Latest month	St George's Previous Month Measure	St George's Latest Month Measure	St George's National Average	St George's Variation	Epsom & St Helier Latest month	Epsom & St Helier Previous Month Measure	Epsom & St Helier Latest Month Measure	Epsom & St Helier National Average	Epsom & St Helier Variation
Exhibited (non-cancer) breast symptoms - cancer not initially suspected	Feb 26	87.7%	92.6%	92.5%		Feb 26	N/A	N/A	92.5%	-
Suspected skin cancer	Feb 26	84.0%	89.1%	91.4%		Feb 26	95.0%	98.5%	91.4%	
Suspected head & neck cancer	Feb 26	85.1%	88.8%	76.3%		Feb 26	93.1%	95.1%	76.3%	
Suspected lower gastrointestinal cancer	Feb 26	71.4%	73.1%	69.3%		Feb 26	75.5%	81.0%	69.3%	
Suspected upper gastrointestinal cancer	Feb 26	62.2%	77.8%	78.2%		Feb 26	78.2%	83.3%	78.2%	
Suspected lung cancer	Feb 26	68.3%	84.3%	83.7%		Feb 26	80.6%	97.8%	83.7%	
Suspected children's cancer	Feb 26	66.7%	88.9%	94.6%		Feb 26	N/A	100.0%	94.6%	-
Suspected urological malignancies (excluding testicular)	Feb 26	62.4%	80.4%	67.6%		Feb 26	81.4%	90.9%	67.6%	
Suspected gynaecological cancer	Feb 26	75.5%	78.4%	70.7%		Feb 26	64.0%	75.0%	70.7%	
Suspected breast cancer	Feb 26	90.7%	93.5%	90.7%		Feb 26	N/A	N/A	90.7%	-
Suspected haematological malignancies (excluding acute leukaemia)	Feb 26	76.9%	56.3%	68.4%		Feb 26	100.0%	100.0%	68.4%	
Suspected sarcoma	Feb 26	N/A	N/A	58.3%	-	Feb 26	N/A	N/A	58.3%	-
Suspected testicular cancer	Feb 26	N/A	100.0%	96.7%	-	Feb 26	N/A	N/A	96.7%	-
Suspected brain/central nervous system tumours	Feb 26	N/A	66.7%	96.2%	-	Feb 26	N/A	100.0%	96.2%	-
Suspected cancer - non-specific symptoms	Feb 26	52.0%	61.1%	59.3%		Feb 26	N/A	96.2%	59.3%	-

Cancer 62 Day Referral to Treatment Standard

KPI	St George's Latest month	St George's Previous Month Measure	St George's Latest Month Measure	St George's National Average	St George's Variation	Epsom & St Helier Latest month	Epsom & St Helier Previous Month Measure	Epsom & St Helier Latest Month Measure	Epsom & St Helier National Average	Epsom & St Helier Variation
Gynaecological	Feb 26	80.0%	66.7%	71.4%		Feb 26	41.7%	87.5%	71.4%	
Skin	Feb 26	79.3%	66.0%	92.6%		Feb 26	80.7%	98.5%	92.6%	
Lung	Feb 26	45.3%	22.9%	61.4%		Feb 26	42.3%	45.8%	61.4%	
Other (a)	Feb 26	70.0%	88.9%	75.7%		Feb 26	100.0%	50.0%	75.7%	
Lower Gastrointestinal	Feb 26	44.8%	71.4%	69.8%		Feb 26	88.0%	73.5%	69.8%	
Head & Neck	Feb 26	76.3%	82.9%	72.7%		Feb 26	84.6%	100.0%	72.7%	
Breast	Feb 26	79.1%	75.9%	69.4%		Feb 26	N/A	100.0%	69.4%	-
Upper Gastrointestinal - Oesophagus & Stomach	Feb 26	100.0%	66.7%	68.3%		Feb 26	100.0%	40.0%	68.3%	
Haematological - Lymphoma	Feb 26	100.0%	80.0%	77.8%		Feb 26	100.0%	60.0%	77.8%	
Upper Gastrointestinal - Hepatobiliary	Feb 26	55.0%	66.7%	86.4%		Feb 26	85.7%	81.8%	86.4%	
Urological - Prostate	Feb 26	97.2%	100.0%	65.2%		Feb 26	93.8%	77.4%	65.2%	
Urological - Other (a)	Feb 26	65.8%	71.0%	74.2%		Feb 26	92.9%	100.0%	74.2%	
Haematological - Other (a)	Feb 26	75.0%	100.0%	100.0%		Feb 26	100.0%	100.0%	100.0%	

Appendix 4
Metric Technical Definitions and Data Sources

Metric	Definition	Strategy Drivers	Data Source
Never Events	Serious incidents that are entirely preventable because guidance or safety recommendations providing strong systemic protective barriers	National Framework for Reporting and Learning from Serious Incidents	Local Data
Patient Safety Incidents Investigated	Any unintended or unexpected incident which could have, or did, lead to harm for one or more patient's receiving healthcare	National Framework for Reporting and Learning from Serious Incidents	Local Data
Venous thromboembolism VTE Risk Assessment	Percentage of patients aged 16 and over admitted in the month who have been risk assessed for VTE on admission to hospital using the criteria in a National VTE Risk Assessment Tool.	NHS Standard Contract & Constitutional Standard	Local Data
Pressure Ulcers	Number of patients with pressure ulcer (Category/Stage 3 & 4) in the Trust over a specific period of time.	gesh Priority - Fundamentals of Care/ National Patient Safety Incidents	Local Data
SHMI	Rolling 12 months ratio between the actual number of patients who die following hospitalisation at a trust and the number that would be expected to die on the basis of average England figures, given the characteristics of the patients treated there.	NHS National Oversight Framework	NHS Digital
Referral to Treatment Waiting Times (RTT)	Monitors the waiting time between when the hospital or service receives your referral letter, or when you book your first appointment through the NHS e-Referral Service for a routine or non-urgent consultant led referral to treatment date.	NHS National Oversight Framework, Constitution, and Priorities & Operational Planning Guidance	NHS England
Cancer 28 Day Faster Diagnosis Standard	The proportion of patients that received a diagnosis (or confirmation of no cancer) within 28 days of referral received date.	NHS National Oversight Framework, Constitution, and Priorities & Operational Planning Guidance	NHS England
Cancer 62 Day Standard	The proportion of patients beginning cancer treatment that do so within 62 days of referral received date. This applies to by a GP for suspected cancer, following an abnormal cancer screening result, or by a consultant who suspects cancer following other investigations (also known as 'upgrades')	NHS National Oversight Framework, Constitution, and Priorities & Operational Planning Guidance	NHS England
Diagnostic Waits > 6 Weeks	Percentage of patients waiting for more than 6 weeks (42 days) for one of the 15 diagnostic tests from referral / request date.	NHS Oversight Framework, Constitution, and Priorities & Operational Planning Guidance	NHS England
4 Hour Operating Standard	Percentage of emergency department attendances admitted, transferred or discharged within four hours of arrival	NHS National Oversight Framework, Constitution, and Priorities & Operational Planning Guidance	NHS England
Emergency Department Corridor Care	A count of the number of patients who received corridor care for more than 45 minutes within the previous 24-hour reporting period, from midnight to midnight, in the same way that attendances are reported. This includes patients receiving treatment, waiting for assessment, admission or transfer. This is limited to ED.	NHS Priorities	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 Provider Finance Return

Appendix 5 – Glossary of Terms

Terms	Description
A&G	Advice & Guidance
ASI	Appointment Slot Issues
CATS	Clinical Assessment and Triage Service
CNS	Clinical Nurse Specialist
CQC	Care Quality Commission
CT	Computerised tomography
CWDT	Children's, Women's, Diagnostics & Therapies
CWT	Cancer Waiting Times
D2A	Discharge to Assess
DDO	Divisional Director of Operations
DM01	Diagnostic wating times
DNA	Did Not Attend
DTA	Decision to Admit
DTT	Decision to Treat
DQ	Data quality
eCDOF	electronic Clinic Decision Outcome Forms
E. Coli	Escherichia coli
ED	Emergency Department
eHNA	Electronic Health Needs Assessment
EP	Emergency Practitioner
EPR	Electronic Patient Records
ESR	Electronic Staff Records
ESTH	Epsom and St Helier Hospital Trust
EUS	Endoscopic Ultrasound Scan
FDS	Faster Diagnosis Standard

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

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

Terms	Description
SALT	Speech and Language Therapy
SDEC	Same Day Emergency Care
SDHC	Surrey Downs Health and Care
SGH	St Georges Hospital Trust
SHC	Sutton Health and Care
SHMI	Summary Hospital-level Mortality Indicator
SJR	Structured Judgement Review
SNTC	Surgery Neurosciences, Theatres and Cancer
SOP	Standard Operating Procedure
TCI	To Come In
ToC	Transfer of Care
TWW	Two-Week Wait
UCR	Urgent Community Response
VTE	Venous Thromboembolism
VW	Virtual Wards
WTE	Whole Time Equivalent

Group Board Meeting (Public)

Meeting on Friday, 08 May 2026

Agenda Item	3.4
Report Title	**Audit and Risk Committees report to the Group Board**
Non-Executive Lead	Pankaj Davé, Chair of the Audit and Risk Committee
Executive Lead(s)	Stephen Jones, Group Chief Corporate Affairs Officer Lizzie Alabaster, Interim Group Chief Finance Officer
Report Author(s)	Pankaj Davé, Chair of the Audit and Risk Committee
Previously considered by	n/a
Purpose	**For Assurance**

Executive Summary

The report sets out the key issues discussed and agreed by the Audit and Risk Committee at its meeting held on 6 May 2026. The key issues the Committee wishes to highlight to the Board are:

- **External Audit and Year End:** The Committee received updates on the 2025/26 external audit, Annual Accounts, Annual Reports and Quality Accounts. The Committee was assured that audit fieldwork had commenced to timetable, no significant issues had been identified to date, and the draft accounts submitted to NHS England reflected delivery of the agreed financial position.
- **Internal Audit:** The Committee welcomed continued improvement in delivery of the Internal Audit Plan, which remained significantly ahead of previous years. Internal audit reports reviewed included International Recruitment (Reasonable Assurance) and Raising Concerns (Partial Assurance), with the latter highlighting the need for continued work to strengthen organisational speaking up culture and staff confidence in raising concerns. The Committee also received the draft Head of Internal Audit Opinion for both Trusts, which remained at Reasonable Assurance.
- **Risk:** The Committee welcomed continued progress in strengthening the Group's risk management framework, including improvements in the quality, visibility and active management of Corporate Risk Registers. The Committee also noted ongoing work to further develop the Group Board Assurance Framework aligned to the emerging Medium-Term Plan and strategic priorities.
- **Declarations of Interest:** The Committee welcomed strong performance in compliance with declarations of interest arrangements across both Trusts, with the highest compliance rates achieved to date amongst decision-making staff. The Committee endorsed further measures to strengthen assurance and transparency during 2026/27, including sample testing and publication of non-compliance at year end.

Action required by Group Board

The Board is asked to:

a) Note the report of the Audit and Risk Committee and the issues highlighted to the Board by the Committee.

b) Receive the Committees' Annual Report 2025/26
c) Approve the Committees' Terms of Reference
d) Note the Committees' Forward Plan 2026/27

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

Appendices	
Appendix No.	**Appendix Name**
Appendix 1	Audit and Risk Committee Annual Report 2025/26
Appendix 2	Audit and Risk Committee Terms of Reference
Appendix 3	Audit and Risk Committee Forward Plan 2026/27

Implications

Group Strategic Objectives

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

Risks

As set out in paper.

CQC Theme

☐ Safe	☐ Effective	☐ Caring	☐ Responsive	☒ Well Led

NHS system oversight framework

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

Financial implications

As set out in substantive reports presented to the Board.

Legal and / or Regulatory implications

N/A

Equality, diversity and inclusion implications

N/A

Environmental sustainability implications

N/A

Audit and Risk Committee Report to Group Board

Group Board, 08 May 2026

1.0 Purpose of paper

1.1 The gesh Audit and Risk Committee met on 6 May 2026. The Committees agreed to bring the following matters to the attention of the Group Board.

2.0 External Audit

2.1 **External Audit and Year End 2025/26**

2.1.1 The Committee received an update from Grant Thornton on progress with the 2025/26 external audit. The auditors confirmed that audit fieldwork had commenced and outlined the planned areas of focus, including management override of controls, valuation of land and buildings, and revenue recognition. The Committee discussed the audit timetable and the importance of early identification and resolution of any significant issues in advance of final approval of the accounts. The Committee was assured that no issues of concern had been highlighted to date and that work on the audit was progressing well.

2.1.2 As well as receiving an update on the progress of the external audit, the Committee received an update on the preparation of the 2025/26 Annual Accounts for both Trusts. The Committee noted that the draft accounts had been submitted to NHS England on 27 April 2026 and reflected delivery of the forecast financial position agreed with NHS England. The Committee reviewed an analytical summary of the draft accounts and discussed year-end accounting adjustments, noting that some adjustments, including NHS Resolution provisions, were notified nationally late in the process and were outside the direct control of the Trusts. The Committee was assured that these adjustments did not impact the adjusted financial performance position against which the organisations were measured.

2.1.3 The Committee also received updates on the production of the 2025/26 Annual Reports and Quality Accounts. The Committee was advised that work was progressing to timetable with a view to the full drafts being considered by the Audit and Risk Committee on 17 June and Boards on 24 June, ahead of the submission deadline to NHS England of 26 June 2026.

3.0 Internal Audit

3.1 The Committee received a regular report from the Group's internal auditors, RSM UK, reviewed progress against the delivery of the 2025/26 internal audit programme, the commencement of the 2026/27 plan, and the follow up of previous internal audit actions.

3.2 The Committee welcomed the continued progress in delivery of the 2025/26 Internal Audit Plan and the positive engagement between management, the governance team and the internal auditors in supporting delivery of the programme. The 2025/26 plan was significantly further ahead than in previous years, with the plan more balanced through the year. Of the 20-25/26 plans, only one audit, related to risk management, which had commenced in late February 2026 remained ongoing but fieldwork was progressing well and the final report was scheduled to be presented to the Committee in June 2026.

3.3 Since the last meeting of the Committee in February 2026, two internal audit reports had been completed:

- **International Recruitment – Reasonable Assurance.**
  The Committee noted that the audit reviewed the Group's international recruitment arrangements, including the use of third parties, pre-employment and right to work checks, onboarding processes, and the management of Certificates of Sponsorship (CoS), with support from the Counter Fraud team.

  The Committee noted that the audit identified a generally sound framework of controls and governance arrangements supporting international recruitment processes across the Group. Positive findings included the use of established recruitment guidance through the South West London Recruitment Hub, compliance monitoring through recruitment trackers and independent documentation checks, and evidence of regular audit and validation processes. The Committee also noted positive findings in relation to pre-employment and right to work checks, where sample testing identified no issues. The Committee heard that the audit also identified evidence of collaborative working across the wider Integrated Care System, including participation in the International Recruitment Network to support shared learning and awareness of changes in immigration and recruitment requirements.

  The audit identified four medium priority management actions. These related principally to strengthening Standard Operating Procedures and governance documentation, including clearer definition of roles and responsibilities, strengthening escalation processes for visa delays or failed checks, embedding Equality, Diversity and Inclusion and GDPR requirements, and establishing clearer review and audit cycles. The Committee also noted findings relating to the management of signed employment contracts and the need to strengthen clarity regarding submission timescales and escalation arrangements where signed documentation was not returned. In addition, the audit identified the need for clearer visibility and formal recording of compliance arrangements with third-party recruitment agencies in relation to NHS ethical recruitment standards. The Committee noted that the review had also considered arrangements relating to Certificates of Sponsorship and associated assurance processes following previous concerns regarding misuse of Home Office systems. The Committee was advised that additional controls had since been implemented, including strengthened segregation of duties, enhanced checks and tighter monitoring arrangements.

- **Raising Concerns – Partial Assurance.**
  The Committee noted that the audit reviewed arrangements relating to Freedom to Speak Up and wider raising concerns processes, including governance oversight, reporting arrangements, accessibility of routes for staff to raise concerns, management of cases and organisational learning, and the overall speaking up culture. The audit related to SGUH only, but there were wider lessons across the Group.

  The Committee noted that the audit identified positive arrangements in relation to the Freedom to Speak Up Guardian processes as well as around Board, Committee and Executive governance oversight and reporting arrangements. The audit highlighted areas of good practice including accessible and well-publicised reporting routes for staff, established governance structures supporting oversight of concerns raised, regular reporting through governance committees, and evidence of organisational commitment to supporting staff to speak up. The Committee also welcomed the positive findings regarding collaboration between the Freedom to Speak Up function

and other governance functions, including Counter Fraud and HR processes, helping to ensure concerns were appropriately directed and managed.

The partial assurance rating was driven principally by the underlying speaking up culture at the Trust. Here, the speaking up questions in the NHS Staff Survey for both 2024 and 2025 demonstrated that the Trust had work to do to improve staff confidence in speaking up in general and around building confidence that the organisation would respond when staff raised concerns. The Trust was in the third quartile nationally when measured against the "raising concerns sub-score" in the NHS Oversight Framework. The Committee heard that the Group's priorities for responding to the NHS Staff Survey feedback – leadership, behaviours, equality, diversity and inclusion, and staff reward and recognition – would be key in building a stronger speak up culture. Alongside this, the Committee heard that the audit identified a number of opportunities to further strengthen arrangements, including strengthening the capture and dissemination of learning arising from cases, and developing a Group-wide Freedom to Speak Up strategy, building on the existing SGUH strategy, to provide a framework to integrate actions to strengthen speaking up.

3.4 The Committee discussed the overall position regarding internal audit recommendations and noted continuing work to reduce the number of overdue actions. Members reflected that timely completion of agreed audit actions remained an important indicator of organisational governance maturity and control effectiveness. The Committee reiterated the importance of clear Executive ownership and accountability for delivery of management actions arising from audit reviews. The Committee also discussed the importance of ensuring that agreed actions remained realistic, deliverable and improvement-focused, with extensions to implementation timelines kept to a minimum. The Committee was assured that the changes to the Executive governance structures, which now included a monthly focus on risk and compliance, would help deliver an improved position, and the Committee welcomed the commitment from the new Group Chief Executive Officer to improve the position and ensure the Group becomes high performing in relation to audit follow-up.

3.5 The Committee received the draft Annual Internal Audit Report and Head of Internal Audit Opinion for both Trusts. The Committee was advised that the draft opinion for both organisations was Reasonable Assurance, reflecting that the organisations generally had an adequate and effective framework for governance, risk management and control, whilst recognising that further improvements remained required in some areas. The Committee discussed the balance of assurance opinions received during the year, progress made in delivery of the internal audit plan, and the importance of embedding improvements arising from audit work. The Committee welcomed the overall position and noted the progress made in strengthening governance, risk management and oversight arrangements across the Group. The Committee recognised that the Opinions remained draft and were subject to change upon completion of the programme, and looked forward to receiving the final Opinions at its meeting in June 2026.

4.0 Counter Fraud

4.1 The Committee received the Annual Counter Fraud Report and Self-Assessment from RSM. The Committee noted the proactive counter fraud work undertaken during the year across both Trusts, including fraud prevention activity, staff training and awareness work, investigation activity and benchmarking against other NHS organisations. The Committee heard that the annual report reflected continued collaborative working between Counter Fraud, Freedom to Speak Up, HR and governance teams, supporting the identification, escalation and management of concerns raised across the organisation.

4.2 The Committee noted the range of proactive work completed during the year, including work relating to international recruitment processes, procurement and financial controls, cyber fraud awareness and staff education activity. It also reviewed benchmarking information within the report and noted improvements in relation to single tender waivers and procurement-related risks, with performance comparing favourably against benchmarked organisations.

4.3 The Committee discussed the importance of maintaining organisational awareness of fraud risks and continuing to strengthen a culture in which staff felt able to raise concerns appropriately, which from a fraud perspective was seen as strong. The Committee also welcomed the continued focus on prevention, awareness and organisational learning alongside investigation activity and noted the positive collaborative relationship between the Trusts and the Local Counter Fraud Specialist service.

5.0 Risk and Governance

Risk

5.1 The Committee welcomed continued progress in refreshing and aligning Corporate Risk Registers across the Group and noted improvements in the visibility, quality and consistency of risk reporting. The Committee heard that structured reviews of Corporate risks had continued, with ongoing work to strengthen the articulation of risks, controls, mitigating actions and sources of assurance.

5.2 The Committee discussed the importance of ensuring that risk registers remained active management tools supporting operational and strategic decision-making, rather than static reporting documents. Members emphasised the need for clear alignment between risk registers, internal audit findings, performance concerns and wider assurance processes to support a more integrated understanding of organisational risk. The Committee also discussed the importance of strengthening consistency of approach across Divisions and Corporate Services, including supporting greater clarity in risk descriptions, scoring and escalation arrangements.

5.3 The Committee welcomed the progress made in strengthening Executive oversight and visibility of risk and noted that the Corporate Risk Registers now demonstrated greater movement, responsiveness and active management than previously.

5.4 The Committee also noted ongoing work to further develop the Group Board Assurance Framework aligned to the emerging Medium-Term Plan and strategic priorities, recognising the importance of ensuring that principal strategic risks remained current, appropriately articulated and robustly assured.

5.5 The Committee acknowledged that further work remained required to continue embedding risk management arrangements consistently across the organisation, including supporting organisational risk capability and maturity, but welcomed the progress that had been made since the introduction of the new Group-wide Risk Management Framework in March 2025.

Managing conflicts of interest

5.6 The Committee received the annual review of Conflicts of Interest arrangements across both Trusts. In 2025/26, both Trusts had recorded the highest compliance rates achieved to date in ensuring declarations were made by staff classified under Trust policy as ‘decision-making staff’ (all staff at Band 8b and above and all staff in certain teams such as procurement and

governance). At SGUH, 93% of the 1,227 decision-making staff had made either a nil return or an active declaration of interest. This was 2 percentage points higher than the previous year. At ESTH, 94% of the 478 decision-making staff had made the appropriate, an increase of 9 percentage points compared to 2-24/25.

5.7 The Committee welcomed the strong performance over the past year, and commended the work of the governance team and staff across the organisation in engaging positively with the process. The Committee reviewed the planned measures to further improve compliance in 2026/27, to undertake sample testing of declarations, and to have a focus on compliance with declarations involving gifts and hospitality over the coming year. The Committee also endorsed introducing new measures to publish a list of staff members who, at year end, should have made a declaration but had failed to do, which was seen as helping to further strengthen the process.

6.0 Risk and Governance

6.1 The Committee received the Committee's draft Annual Report 2025/26, reviewed proposed minor amendments to the Committee's Terms of Reference and considered the proposed Forward Plan for 2026/27. The changes to the Terms of Reference:

- Clarified the responsibilities between the Audit And Risk Committee and the Infrastructure Committee in relation to oversight of digital, cybersecurity and information governance, with these moving to the Infrastructure Committee from the start of 2026/27, as proposed between the two Committees in the latter part of 2025/26.

- Minor changes to draw out the role of the Committee in relation to overseeing internal audit follow up actions, and in relation to oversight of risk..

6.2 The Committee endorsed these changes, along with the Annual Report and Forward Plan and recommends these to the Board.

7.0 Recommendations

6.1 The Board is asked to:

a) Note the report of the Audit and Risk Committee and the issues highlighted to the Board by the Committee.
b) Receive the Committees' Annual Report 2025/26
c) Approve the Committees' Terms of Reference
d) Note the Committees' Forward Plan 2026/27

Pankaj Davé
Audit and Risk Committee Chair, NED

Group Board Meeting (Public)

Meeting on Thursday, 05 March 2026

Agenda Item	4.1	
Report Title	**People Committees Report to Group Board**	
Non-Executive Lead	Yin Jones, People Committees Chair	
Report Author(s)	Yin Jones, People Committees Chair	
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 April 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:

- NHS Staff Survey 2025: The Committee discussed the results of the 2025 NHS Staff Survey and noted that both Trusts remained below national benchmarks in areas including morale, learning and development, flexible working and recognition, despite staff engagement scores remaining above average. Concerns relating to burnout, leadership behaviours, bullying and inequity of experience for BAME and Disabled staff were highlighted. The Committee welcomed the emerging plans for Group-wide responses to the survey feedback focused around four themes: leadership, behaviours, equality, diversity and inclusion, and staff reward and recognition.

- Talent Management: The Committee discussed the importance of strengthening leadership capability, succession planning and inclusive career development across the Group. Members welcomed ongoing leadership development and Inclusion Board initiatives and emphasised the need for measurable impact on workforce culture and staff experience. The Committee also welcomed the roll out of the new gesh People Management Programme.

- Freedom to Speak Up: The Committee reviewed the themes arising from concerns raised by staff to the Group FTSU Guardian during Q3 and Q4 2025/26, with management conduct and bullying and harassment remaining two consistent themes across the Group. Members discussed concerns relating to psychological safety, delays in investigations and staff confidence in organisational processes, whilst welcoming work to strengthen the Group-wide FTSU approach through the development of a Group FTSU strategy and a structured approach to identifying and disseminating learning from concerns.

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 April 2026.

Committee Assurance	
Committee	People Committees
Level of Assurance	Not Applicable

Appendices	
Appendix No.	**Appendix Name**
Appendix 1	People Committees Annual Report 2025/26
Appendix 2	People Committees Terms of Reference
Appendix 3	People Committees Forward Plan 2026/27

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, 08 May 2026

1.0 Purpose of paper

1.1 This report sets out the key issues considered by the People Committees at its meeting in April 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 20 April 2026, the Committees considered the following items of business:

20 April 2026

- Group Chief People Officer Update
- NHS Staff Survey 2025 Report
- Talent Programme Update
- Staff Health and Wellbeing Report
- Freedom to Speak Up Guardian Report
- Workforce Key Performance Indicators Report
- Covid and Flu Vaccination Programme Update
- Committee Annual Report 2025/26, Terms of Reference Review and Forward Plan

2.2 The Committees, chaired by Yin Jones, meet every two months as agreed by the Group Board. The meeting on 20 April 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) <u>NHS Staff Survey 2025</u>
The Committee reviewed the NHS Staff Survey 2025 results and the proposed corporate response programme. The Committee noted that the survey findings provided a clear and compelling mandate for cultural improvement across the Group and aligned closely with the Care Quality Commission's Well-Led findings and Regulation 17 requirements at St George's. The Committee discussed the headline survey findings in detail. Members noted that both ESTH and STG performed below national averages across a number of key People Promise themes, particularly: learning and development; flexible working; recognition and reward; and staff morale.

The Committee noted that ESTH ranked 13th of 17 London Acute and Community Trusts and St George's ranked 17th of 17 London Acute and Community Trusts overall. The Committee also noted that staff engagement remained a relative strength across both organisations, despite being lower than in 2024, with both Trusts scoring above the national average for staff engagement, reflecting continued commitment from staff to patient care despite operational pressures.

Discussion focused on the significant workforce and cultural themes emerging from the survey, including: workload pressure and burnout; concerns regarding leadership behaviours; perceptions of inconsistent management practice; concerns relating to fairness, career progression and recognition; frustration regarding digital infrastructure and estates issues; staffing pressures and operational workload; and staff concerns regarding organisational change and communication.

The Committee discussed the significant disparities in experience for Black, Asian and Minority Ethnic staff and Disabled staff and the higher levels of harassment reported by BAME and Disabled colleagues compared with national benchmarks. The Committee recognised that these findings reinforced the importance of accelerating work relating to anti-racism, inclusion and civility, leadership behaviours, equitable career progression, and staff voice and empowerment, and wider organisational culture improvement.

The Committee noted the emerging four areas of Group-wide focus in response to the survey, which the Group Executive Committee had agreed, which related to: leadership, behaviours, equality, diversity and inclusion, and staff reward and recognition. The Committee recognised that successful delivery would require sustained organisational focus, improved capacity and shared ownership across all levels of the organisation.

b) Talent Management Programme

The Committee received an update regarding the Group's Talent Programme and discussed the importance of developing a more systematic and inclusive approach to leadership development, succession planning and workforce sustainability across the organisation. The Committee noted that the programme forms a key part of the Group's wider organisational development and culture agenda and is intended to support delivery of the People Strategy, strengthen leadership capability and improve long-term workforce resilience. The Committee reflected that the findings from the NHS Staff Survey reinforced the importance of investing in leadership and talent development, particularly given concerns relating to inconsistent leadership behaviours, inequity in career progression, staff morale and organisational culture.

The Committee noted that the programme includes workstreams relating to inclusive recruitment, leadership and management development, succession planning, career conversations and appraisal, and the Inclusion Board initiative.
Discussion focused particularly on the importance of strengthening leadership capability across all levels of the organisation and ensuring that leadership behaviours are consistent, compassionate and supportive of organisational change.

The Committee also discussed the need to strengthen succession planning arrangements, improve internal progression opportunities and ensure that development opportunities are experienced as transparent and equitable by staff across all professional groups. Members welcomed the continued development of the Inclusion Board initiative and recognised its role in supporting diverse leadership development and improving representation within senior decision-making structures.

The Committee noted ongoing work relating to the rollout of the Group-wide Leadership and People Management programme, multiprofessional leadership development, apprenticeship pathways and organisational development support for challenged services. It also emphasised the importance of ensuring that the impact of talent management activity is measurable over time and linked clearly to improvements in workforce culture, staff experience, retention and organisational performance.

4.0 Key Issues on which the Committees received assurance

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

a) Workforce KPI Report

The Committee reviewed the Workforce KPI Performance Report and discussed workforce performance across key indicators including vacancies, turnover, temporary staffing usage, sickness absence and workforce deployment.

The Committee noted that overall workforce deployment had reduced slightly during February 2026, with reductions in bank and agency usage partially offset by a small increase in substantive staffing. Members welcomed that vacancy and turnover rates remained within agreed thresholds.

Discussion focused particularly on sickness absence and workforce productivity. The Committee noted that, while still high, sickness absence had reduced slightly during the reporting period, although stress and anxiety remained the most significant driver of absence. Members also noted the continued operational impact associated with sickness absence and workforce pressure. The Committee discussed the importance of strengthening attendance management, early intervention and targeted support in areas experiencing workforce challenges. Members also reflected on the need to ensure that workforce metrics are used proactively to support operational improvement and workforce planning.

The Committee noted ongoing work relating to attendance improvement, workforce productivity and development of Group-wide workforce KPIs, and agreed that it had received reasonable assurance regarding workforce performance monitoring and workforce improvement arrangements.

b) Freedom to Speak Up Report

The Committee reviewed the Group Freedom to Speak Up (FTSU) Report for Q3 and Q4 2025/26, which provided a thematic analysis of concerns raised across the Group and highlighted emerging workforce and cultural issues. The Committee noted that 175 concerns had been raised across the Group through the FTSU service during the second half of 2025/26, 90 at SGUH and 85 at ESTH.

The Committee noted that management conduct, bullying and harassment, worker safety and HR policy concerns remained the dominant themes at SGUH while at ESTH the main themes were management conduct, bullying and harassment and discrimination. The report identified a number of contributing factors, including operational pressure on managers, delays in investigations and case handling, gaps in policy understanding and increasing tensions arising from workforce and service pressures. The Committee discussed concerns highlighted within the report relating to:

- prolonged investigation processes;
- lack of timely intervention and accountability;
- perceived inconsistency in the application of HR policies;
- concerns regarding impartiality and trust in organisational processes;
- breaches of confidentiality; and
- the psychological impact of unresolved workplace conflict on staff wellbeing and psychological safety.

Discussion focused on the wider organisational and cultural implications of the themes emerging through the FTSU service. Members reflected that many of the issues identified through FTSU aligned closely with themes emerging from the NHS Staff Survey, particularly in relation to leadership behaviours, workload pressures, bullying and harassment, psychological safety and confidence in organisational responsiveness. The Committee discussed the importance of ensuring effective triangulation between FTSU intelligence, staff survey findings, workforce metrics and wider organisational culture work in order to identify areas requiring early intervention and support.

The Committee welcomed the ongoing development of the Group-wide FTSU approach, including adoption of the national FTSU policy, strengthened triage arrangements and planned development of a Group-wide FTSU vision and strategy. The Committee recognised that, whilst reasonable assurance could be taken regarding the resourcing and operation of the FTSU service itself, it agreed that assurance was limited on the wider speaking up culture across the Group.

5.0 Other issues considered by the Committees

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

a) Staff Health and Wellbeing Report
The Committee reviewed the Staff Health and Wellbeing report and discussed the continued importance of supporting workforce wellbeing in the context of sustained operational pressures, workforce shortages and sickness absence. The Committee recognised the close relationship between staff wellbeing, workforce productivity, retention, staff experience and patient care, and noted the ongoing development of the Group Health and Wellbeing Strategy and wider wellbeing support arrangements. Members discussed the continuing challenge posed by sickness absence, particularly in relation to stress, anxiety and workload pressures, and reflected on the alignment between these issues and themes emerging from the NHS Staff Survey, including burnout, staffing pressures and emotional exhaustion. The Committee also discussed the importance of ensuring that managers are appropriately supported to address attendance, wellbeing and psychological safety issues within teams. The Committee welcomed the continued integration of wellbeing initiatives within wider organisational development and workforce improvement programmes and emphasised the importance of ensuring that staff wellbeing support remains visible and accessible.

a) Transforming People Services:
As part of the Group Chief People Officer's regular update, the Committee was briefed on NHS England's new Transforming People Services programme, which sets out a long-term plan to redesign and modernise HR and people services across the NHS. The programme aims to move NHS people services from fragmented, transactional HR models towards a more standardised, digital-first and strategically focused operating model, making greater use of automation and AI, regional shared services models, harmonised policies and a new "digital front door" for HR services. NHS England identifies significant opportunities to improve staff and manager experience, reduce duplication and release HR capacity away from transactional activity towards workforce transformation, leadership, culture and organisational development. London and the South West have been identified as 'accelerator regions', expected to begin implementation first.

The Committee welcomed the update and sought clarity about what the programme would mean in reality for the Group and how it aligned with the Group's own corporate services transformation programme. The Committee was told that the Group regarded the programme as sound and that it aligned well with organisational priorities around digitisation and consolidation of HR services. The challenge would be to balance local transformation plans with the emerging regional model to avoid undertaking major restructuring activity prematurely. The Committee also enquired about the timeframe for implementation and heard that the programme timetable suggested a go-live date of 2028/29, and suggested that some aspects, such as deployment of digital infrastructure, might be better centrally developed rather than individual organisations developing their own local approaches. While supportive of the direction of travel, the Committee noted risks in relation to reducing frontline HR support, given the record of national digital transformation programmes in the NHS. Overall, however, the Committee welcomed the programme as an opportunity to refocus HR support from transactional work and towards organisational development and cultural change, but likewise noted the significant operational pressures, historic workforce issues and transformational demands on the Group's HR function at the present time.

b) Covid and Flu Vaccination Programme Update

The Committee received the Covid and Flu Vaccination Programme Update for noting. The Committee noted the ongoing arrangements in place to support workforce vaccination uptake and staff protection, particularly in the context of operational resilience and workforce wellbeing. Members recognised the importance of maintaining appropriate vaccination coverage across the workforce in order to support staff health, reduce operational disruption and protect patient safety.

c) Committee Effectiveness 2025/26

The Committee reviewed its Annual Report for 2025/26, refreshed Terms of Reference and Forward Plan for 2026/27. The Committee reflected on the continued development of its role and oversight arrangements over the course of the year, noting the increasing emphasis placed on workforce culture, staff experience, organisational development and workforce sustainability. Members discussed the importance of ensuring that Committee business remains strategically focused and aligned to delivery of the People Strategy, whilst continuing to provide effective assurance regarding operational workforce risks and performance. The Committee noted the intention to streamline the forward plan during 2026/27 in order to support a more focused and outcomes-based approach to assurance. Members welcomed the continued move away from process-driven reporting towards greater emphasis on workforce outcomes, culture and impact.

The Committee approved its Annual Report 2025/26 to the Board, and agreed to propose to the Board some minor amendments to the Committee's Terms of Reference which focus on:

- tidying-up of the purpose and duties of the Committees to reflect the new Group Transformation Programme
- Amendments to the membership of the Committee, reflecting that the Group Chief Finance Officer did not need to be a standing member of the Committee
- Expectations around timeliness of submission of papers.

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 20 April 2026.

People Committees Annual Report 2025/26

1 April 2025 – 31 March 2026

Contents

People Committees Annual Report 2025/26

1. Introduction

Since the formation of the St George's, Epsom and St Helier University Hospitals and Health Group, a number of Board Committees have met as Committees-in-Common across the Group. Since April 2022, this has included the People Committees, Quality Committees, Finance Committees and Remuneration Committees of the two Trusts, with the Infrastructure and Audit and Risk Committees also operating as Committees-in-Common since October 2023 and May 2024 respectively.

The People Committees maintained a bi-monthly cycle of meetings throughout 2025/26, following the introduction of this rhythm of meetings in April 2024. This report sets out a high-level overview of the work of the People Committees-in-Common in 2025/26. It provides an integrated report on the key matters considered by the Committees, highlighting how the Committees have discharged their responsibilities as set out in their terms of reference. Where appropriate, it highlights issues that were considered which related solely to either St George's or Epsom and St Helier. The purpose of this report is not to provide a detailed account of all matters considered by the Committees but to give an overview of how the Committees have discharged their responsibilities as set out in their terms of reference over the past year.

2. Committee purpose and duties

The People Committees of the two Trusts have adopted identical terms of reference in order to ensure that there is consistency of purpose and duties across the two Committees. The Committees' purpose and duties are set out in the terms of reference (appendix 1).

2.1 Purpose

The purpose of each Committee is to provide assurance to the Board – through the Group Board arrangements – on the development and delivery of the Trust's strategy and plans for a sustainable workforce that supports the provision of safe, high quality, patient-centred care and the oversight of strategic risks relating to people by:

- Overseeing and providing assurance to the Board on the implementation of the Group Strategy in relation to people, specifically the Group strategic objective of engaging and empowering staff.
- Overseeing the development of relevant people, culture and organisational development strategies that support the new Group Strategy and monitoring progress in the implementation of these, in the context of the local Integrated Care System(s), the Trust's financial and operational plans, and the national NHS People Plan.
- Monitoring workforce key performance indictors and identifying and reviewing themes and trends, seeking assurance that appropriate action is being taken to respond to and learn from these.
- Overseeing the development of a culture that empowers and supports staff to deliver to their best, including in relation to equality, diversity and inclusion, raising concerns, and staff health and wellbeing.

- Overseeing education, training and development plans.
- Monitoring the Trust's engagement with staff and work to improve engagement.
- Seeking assurance that key risks relating to workforce, culture, equality, diversity and inclusion, as included on the Board Assurance Framework and the Corporate Risk Register, are being effectively managed and mitigated.
- Providing assurance that legal and regulatory requirements relating to the workforce are met.
- Ensuring appropriate governance arrangements are in place in relation to people, culture and organisational development issues and that the Committee is able to provide the Trust Board with assurance on these matters as appropriate.

3. Membership and attendance

3.1 Members and attendees

During the reporting period (April 2025 to March 2026), the following were members or regular attendees of the People Committees-in-Common:

St George's People Committee			
Name	**Role**	**Designation**	**Period**
Yin Jones	Member	Non-Executive Director, Committee Chair (from 1 January 2025)	1 April 2025 – 31 March 2026
Lizzie Alabaster	Member	Group Chief Finance Officer	1 December 2025 – 31 March 2026
Elaine Clancy	Member	Group Chief Nursing Officer	1 October 2025 – 31 March 2026
Pankaj Davé	Member	Non-Executive Director	1 April 2025 – 31 March 2026
Andrew Murray	Member	Non-Executive Director	1 April 2025 – 31 March 2026
Victoria Smith	Member	Group Chief People Officer	1 April 2025 – 31 March 2026
Andrew Grimshaw	Member	Group Chief Finance Officer	1 April 2025 – 30 November 2025
Richard Jennings	Member	Group Chief Medical Officer	1 April 2025 – 31 March 2026
Kate Slemeck	Member	Managing Director – St George's	1 April 2025 – 31 March 2026
Arlene Wellman	Member	Group Chief Nursing Officer	1 April 2025 – 31 August 2026
Luci Etheridge	Attendee	Site Chief Medical Officer	1 April 2025 – 31 March 2026
Nicole Porter-Garthford	Attendee	Group Director of Employee Services	1 April 2025 – 31 March 2026
Stephen Jones	Attendee	Group Chief Corporate Affairs Officer	1 April 2025 – 31 March 2026
Onai Muchemwa	Attendee	Site Director of People – SGUH	1 April 2025 – 31 March 2026

Epsom & St Helier People Committee			
Name	**Role**	**Designation**	**Period**
Yin Jones	Member	Non-Executive Director, Committee Chair (from 1 January 2025)	1 April 2025 – 31 March 2026
Lizzie Alabaster	Member	Group Chief Finance Officer	1 December 2025 – 31 March 2026
Elaine Clancy	Member	Interim Group Chief Nursing Officer	1 October 2025 – 31 March 2026
Pankaj Davé	Member	Non-Executive Director	1 October 2025 – 31 March 2026

Epsom & St Helier People Committee			
Name	**Role**	**Designation**	**Period**
Andrew Murray	Member	Non-Executive Director	1 April 2025 – 31 March 2026
Phil Wilbraham	Member	Associate Non-Executive Director	1 April 2025 – 31 March 2026
Victoria Smith	Member	Group Chief People Officer	1 April 2025 – 31 March 2026
James Blythe	Member	Managing Director – Epsom & St Helier	1 April 2025 – 30 September 2025
Andrew Grimshaw	Member	Group Chief Finance Officer	1 April 2025 – 30 November 2025
Richard Jennings	Member	Group Chief Medical Officer	1 April 2025 – 31 March 2026
Alex Shaw	Member	Managing Director – Epsom & St Helier	1 October 2025 – 31 March 2026
Arlene Wellman	Member	Group Chief Nursing Officer	1 April 2025 – 31 August 2025
Rebecca Suckling	Attendee	Site Chief Medical Officer	1 April 2025 – 31 March 2026
Stephen Jones	Attendee	Group Chief Corporate Affairs Officer	1 April 2025 – 31 March 2026
Nicole Porter-Garthford	Attendee	Group Director of Employee Services	1 April 2025 – 31 March 2026
Steve Russell	Attendee	Site Director of People - ESTH	1 April 2025 – 31 March 2026
Thirza Sawtell	Attendee	Managing Director – Integrated Care	1 April 2025 – 31 March 2026

Members of the St George's University Hospitals NHS Foundation Trust Council of Governors also regularly attended to observe meetings of the People Committees-in-Common during the period, including Jackie Parker, Chelliah Lohendran, Alfredo Benedicto, John Hallmark, and Jane Curley.

3.2 Committee meeting attendance

Under the Committees-in-Common arrangements, the People Committee of each Trust was required to be quorate. The Committee held a total of 6 meetings during the reporting period. Five meetings of the SGUH People Committee were quorate, with February 2026 being inquorate. Four meetings of the ESTH People Committee were quorate, with April 2025 and August 2025 being inquorate.

Attendance			
Name	**Role**	**Trust**	**Attendance**
Yin Jones	Member/Committee Chair	SGUH	5/6
Pankaj Davé	Member	Both	6/6 (SGUH) 3/3 (ESTH)
Andrew Murray	Member	Both	5/6
Phil Wilbraham	Member	ESTH	5/6
James Blythe	Member	Both	6/6
Andrew Grimshaw	Member	Both	2/4
Richard Jennings	Member	Both	5/6
Kate Slemeck	Member	SGUH	3/6
Victoria Smith	Member	Both	5/6
Arlene Wellman	Member	Both	2/3
Elaine Clancy	Member	Both	2/3
Rebecca Suckling	Attendee	ESTH	4/6
Luci Etheridge	Attendee	SGUH	5/6
Stephen Jones	Attendee	Both	4/6

In addition to the above, the Group Chair, Group Chief Executive Officer (GCEO) and Group Deputy Chief Executive Officer (GDCEO) attended some meetings of the People Committees-in-Common during the reporting period.

The following members of the St George's Council of Governors observed meetings of the People Committees-in-Common during this period:

SGUH Governors observing		
Name	Role	Attendance
Alfred Benedicto	Lead Governor	3
John Hallmark	Public Governor, Wandsworth	2
Chelliah Lohendran	Public Governor, Merton	3
Jackie Parker	Public Governor, Wandsworth	4
Jane Curley	Public Governor – Wandsworth	1

4. Committee activity and focus

During 2025/26, the People Committee continued to provide oversight and assurance to the Board on the development and delivery of a sustainable, engaged and high-performing workforce. The Committee met bi-monthly and maintained a structured programme of work aligned to strategic people priorities, regulatory requirements, and key workforce risks.
Across the year, the Committee consistently reported an overall position of reasonable assurance, concluding that core systems of internal control were generally operating effectively, but that improvements were required in several key areas.

A clear theme throughout the year was the distinction between:

- areas where robust controls and established processes provided confidence, and
- areas where delivery depended on cultural change, pace of implementation, or demonstrable impact, where assurance was more limited.

The Committee increasingly focused on the interdependencies between workforce, finance, quality, and culture, particularly in the context of financial recovery, productivity challenges, and system-wide workforce pressures.

4.1 Workforce performance, productivity and affordability

Workforce performance remained a core and recurring focus for the Committee throughout the year. The Committee reviewed monthly workforce KPIs, including:

- vacancy rates
- turnover
- sickness absence
- appraisal and mandatory training compliance
- workforce size and skill mix
- temporary staffing (bank and agency)

Early in the year, the Committee identified significant concern regarding workforce growth beyond funded establishment, with deployment exceeding plan by 868 WTE, and emphasised the need for improved triangulation between workforce and financial data.

Through the middle of the year, the Committee took some assurance from:

- reductions in vacancy rates
- stabilisation of substantive staffing
- reductions in agency and bank usage
- overall reductions in workforce deployment over several months

However, by the latter part of the year, the Committee noted concerns around:

- under-delivery of workforce cost improvement plans (CIP)
- sickness absence remaining above target, with mental health and musculoskeletal conditions prominent drivers
- emerging productivity challenges, with workforce productivity below pre-pandemic levels
- sustained operational pressures reflected in exception reporting and staffing gaps

By year-end, sickness absence had increased further (to c.6.1%), prompting the Committee to request a dedicated deep dive, indicating that this remained an area of concern requiring strengthened grip and targeted intervention.

4.2 Staff experience, engagement and organisational culture

The Committee maintained oversight of staff experience through NHS Staff Survey results and action plans, staff engagement initiatives, and leadership behaviours and organisational culture.

The 2024 Staff Survey demonstrated improvement in engagement and national ranking, with particular strengths in engagement and compassion. However, the Committee identified ongoing gaps in flexible working experience, access to learning and development, appraisal quality, perceptions of safe staffing and workload, and pay satisfaction.

The Committee emphasised the importance of translating survey findings into measurable, locally owned actions, strengthening accountability through KPIs and outcome measures, and ensuring staff could see tangible improvements (“you said, we did”).

Later in the year, the Committee reviewed plans for the 2025 Staff Survey (with focus on participation and engagement) and final response rates and early feedback. The Committee reviewed concerns relating to lower response rates in some parts of the Group, barriers to participation (e.g. lack of protected time, survey fatigue, technical access issues), and the need to maintain trust through visible follow-through on actions.

Overall, the Committee recognised positive trajectory, but did not consider that improvements were yet sufficiently embedded or consistently experienced across the organisation to take a higher level of assurance.

4.3 Equality, diversity and inclusion (EDI)

EDI was a major and increasing focus of Committee scrutiny throughout the year.
The Committee reviewed:

- EDI action plan progress
- Workforce Race Equality Standard (WRES) and Workforce Disability Equality Standard (WDES) data
- inclusion initiatives (e.g. Shadow Board / Inclusion Board)
- staff survey disparities
- pay gap reporting (gender, ethnicity, disability)

Discussions at the Committee in the early part of the year highlighted the need to move from broad action plans to targeted, high-impact interventions to focus on root causes of disparities, not just reporting metrics.

Despite progress in refining the EDI approach, in December 2025 the Committee concluded that delivery was behind plan, with overdue actions, the regulatory context (including Well-Led findings) heightened concern, and there was insufficient evidence of measurable impact

on staff experience. Accordingly, the Committee assigned limited assurance to the EDI action plan.

The Committee reviewed pay gap data in February 2026 and identified:

- structural drivers (e.g. Clinical Excellence Awards)
- the need for improved public explanation and deeper analysis
- ongoing inequalities linked to recruitment patterns and career progression

EDI therefore remained a priority area for strengthened delivery and assurance.

4.4 Speaking up, staff voice and psychological safety

The Committee reviewed reports from the Group Freedom to Speak Up (FTSU) Guardian reports in June and October 2025. The Committee noted improved processes and standardisation and increased staff confidence in raising concerns. However, the Committee made a clear distinction between:

- process assurance in relation to the establishment, configuration and operation of the Group's FTSU Guardian function, on which it took reasonable assurance, and
- outcome assurance in relation to the wider culture of the organisation on speaking up, where the Committee agreed a limited assurance rating.

In relation to concerns raised to the FTSU Guardian, the principal concern for the Committee was the timeliness and effectiveness of resolving concerns, particularly complex or historic cases and the need to ensure concerns were addressed at local level, not escalated unnecessarily. This resulted in a split assurance position, with limited assurance specifically on outcomes and impact. This theme remained consistent throughout the year and represents a key area of organisational learning and cultural development.

4.5 Medical workforce, safety and professional standards

The Committee maintained oversight of:

- medical appraisal and revalidation
- designated body compliance
- Guardian of Safe Working reports
- GMC training survey and medical education

In these areas, the Committee received consistently positive assurance, including high appraisal completion rates, effective revalidation processes, and strong governance arrangements for professional standards. However, safety signals emerged through exception reporting, particularly in acute medicine and high-pressure specialties, concerns about workload, rota design, and staffing levels, and implementation of national requirements (e.g. overtime payment rules).

The Committee interpreted rising exception reporting as a positive indicator of speaking-up culture, but also evidence of ongoing operational pressure and workforce gaps.

The Committee also monitored:

- the Resident Doctors 10-Point Plan
- industrial action risks
- improvements to working conditions and facilities

Overall, assurance in this domain was strong on governance, but qualified by operational pressures affecting staff experience and safety.

4.6 People strategy, transformation and operating model

The Committee oversaw a wide range of strategic programmes, including:

- People Strategy 2024–26 delivery
- People function integration
- workforce controls programme
- performance and development redesign
- people policy harmonisation
- target operating model (TOM) for HR services
- leadership and talent development initiatives

The Committee was supportive of the strategic direction and noted strong governance arrangements, progress in integration of the People function, and development of new operating models and systems. However, a consistent theme was that impact on key workforce metrics was not yet demonstrable (particularly mid-year), further granularity, metrics and evaluation were required, and implementation complexity and pace remained risks.

By February 2026, the Committee welcomed a clearer delivery plan for the final year of the People Strategy, development of performance dashboards, progress in defining the HR target operating model. However, it continued to request further detail and evidence of impact, indicating partial rather than full assurance in this area.

4.7 Strategic risk

In 2025/26, the Committee oversaw the three people risks on the Group Board Assurance Framework, which related to: staff experience and wellbeing (SR12); culture and EDI (SR13); and developing tomorrow's workforce (SR14). All three risks were scored at 20 (5c x 4l) and a "limited" assurance rating at the start of the year. While the Committee monitored these strategic risks in-year, it did not consider that the position warranted either reducing the risk score or increasing the assurance rating.
The key drivers of the elevated risk position included:

- ongoing workforce pressures, including high sickness absence, productivity below pre-pandemic levels, and challenges in delivering workforce cost improvements
- variability in staff experience, despite improvements in staff survey results
- limited progress and impact in EDI delivery, including overdue actions and continued disparities
- concerns regarding the timeliness and effectiveness of resolving staff concerns, particularly through Freedom to Speak Up
- the early stage of impact from major transformation programmes, including the People Strategy

The Committee noted a range of mitigating actions, including delivery of the People Strategy, strengthened workforce controls, policy harmonisation, and a more focused EDI action plan. While these provide confidence in direction of travel, most remain in delivery and have yet to translate into measurable risk reduction.

Overall, the Committee concluded that strategic people risks were well understood and actively managed, but assurance remained limited at a strategic level, with further progress

required to demonstrate sustained improvement. The Committee will continue to focus in 2026/27 on evidencing impact, reducing risk scores, and strengthening alignment between workforce, finance and quality to ensure effective risk mitigation.

5. Overview of assurance

The Committee consistently received reasonable assurance in the following areas:

- Workforce KPI reporting and governance, with improving trends in several indicators
- Medical appraisal, revalidation and designated body compliance, with high completion rates and robust oversight
- Development of group-wide people policies, with good progress in harmonisation
- Health and wellbeing initiatives, with expanded provision and strategic alignment
- Flexible working policy development and implementation plans
- Elements of People function integration and programme governance

These areas were characterised by:

- established frameworks
- clear metrics and reporting
- demonstrable compliance or progress

The Committee identified several areas where assurance was limited or incomplete:

- EDI delivery and impact: Overall assurance was limited due to overdue actions, limited evidence of measurable impact, and ongoing disparities in staff experience.
- Freedom to Speak Up outcomes: While the Committee took reasonable assurance that the FTSU Guardian Service was operating effectively, delays in resolving concerns and variable local resolution meant the Committee took limited assurance on outcomes.
- Workforce pressures and productivity: The assurance position was mixed in the context of sickness absence being above target, under-delivery of workforce CIP, and productivity continuing to be below pre-pandemic levels.
- Transformation impact (People Strategy and programmes): Assurance here was developing, with the Committee noting insufficient evidence of impact on key metrics (particularly mid-year) and reliance on future delivery.

6. Committee Effectiveness

The Committee undertook its annual effectiveness review in February 2026, in line with good governance practice. Feedback was gathered via a survey of Committee members, Executive colleagues and regular attendees.

Overall, respondents considered the Committee to be operating reasonably effectively, with all respondents rating it as either *very effective* or *somewhat effective*. This represents a broadly positive position, although slightly less strong than the previous year, with an even split between these two ratings.

The review identified a number of areas of strength, including:

- effective chairing of meetings, supporting constructive and open discussion
- high-quality contributions from Committee members and attendees, particularly the People function
- improving quality and consistency of papers, with strong examples in staff survey and workforce reporting

- effective oversight of the people function and key workforce issues

A number of opportunities for improvement were also identified:

- strengthening the Committee's focus on people issues in the round, rather than primarily oversight of the HR function
- greater scrutiny of actions arising from staff surveys, including delivery at Group, site and divisional level
- increased focus on key cultural priorities, particularly bullying and harassment and EDI
- clearer articulation of the Committee's role in relation to workforce planning and headcount, and alignment with other Board Committees
- improving clarity and conciseness of papers, including clearer asks of the Committee
- reviewing agenda structure and meeting length, to ensure time is used effectively

Respondents considered that the Committee has an appropriate membership with the necessary skills and experience. The Committee considered that the Group Chief Finance Officer did not need to be a member of the Committee, but instead decided that a representative from finance should attend where specific items warranted this.

The Committee has agreed that the findings of the review will inform updates to its terms of reference, refinement of its forward workplan for 2026/27, and a continued focus on strengthening assurance and effectiveness.

7. Committee Forward Plan and Terms of Reference

The terms of reference for the Committee has been reviewed in the context of the Committee annual effectiveness review, and developments within the organisation and externally. No major changes are considered to be necessary and, overall, the terms of reference is considered to be fit for purpose. There are some minor amendments which are recommended to the Committee, which are set out as track changes in Appendix 2:

- Membership and attendance:
    - In line with the discussion on Committee effectiveness in February 2026, the ToR has been updated to remove from the membership the Group Chief Finance Officer. The GCFO was, in practice, not a regular attendee at the Committee, and the Committee felt that the GCFO's membership was not required and that, where there were specific items that warranted the GCFO's attendance the GCFO or senior member of the finance team would be invited to the meeting.
    - The list of regular attendees at the Committee has been refreshed to reflect the roles across the senior leadership of the HR department.
- Meeting arrangements: Further to the discussion in February, a line has been added to the ToR making clear the expectations that papers are circulated on time, with late papers to be accepted only with the agreement of the Chair.
- Purpose and duties: A tidying-up of the purpose and duties of the Committees is proposed to reflect the Board's decision to close the nine Strategic Initiatives in the Group Strategy and replace these with the 13 workstreams of the new Group Transformation Programme. The existing ToR refers to the Committee's work in overseeing the two Strategic Initiatives related to people (i.e. the High Performing Teams, and Transforming our Culture Strategic Initiatives). As these have now been replaced by the Transformation Programme, the ToR has been updated to remove

references to the Strategic Initiatives. Instead, a reference has been added to the role of the Committee in seeking assurance in relation the people related aspects of the Transformation Programme.

The Committee Forward Planner will require further refinement to extend this to cover the December 2026 and February 2027 meetings but has been produced to ensure the Committee maintains a strategic focus and to introduce a core theme for each meeting. As the current People Strategy runs to the end of 2026, work is underway to develop a successor strategy and the intention is to structure the December 2026 and February 2027 meetings on the basis of the new strategy. Items may be added to individual agenda or the forward planner during the year to meet the operational and strategic needs of the Group and individual sites. The forward planner will regularly be kept under review by relevant executive and non-executive directors in collaboration with the Corporate Governance Team.

8. Conclusion

During 2025/26, the People Committee maintained oversight of a broad and complex people agenda, with a structured programme of work covering workforce performance, staff experience, culture, EDI, and strategic transformation.

Over the course of the year, the Committee received reasonable assurance in a number of areas, particularly where established controls, regular reporting and clear governance arrangements were in place, including workforce KPIs, medical workforce governance, and aspects of policy development and implementation.

The Committee also noted that a number of significant programmes and initiatives are underway to address longer-term workforce challenges, including delivery of the People Strategy, development of the People function, and targeted interventions to improve staff experience and inclusion.

However, in some areas, particularly those relating to culture, EDI, staff voice, and aspects of workforce performance, the Committee recognised that progress is still developing, and that further work is required to demonstrate consistent and measurable impact. Strategic people risks remained elevated throughout the year, reflecting the scale and complexity of these challenges.

Overall, the Committee considers that the organisation has appropriate plans and governance in place, and that there is a clear direction of travel. The Committee will continue to monitor progress closely in 2026/27, with a particular focus on evidencing impact, strengthening assurance, and supporting delivery of sustained improvement across the people agenda.

People Committee

Terms of Reference

1. Name

The Committee shall be known as the “People Committee”.

2. Establishment and Authority

The Committee is constituted as a committee of the Board of Directors and is authorised by the Board to:

i. Act within its terms of reference.
ii. Seek any information it requires, and all staff are required to cooperate with any request made by the Committee.
iii. Instruct professional advisors and request the attendance of individuals and authorities from outside the Trust with relevant experience and expertise if it considers this necessary or expedient to the carrying out of its functions.
iv. Obtain such internal information as is necessary and expedient to the fulfilment of its functions.

3. Purpose

The purpose of the Committee is to provide assurance to the Board on the development and delivery of a sustainable, engaged and empowered workforce that supports the provision of safe, high quality, patient-centred care by:

- Overseeing and providing assurance to the Board on the implementation of the Group Strategy in relation to people.
-
- Overseeing the development of relevant people, culture and organisational development strategies that support the new Group Strategy and monitoring progress in the implementation of these, in the context of the local Integrated Care System(s), the Trust’s financial and operational plans, and the national NHS People Plan.
- Monitoring workforce key performance indictors and identifying and reviewing themes and trends, seeking assurance that appropriate action is being taken to respond to and learn from these.
- Overseeing the development of a culture that empowers and supports staff to deliver to their best, including in relation to equality, diversity and inclusion, psychological safety and raising concerns, and staff health and wellbeing.
- Seeking assurance in relation to education, training and development plans.

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- Seeking assurance in relation to improving staff engagement.
- Seeking assurance that key risks relating to workforce, culture, equality, diversity and inclusion, as included on the Group Board Assurance Framework and the Corporate Risk Register, are being effectively managed and mitigated.
- Providing assurance that legal and regulatory requirements relating to people issues are met.
- Ensuring appropriate governance arrangements are in place in relation to people, culture and organisational development issues and that the Committee is able to provide the Trust Board with assurance on these matters as appropriate.

4. Duties

The Committee's duties as delegated by the Trust Board, include:

Workforce Strategy and planning

- Overseeing and providing assurance to the Board on the implementation of the Group Strategy in relation to people, specifically the Group strategic objective of engaging and empowering staff by:
  - Getting the basics right (payroll, recruitment, employee relations, good people management practice);
  - Putting staff experience and wellbeing at the heart of what we do;
  - Fostering an inclusive culture that embeds our values;
  - Developing tomorrow's workforce;
  - Working differently ('flexible by default', digitally-supported working, leaders, continuous improvement).
- Monitoring the implementation of relevant people, culture and organisational development strategies that support the new Group Strategy, in the context of the local Integrated Care System(s), financial and operational plans, and the national NHS People Plan including:
  - Implementation and delivery of the People Strategy 2024-26
  - Development of a People Strategy beyond 2026
- Overseeing and seeking assurance around the transformation programme as it relates to people and culture, including in relation to clinical workforce transformation, the development of a quality management system, and the people aspects of the operating model.
- Reviewing and seeking assurance in relation to risks to the delivery of the Group's people strategy and related Trust plans.

Workforce performance, themes and trends

- Reviewing themes and trends in relation to relevant workforce performance indicators and seeking assurance on actions to improve performance, and escalating issues to the Board as appropriate. This includes: recruitment and retention, vacancy, turnover, sickness absence, use of bank and agency staff,

appraisal rates, mandatory and statutory training (clinical and non-clinical), and employee relations.

- Seeking assurance in relation to the experience of junior medical staff and actions to drive improvements, including receiving reports from the Guardian of Safe Working.

Staff engagement and wellbeing

- Seeking assurance on plans to improve engagement with staff, with the aim of securing increasing levels of staff engagement.
- Reviewing the results of the annual NHS staff survey and seeking assurance in relation to the development and implementation of action plans to address issues identified.
- Seeking assurance in relation to the effectiveness of the Group's arrangements to support staff health and wellbeing.

Culture, Equality, Diversity and Inclusion

- Seeking assurance in relation to development and delivery of action plans to strengthen culture, equality, diversity and inclusion and monitoring performance in relation to equality indicators drawing relevant issues to the attention of the Board.
- Monitoring and providing assurance to the Board on the actions taken to comply with the Equality Act 2010 in relation to staff. The Quality Committee will monitor the compliance with the Equality Act 2010 in relation to patients.
- Overseeing actions to comply with relevant regulatory frameworks relating to equality, diversity and inclusion.
- Receiving regular reports relating to equality, diversity and inclusion, and reviewing prior to consideration by the Board:
    - the Workforce Race Equality Standard (WRES) and improvement action plans.
    - the Workforce Disability Equality Standard (WDES) and improvement action plans.
    - The Trust's performance in relation to the gender pay gap and the ethnicity pay gap.
- Reviewing the key trends and themes arising from concerns raised by staff, including receiving regular reports from the Freedom to Speak Up Guardian.

Education and Organisational Development

- Overseeing and seeking assurance in relation to the development and implementation of strategies and plans for education, training and development across the Trust and in partnership with other organisations.
- Overseeing and seeking assurance in relation to the Trust's plans for leadership and organisational development.

General

- Referring any matter to any other Board Committee and respond to items referred to the Committee from other Board Committees.
- Obtaining assurance on the strategic risks to delivery of the strategic objectives in relation to workforce, organisational development, culture, and equality and diversity with a particular focus on issues that are cross-cutting or trust-wide, or specific issues which should be reviewed at the committee.
- Reviewing material findings arising from internal and external audit reports covering matters within the Committee's remit and seek assurance that appropriate actions are taken in response.
- Ensuring there is a system in place to review and approve relevant policies and procedures that fall within the remit of the Committee.
- Receiving and review reports on significant concerns or adverse findings highlighted by regulators, peer review exercises, surveys and other external bodies in relation to areas under the remit of the Committee, seeking assurance that appropriate action is being taken to address these.
- Reviewing any Trust strategies prior to approval by the Board (if required) and monitor their implementation and progress.

5. Membership and Attendance

A non-executive director will be Chair of the Committee and in his/her absence, an individual will be nominated by the remaining members of the Committee to chair the meeting.

The Group Chief People Officer is the executive lead for the Committee.

Membership of the Committee comprises:

- Four Non-Executive Directors (including the Chair)
- Group Chief People Officer
- Group Chief Nursing Officer
- Group Chief Medical Officer
- Managing Director(s)

The following are expected to attend but will not be counted towards quoracy.

- Group Director of Culture and Organisational Development
- Group Director of Employee Services
- Site Director of People
- Group Chief Corporate Affairs Officer
- Group Chief Communications and Engagement Officer

Other directors and staff may attend meetings when specific items are on the agenda and / or with the prior permission of the Chair.

An attendance register will be held for each meeting and an annual register of attendance will be set out in the Trust's Annual Report.

All members and attendees named above are expected to attend every meeting with a minimum attendance of 75% over the course of a financial year.

6. Quorum

The quorum for any meeting of the People Committee shall be a minimum of four members of the Committee including:

- At least two Non-Executive Directors
- At least two Executive Directors

Non-quorate meetings: Non-quorate meetings may go ahead unless the Chair decides not to proceed. Any decision made by the non-quorate meeting must however be formally reviewed and ratified at the subsequent quorate meeting or the Board.

7. Accountability and Reporting Arrangements

The People Committee operates under the delegated authority of the Board of Directors and remains ultimately accountable at all times to the Trust Board of Directors.

Under the Group Board arrangements, the People Committee, acting as part of a Group-wide People Committees-in-Common, will report to the Group Board on the meetings that have taken place since the last Group Board meeting. This will include:

- A list of all items considered by the Committee-in-Common during the relevant period
- Key issues for escalation to the Group Board
- Key issues on which the Committee-in-Common received assurance
- Other issues considered by the Committee-in-Common
- Review of risks assigned to the Committee-in-Common

8. Meeting Format and Frequency

The Committee will meet bi-monthly (every other month) and ahead of Group Board meetings so that a report to the Group Board can be provided and any advice on material matters given. Additional meetings may be called by the Chair as necessary, who may also cancel or rearrange meetings in exceptional circumstances.

9. Declarations of Interest

All members of the Committee must declare any actual or potential conflicts of interest. These will be recorded in the minutes.

Anyone with a relevant or material interest in a matter under consideration may be excluded from the meeting for the duration of the relevant item.

10. Meeting Arrangements and Secretariat

The Group Chief Corporate Affairs Officer will ensure secretarial support is provided for the People Committee. This will include the following;

- Preparing a forward plan for the Committee.
- Calling for, collating and distributing meeting papers.
- Taking accurate minutes.
- Producing an action log and chasing completion of actions.

The agenda for the meeting will be agreed in advance with the Committee Chair, based on the forward plan and in conjunction with the executive lead.

All papers and reports to be presented at the Committee must be approved by the relevant executive director.

The agenda and papers for the meeting will be circulated not less than five working days before the meeting. Papers submitted after the deadline will be accepted only with the agreement of the Committee Chair.

11. Review of Committee effectiveness and Review of Terms of Reference

The Committee shall undertake an annual review of effectiveness, the results of which will be considered by the Committee and will be presented, in summary, to the Group Board.

These Terms of Reference shall be subject to an annual review. Any changes to these Terms of Reference may only be made by the Group Board following review by the Committee.

Document Control

Profile	
Document name	People Committee Terms of Reference
Version	1.3
Executive Sponsor	Group Chief People Officer
Author	Group Chief Corporate Affairs Officer
Approval	
Date of Committee approval	20 February 2025
Date of Trust Board approval	6 March 2025
Date for next review	April 2026

People Committees

Draft Forward Planner 2026-27

Standing Items for Each Meeting	
Item	**Source/Author**
Welcome and Apologies	Committee Chair
Declarations of Interest	All members
Minutes of previous meeting	Committee Chair
Action Log and Matters Arising	Committee Chair
Group Chief People Officer Update Report	Victoria Smith, GCPO
New Risks and Issues for Escalation to Board or Regulators	Committee Chair
Draft Agenda for next meeting and Forward Plan	Committee Chair
Reflections on Meeting	All
Any Other Business	Committee Chair

Monday 20 April 2026 Papers to be submitted by 13 April 2026		
Items for review / assurance	**Exec Lead**	**Board Y/N**
Workforce Performance Report	GCPO	N
Staff Experience and People Strategy Focus: Inclusive Culture, Values and Wellbeing		
Inclusive Talent Programme	GCPO	N
NHS Staff Survey 2025	GCPO	Y
Staff Health & Wellbeing Report	GCPO	N
Freedom to Speak Up Guardian Report	GCCAO / GFTSUG	Y
Committee Planning 2026/27 • Committee Annual Report 2025/26 • Terms of Reference Review • Committee Forward Plan 2026/27	GCCAO	Y
Items for note		
Covid and Flu Vaccination Programme Update	GCNO	N

Thursday 18 June 2026 Papers to be submitted by 11 June 2026		
Items for Review/Assurance	**Exec Lead**	**Board Y/N**
Workforce performance report	GCPO	N
Staff Experience and People Strategy Focus: Getting The Basics Right		
Employee Relations - Sickness absence focus	GCPO	N
MTP – Temporary Staffing focus	GCPO	N
Job Evaluation	GCPO	N
People Policies	GCPO	N
NHS 10 Point Plan for Improving Resident Doctors' Working Lives	GCMO	N
Medical Revalidation Report Q3/Q4 and Annual Report 2025/26	GCMO / Site ROs	Y
Guardian of Safe Working (GoSW) Q4	GCMO	N
Corporate Risk Register	GCCAO	Y
Business Assurance Framework (BAF)	GCCAO	Y

Items for Note		
Facility Time Reporting	GCPO	N

20 August 2026 Papers to be submitted by 13 August 2026		
Items for Review/Assurance	**Exec Lead**	**Board Y/N**
Workforce Performance Report	GCPO	N
Staff experience and People Strategy Focus: Improving learning and wellbeing		
Staff Wellbeing (OH, Staff Support, H&WB)	GCPO	N
Sexual Safety	GCPO	N
Violence & Aggression	GCPO	N
Flexible Working	GCPO	N
Reward & Recognition	GCPO	N
Workforce Race Equality Standards (WRES) for publication	GCPO	Y
Workforce Disability Equality Standards (WDES) for publication	GCPO	Y
Freedom To Speak Up – Q1 2026/27 Report and Annual Report	GCCAO / GFTSUG	Y
Guardian of Safe Working, Q1 2026/27 and Annual Report 2025/26	GCMO / Site ROs	N
Items for Note		
Staff Survey – NSS 2026 planning	GCPO	N

22 October 2026 Papers to be submitted by 15 October 2026		
Items for Review/Assurance	**Exec Lead**	**Board Y/N**
Workforce Performance Report	GCPO	N
Staff Experience and People Strategy Focus: Embracing Integrated Ways of Working		
gesh EDI action plan - Equality Delivery System (EDS) 2025 - Public Sector Equality Duty (PSED) 2025	GCPO	Y
Group working update	GCPO	N
Merger Organisation Design	GCPO	N
Transformation - Quality Management System	GDCEO / GDS	N
General Medical Council National Training Survey	GCMO	N
Freedom To Speak Up – Q2 2026/27 Report	GCCAO / GFTSUG	Y
Guardian of Safe Working Q2 2026/27	GCMO (ESTH & SGUH GOSW)	N
NMC Annual Revalidation Report	GCNO	Y
Corporate Risk Register	GCCAO	Y
Business Assurance Framework (BAF)	GCCAO	Y
Items for Note		
Covid and Flu Vaccination Programme Update	GCNO	N
Staff survey – NSS 2026 planning	GCPO	
Education Update: Undergraduate Medical Education	GCMO	

Group Board Meeting (Public)

Meeting on Friday, 08 May 2026

Agenda Item	4.2	
Report Title	2025 Staff Survey and Response	
Executive Lead(s)	Victoria Smith, Group Chief People Officer	
Report Author(s)	Tairu Drameh, Head of Culture and Staff Engagement	
Previously considered by	People Committees	20 April 2026
Purpose	**For Review**	

Executive Summary

The 2025 NHS Staff Survey results for St George's and Epsom & St Helier show that colleagues remain highly committed to patient care, with both Trusts achieving a staff engagement score of **6.81** which is above the national average of **6.74**. This reflects that our staff are motivated and proud of the care they provide.

The survey also highlights areas where improvement is required to ensure all colleagues have a positive and supportive experience at work. Both Trusts scored below national averages in key areas such as:

- **Learning and Development** (ESTH: 5.47; STG: 5.45 vs national 5.57)
- **Flexible Working** (ESTH: 6.09; STG: 5.93 vs national 6.22)
- **Recognition and Reward** (ESTH: 5.85; STG: 5.76 vs national 5.87)
- **Morale** (ESTH: 5.80; STG: 5.71 vs national 5.84)

Across both Trust, the benchmarked questions, show that the biggest gaps in performance against the national averages are in health and well-being (STG: 48.19%, ESTH: 47.22%), pay (STG: 28.21, ESTH: 28.32%), flexible working (STG: 52.12, ESTH: 53.45%), and discrimination (STG: 12.70%, ESTH 10.39%). ESTH also shows substantial deficits in career development (45.98%) and support to develop potential (50.32%) (see table 2).

Within London, both Trusts sit in the lower quartile of Acute and Community providers, with ESTH ranked **13th of 17** and St George's ranked **17th of 17** based on overall performance across the People Promise themes.

Free-text feedback from both sites highlights significant concerns regarding the reliability of IT and digital infrastructure, with outdated and frequently failing systems creating operational delays, increasing administrative burden, and posing perceived risks to patient safety. Staff also highlighted

longstanding estates and facilities issues, including inadequate equipment, insufficient devices to support digital workflows, poor environmental conditions, and a lack of appropriate staff spaces.

The results also highlight disparities in experience for some staff groups. Harassment levels for Disabled staff (ESTH: 29.26%; STG: 31.21%) and for Black, Asian and Minority Ethnic staff (ESTH: 27.03%; STG: 28.05%) are above national benchmarks. In addition, only **67.19%** of Disabled colleagues reported receiving the reasonable adjustments they need, compared with a national average of **73.92%**.

These findings align with the Care Quality Commission's Well-Led recommendations for St George's, particularly the need to strengthen how staff feedback informs cultural improvement. The organisational response focuses on meaningful engagement, leadership development, and creating a more inclusive and equitable working environment. Targeted support will be provided to 20 services with the lowest engagement scores, and quarterly national pulse surveys will track progress from April 2026.

Overall, the survey provides a clear opportunity to build on strengths, address concerns raised by staff and ensure that improvements in culture and leadership translate into better experiences for both colleagues and patients.

Action required by Group Board

The Board is asked to:

a. **To note** the analysis of the 2025 Staff Survey.
b. **To agree** the engagement plan for 2026, as outlined in Appendix B.

Committee Assurance	
Committee	Group Board (Public)
Level of Assurance	Not Applicable

Appendices	
Appendix No.	**Appendix Name**
Appendix 1	Appendix A: Retrospective assessment – 2024/25 Activities
Appendix 2	Appendix B: Corporate action plan – 2026 focus
Appendix 3	Appendix C: Teams with low survey respondents (No survey reports)

Implications

Group Strategic Objectives

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

Risks

The survey highlights risks related to morale, leadership capability, equality of experience, and workforce sustainability.

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

Some improvement activities may require investment, particularly in leadership development and staff wellbeing.

Legal and / or Regulatory implications

The organisational response supports compliance with CQC Well-Led requirements, including the Regulation 17 notice for St George's.

Equality, diversity and inclusion implications

The findings reinforce the need to accelerate work on inclusion, particularly around harassment, career progression, and reasonable adjustments.

Environmental sustainability implications

No direct environmental implications identified.

2025 Staff Survey and Corporate Response
Group Board, 08 May 2026

1.0 Purpose of paper

1.1 To present the 2025 Staff Survey results for the group (ESTH and STG), outline the corporate and local organisational response, and seek executives and Board approval for the proposed systemwide cultural improvement approach aligned with CQC Regulation 17 requirements

2.0 Background

2.1 The 2025 Staff Survey results were published nationally on 13 March 2026

2.2 This report builds on the update presented to GEC in February 2026 and provides detailed benchmarking against national, London Acute/Community, and peer Trusts. It integrates quantitative theme scores, WRES/WDES indicators, and qualitative free-text analysis to provide a comprehensive view of staff experience.

2.3 The findings reinforce themes raised by the CQC Well-Led inspection at St George's, including the need for stronger leadership behaviours, improved staff voice, and more consistent cultural practices across the Group. The report sets out the corporate actions required to address these issues and meet regulatory expectations.

3.0 [Key issues for consideration]

3.1 Both ESTH and STG score below national averages in learning and development, flexible working, recognition, and morale. STG faces deeper challenges, ranking last among London Acute and Community Trusts.

3.2 The survey highlights significant disparities for BAME and Disabled staff, including higher harassment rates and a *"6.7% gap in reasonable adjustments."*

3.3 Free-text feedback reveals widespread concerns about workload, burnout, inconsistent leadership behaviours, and perceptions of "top-heavy" management structures.

3.4 The Trust must demonstrate how staff feedback is used to improve culture and measure impact. The proposed corporate response directly supports this requirement.

3.5 Delivery of the improvement programme is at risk without strengthened capacity, prioritisation, and shared ownership across divisions.

4.0 Sources of assurance

4.1 The survey uses the NHS Staff Survey Coordination Centre methodology, providing robust, comparable data across Trusts.

4.2 The corporate response to the survey will follow the **Board-agreed** approach to driving improvement and sustainable cultural change

4.3 The report triangulates theme scores, WRES/WDES indicators, and free-text analysis - “The quantitative benchmark scores validate the qualitative themes.”

4.4 Divisional Management Boards, HRBP-led working groups, and site-level engagement groups are already reviewing results and developing action plans.

4.5 The Staff Engagement Working Group will provide structured diagnostics, leadership support, and monthly pulse monitoring for 20 challenged services.

4.6 From April 2026, quarterly pulse surveys will provide ongoing measurement of progress at Trust, Directorate, and Service level.

5.0 Implications

5.1 The implications of the findings from the 2025 staff survey are as follows.

- **Strategic implications:** The findings directly impact the Group’s strategic objective of having “empowered, engaged staff” and are essential to delivering safe, high-quality care.
- **Financial implications:** Resource constraints may limit delivery of leadership development, engagement activities, and targeted support. Investment may be required to meet CQC expectations and mitigate workforce risks.
- **Legal and regulatory implications:** The report supports compliance with CQC Regulation 17. Persistent WRES/WDES disparities and gaps in reasonable adjustments pose potential legal risks.
- **Risk implications:** The survey highlights risks related to morale, burnout, leadership capability, equality of experience, and operational fragmentation. The survey also provides early warning signals about pressures that can undermine safe and effective care.
- **Equality, diversity and inclusion implications:** Significant disparities for BAME and Disabled staff require accelerated action, including anti-racism work, inclusive recruitment, and improved reasonable adjustments.
- **Environmental sustainability implications:** No direct environmental implications identified.

6.0 Recommendations

6.1 The Board is asked to:

a. **To note** the analysis of the 2025 Staff Survey.

b. **To agree** the engagement plan for 2026, as outlined in Appendix B.

Report Title: 2025 Staff Survey and Corporate Response

Date: 19 March 2026

Author: Tairu Drameh. Head of Culture and Staff Engagement

1. Introduction

This report offers a detailed comparison of the 2025 NHS Staff Survey results for St George's Hospital (STG) and Epsom and St Helier Hospital (ESTH) against national and London benchmarks. The analysis examines performance across key domains of the NHS People Promise, staff engagement and morale, and workforce equality standards.

Staff engagement and morale remain fundamental to clinical safety; extensive research shows that highly engaged teams deliver better patient outcomes and experience lower turnover. This report integrates quantitative theme scores with Workforce Equality Standards (WRES/WDES) data and qualitative free-text insights to provide a comprehensive view of staff experience. These findings will directly shape our cultural and engagement priorities for 2026/27.

2. Benchmark of gesh survey scores against the national average

The table below compares the performance of STG and ESTH against the national average for Acute and Acute & Community Trusts. Our corporate actions and initiatives are designed to exceed national benchmarks, and move both organisations closer to the scores demonstrated by high-performing Trusts.

Table 1: gesh against national average 2025

People Promise Theme	ESTH Score	STG Score	National Average	Preliminary Insight
We are Compassionate and Inclusive	7.21	7.17	7.28	ESTH and STG both sit slightly below the national average, suggesting that staff do not consistently experience compassionate and inclusive cultures across either organisation.
We are Recognised and Rewarded	5.85	5.76	5.87	ESTH and STG both score slightly below the national average, indicating lower levels of reported recognition and reward across both organisations.
We Each Have a Voice That Counts	6.58	6.56	6.60	ESTH and STG are closely aligned and sit just below the national average, indicating similar levels of reported voice across both organisations.
We are Safe and Healthy	6.14	5.98	6.07	ESTH is slightly above the national average, while is slightly below, indicating differing levels of reported safety and wellbeing

People Promise Theme	ESTH Score	STG Score	National Average	Preliminary Insight
				across the two organisations.
We are Always Learning	5.47	5.45	5.57	ESTH and STG both score below the national average, indicating lower reported levels of learning and development across both organisations.
We Work Flexibly	6.09	5.93	6.22	ESTH and STG both score below the national average, indicating lower reported levels of flexible working across both organisations.
We are a Team	6.65	6.66	6.75	ESTH and STG are close to the national average of 6.75, indicating similar reported levels of teamwork across both organisations.
Staff Engagement	6.81	6.81	6.74	ESTH and STG both score, above the national average, indicating higher reported levels of staff engagement across both organisations.
Morale	5.80	5.71	5.84	Both trusts sit slightly below national morale levels, with STG lower, indicating pressure and workload concerns.

Insights

Across the People Promise themes, ESTH and STG show a mixed position against national benchmarks: both trusts score below national levels for flexible working and morale, sit close to national levels for teamwork, and exceed the national average only on staff engagement.

As part of our response to these results, staff survey feedback is being directly integrated into the Clinical Workforce Transformation Programme, with a focus on strengthening management practices and improving feedback loops across both organisations.

3.1 Biggest negative disparity against the national benchmark

4 Table 2: Questions with the largest negative gaps for gesh against national average

Survey Question	STG 2025	STG Disparity	ESTH 2025	ESTH Disparity	National Avg.
Q11a – Organisation takes positive action on health & well-being	48.19%	**–4.97%**	47.22%	**–5.94%**	53.16%
Q4c – Satisfaction with level of pay	28.21%	**–3.24%**	28.32%	**–3.13%**	31.45%

Survey Question	STG 2025	STG Disparity	ESTH 2025	ESTH Disparity	National Avg.
Q4d – Satisfaction with flexible working opportunities	52.12%	**–3.82%**	53.45%	**–2.49%**	55.94%
Q16b – Experienced discrimination from manager/colleagues (lower is better)	12.70%	**+4.01%**	10.39%	**+1.70%**	8.69%
Q24b – Opportunities for career development	48.78%	1.61%	45.98%	**–4.41%**	50.39%
Q24d – Supported to develop potential	51.89%	-2.17%	50.32%	**–3.74%**	54.06%

Insights

Overall, the areas identified in Table 2 represent the most material negative drivers of staff experience within gesh. The findings highlight systemic challenges across both STG and ESTH in relation to inclusion, staff support, and development. Rightfully, these are the areas that our corporate actions seek to address.

3. Where we rank in the London acute and community league table

This section ranks gesh against top and bottom 17 London Acute and Community trusts based on their **Overall Performance Score** (calculated as the mean of all 7 People Promise themes plus Staff Engagement and Morale). The London Acute and community Trusts Average is **6.41**.

Table 3: ESTH and STG ranking against the top and bottom London Acute and Community Trusts

Rank	Trust Name	Overall Performance	Performance Category
1	Guy's and St Thomas' NHS Foundation Trust	6.69	Top Performer
2	University College London Hospitals NHS Foundation Trust	6.69	Top Performer
13	**Epsom and St Helier University Hospitals**	**6.29**	Lower Quartile
16	King's College Hospital NHS Foundation Trust	6.24	Bottom Performer
17	**St George's University Hospitals**	**6.23**	Bottom Performer

3.1 Performance: gesh vs. London average

The table below provides a concise analysis of how **ESTH** and **STG** compare to the wider London Acute/Community peer group.

Table 4: gesh performance benchmarked against London Acute and Community average

Feature	ESTH	STG	Insight
Overall Rank	**13th** of 17	**17th** of 17	Both trusts sit in the bottom quartile of London providers.
Primary Strength	**Health & Safety** (6.14) vs London Avg.: 6.11	**Teamwork** (6.66) vs London Avg.: 6.81	ESTH is the only trust in this comparison to outperform the London average in any category (+0.03 in Safety).
Primary Weakness	**Learning & Dev** (5.47)	**Learning & Dev** (5.45)	Professional development is the largest deficit for both trusts vs. the London average: 5.79 (-0.32 to -0.34).
Morale Variance	-0.11 vs. London Avg.: 5.91	-0.20 vs. London Avg.: 5.91	STG faces a significantly deeper morale challenge, scoring the lowest in this comparison group.
Work Flexibility	6.09 (Near London Avg.: 6.12)	5.93 (Well below London Avg.: 6.12)	Flexibility is a major drag on STG ranking; ESTH is much closer to the regional norm.
Staff Engagement	6.81 (London Avg.: 6.93)	6.81 (London Avg.: 6.93)	Despite different rankings, both our trusts share an identical engagement score, suggesting that there is opportunity for improvement at both Sites.
Strategic Gap	**-0.12** from Avg.	**-0.18** from Avg.	STG requires nearly double the improvement of ESTH to reach the regional performance mean.

Insights

- **ESTH:** The data suggests we have a stable environment regarding physical safety and flexibility, but we do need to focus on "Always Learning" theme to move up the rankings.

- **STG:** Our bottom ranking is driven by a combination of low flexibility and poor morale. Addressing issues relating to adequate materials, supplies and equipment and intention to leave within the next 12 months is essential to closing the 0.18 gap to the London average.

- The results indicate that **'We Are Always Learning'** remains one of our lowest-scoring People Promise elements, with theme scores of **5.47 (ESTH)** and **5.45 (STG)**, both sitting below the national average of **5.57**. This indicates that colleagues are not consistently experiencing the learning and development culture needed to underpin effective Quality Improvement (QI) and the Quality Management System (QMS). Given the importance of learning to sustained improvement, this represents a significant opportunity area for us. To ensure our improvement efforts align with operational realities, we will explore with Site teams whether strengthening learning and development, should be prioritised as part of their local QI and QMS plans.

4. Workforce Equality Standards (WRES and WDES)

Equality of experience remains a top corporate priority, yet the 2025 data shows persistent

disparities for BAME and Disabled staff.

Table 5: WRES and WDES standards benchmarked with national average

Indicator	ESTH	STG	National Benchmark	Insight
BAME: Harassment (Staff)	24.40% (white: 23.39%)	25.73% (white: 23.73%)	24.78%	BAME staff at ESTH and report higher levels of harassment from colleagues than white staff at the same trusts and both BAME results sit close to or slightly above the national average.
BAME: Career Progression	48.31% (white: 51.14%)	45.11% (white: 50.3%)	49.70%	BAME staff report lower perceptions of fair career progression at ESTH and STG compared with white staff at the same trusts, and both BAME results sit below the national average.
Disabled: Harassment (Staff)	26.15% (non-disabled: 17.69%)	27.68% (non-disabled: 18.14%)	25.24%	Higher than average harassment for disabled colleagues.
Reasonable Adjustments	68.10%	67.59%	73.65%	Staff reporting that reasonable adjustments were made is lower at both ESTH and STG compared with the national average, with around a 6% difference.

Insights

Our results show a 6% gap in "Reasonable Adjustments" compared to the national average. This is an organisational risk that impacts both wellbeing and legal compliance. Furthermore, the higher rates of harassment for both BAME and disabled staff suggest that our relatively high "Compassionate and Inclusive" scores are not yet universal across all protected groups.

To address reasonable, adjust issues, the People function has been increasing capacity to deliver timely reasonable adjustments for Disabled colleagues.

5. Free Text Feedback thematic analysis

The 2025 survey thematic analysis for the group reveals the following qualitative insights:

Table 6: qualitative feedback themes and observations

Theme	Mentions*	Key Observations
Management and Leadership	1,061	Widespread concerns regarding "top-heavy" structures, with many staff feeling there are too many Band 8/9 managers relative to frontline clinicians. Frequent reports of favouritism, lack of transparency in decision-making, and a perceived disconnect between senior leadership and ward reality.
Workplace Culture	977	A polarised environment: while some report "supportive and friendly" teams, others describe a "toxic" culture characterized by cliques and an "us vs. them" mentality between different professional groups or bands.
Wellbeing and Stress	609	Significant reports of staff shortages, burnout, emotional exhaustion, and chronic stress. Staff feel "psychologically unsafe" in some areas and say that there is insufficient support for wellbeing, especially in high-pressure roles.
Pay and Recognition	469	Major focus on banding inconsistencies (particularly for Housekeepers and Receptionists seeking Band 3). Concerns that pay does not reflect the cost of living or the level of responsibility, alongside frustration over reduced bank rates.
Organisational Change	413	Frustration with the implementation of new systems (e.g., iCLIP/Rio) and "top-down" restructuring. Staff feel change is often implemented without adequate consultation or training, leading to increased risk and confusion.
Training and Development	409	Perceived lack of equity in career progression. Opportunities for development and / or promotion are sometimes seen as "secretive" or reserved for specific groups (e.g., full-time or more senior staff), leaving junior or part-time staff feeling overlooked.
Workload	375	Unbalanced distribution of tasks where high performers are "rewarded" with more work. Many staff report regularly working through breaks and covering multiple roles due to unfilled vacancies.
Facilities or Infrastructure	305	Focus on slow and poorly integrated IT and inadequate physical infrastructure (e.g., lack of staff rest areas, parking issues, and poor temperature control).
Staffing Levels	303	Chronic understaffing is cited as the primary driver of low morale and poor retention. High turnover is leading to a less experienced workforce and increased pressure on the remaining senior staff.
Bullying and Harassment	237	Serious allegations of bullying by senior consultants and managers. Reports include "public belittling," nationality-based bias, and a fear of retaliation for staff who choose to "speak up" or report concerns.

**Mentions represent the frequency of thematic keywords within the anonymised text comments*

for gesh (combined ESTH and STG).

Insight

The qualitative feedback across both Trusts reveals that staff are deeply committed to patient care but under significant structural and cultural strain. They highlight several pressures, including feeling that senior managers don't understand their day-to-day realities, the strain of ongoing financial challenges and digital changes, and inconsistent support across gesh.

We have acted on the Band 2–3 HCSW issue and established an appeal route for other Band 2 staff who believe their job description requires review.

5.1 Qualitative staff feedback links to the survey quantitative scores

The quantitative benchmark scores validate the qualitative themes, showing areas where gesh sits near or below the national average.

- **Morale and burnout:** Both trusts report low scores for **Morale** (STG: 5.71; ESTH: 5.80). Specifically, the "Burnout" sub-score (STG: 4.89; ESTH: 5.08) directly mirrors the qualitative descriptions of "emotional exhaustion" and "chronic stress" found in the text reports.

- **Recognition and reward:** The frustration over banding and pay is reflected in the scores for **"We are recognised and rewarded"** (STG: 5.76; ESTH: 5.85), both of which are below the national best results (6.34).

- **Safe and healthy climate:** The qualitative reports of bullying and a lack of support for raising concerns align with the **"Raising concerns"** sub-score (STG: 6.18; ESTH: 6.29), which remains significantly lower than the best-performing trusts (7.02).

- **Inclusion and equality:** While **"Diversity and equality"** scores are quantitatively high (STG: 8.08; ESTH: 8.23), the qualitative feedback highlights specific instances of nationality-based bias and accent discrimination that suggest the lived experience of some of our global majority staff is not yet fully reflected in the headline figures. For example experiences of discrimination from managers or colleagues are significantly higher for staff from other ethnic groups (**14.12%** for ESTH; **15.82%** for STG) than for White staff (**7.56%** for ESTH; **8.49%** for STG).

6. Engagement activities at local level

6.1 Empowering leaders through resources and toolkits

To ensure a consistent and effective response to survey feedback, a comprehensive suite of resource assets and toolkits has been produced and shared with HRBPs, divisional leaders and managers. These tools are designed to move beyond data analysis and into meaningful action:

- **Tailored infographics:** Data has been visualised through infographics at the divisional, care group, service, and team levels to provide clear, accessible insights into local performance.

- **The A3 action planning model:** Managers are required to use a simplified A3 model template to develop their action plans. This model focuses on defining the problem, identifying the current state through specific team scores, and committing to three impactful countermeasures with clear implementation steps.

- **Structured discussion guides:** A guide for working groups has been provided to facilitate deep-dive discussions, using "5 Whys" analysis to identify root causes and establish success measures.

- **Thematic analysis frameworks:** Comprehensive guidance has been issued to help managers interpret RAG (Red-Amber-Green) ratings across the **People Promise** and **Culture and Leadership** framework themes. These documents provide illustrative examples and actionable insights for areas such as Compassionate Leadership, Recognition, and Team Working.

6.2 Closing the feedback loop: "you said, we did"

Year-on-year, staff have reported a lack of visibility regarding the results and subsequent actions of the staff survey. To address this, our response mandates that teams see and discuss their results together:

- **Meaningful local discussion:** Managers are tasked with sharing team-level infographics and using them as the foundation for transparent, collaborative dialogue.

- **Visible communication:** Teams are encouraged to use a "You Said, We Did" communication style via newsletters, team meetings, and directorate townhalls to explicitly link improvements to staff feedback.
- **Board to Ward Priorities:** Huddles will include conversations about what needs to change for team members to agree with these two statements: ‘Would recommend organisation as place to work’ and ‘If friend/relative needed treatment would be happy with standard of care provided by organisation’ to encourage ongoing conversations about engagement and local action.

6.3 Working group support

- **HRBP-led staff survey working groups**: HRBPs are supporting divisions to establish working groups focused on continuous improvement and local engagement actions.

- **Engagement events and workshops**: A programme of staff engagement events, webinars and workshops will begin in mid-May 2026 led by the HRBPs and OD Team to support teams and strengthen staff voice, creativity and collaboration.

- **Site-level working groups**: Site leaders across both Trusts continue to oversee staff survey action planning and engagement delivery through established site-level groups.

6.4 Divisional engagement and planning

All divisions are actively engaging with staff survey results and progressing action plans, aligning actions with CQC Well-Led findings where relevant. Where plans are not yet fully formed, divisions report that engagement and planning are underway at local team level.

6.5 Targeted support for challenged services

The Staff Engagement Working Group will deliver targeted support to 20 challenged staff-engagement services across GESH (10 at ESTH and 10 at STG). The support will focus on stabilising low-scoring areas, strengthening leadership capability, and establishing a sustainable, repeatable model for organisational rollout.

Services / teams with insufficient survey response rates (less than 10 staff participated in the survey with no published report) have been identified and will be supported to improve participation (See appendix C).

The aim is to achieve measurable improvements in local engagement scores and response rates within 12 months through clearer ownership and structured engagement activity.

Key elements of the approach include:

- Assignment of a named leadership sponsor/champion for each service / team
- Facilitated team engagement discussions
- Development and delivery of local improvement plans
- Increased and visible leadership presence

6.6 National quarterly pulse survey

To support the measurement and monitoring of the impact of both our corporate actions and local divisional and service actions, the group will participate in the National Quarterly Pulse Survey starting in April 2026. The first survey will take place between **1 - 30 April 2026**.

Results from the April survey will be available at **Trust level** for that quarter. From **Quarter 2 onwards (July 2026 survey)**, results will be provided at **Trust, Directorate, and Service level**, enabling more detailed analysis and supporting targeted improvement actions across the group.

7. Corporate Actions

7.1 What we have learned (2024–2025)

Our retrospective assessment (Appendix A) highlights three clear insights:

1. What is working and being embedded

- Interventions that **build leadership capability, improve day-to-day team experience, and are locally owned** (e.g. What Matters to You (WMTY), leadership programmes, HWB champions) show the strongest impact.

- Targeted approaches have delivered **measurable improvements in staff experience**, including:
    - Improvement across **61/99 staff survey questions** in WMTY pilot areas
    - Gains in **8/9 NHS People Promise themes**
    - Increased participation and impact in **recognition programmes and leadership development**

2. What we are standardising into business as usual

- High-value interventions (e.g. EDI policies, people management programme, wellbeing support, apprenticeships) are now embedded into **core organisational processes**.
- This reflects a shift from **standalone initiatives to systemic capability and infrastructure**.

3. What we are stopping or narrowing

- We have deliberately reduced lower-impact activity (e.g. standalone wellbeing programmes, broad action plans)
- Focus is now on **fewer, higher-impact interventions**, particularly:
    - Leadership capability
    - Inclusive recruitment and workforce equity
    - Team-level engagement

7.2 Our whole-system approach

We are taking a **consolidated, whole-system approach** to improving staff experience, ensuring that action is driven not only at team, service and divisional level, but also across corporate functions and organisational infrastructure:

- **Triangulation of insight**: Staff Survey, Pulse Survey, WRES/WDES, and CQC Well-Led findings
- **Integration with transformation**:

  We are aligning this work with the Trust's transformation infrastructure by:

    - Embedding staff experience and wellbeing into transformation programmes
    - Using the Transformation Team's **Quality Management System (QMS)** and **Quality Improvement (QI)** capability to support structured, sustainable improvement
    - Building leadership and team capability to identify, test and embed changes

- **Working with Digital and Estates to address system barriers**:

  A key development in our approach is **closer alignment with Digital and Estates teams**, recognising that many of the issues raised by staff relate to **systems, environments, and tools**, not just behaviours. We are therefore:

  - Working with Digital and Estates leads to **prioritise improvements** that will have the greatest impact on staff experience and operational efficiency
  - Ensuring that these actions are **tracked alongside divisional engagement plans** and reported through the same governance structures

    Examples include:

  - Digital improvements to reduce system inefficiencies and administrative burden
  - Estates improvements to enhance working environments, rest spaces, and staff facilities

- **Shift in approach**:
  - From “annual survey response” to **continuous engagement and improvement culture**
  - Actions triangulated with the findings from the **CQC Well-Led assessments and local discussions**

7.3 Our four priority themes (2026 focus)

We are prioritising **four themes**, with a small number of high-impact actions in each:

1. Leadership capability

- Strengthen **people management and leadership consistency**
- Embed **high-performing team behaviours**
- Ensure **monthly team engagement and improvement conversations**

2. Behaviours

- Focus on **civility, kindness, and psychological safety**
- Address **inappropriate behaviours (including sexual misconduct)**
- Embed expectations through **team-level practice**

3. Recognition & celebration

- Scale **meaningful recognition approaches**
- Strengthen **connection to organisational purpose and CARE strategy**
- Increase **visibility and inclusivity of recognition**

4. Diversity & inclusion

- **Improve equity in recruitment, progression and experience** by ensuring fair access to opportunities, transparent progression, and inclusive support throughout staff careers
- Strengthen **leadership accountability** by senior leaders setting clear D&I objectives, report progress quarterly and complete relevant L&D training
- Focus on **reducing inequity in workforce outcomes**

7.4 What we are asking leaders to do

We are clear that this is a **leadership responsibility**, supported by corporate infrastructure.

At **site, division and directorate level**, leaders are expected to:

- Hold **monthly team meetings** (“conversations that matter”)
- Review and act on **local staff feedback and survey data**
- Focus on **2–3 priority improvements aligned to the four themes**
- Support **nominated team champions (particularly in low-performing teams)**
- Embed **recognition and inclusive behaviours into daily practice**

7.5 Measuring success and impact

We are focusing on a **small set of key indicators**:

Primary outcomes

- Recommend organisation as a place to work
- Recommend organisation as a place to receive care

Supporting metrics

- Staff Survey (theme-level improvement)
- Pulse Survey (wellbeing focus)
- WRES / WDES indicators
- Recruitment and progression equity
- Recognition and engagement scores

Monitoring approach

- Quarterly dashboard
- Directorate-level tracking
- Targeted deep dives in priority areas

7.6 In-year priorities (what will make the difference)

To ensure impact, we will prioritise:

- 2 - 3 high-impact actions per theme (Appendix B)
- Consistent leadership behaviour at team level
- Targeted support to lowest-performing teams
- Clear measurement and accountability

8. Conclusion

Our 2025 Staff Survey results provide a clear and compelling mandate for change across our group. While staff engagement remains a relative strength and demonstrates the deep commitment our people have to patient care, the wider results highlight significant structural, cultural, and operational challenges that must be addressed with urgency and consistency. The data shows that both ESTH and STG continue to face pressures around morale, learning and development, flexible working, and equality of experience - issues that are further reinforced by key themes emerging from free-text feedback, including burnout, inconsistent leadership behaviours, concerns about fairness, and the impact of chronic staffing pressures.

The disparities highlighted through WRES and WDES indicators, particularly around harassment and reasonable adjustments, underline the importance of accelerating our work to become an antiracist and fully inclusive organisation. These findings also align closely with the CQC's Regulation 17 notice for St George's, reinforcing the need for a coherent, systemwide cultural response that is grounded in meaningful staff voice and measurable improvement.

Our corporate and local actions ranging from strengthened leadership development and inclusive recruitment to targeted support for challenged services and the introduction of quarterly pulse surveys provide a clear framework for delivering sustainable change. However, the risks identified in this report, including capacity constraints, operational fragmentation, and resource limitations, highlight that improvement will require shared ownership across all levels of the organisation. Embedding new behaviours, strengthening accountability, and ensuring alignment across sites will be essential to achieving long-term impact.

Appendix A: Retrospective assessment – 2024/25 Activities

A1. What is working and being embedded

Activity	Status	Metrics / Impact	NHS People Promise Alignment	Corporate Theme	Notes
HWB Strategy Development (HWB)	In Delivery	Shifted from wellbeing standards to comprehensive HWB strategy; aligned with People Strategy and gesh CARE Strategy	We care for staff health & wellbeing	Leadership Capability	Established HWB Steering Group with ~70 reps from diverse roles, ensuring inclusive strategy design
What Matters to You (WMTY) Programme (HWB)	In Delivery	Improved in 61/99 questions; improved in 8/9 People Promise themes; gains in stress & burnout, autonomy/control, EDI sub-scores	We are inclusive, compassionate & effective leaders; We care for staff health & wellbeing	Behaviours	Piloted with 15 teams; strong engagement from Cancer Care Group; continuing in 2026 with 10 new teams
HWB Champions Network (HWB)	In Delivery	Peer support and local events driven by 48 champions at STGH and 15 at ESTH	We care for staff health & wellbeing; We respect each other	Behaviours	2026: Growing network at ESTH; standardising training, support and networking
Night Owl Project (New for 2026) (HWB)	In Delivery	Tailored support for night shift staff (~50% workforce); shareable resources available	We care for staff health & wellbeing	Leadership Capability	Funded for STGH; shareable resources for ESTH: Timeshifter app, sleep education modules, sleep disorder screening tool
Leadership accountability and governance (EDI)	In Delivery	EDI objectives for Board members; Executive & SLT objectives complete; Executive Sponsorship for Staff Networks	We are inclusive, compassionate & effective leaders; We give equal opportunities	Leadership Capability	Interventions from 2025 EDI Action Plan; systemic impact on leadership behaviour, recruitment, workforce experience
Inclusive recruitment and talent (EDI)	In Delivery	Inclusive recruitment framework; Culture & Inclusion interview questions; 50+ trained B7+ Recruitment Inclusion	We give equal opportunities	Diversity & Inclusion	Key metrics: representation/progression at senior levels; recruitment outcomes; staff experience &

Activity	Status	Metrics / Impact	NHS People Promise Alignment	Corporate Theme	Notes
		Specialists; ERAF/EQIA in Talent Management pilots; Talent Management Plan launched			engagement; reduction in inequity
Culture and Engagement (EDI)	In Delivery	Ask Aunty app launched; EDI embedded into all induction routes; Effective Communications Training	We respect each other; We are inclusive, compassionate & effective leaders	Behaviours	Interventions from 2025 EDI Action Plan; measurable improvement in inclusion and engagement indicators
Group Reward and Recognition (Comms)	In Delivery	1,000 staff rewarded via CARE awards; 900 nominations in 2025; 600 colleagues celebrated 25-year service; recognition scores 51%; 89% rated experience ‘Excellent’; 97% said event important; 95% understood charity/sponsor funded	We recognise & celebrate success; We respect each other	Recognition & Celebration	12 award categories linked to CARE strategy; VIP hosts and celebrity contributors; national media coverage
Apprenticeships Programme (L&D)	In Delivery / BAU	76% increase in participation; supports leadership pipeline, service improvement and digital transformation	We are inclusive, compassionate & effective leaders; We give equal opportunities	Leadership Capability	Focus now on evidencing workforce impact and maximising levy usage
MAST Review (L&D)	In Delivery	Reduced time burden; aligned requirements across sites; increased time for development	We are inclusive, compassionate & effective leaders	Leadership Capability	Aligning with national NHS guidance
gesh Leadership Programme (Talent)	In Delivery / Transitioning to BAU	3 cohorts delivered; multiprofessional leadership development; improved collaboration and collective leadership. Tiered development	We are inclusive, compassionate & effective leaders	Leadership Capability	Tier 1 & 2 delivered; Tier 3 in development.To be absorbed into LMDP (Q3 26/27); risks mitigated via Culture & OD team

Activity	Status	Metrics / Impact	NHS People Promise Alignment	Corporate Theme	Notes
		(Tier 1–3); aim to reach 85% of 2,500 managers in 24 months			
Appraisals & Career Conversations (Talent)	In Delivery / BAU	Improved appraisal quality; ongoing dialogue replacing annual-only approach	We are inclusive, compassionate & effective leaders	Leadership Capability	Part of Talent Programme redesign
Inclusion Board (Pilot) (Talent)	BAU / Pilot	Supporting inclusive leadership and talent progression	We give equal opportunities	Diversity & Inclusion	Currently mid-delivery; part of Talent Management approach
Career Conversations (Pilot) (Talent)	BAU / Pilot	Improved quality of appraisal and ongoing dialogue	We are inclusive, compassionate & effective leaders	Leadership Capability	Mid-design; aligned to Talent Programme

A2. Transitioning to business as usual

Activity	Status	Metrics / Impact	NHS People Promise Alignment	Corporate Theme	Notes
Policies and processes (EDI)	BAU / On Demand	Sexual Misconduct Policy; Flexible Working Policy; Disability in the Workplace Policy; Centralised reasonable adjustments process	We respect each other; We give equal opportunities	Diversity & Inclusion	Successfully delivered and embedded within standard organisational processes
Workforce experience and support (EDI)	BAU / On Demand	Menopause training; Wellbeing Toolkits; bespoke onboarding for international nurses/midwives	We care for staff health & wellbeing; We give equal opportunities	Leadership Capability	Transitioned to BAU / on-demand availability
Insight and assurance (EDI)	BAU / On Demand	Annual Pay Gap Report (Gender, Ethnicity, Disability); WRES and WDES	We give equal opportunities	Diversity & Inclusion	Embedded as routine organisational assurance processes

Activity	Status	Metrics / Impact	NHS People Promise Alignment	Corporate Theme	Notes
Organisational Capability (EDI)	BAU / On Demand	Redesigned EDI Workforce function; Ask Aunty resources available group-wide; EDI embedded in all induction programmes	We give equal opportunities; We are inclusive, compassionate & effective leaders	Leadership Capability	Embedded within standard organisational capability structures

A3. what we are stopping or narrowing

Activity	Status	Metrics / Impact	NHS People Promise Alignment	Corporate Theme	Notes
Wellbeing Standards (HWB)	Stopped	N/A	N/A	Leadership Capability	Moved away from standalone wellbeing standards in favour of integrated HWB strategy
Standalone Health Promotion & Training (HWB)	Stopped	N/A	N/A	Leadership Capability	Reduced number of standalone health promotion and training; wellbeing content now embedded into leadership training due to low uptake
Focused delivery / high-impact actions (EDI)	Stopped	N/A	N/A	Diversity & Inclusion	Delivery narrowed to high impact actions, particularly inclusive recruitment and ER, based on Board, staff feedback and CQC Well Led recommendations

Appendix B: Corporate action plan – 2026 focus

B1. Your Voice, Our Action Plan (Corporate Delivery)

Theme	Priority Action	Expected Impact / Metrics	Lead	Timeline
Leadership	1. Wide engagement on merger to develop shared values, behaviours and core capabilities	Alignment on vison for gesh, values & behaviours, increased engagement	Strategy and People	Q2 - Q4
	2. “Conversations that matter” (1:1s, weekly huddles, monthly meetings, annual reviews including Career conversations)	Improved connection, feedback culture, clear career progression, retention metrics	People	Q1 - Q4 (ongoing)
	3. gesh People Management Programme (Tiers 1,2,3)	Enhanced skills & learning uptake		Q2 - Q4
	4. Quality Management System + Continuous Improvement development programme	Process improvements and empowerment	Continuous Improvement	Q2 - Q4
Behaviour	5. Kindness and Respect Campaign which covers teamwork, participation and civility	Improved staff culture, engagement scores	People and Comms	Q2 - Q4
	6. New approach to patient/visitor violence & aggression, harassment, and racism	Patient satisfaction metrics, safety improvements	Health & Safety	Q2 – Q3
Diversity & Inclusion	7. Inclusive Recruitment	Diverse workforce metrics, equity in career progression	People	Q2 - Q4
	8. Inclusion Board	Shared decision-making, Career progression, retention		Q2 - Q4
	9. Embedding flexible working and access to reasonable adjustments	Staff satisfaction, retention, inclusion		Q2 - Q4
	10. Wellbeing initiatives (absentee management, improved OH and physio access, safe staffing and rostering)	Improved wellbeing, reduced absenteeism, increased productivity	Clinical Workforce Productivity	Q1 - Q4 (ongoing)
	11. Health Inequalities	Reduction in measurable disparities, improved equity metrics (e.g., patient outcomes by demographic)	Health Equity and Patient Experience / Inclusion	Q1 - Q4 (ongoing)
Recognition & Celebration	12. Recognition strategy & local recognition toolkit	Increased staff recognition, engagement	Communications	Q2 - Q4
	13. gesh events (CARE awards, gesh 25, Big Week)	Staff engagement, recognition		Q2 - Q4

B2. Team / service-level actions (Local Implementation)

Theme	Priority Action	Expected Impact / Metrics	Lead	Timeline
Leadership	Develop 2–3 action plans per team	Completion of team action plans, clear priorities, measurable improvements	Manager	Q2
	"Conversations that matter" - 1:1s, weekly huddles, monthly meetings, annual reviews	Staff engagement, improved feedback culture, participation rate	Manager	Q2 - Q4 (ongoing)
	Sponsor local champions/leads	Increased staff engagement, champions actively leading initiatives, visibility of engagement activities	DMB Sponsor	Q2–Q4 (ongoing)
Behaviour	Civility & Kindness	Staff culture improvements, reduction in complaints/conflicts, engagement survey scores	Manager / Engagement Champion	Q2–Q3
	New approach to patient/visitor violence, aggression, harassment, and racism	Reduction in incidents, improved staff safety perception, patient feedback	Manager / engagement Champion	Q2 –Q4
Diversity & Inclusion	Embedding flexible working	Staff satisfaction, retention, utilization of flexible working options	Manager	Q2–Q4
Recognition & Celebration	Recognition strategy & local recognition toolkit	Uptake of recognition tools, measurable recognition events, engagement survey results	Manager / Engagement Champion	Q2–Q4

Appendix C: Teams with low survey respondents (No survey reports)

Staff Survey participation across ESTH and STG shows significant variation, with notable engagement gaps in both operational and clinical teams. Several critical areas recorded response rates below 30%, signalling the need for immediate, targeted action with clear divisional leadership accountability to ensure a representative staff voice. The tables in this section list only those teams with fewer than 10 respondents, and their survey results have been suppressed in line with staff survey confidentiality rules and GDPR requirements.

The teams that are highlighted in red are those more than 15 staff with fewer than 6 respondents to the staff survey, indicating they require urgent focus and support.

1. Epsom and St Helier - Low participation teams

Clinical Services

Service	Team	Eligible	Respondents	Response Rate
Clinical Services	**343 K92076 Histopathology (EPS)**	**17**	**4**	**23.5%**
Clinical Services	343 K90325 Haem/Anti-Coag/Imm Pod (EPS)	18	6	33.3%
Nursing	343 K90287 Whitfield Unit C6 (EPS)	17	7	41.2%
Radiology	**343 K90308 Ultrasound (EPS)**	**18**	**3**	**16.7%**

EOC

Service	Team	Eligible	Respondents	Response Rate
EOC	343 K92058 EOC - Support Staff (EPS)	17	9	52.9%

Estates & Facilities

Service	Team	Eligible	Respondents	Response Rate

Estate Management	**343 K92128 Property Maintenance (EPS)**	**20**	**2**	**10.0%**
Estate Management	**343 K90170 Property Maintenance (STH)**	**17**	**2**	**11.8%**
Facilities	343 K90045 Nursery Woodlands (STH)	24	8	33.3%
Facilities	343 K90273 Switchboard	18	5	27.8%

Medicine

Service	Team	Eligible	Respondents	Response Rate
A&E Admin	**343 K92133 A& E Admin Team (EPS)**	**25**	**3**	**12.0%**
Cardiology	343 K92205 Ward Coronary Care Unit (EPS)	23	7	30.4%
Care of the Elderly	343 K92207 Alex Ward (EPS)	30	8	26.7%
AMU	343 K92086 Med Staff AMU (EPS)	27	8	29.6%
Stroke	**343 K92097 Med Staff Stroke (EPS)**	**19**	**2**	**10.5%**

Planned Care

Service	Team	Eligible	Respondents	Response Rate
Endoscopy	343 K92369 Endoscopy (EPS)	20	9	45.0%
Intensive Care HDU	343 K90522 Critical Care: ITU HDU- EPS	28	8	28.6%
Intensive Care HDU	343 K90520 Critical Care: ITU HDU- Medics	33	9	27.3%
Surgery	343 K90125 Urology Medical Staff	27	6	22.2%

Service	Team	Eligible	Respondents	Response Rate
Surgery	343 K90121 Gen Surg Med Staff	46	9	19.6%
Pain Management	343 K90037 Chronic Pain (STH)	16	9	56.3%

Women & Children's Services

Service	Team	Eligible	Respondents	Response Rate
Gynaecology	343 K92092 Med Staff Obs and Gynae (EPS)	32	6	18.8%

Finance

Service	Team	Eligible	Respondents	Response %
Finance	**343 K94644 Clinical Coding**	**19**	**4**	**21.1%**

Sutton Health & Care

Service	Team	Eligible	Respondents	Response Rate
Community Services	343 K90465 SH and C - Wallington PCN	16	8	50.0%
Community Services	343 K90499 SH and C - Cheam and South Sutton PCN	16	8	50.0%

2. St George's - Low participation teams

Children & Women's Diagnostic & Therapy Services

Service	Team (Original)	Eligible	Respondents	Response Rate
Neonatal	Newborn Services Medical Staff and Income 712506	18	7	38.9%
Paediatric Community Therapy	Complex Needs Therapy 712509	18	7	38.9%
Paediatric Medicine	Community Paed Medical & Admin 712521	23	8	34.8%
Paediatric Medicine	Fred Hewitt Ward 712523	29	6	20.7%
Paediatric Medicine	Paediatric Junior Doctors 714414	56	6	10.7%
Paediatric Surgery	**Paed Surgery Medical Staff & Support 712539**	**19**	**5**	**26.3%**
Intensive Therapy Unit	**Hospital 247 712576**	**19**	**4**	**21.1%**
Breast Screening	Breast Surgery 712589	21	9	42.9
Imaging	Nursing & RDA 712603	24	6	25%
Outpatients	**General Surgery & Rheumatology Outpatients 712621**	**19**	**4**	**21.1%**
Acute Rehab	T&O Physio 712663	19	7	36.8%
Obstetrics	Ante Natal Clinic 712678	17	6	35.3%
Obstetrics	**Carmen Suite 712680**	**25**	**5**	**20%**
Obstetrics	**O & G Junior Medical Staff 712688**	**26**	**4**	**15.4%**
Obstetrics	Obstetrics Medical Staff 712689	24	9	37.5%

Corporate Division

Service	Team	Eligible	Respondents	Response Rate
Group Chief Nurse	Group Chaplaincy and Voluntary Services 713003	20	9	45
Group Chief Nurse	Group Complaints And PALS 713031	19	6	31.6

Service	Team	Eligible	Respondents	Response Rate
HR Operations	Workforce Intelligence and Rostering 714237	23	6	26.1

Estates and Facilities Division

Service	Team	Eligible Sample	Respondents	Response Rate
Engineering Services	**Electrical & Mechanical**	**18**	**5**	**27.8%**
Engineering Services	Engineering	33	9	27.3%

Medicine and Cardiovascular Division

Service	Team	Eligible	Respondents	Response Rate
Acute Medicine	Same Day Emergency Care (SDEC) 714378	17	6	35.3%
Senior Health	Dalby Ward (Senior Health) 712702	47	7	14.9%
Cardiac Surgery	**Cardiac Surgery Medical Staff 712713**	**24**	**4**	**16.7%**
Thoracic Surgery	Caroline Ward 712791	31	7	22.6%
Vascular Surgery	Cheselden Ward 712795	31	6	19.4%
Vascular Surgery	**Vascular Surgery Medical Staff 712801**	**21**	**5**	**23.8%**
Vascular Surgery	**Vascular Surgery Other & Laboratory 712800**	**20**	**2**	**10%**
Cardiology CAG.	Belgrave Ward AMW 712715	33	7	21.2%
Cardiology CAG.	Coronary Care Unit 712724	29	7	24.1%
Cardiology CAG.	E C H O 712726	32	9	28.1%
Cardiology CAG.	Heart Failure Unit 712727	22	8	36.4%
Cardiology CAG.	**James Hope Ward 712728**	**17**	**3**	**17.6%**
Clinical Haematology	Clin Haematology Medical Staff 712740	24	7	29.2%
Clinical Haematology	**Gordon Smith Ward 712742**	**22**	**5**	**22.7%**
Clinical Haematology	**Ruth Myles Ward 712746**	**24**	**3**	**12.5%**
Medical Oncology & Palliative Care	Oncology Day Care 712747	18	9	50%

Service	Team	Eligible	Respondents	Response Rate
Medical Oncology & Palliative Care	Trevor Howell Ward 712751	33	6	18.2%
Renal	Champneys Ward 712753	33	6	18.2%
Renal	Renal Medical Staff 712756	35	9	25.7%
Dermatology & Lymphoedema	Dermatology 712763	25	7	28%
Dermatology & Lymphoedema	Lymphoedema Clinic 712768	19	9	47.4%
Rheumatology	Rheumatology Income and Direct Costs 712789	19	6	31.6%

SWL Pathology Division

Service	Team	Eligible	Respondents	Response Rate
SWLP Central Reception	SWLP SGH Shared Costs 713122	37	8	21.6%
SWLP Group 3	SWLP Group 3	46	9	19.6%

Surgery & Neurosciences Division

Service	Team	Eligible	Respondents	Response Rate
Anaesthetics	Anaesthetics SDU Direct Costs 712898	19	6	31.6%
Theatre Services	Cardiac Theatre Costs 712907	20	6	30%
Theatre Services	**Neurosciences Theatre 712913**	**27**	**5**	**18.5%**
Theatre Services	QMH Scrub 712918	22	9	40.9%
Theatre Services	Renal & Urology Theatre Costs 712920	16	8	50%
Theatre Services	Theatre Portering 712925	24	6	25%
Cancer	Cancer Performance Team & Support 712804	28	8	28.6%
Neuroradiology	Neuroradiology Medical Staff 712833	21	8	38.1%
Neurosurgery	Neurosurgery Income & Senior Nurses 712838	18	6	33.3%

Service	Team	Eligible	Respondents	Response Rate
Neurosurgery	Neurosurgery Medical Staff 712839	41	8	19.5%
Surgery Directorate Overheads	Ward Budget Surg & CLS 712844	19	9	47.4%
ENT & Audiology	**ENT Medical Staff 712855**	**23**	**1**	**4.3%**
General Surgery	General Surgery Medical Staff 712861	36	8	22.2%
Max Fax	Maxfax Medical & Laboratory 712870	26	7	26.9%
Plastic Surgery	Keate Ward 712873	34	9	26.5%
Plastic Surgery	**Plastic Surgery Income and Direct Costs 712875**	**16**	**5**	**31.3%**
Plastic Surgery	**Plastic Surgery Medical Staff 712876**	**29**	**1**	**3.4%**
Trauma & Orthopaedics	Major Trauma Ward 712880	31	9	29%
Urology	Urology Income Specialist Nurses 712889	23	7	30.4%
Urology	Urology Medical Staff 712890	30	7	23.3%
Urology	Vernon Ward 712893	36	9	25%

Group Board

Meeting in Public on Friday, 08 May 2026

Agenda Item	4.3	
Report Title	**Group Freedom to Speak Up Report Q3-Q4 2025/26**	
Executive Lead(s)	Stephen Jones, Group Chief Corporate Affairs Officer (Executive Lead for Freedom to Speak Up)	
Report Author(s)	Karyn Richards-Wright, Group Freedom to Speak Up Guardian	
Previously considered by	People Committees Group Executive Committee	20 April 2026 14 April 2026
Purpose	**For Assurance**	

Executive Summary

This report provides the Group Board with a thematic analysis of concerns raised with the Freedom to Speak Up Guardians across the gesh Group during Q3 and Q4 2025/26.

St George's:

- A total of 90 concerns were raised with the FTSU Guardian over the second half of the year.
- The staff groups which raised the highest number of concerns were: Administrative and Clerical staff (34) 37.8%; and Nursing and Midwifery staff (23 concerns – 25.6%).
- In terms of concerns raised across the Divisions:
  - 31 concerns (34.4%) were raised from SNCT (mainly made up of a large collective concerns from theatres staff)
  - Corporate Division: 19 concerns (21.1%)
  - MedCard and CWDT each had a total of 18 concerns (20%);
  - SWL Pathology had 2 concerns raised (2.2%)
  - Research and Development had 1 concern (1.1%)
  - Unknown 1 concern (1.11%)
- The three main types of concern raised were: Management Conduct – 30 concerns (33.3%); Bullying and Harassment – 29 concerns (32.2%); HR policies – 21 concerns (23.3%)

Epsom and St Helier

- A total of 85 cases were raised with the FTSU Guardian over the same period (Q3-Q4 25/26).
- The staff groups which have raised the highest number of concerns were: Nursing and Midwifery (24 concerns – 28.2%) and Administrative and Clerical staff (23 concerns – 27%).
- In terms of concerns raised across the Divisions:
  - 40 concerns (47%) were raised by staff within the Medicine Division
  - 9 concerns each (10.6%) were raised by staff within the Surgery and Cancer and Clinical Services Division
  - 8 concerns (9.4%) were raised by staff within the Women's and Children's Division
  - 6 concerns were raised by staff within the Corporate Division (7%)
  - 3 concerns were raised by staff within the Patient Services Division (3.5%)
  - 1 concern was raised by staff within each of the Estates & Facilities Division, the Renal Division, and SWLEOC (1.2% each)

- For Integrated Care:
  - 6 concerns were raised by staff in Sutton Health and Care (7%)
  - 1 concern was raised by staff in Surrey Downs Health & Care (1.17%)
- The three man types of concerns were: Management Conduct - 54 concerns (63.5%), Bullying and Harassment - 29 concerns (34.1%); and HR policies – 21 concerns (24.7%).
- At present, the Speak Up training at ESTH is not mandatory unlike at SGUH where the training is part of the MAST programme.

We adopted the new national Freedom to Speak Up Policy as one of the first Group-wide policies, in line with national guidelines from NHS England in January 2025. We have also developed a standardised process, within the team, for triaging concerns raised to the FTSU service to help ensure consistency in the way in which concerns are dealt with and escalated, which includes clarity on how the service escalates immediate patient safety concerns and its process for undertaking an early stage assessment of the risk of concern raisers encountering detriment.

We have seen an increase in staff raising that they fear detriment due to raising concerns as opposed to actually suffering detriment. As such, in line with national guidance from the National Guardian's Office, our triage process also sets out our process for checking in with concern raisers six and 12 months after raising a concern.

Timely resolution of concerns, especially for complex or historical concerns, confidentiality of concerns and effective communication with the Guardian remain issues Group-wide. We are seeing an increase in staff stating that they intend raising their concerns externally, especially those who contact FTSU following raising formal processes i.e. grievances and who feel that the length of time resolution and outcomes take is affecting their wellbeing and performance at work.

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

Action required by Group Board

The Board is asked to:

a. Note the number of concerns reported to the FTSU Guardians in Q3 and Q4 2025/26 for both SGUH and ESTH and the staff groups reporting.
b. Note the themes emerging from FTSU cases in this period.
c. Note the recommendations of the Group FTSU Guardian as set out in section 5 of the report
d. Note the priorities of the Group FTSU service in the coming months.

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

Appendices	
Appendix No.	**Appendix Name**
Appendix 1	Raising Concerns Sub-Scores – NHS Staff Survey 2025

Implications

Group Strategic Objectives

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

Risks

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

CQC Theme

☒ Safe	☒ Effective	☒ Caring	☒ Responsive	☒ Well Led

NHS system oversight framework

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

Financial implications

There are no specific financial implications relating to this report.

Legal and / or Regulatory implications

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

Equality, diversity and inclusion implications

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

Environmental sustainability implications

There are no specific environmental sustainability implications of this report.

Group Freedom to Speak Up Report, Q3-Q4 2025/26
Group Board, 08 May 2026

1.0 Purpose

1.1 This report provides the Group Board with a thematic analysis of concerns raised with the Freedom to Speak Up Guardians across the Group during Q3 and Q4 2025/26. The report sets out key themes and trends in the number, type and origin of concerns and highlights cross cutting and emerging issues.

2.0 Background

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

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

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

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

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

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

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

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

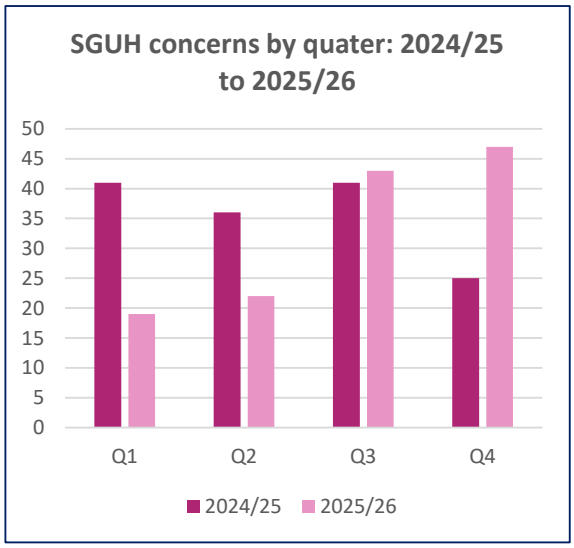
2.5 There is currently no corresponding FTSU vision and strategy approved by the Board for ESTH, but the principles and approach adopted in the SGUH strategy could equally apply at ESTH. There are plans for a Group-wide FTSU vision and strategy as an important step in strengthening our approach to speaking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

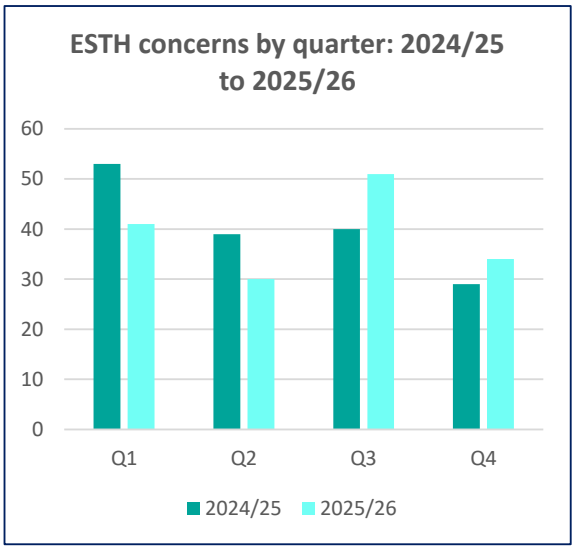
3.0 Current SGUH and ESTH FTSU activity

(a) Total number of concerns raised via Freedom to Speak Up in Q3 & Q4 2025/26

3.1 Between 1 October 2025 and 31 March 2025, a total of 175 concerns were raised with the FTSU Service across the gesh Group. SGUH staff raised a total of 90 concerns, 43 concerns in Q3 and 47 concerns in Q4. In the same period, 85 concerns were raised from ESTH staff, with 51 concerns raised in Q3 and 34 in Q4. Of the 175 concerns raised across gesh, 50 (28.6%) were advice cases and 125 (71.4%) required escalation or intervention by the FTSU Guardian.

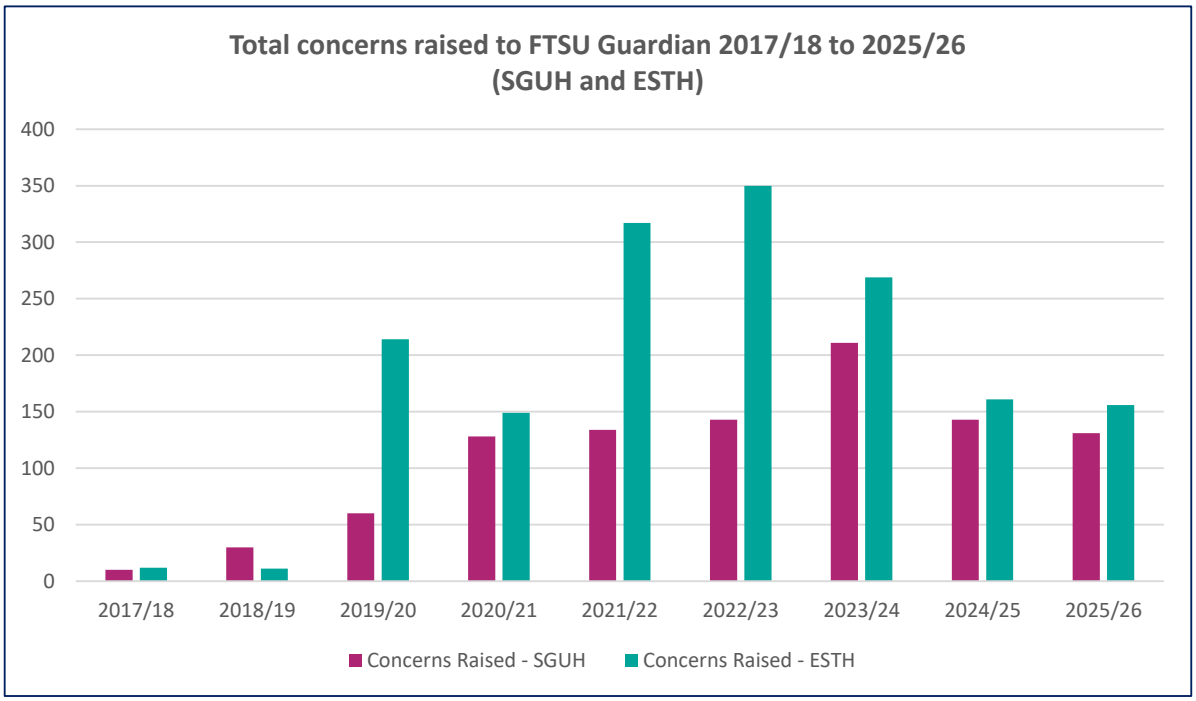
3.2 Comparing to the same period last year when there were a total of 135 this shows a 29.63% increase for this period. There has been a notable increase in Freedom to Speak Up (FTSU) cases compared to the same period last year, increasing from 135 to 175. This increase does take into account an increase in collective concerns raised throughout gesh and an increase in concerns pertaining to consultations and restructures together with process concerns. Proactive measures in the coming months will be taken to monitor this and work closely with teams and Divisions.





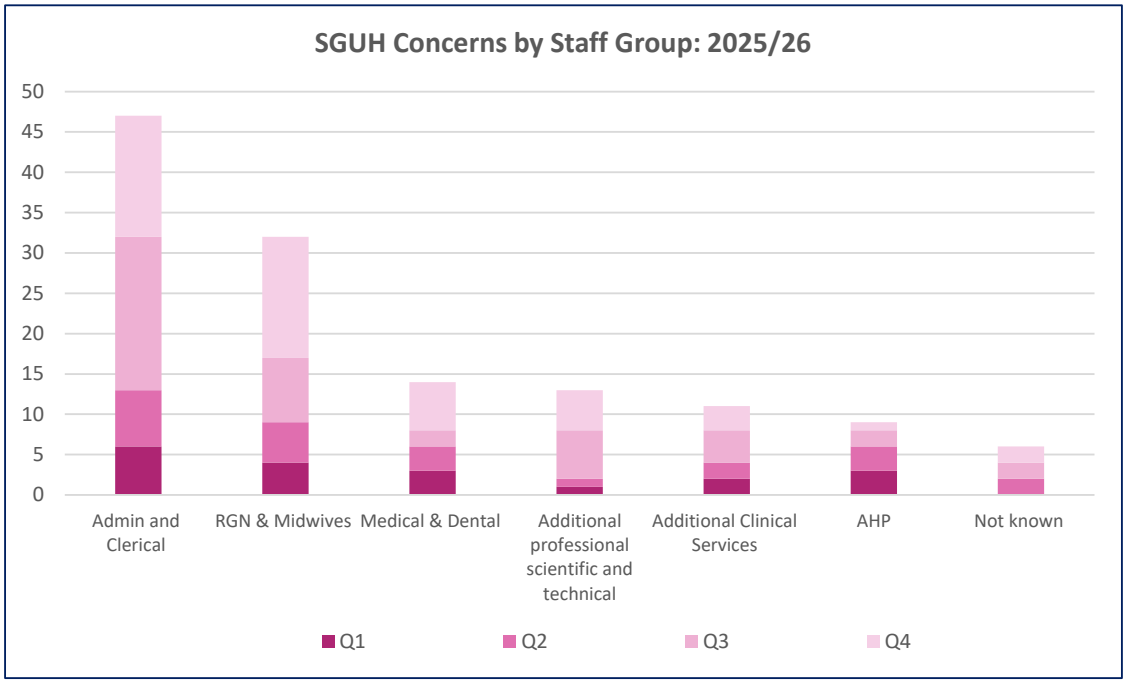
3.3 The concerns raised in Q3 and Q4 bring the 2025/26 total number of concerns raised by staff to the FTSU Guardian to 131 concerns at SGUH and 156 at ESTH. This represents a 8.4% fall in the total number of concerns raised via FTSU at SGUH in 2025/26 compared with the previous year, and a 3.1% fall at ESTH.

3.4 The chart below shows the number of concerns raised by staff at each Trust with the FTSU Guardian over the past nine years. As reported previously (June 2024), there were differences historically in the way in which FTSU concerns were recorded at SGUH and ESTH. A common approach to the recording of concerns was adopted from the start of Q4 2023/24 in line with the National Guardian's Office (NGO) guidance, which resulted in a reduction in the number of FTSU concerns at ESTH in 2023/24. Since 2023/24 gesh FTSU team have had an aligned reporting process relating to concerns raised and this provides a consistent picture for reporting purposes. It remains the case that, proportionate to its size, there are proportionately more concerns raised with the FTSU Guardian at ESTH than at SGUH.



(b) Concerns raised by staff group in Q3 & Q4 2025/26

3.3 The following charts show the concerns raised via FTSU by different staff groups at SGUH, both over the course of Q3 and Q4. Administrative and Clerical Staff remain the staff group which has raised the most concerns, followed by Nursing and Midwifery staff, reflecting the pattern seen in previous years.

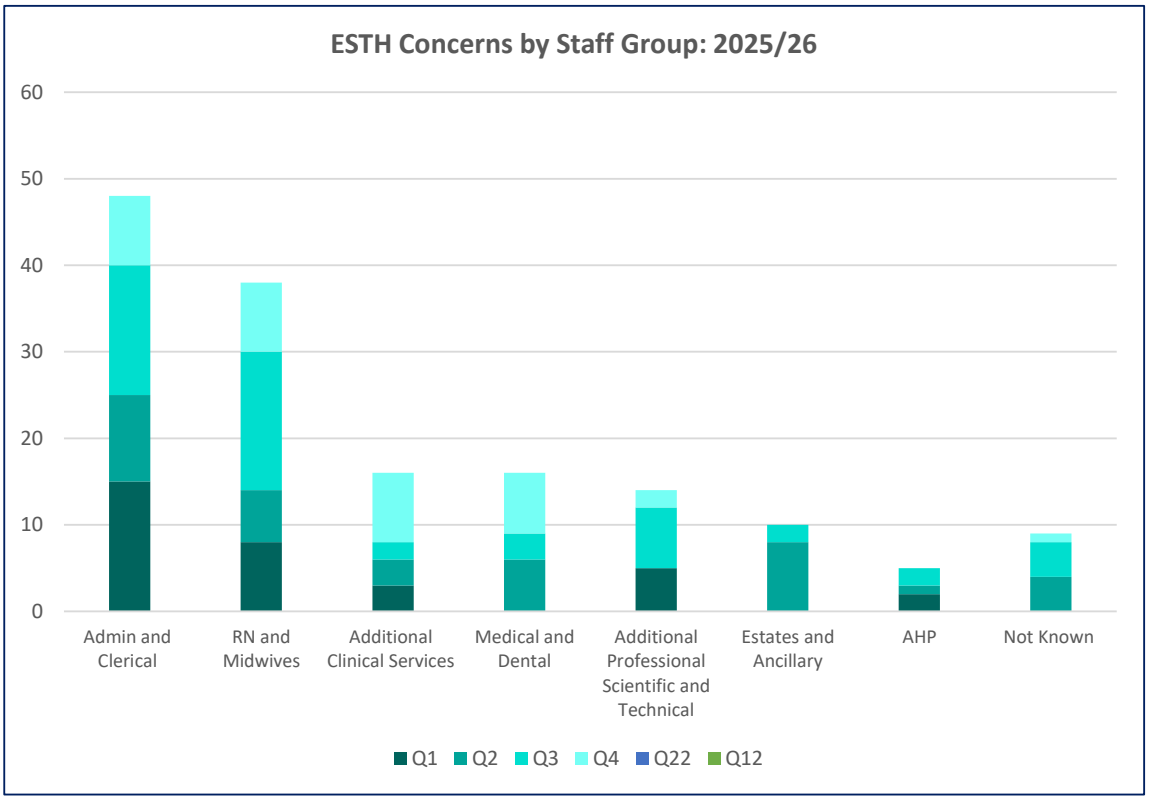


3.4 Staff groups at SGUH who have raised concerns with the FTSU Guardian over Q3 & Q4:

- **Administrative and Clerical staff** are the staff group which raised the highest number of concerns to the FTSU Guardian over 2025/26. A total of 47 concerns were raised by Admin & Clerical staff in 2025/26, of which 34 concerns were raised in Q3 and Q4.
- **Nursing and Midwifery** staff raised the second highest number of concerns overall, with 32 concerns raised over 2025/26, of which 23 concerns were raised in Q3 and Q4.
- **Medical & Dental staff** raised the third highest number of concerns, with 14 concerns raised over 2025/26, of which 8 concerns were raised in Q3 and Q4.
- **Additional Professional Scientific and Technical staff** raised a total of 13 concerns in 2025/26, of which 11 were raised in Q3 and Q4.
- **Additional Clinical Services** staff raised 11 concerns in 2025/26, of which 7 were raised in Q3 and Q4 2025/26.
- **Allied Health Professionals** raised a total of 9 concerns during the year as a whole, of which 3 were raised in Q3 and Q4.
- **Unknown** staff groups accounted for 6 concerns during the year as a whole, and 4 in Q3 and Q4.

(c) .Concerns raised by staff group in Q3 and Q4 (ESTH)

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



3.6 Staff groups which have raised concerns with the FTSU Guardian at ESTH over Q3 and Q4 2025/26 shows that:

- **Administrative and Clerical staff** are the staff group which raised the highest number of concerns to the FTSU Guardian over the past year (2025/26), a total of 28 concerns for 2025/26, of which 23 were raised in Q3 and Q4. Concerns from Admin & Clerical staff amount to 31% of all concerns raised at ESTH in 2025/26.

- **Nursing and Midwifery** staff raised the second highest number of concerns in 2025/26, with 38 concerns raised over the course of the year, including 24 concerns raised in Q3 and Q4. Concerns from Nursing and Midwifery staff account for 24.3% of all concerns in 2025/26.

- **Medical and Dental** staff raised the joint third highest number of concerns in 2025/26, with a total of 16 concerns raised, of which 10 were raised in Q3 and Q4.

- **Additional Clinical Services** staff raised the joint third highest number of concerns in 2025/26, with 16 concerns raised over the year as a whole, including 10 in Q3 and Q4 2025/26.

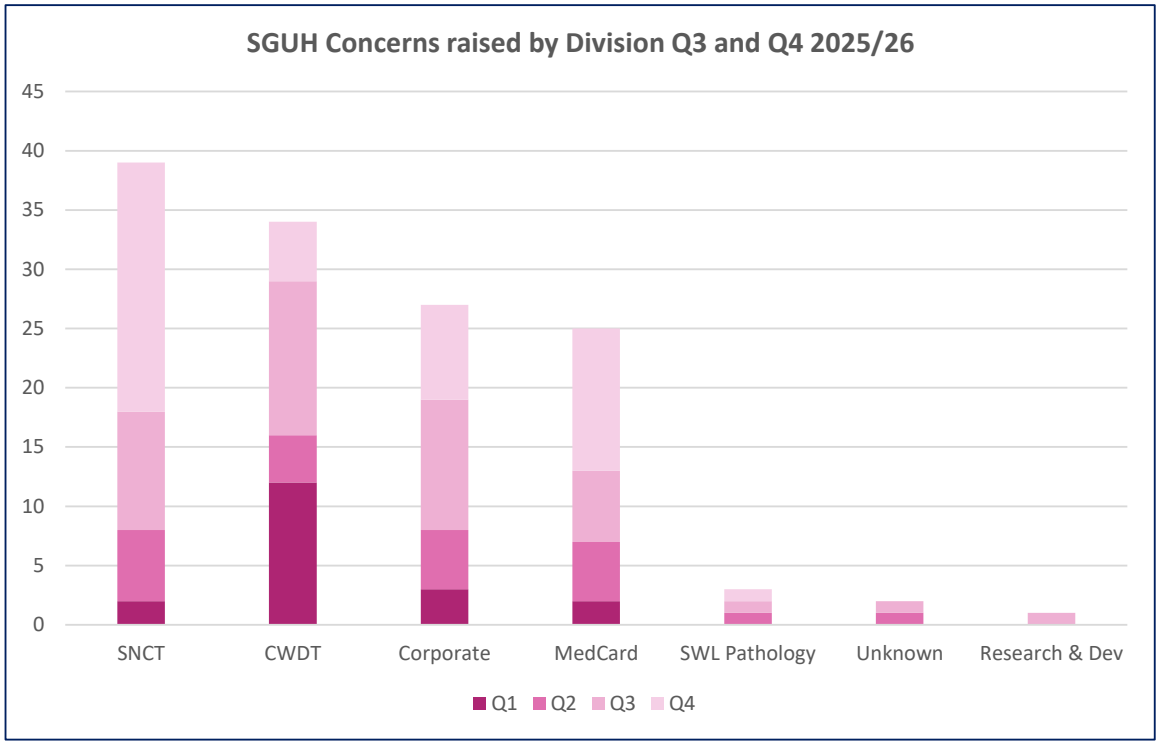
- **Additional Professional Scientific and Technical** staff raised 14 concerns across the year as a whole, of which 9 were raised in Q3 and Q4.

- **Estates, Facilities & Ancillary staff** raised a total of 10 concerns across the year, of which 2 were raised in Q3 and Q4.

- **Allied Health Professionals** raised a total of 5 concerns across 2025/26, of which 2 concerns were raised in Q3, with none in Q4.
- **Unknown staff groups** accounted for 9 concerns throughout 2025.26, including 5 in Q3 and Q4.

(d) Concerns raised by Divisions 2025/26 (SGUH)

3.9 The following chart shows the number of concerns raised by Division at SGUH in 2025/26:



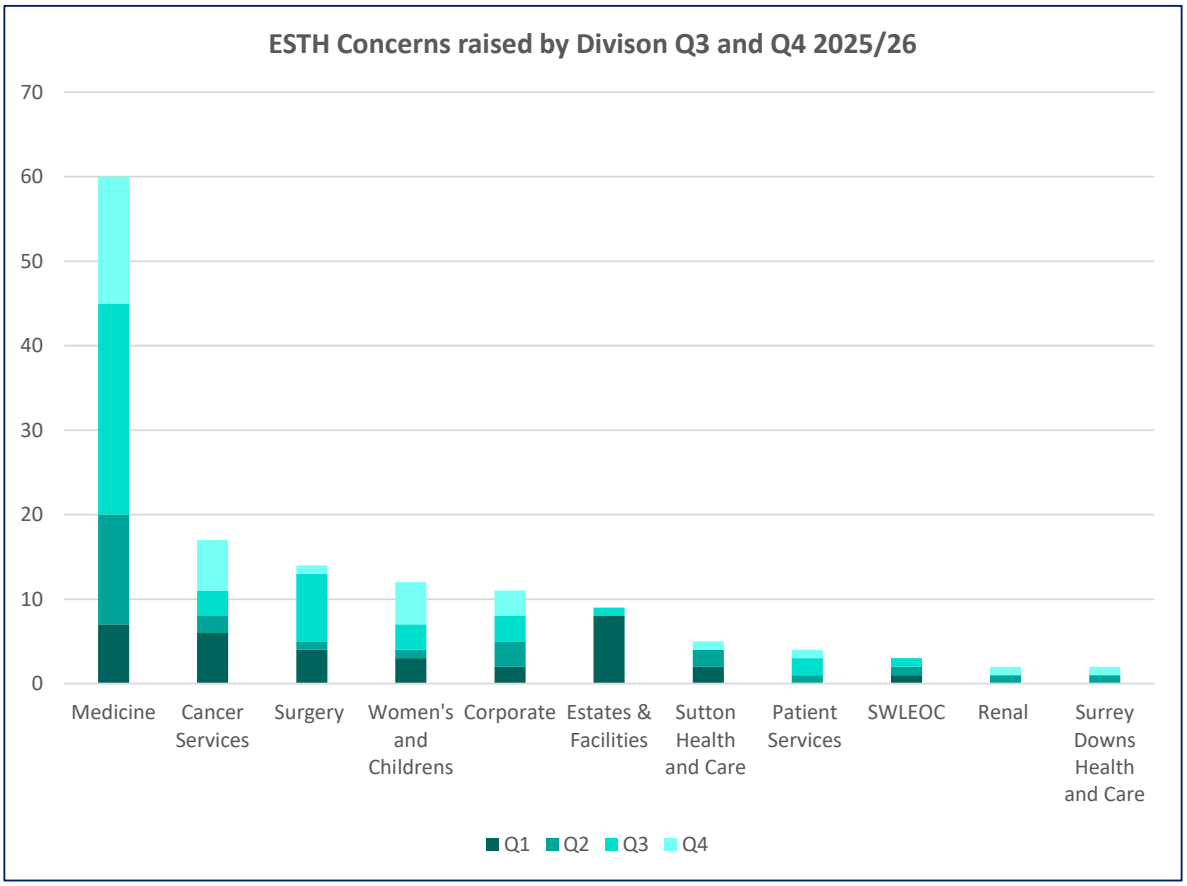
3.10 An analysis of the concerns raised by Division with the FTSU Guardian over the 2 quarters at SGUH shows that:

- Staff from SNCT Division raised the highest number of concerns in Q3 and Q4 2025/26 31 (34.44%), bringing the total number of concerns raised by staff in SNCT to 39 for 2025/26 as a whole, the first time the SNCT Division has recorded the highest number of concerns (previously CWDT consistently recorded the highest numbers).
- Staff in CWDT raised a total of 18 concerns over the second half of the year, bringing the total number of concerns to 34 for 2025/26.
- Staff from the Corporate Division raised 19 concerns in the second half of the year, bringing the total number of concerns raised in 2025/26 to 27.
- MedCard staff both raised 18 concerns over Q3 and Q4 2025/26, bringing the total number of concerns raised by staff in MedCard to 25 over the course of 2025/26.

- SWL Pathology staff raised 2 concerns over Q3 and Q4 2025/26, bringing the total to 3 over 2025/26 as a whole.
- Research and Development accounted for 1 concern

(e) Concerns raised by Division (ESTH)

3.11 The following chart shows the number of concerns raised by Division at ESTH over 2025/26:



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

- **Medicine Directorate** staff raised the most concerns, a total of 60 concerns for the year as a whole, with 40 of these raised during Q3 and Q4 2025/26. Concerns within Medicine represent 38.4% of all concerns raised by staff in 2025/26.
- **Cancer Services** staff raised 17 concerns during 2025/26 with 9 of these raised in Q3 and Q4. Cancer Services concerns represent 10.9% of all concerns.
- **Surgery** staff raised 14 concerns over 2025/26, with 9 of these raised in Q3 and Q4. Surgery concerns represent 9% of all concerns.
- **Women's and Children's** staff raised 12 concerns in 2025/26, with 8 of these raised in Q3 and Q4. W&C concerns represent 7.7% of all concerns.

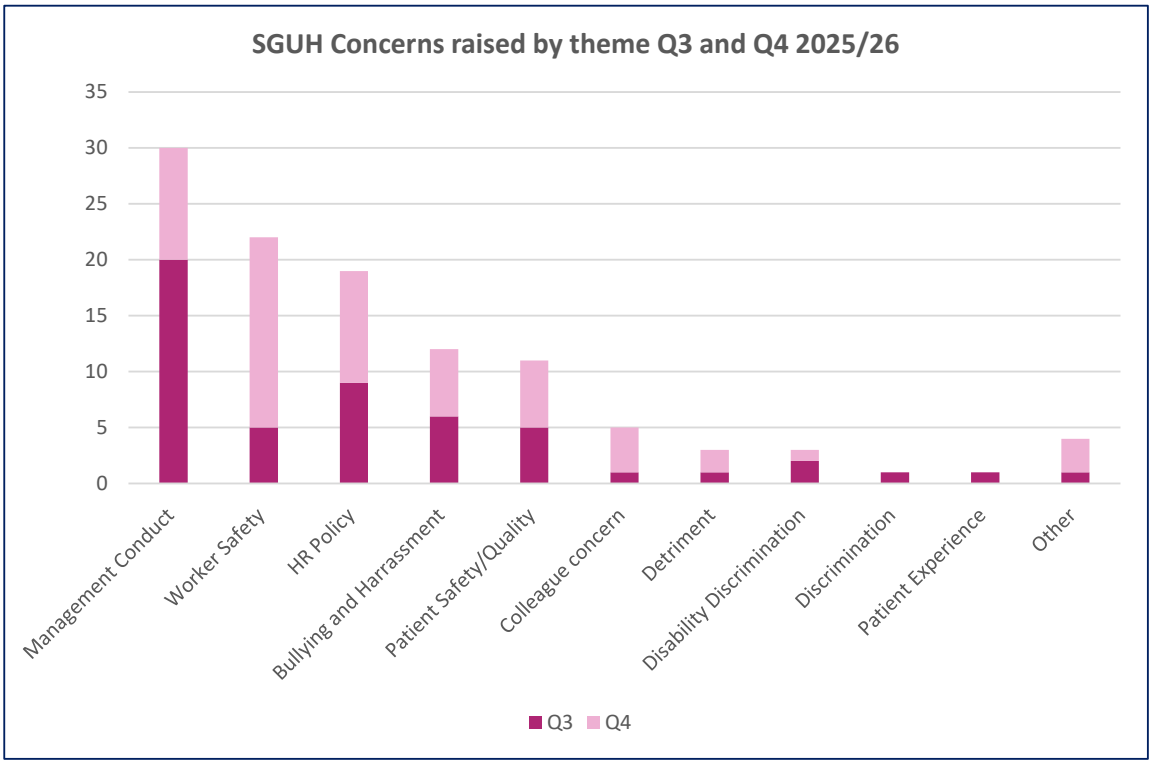
- **Corporate** staff raised 11 concerns, 6 of which were raised in Q3 and Q4. Corporate concerns represent 7% of all concerns.
- **Estates and Facilities** staff raised 9 concerns in 2025/26, of which 8 were raised in Q1. One further concern was raised in Q3 and none in Q4.
- **Integrated Care** saw 5 concerns raised from staff in Sutton Health and Care and 2 raised in Surrey Downs Health and Care.
- **Patient Services, Renal and SWLEOC** staff raised 4, 3 and 2 concerns respectively over 2025/26.

4.0 FTSU Themes

4.1 As well as analysing concerns raised by staff group and division, we also look at the types of concern being raised and the themes within these. Across the Group, the key themes in the concerns raised via FTSU in Q3 & Q4 2025/26 are:

(a) Themes in concerns raised to FTSU by staff at SGUH

4.2 The chart below illustrates the themes in the concerns raised by staff at SGUH during Q3 and Q4 2025/26:



4.3 The three main themes in concerns raised to the FTSU Guardian at SGUH are: (i) management conduct; (ii) worker safety, and (iii) HR policy. The themes and frequency of these concerns appear to be influenced by several interrelated organisational factors:

(i) Management conduct

- **Capacity constraints and competing demands**. Managers report to the Guardian that they are operating under significant workload pressures, with limited time and resources to address issues proactively. This leads to delayed decision making or reduced engagement in conflict resolution with staff, which may be perceived as poor conduct rather than a consequence of organisational strain. The Guardian also often suggests to managers engaging in regular 1 to 1's with staff ensuring that issues can be identified and resolved swiftly and also used as a means to build trust between managers and the staff they manage. It is noted however that many managers and staff alike confirm that due to time and resource restraints this is difficult to achieve.
- **Knowledge gaps and policy interpretation**. In some cases, staff have a lack of understanding of organisational policies and procedures. This can result in unrealistic expectations of managers, who are then held accountable for perceived inconsistencies or failures in policy application, even where guidance may be misinterpreted. Issues such as staging for sickness seem also to be an issue staff feel managers target them with rather than an organisational requirement.
- **Systemic organisational pressures.** Increasing service demands, alongside reduced staffing or resources, can create pressurised environments. These conditions may impact management behaviour and communication with staff contributing to tensions or misunderstandings between managers and staff rather than deliberate misconduct.
- There are instances where the behaviour of some managers is not in line with trust values. Staff feel that these issues are not addressed appropriately and that managers are, at times, protected by the organisation when these incidents are reported.

(ii) Worker Safety

- **Prolonged investigation processes**. Extended delays and timeframes for workplace investigations are continuing to contribute to heightened stress and uncertainty for staff, negatively impacting both performance and wellbeing, and in some cases resulting in increased and prolonged sickness absence.
- **Psychological impact on worker safety**. Ongoing unresolved issues can create a sustained sense of anxiety and lack of psychological safety, affecting the ability for staff to feel secure and supported in their roles.
- **Workplace conflict and interpersonal strain**. Escalating conflict between colleagues is contributing to a perceived unsafe working environment, where tension and breakdowns in professional relationships undermine team effectiveness and staff confidence.

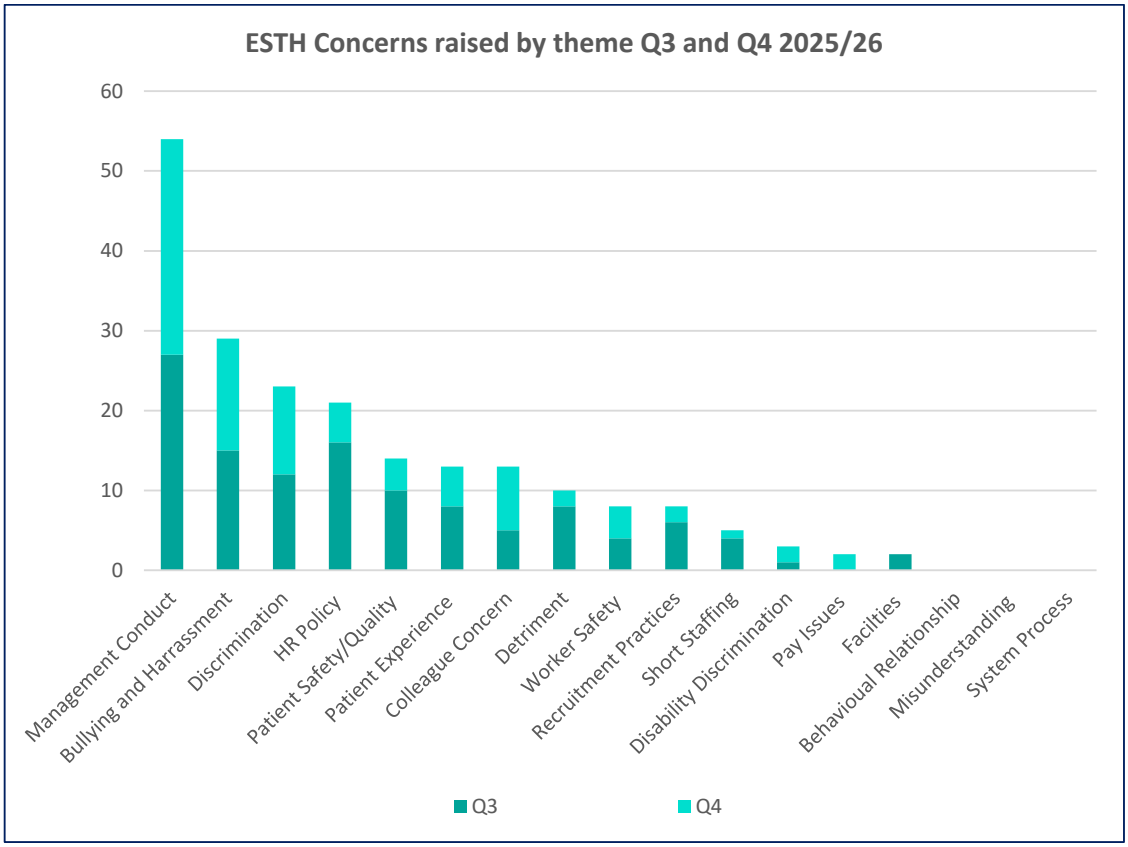
(iii) HR Policy

- **Inconsistent adherence to policy timelines**. Staff are raising concerns where organisational processes, particularly around investigations and case handling, are not completed within stated timeframes, leading to perceptions that policies are not being applied consistently or fairly. Further, that no meaningful explanations are given to staff when this is raised with managers/HR.

- **Perceived lack of impartiality within HR**. There is a growing belief among some staff that HR may not act as a neutral party, particularly when individuals make direct contact, leading to assumptions that HR is aligned more closely with management perspectives.
- **Lack of trust in policy application.** Where there are perceived deviations from policy or unclear communication about decisions, staff confidence in HR processes is reduced, resulting in increased scrutiny and challenge of how policies are interpreted and implemented and increased reports of unhappiness to the FTSU Guardian.

(b) Themes in concerns raised to FTSU by staff at ESTH

4.4 The chart below illustrates the themes in the concerns raised by staff at ESTH during Q3 and Q4 2025/26:



4.5 The three main themes in concerns raised to the FTSU Guardian at ESTH are: (i) management conduct; (ii) bullying and harassment, and (iii) discrimination.

4.6 The concern related to management conduct and leadership style relate to:

- Unaddressed inappropriate behaviour: Concerns are increasing where both managers and staff are perceived to engage in poor or unprofessional behaviour that is not consistently challenged or addressed, leading to a normalisation of unacceptable conduct.

- Breaches of confidentiality: Incidents involving the inappropriate sharing or handling of sensitive information are undermining trust, with staff feeling that confidentiality is not always maintained in line with expected standards. Examples such as discussions around why staff are off on sick leave being discussed by managers with staff.
- Lack of timely intervention and accountability: Delays or inconsistencies in responding to behavioural concerns can create a perception that issues are not taken seriously, contributing to escalation and a higher volume of reported cases. Some staff at ESTH report that they feel due to management friendships they do not feel that steps are taken to address issues reported.

5.0 Recommendations

5.1 It is good practice for FTSU Guardians to set out recommendations to the Executive and Board based on their experience of dealing with staff concerns. The following recommendations are suggested:

- **Strengthen timeliness and oversight of processes:** Introduce clear service level expectations for HR cases and grievances, supported by regular monitoring, escalation triggers, and transparent communication. Failure to address continued delays risks concerns being escalated externally and an increase in ET claims.
- **Enhance management accountability and capability:** Provide targeted training and supervision for managers on handling concerns, conduct, and conflict resolution, alongside clear accountability measures. Without this, there is a heightened risk of unresolved issues and reputational damage.
- **Improve staff awareness and engagement with policies:** Deliver accessible guidance, regular briefings, and opportunities for dialogue to ensure staff understand organisational policies and procedures. If not addressed, misunderstandings may persist, leading to increased complaints, loss of trust and continued management conflict concerns.

6.0 Speak Up, Listen Up, Follow Up Training

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

6.2 The Guardian has regularly updated the committee on the disparity between staff across gesh who have completed the FTSU training. Consistently over 90% of staff at SGUH have completed the training whereby less than 1% at ESTH. The training is mandatory at SGUH and not at ESTH.

7.0 Priorities for FTSU Service Going Forward

7.1 In terms of the priorities of the Group FTSU Service over the first two quarters of 2026 we are focused on:

- **Strengthen focus on detriment and sexual safety cases**. Work in partnership with the organisation to ensure concerns relating to detriment and sexual safety are promptly identified, thoroughly investigated, and appropriately addressed, with learning captured to prevent recurrence and minimise organisational risk.
- **Improve visibility and accessibility of the FTSU service**. Prioritise recruitment to fill current vacancies within the FTSU team, recognising the impact this has on Guardian visibility, staff access, and confidence in speaking up.
- **Enhance engagement and early intervention**. Increase proactive engagement with staff and managers to promote speaking up, support early resolution of concerns, and ensure issues are addressed before escalation, reinforcing a positive and open culture.
- **Systematise and disseminate learning from concerns.** While learning is currently identified from concerns raised to FTSU, we are planning to strengthened in a more systematic way how learning is identified and shared, and disseminated to staff across the Group to support the building of staff confidence in speaking up.

8.0 NHS Staff Survey 2025 – Raising Concerns

8.1 Four questions in the NHS Staff Survey are used to produce an overall score for the healthiness of the speak up culture in an organisation. The questions are:

- Q20a: Would feel secure raising concerns about unsafe clinical practice
- Q20b: Would feel confident the organisation would address concerns about unsafe clinical practice
- Q25a: Feel safe to speak up about anything that concerns me in this organisation
- Q25f: Feel organisation would address any concerns I raised

8.2 Attached at Appendix 1 is an analysis of the speaking up responses to the four speak up questions in the NHS Staff Survey 2025. This analysis sets out the scores across the Trusts as a whole and by Division. Overall, both Trusts are in the third quartile nationally for their speak up metrics, as set out in the NHS Staff Survey (SGUH scoring 6.2 and ESTH 6.3 in the people promise theme for speaking up):

- Within ESTH, results for Sutton Health and Care and Surrey Downs Health and Care score significantly above the Trust average (at 6.7 and 6.9 respectively) as does SWLEOC (at 6.9) and Renal (at 6.8). Women's and Children's (6.1), Medicine (6.0) and Planned Care (6.1) all score below the Trust average, with Clinical Services (5.5) scoring significantly below the Trust average.
- Within SGUH, all three clinical divisions score the same as the Trust average (6.2), though SNCT and MedCard have seen declines from 6.4 in 2024.

9.0 Recommendation

9.1 The Group Board is asked to:

a) Note the number of concerns reported to the FTSU Guardians in Q3 and Q4 for both SGUH and ESTH and the staff groups reporting.
b) Note the themes emerging from FTSU cases in this period.
c) Note the recommendations of the Group FTSU Guardian as set out in section 5 of the report.
d) Note the priorities of the new Group FTSU service in the coming months.

NHS
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University Hospitals and Health Group

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Appendix 1: Raising Concerns Sub-Scores NHS Staff Survey 2025

Group Board
8 May 2026

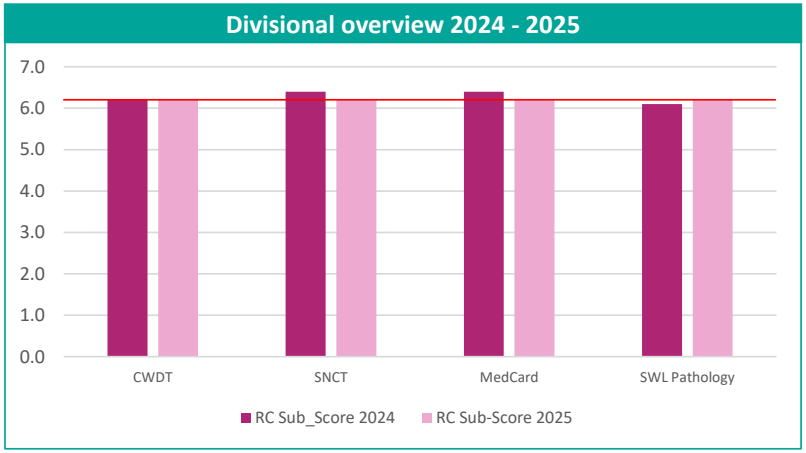
Raising Concerns Sub-Scores – NHS Staff Survey 2025

St George's Site

		Children's, Women's, Diagnostics and Therapies				Surgery, Neurosciences, Cancer and Theatres				Medicine and Cardiovascular				SWL Pathology				Trust Score 2025
		Division Score 2025	Division Score 2024	Divison Score 2025 vs 2024	Division Score 2025 vs Trust score	Division Score 2025	Division Score 2024	Divison Score 2025 vs 2024	Division Score 2025 vs Trust score	Division Score 2025	Division Score 2024	Divison Score 2025 vs 2024	Division Score 2025 vs Trust score	Division Score 2025	Division Score 2024	Divison Score 2025 vs 2024	Division Score 2025 vs Trust score	
q20a	Would feel secure raising concerns about unsafe clinical practice	70.5%	70.7%	-0.2%	70.5%	67.7%	71.2%	-3.5%	67.7%	71.7%	74.0%	-2.4%	71.7%	69.1%	66.2%	2.9%	69.1%	67.9%
q20b	Would feel confident that organisation would address concerns about unsafe clinical practice	50.8%	51.4%	-0.7%	50.8%	53.0%	55.2%	-2.2%	53.0%	55.5%	58.8%	-3.4%	55.5%	53.2%	52.4%	0.8%	53.2%	51.7%
q25e	Feel safe to speak up about anything that concerns me in this organisation	58.9%	58.5%	0.4%	58.9%	59.2%	60.7%	-1.5%	59.2%	58.4%	60.4%	-2.0%	58.4%	57.2%	54.5%	2.7%	57.2%	58.1%
q25f	Feel organisation would address any concerns I raised	41.9%	43.8%	-1.9%	41.9%	45.5%	48.6%	-3.0%	45.5%	47.3%	48.3%	-1.1%	47.3%	44.7%	42.3%	2.4%	44.7%	44.4%
PP3_2	*Raising concerns sub-score*	6.2	6.2	0.0	6.2%	6.2	6.4	-0.2	6.2	6.2	6.4	-0.2	6.2	6.2	6.1	0.1	6.2	6.2

Commentary

- The Raising Concerns Sub-Score is one of only two Staff Survey metrics included in the NOF (the other being overall staff survey engagement theme score).
- All Divisions are in line with the overall Trust position for the raising concerns sub-score (at 6.2)
- Within this:
  - CWDT is unchanged overall (6.2 in both years)
  - SNCT and MedCard have declined from 6.4 in 2024 to 6.2 in 2025
  - SWL Pathology has improved from 6.1 in 2024 to 6.2 in 2025



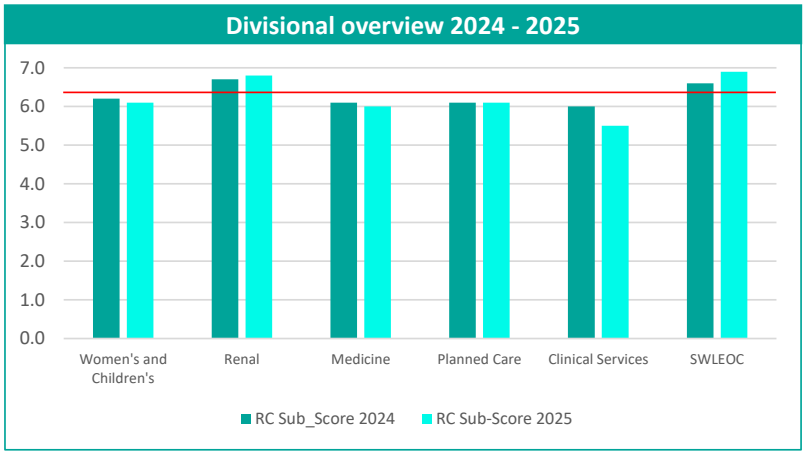
Raising Concerns Sub-Scores – NHS Staff Survey 2025

Epsom & St Helier Site

		Women & Children's Services				Renal Services				Medicine				Planned Care				Clinical Services				EOC				Trust Score 2025
		Division Score 2025	Division Score 2024	Divison Score 2025 vs 2024	Division Score 2025 vs Trust score	Division Score 2025	Division Score 2024	Divison Score 2025 vs 2024	Division Score 2025 vs Trust score	Division Score 2025	Division Score 2024	Divison Score 2025 vs 2024	Division Score 2025 vs Trust score	Division Score 2025	Division Score 2024	Divison Score 2025 vs 2024	Division Score 2025 vs Trust score	Division Score 2025	Division Score 2024	Divison Score 2025 vs 2024	Division Score 2025 vs Trust score	Division Score 2025	Division Score 2024	Divison Score 2025 vs 2024	Division Score 2025 vs Trust score	
q20a	Would feel secure raising concerns about unsafe clinical practice	72.4%	72.1%	0.2%	72.4%	80.8%	72.1%	8.7%	80.8%	68.1%	66.9%	1.2%	68.1%	67.1%	64.8%	2.3%	67.1%	61.8%	67.0%	-5.2%	61.8%	75.4%	69.0%	6.4%	75.4%	70.2%
q20b	Would feel confident that organisation would address concerns about unsafe clinical practice	49.1%	51.4%	-2.3%	49.1%	70.3%	64.3%	6.0%	70.3%	51.3%	54.9%	-3.6%	51.3%	52.6%	54.0%	-1.5%	52.6%	36.2%	49.0%	-12.8%	36.2%	69.7%	62.2%	7.6%	69.7%	56.1%
q25e	Feel safe to speak up about anything that concerns me in this organisation	50.5%	54.9%	-4.3%	50.5%	67.8%	66.8%	0.9%	67.8%	54.8%	55.0%	-0.2%	54.8%	51.9%	53.4%	-1.5%	51.9%	46.5%	54.9%	-8.4%	46.5%	65.5%	58.9%	6.6%	65.5%	57.3%
q25f	Feel organisation would address any concerns I raised	36.7%	41.8%	-5.0%	36.7%	55.2%	59.0%	-3.8%	55.2%	41.7%	45.6%	-3.9%	41.7%	40.4%	44.8%	-4.5%	40.4%	30.4%	39.0%	-8.6%	30.4%	59.3%	50.6%	8.6%	59.3%	46.3%
PP3_2	*Raising concerns sub-score*	6.1	6.2	-0.1	6.1	6.8	6.7	0.1	6.8	6.0	6.1	-0.1	6.0	6.1	6.1	0.1	6.1	5.5	6.0	-0.6	5.5	6.9	6.6	0.3	6.9	6.3

Commentary

- The Raising Concerns Sub-Score is one of only two Staff Survey metrics included in the NOF (the other being overall staff survey engagement theme score).
- SWLEOC and Renal Services are the two Divisions at ESTH that have Raising Concerns Sub-Scores higher than the Trust overall. Both Divisions have also improved their Sub-Score in 2025 from the previous year:
  - SWLEOC (from 6.6 in 2024 to 6.9 in 2025)
  - Renal Services (from 6.7 in 2024 to 6.8 in 2025)
- Three Divisions have recorded a reduction in their Raising Concerns Sub-Score in 2025 compared with the previous year:
  - Women's and Children's and Medicine have both fallen by 0.1 in 2025
  - Clinical Services has seen a substantial decline in 2025, from 6.0 in 2024 to 5.5 in 2025 (a fall of 0.5 overall)



Raising Concerns Sub-Scores – NHS Staff Survey 2025

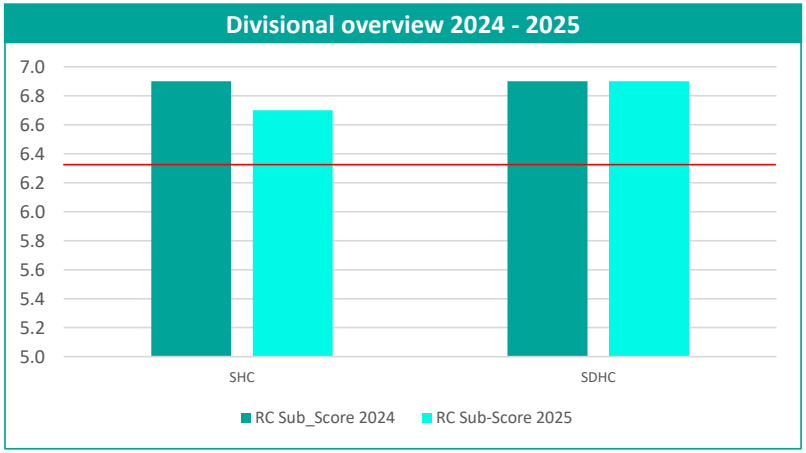
Integrated Care Site

		Sutton Health & Care				Surrey Downs Health & Care				Trust Score 2025
		Division Score 2025	Division Score 2024	Divison Score 2025 vs 2024	Division Score 2025 vs Trust score	Division Score 2025	Division Score 2024	Divison Score 2025 vs 2024	Division Score 2025 vs Trust score	
q20a	Would feel secure raising concerns about unsafe clinical practice	79.7%	80.6%	-1.0%	79.7%	79.4%	81.2%	-1.8%	79.4%	70.2%
q20b	Would feel confident that organisation would address concerns about unsafe clinical practice	62.4%	69.6%	-7.2%	62.4%	68.5%	62.4%	6.2%	68.5%	56.1%
q25e	Feel safe to speak up about anything that concerns me in this organisation	64.2%	68.9%	-4.7%	64.2%	67.7%	71.0%	-3.2%	67.7%	57.3%
q25f	Feel organisation would address any concerns I raised	48.6%	59.0%	-10.3%	48.6%	60.3%	56.0%	4.3%	60.3%	46.3%
PP3_2	*Raising concerns sub-score*	6.7	6.9	-0.3	6.7	6.9	6.9	0.1	6.9	6.3

Commentary

- Both Sutton Health & Care and Surrey Downs Health and Care recorded significantly higher raising concerns sub-scores in the 2025 NHS Staff Survey compared with the Trust average – both recording sub-scores of 6.7 and 6.9 respectively

- For Sutton Health and Care, there were significant drops in the confidence of staff that the organisation would respond to concerns raised by staff – with the confidence that the organisation would respond to safety concerns falling by 7.2 percentage points and confidence that the organisation would respond to any concerns falling by 10.3 percentage points. This was in contrast to Surrey Downs Health & Care which recorded increases in both of these metrics.



Raising Concerns Sub-Scores – NHS Staff Survey 2025

Corporate Services – SGUH

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2025 NHS Staff Survey Response Rate

Corporate Service	Response Rate %	Eligible	Responsed
Group Chief Medical Officer	78.8	33	26
Group Communications	78.6	14	11
Group Corporate Affairs	72.7	33	24
Research and Development	68.8	96	66
Finance	61.4	140	86
Group Chief Nursing Officer	55.3	199	110
Estates & Facilities	53.0	379	201
ICT	51.6	155	80
HR Operations	50.0	192	96

2025 NHS Staff Survey Raising Concerns Sub-Score

		Corporate Division				Estates & Facilities				Research & Development				Trust Score 2025
		Division Score 2025	Division Score 2024	Divison Score 2025 vs 2024	Division Score 2025 vs Trust score	Division Score 2025	Division Score 2024	Divison Score 2025 vs 2024	Division Score 2025 vs Trust score	Division Score 2025	Division Score 2024	Divison Score 2025 vs 2024	Division Score 2025 vs Trust score	
q20a	Would feel secure raising concerns about unsafe clinical practice	57.3%	59.0%	-1.6%	57.3%	53.2%	53.2%	0.0%	53.2%	75.8%	71.8%	4.0%	75.8%	67.9%
q20b	Would feel confident that organisation would address concerns about unsafe clinical practice	45.6%	46.6%	-1.1%	45.6%	46.8%	41.9%	4.9%	46.8%	59.1%	59.0%	0.1%	59.1%	51.7%
q25e	Feel safe to speak up about anything that concerns me in this organisation	53.8%	55.2%	-1.4%	53.8%	56.8%	54.0%	2.9%	56.8%	56.1%	53.8%	2.2%	56.1%	58.1%
q25f	Feel organisation would address any concerns I raised	44.0%	41.3%	2.7%	44.0%	46.3%	31.7%	14.6%	46.3%	48.5%	46.2%	2.3%	48.5%	44.4%
PP3_2	***Raising concerns sub-score***	**6.0**	**6.0**	**0.0**	**6.0%**	**6.1**	**5.6**	**0.6**	**6.1**	**6.2**	**6.3**	**-0.1**	**6.2**	6.2
		Staff: 627/1139				Staff: 201/379				Staff: 66/96				

Raising Concerns Sub-Scores – NHS Staff Survey 2025

Corporate Services – SGUH

		Finance				Human Operations				Education & Development				Group Chief Nursing Officer				Group Deputy Chief Executive				Trust Score 2025
		Division Score 2025	Division Score 2024	Divison Score 2025 vs 2024	Division Score 2025 vs Trust score	Division Score 2025	Division Score 2024	Divison Score 2025 vs 2024	Division Score 2025 vs Trust score	Division Score 2025	Division Score 2024	Divison Score 2025 vs 2024	Division Score 2025 vs Trust score	Division Score 2025	Division Score 2024	Divison Score 2025 vs 2024	Division Score 2025 vs Trust score	Division Score 2025	Division Score 2024	Divison Score 2025 vs 2024	Division Score 2025 vs Trust score	
q20a	Would feel secure raising concerns about unsafe clinical practice	43.5%	55.2%	-11.6%	43.5%	53.2%	53.2%	0.0%	53.2%	61.2%	65.2%	-4.0%	61.2%	73.6%	69.4%	4.2%	73.6%	50.0%	63.6%	-13.6%	50.0%	67.9%
q20b	Would feel confident that organisation would address concerns about unsafe clinical practice	38.8%	50.6%	-11.8%	38.8%	46.8%	41.9%	4.9%	46.8%	38.8%	47.8%	-9.1%	38.8%	52.7%	43.9%	8.8%	52.7%	50.0%	40.9%	9.1%	50.0%	51.7%
q25e	Feel safe to speak up about anything that concerns me in this organisation	52.3%	55.7%	-3.4%	52.3%	56.8%	54.0%	2.9%	56.8%	55.1%	54.3%	0.8%	55.1%	54.1%	51.0%	3.1%	54.1%	50.0%	77.3%	-27.3%	50.0%	58.1%
q25f	Feel organisation would address any concerns I raised	46.5%	46.6%	-0.1%	46.5%	46.3%	31.7%	14.6%	46.3%	30.6%	39.1%	-8.5%	30.6%	39.4%	35.7%	3.7%	39.4%	57.1%	50.0%	7.1%	57.1%	44.4%
PP3_2	*Raising concerns sub-score*	5.9	6.3	-0.3	5.9	6.1	5.6	0.6	6.1	5.7	6.2	-0.5	5.7	6.2	6.0	0.2	6.2	6.6	6.4	0.2	6.6	6.2
		Staff: 86/140				Staff: 96/192				Staff: 49/93				Staff: 110/199				Staff: 14/21				

		Group Chief Medical Officer				Group Corporate Affairs				Group Communications				Research & Development				Trust Score 2025
		Division Score 2025	Division Score 2024	Divison Score 2025 vs 2024	Division Score 2025 vs Trust score	Division Score 2025	Division Score 2024	Divison Score 2025 vs 2024	Division Score 2025 vs Trust score	Division Score 2025	Division Score 2024	Divison Score 2025 vs 2024	Division Score 2025 vs Trust score	Division Score 2025	Division Score 2024	Divison Score 2025 vs 2024	Division Score 2025 vs Trust score	
q20a	Would feel secure raising concerns about unsafe clinical practice	57.7%	47.4%	10.3%	57.7%	58.3%	55.2%	3.2%	58.3%	54.5%	45.5%	9.1%	54.5%	75.8%	71.8%	4.0%	75.8%	67.9%
q20b	Would feel confident that organisation would address concerns about unsafe clinical practice	46.2%	36.8%	9.3%	46.2%	50.0%	51.7%	-1.7%	50.0%	27.3%	36.4%	-9.1%	27.3%	59.1%	59.0%	0.1%	59.1%	51.7%
q25e	Feel safe to speak up about anything that concerns me in this organisation	46.2%	36.8%	9.3%	46.2%	66.7%	62.1%	4.6%	66.7%	36.4%	45.5%	-9.1%	36.4%	56.1%	53.8%	2.2%	56.1%	58.1%
q25f	Feel organisation would address any concerns I raised	30.8%	15.8%	15.0%	30.8%	62.5%	44.8%	17.7%	62.5%	27.3%	36.4%	-9.1%	27.3%	48.5%	46.2%	2.3%	48.5%	44.4%
PP3_2	*Raising concerns sub-score*	6.0	5.2	0.8	6.0	6.2	6.0	0.2	6.2	5.3	5.8	-0.5	5.3	6.2	6.3	-0.1	6.2	6.2
		Staff: 26/33				Staff: 24/33				Staff: 11/14				Staff: 66/96				

Raising Concerns Sub-Scores – NHS Staff Survey 2025

Corporate Services – ESTH

2025 NHS Staff Survey Response Rate

Corporate Service	Response Rate %	Eligible	Responsed
Finance	56.7	67	38
Digital	54.5	88	48
Estates & Facilities	44.8	723	324

2025 NHS Staff Survey Raising Concerns Sub-Score

		Finance				Digital				Estates & Facilities				Trust Score 2025
		Division Score 2025	Division Score 2024	Divison Score 2025 vs 2024	Division Score 2025 vs Trust score	Division Score 2025	Division Score 2024	Divison Score 2025 vs 2024	Division Score 2025 vs Trust score	Division Score 2025	Division Score 2024	Divison Score 2025 vs 2024	Division Score 2025 vs Trust score	
q20a	Would feel secure raising concerns about unsafe clinical practice	69.4%	63.5%	6.0%	69.4%	53.2%	56.9%	-3.7%	53.2%	57.7%	62.7%	-4.9%	57.7%	70.2%
q20b	Would feel confident that organisation would address concerns about unsafe clinical practice	61.1%	50.0%	11.1%	61.1%	46.8%	44.1%	2.7%	46.8%	60.3%	62.4%	-2.1%	60.3%	56.1%
q25e	Feel safe to speak up about anything that concerns me in this organisation	59.5%	59.6%	-0.2%	59.5%	45.8%	51.7%	-5.9%	45.8%	60.6%	63.0%	-2.4%	60.6%	57.3%
q25f	Feel organisation would address any concerns I raised	56.8%	53.8%	2.9%	56.8%	33.3%	35.6%	-2.3%	33.3%	55.9%	59.6%	-3.7%	55.9%	46.3%
PP3_2	*Raising concerns sub-score*	6.7	6.5	0.3	0.1	6.1	6.1	-0.1	6.1	6.4	6.5	-0.1	6.4	6.3
		Staff: 38/67				Staff: 48/88				Staff: 324/723				

Group Board

Meeting in Public on Friday, 08 May 2026

Agenda Item	5.1	
Report Title	**Fit and Proper Persons Test Annual Compliance Report 2025/26**	
Executive Lead(s)	Stephen Jones, Group Chief Corporate Affairs Officer	
Report Author(s)	Kelly Brown, Senior Corporate Governance Manager	
Previously considered by	-	-
Purpose	**For Assurance**	

Executive Summary

This paper provides assurance to the Group Board that all Board Directors at both Trusts within the Group remain fit and proper for their roles in line with Regulation 5 of the *Health and Social Care Act 2008 (Regulated Activities) Regulations 2014* and the *Fit and Proper Persons Test Framework (FPPT) for England* published in August 2023.

All Directors on the Boards of both Epsom and St Helier University Hospitals NHS Trust (ESTH) and St George's University Hospitals NHS Foundation Trust (SGUH) have successfully undergone all of the required checks under the Fit and Proper Persons Test Framework in 2025/26 and the two Trusts will make the required submissions to NHS England following the Group Board's consideration of this report, ahead of the 30 June 2026 deadline.

The relevant FPPT checks were completed for all new Board members.

Action required by Group Board

The Group Board is asked to note that the Fit and Proper Persons Test has been conducted for the period 2025/26 and that all Board members of both ESTH and SGUH satisfy the requirements of the Test.

Committee Assurance	
Committee	N/A
Level of Assurance	Not Applicable

Appendices	
Appendix No.	**Appendix Name**
Appendix 1	FPPT Checks Annual Compliance 2025/26

Implications

Group Strategic Objectives

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

Risks

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

CQC Theme

☐ Safe	☐ Effective	☐ Caring	☐ Responsive	☒ Well Led

NHS system oversight framework

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

Financial implications

There are no financial implications.

Legal and / or Regulatory implications

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

Equality, diversity and inclusion implications

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

Environmental sustainability implications

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

Fit and Proper Persons Test Annual Compliance Report 2025/26
Group Board, 08 May 2026

1.0 Purpose of paper

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

2.0 Background

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

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

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

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

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

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

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

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

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

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

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

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

3.0 Fit and Proper Persons Test: Summary of Checks Undertaken

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

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

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

4.0 Fit and Proper Persons Test: Outcome and Compliance 2025/26

4.1 During February and March 2025/26, under the supervision of the Group Chair, who is accountable for FPPT under the Framework, all existing Board members of both ESTH and SGUH underwent the annual FPPT assessment as outlined above for 2025/26:

- All Board members completed Annual FPPT Self Assessment Forms. These forms have been reviewed and are all satisfactory.
- The further annual checks, set out above, were undertaken by an independent background checks company contracted by South West London Recruitment Hub. These have been completed for all Board members and no issues have been identified that affect the fit and proper status of any member of either Trust Board.

4.2 Appendix 1 sets out the completion of the tests for members of the ESTH and SGUH Boards for 2025/26.

4.3 Following the completion of the FPPT checks and review of this report by the Group Board, both ESTH and SGUH will make annual compliance submissions to NHS England in line with the requirements of the Framework, ahead of the deadline of 30 June 2026.

New Board members, 2025/26

4.4 During 2025/26, the following Board members joined the Boards:

Board member	Role	Trust	Date joined	FPPT completed
Sir Mark Lowcock	Group Chair	Both	1 April 2025	Y
Michael Pantlin	Group Deputy Chief Executive Officer	Both	Interim - 22 April 2025 Substantive - 1 September 2025	Y
Khadir Meer	Associate Non-Executive Director	SGUH	24 April 2025	Y
Ralph Michell*	Group Chief Transformation Officer	Both	1 April 2025	Y
Elaine Clancy	Interim Group Chief Nursing Officer	Both	15 September 2025	Y
James Blythe**	Interim Group Chief Executive Officer	Both	18 September 2025	Y
Alex Shaw	Interim Managing Director - ESTH	ESTH	18 September 2025	Y
Leonie Penna	Non-Executive Director SGUH, Associate Non-Executive Director ESTH	Both	1 October 2025	Y
Pankaj Davé***	Non-Executive Director	ESTH	1 October 2025	Y
Bidesh Sarkar	Non-Executive Director	Both	13 October 2025	Y
Elizabeth Alabaster	Interim Group Chief Financial Officer	Both	1 December 2025	Y

** The role of Group Chief Transformation Officer was temporarily a Board level role between 1 April 2025 and 31 August 2025 during the period in which the role of Group Deputy Chief Executive Officer was filled on an interim basis. Ralph Michell served as GCTO on the Board from 1 April 2025 to 31 August 2025, at which point the GCTO post reverted to being a Group Director role reporting into the Group Deputy Chief Executive Officer.*
*** James Blythe held a pre-existing substantive appointment as Managing Director at ESTH*
*** Pankaj Davé held a pre-existing appointment as a Non-Executive Director at SGUH, which started on 1 February 2025*

4.5 Beyond the reporting year 2025/26, the Group appointed a new Group Chief Executive Officer, Matthew Shaw, who started in post on 7 April 2026. All FPPT checks we successfully completed ahead of Dr Shaw taking up his appointment. For reporting purposes, Dr Shaw's FPPT status will be incorporated into 2026/27 reporting.

Departing Board members, 2024/25

4.6 Under the FPPT Framework, the employing NHS organisation is required to complete a Board Member Reference for any departing Board member using the prescribed reference template. Board Member References have been completed for departing Board members of both ESTH and SGUH in 2025/26:

Board member	Role	Trust	Date left	Board Member Reference Completed
Arelene Wellman	Group Chief Nursing Officer	Both	31 August 2025	Y
Ralph Michell*	Group Chief Transformation Officer	Both	31 August 2025	Y
Jaqueline Totterdell	Group CEO	Both	18 September 2025	Y
Ann Beasley	Non-Executive Director	Both	12 October 2025	Y
Peter Kane	Non-Executive Director	Both	30 September 2025	Y
Andrew Grimshaw	Group Chief Financial Officer	Both	30 November 2025	Y

** See corresponding note in the above table. Ralph Michell served as GCTO on the Board from 1 April 2025 to 31 August 2025.*

Conclusion

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

5.0 Recommendations

5.1 The Group Board is asked to note that the Fit and Proper Persons Test has been conducted for the period 2025/26 and that all Board members of both ESTH and SGUH satisfy the requirements of the Test.

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

St George's University Hospitals NHS Foundation Trust - Fit and Proper Persons Test Annual Compliance 2025/26

Last Name	First Name	Job Role	Qualifications Check	Occupational Health Check	References Check	Open/Upheld Disciplinary Case	Open/Upheld Grievance Case	Social Media Date Checked	Not Disqualified as a Charitable Trustee	Not Disqualified from Directors Register	No Employment Tribunal Judgements	DBS Requirements	Not Found on Insolvency Register	Prof Reg Check	Self-Declaration
Lowcock	Mark	Chair (from 1 April 2025)	Completed	Completed	Completed	None	None	Completed	Confirmed	Confirmed	Confirmed	Confirmed	Confirmed	N/A	Completed
Armstrong	Natalie	Non-Executive Director	Completed	Completed	Completed	None	None	Completed	Completed	Completed	Completed	Completed	Confirmed	N/A	Completed
Beasley	Ann	Non-Executive Director (to 12 October 2025)	Completed	Completed	Completed	None	None	Completed	Confirmed	Confirmed	Confirmed	Confirmed	Confirmed	N/A	Completed
Davé	Pankaj	Non-Executive Director	Completed	Completed	Completed	None	None	Completed	Confirmed	Confirmed	Confirmed	Confirmed	Confirmed	N/A	Completed
Jones	Chiew Yin	Non-Executive Director	Completed	Completed	Completed	None	None	Completed	Confirmed	Confirmed	Confirmed	Confirmed	Confirmed	N/A	Completed
Kane	Peter	Non-Executive Director (to 30 September 2025)	Completed	Completed	Completed	None	None	Completed	Confirmed	Confirmed	Confirmed	Confirmed	Confirmed	N/A	Completed
Meer	Khadir	Associate Non-Executive Director (from 24 April 2025)	Completed	Completed	Completed	None	None	Completed	Completed	Completed	Confirmed	Confirmed	Confirmed	N/A	Completed
Murray	Andrew	Non-Executive Director	Completed	Completed	Completed	None	None	Completed	Confirmed	Confirmed	Confirmed	Confirmed	Confirmed	Confirmed	Completed
Penna	Leonie	Non-Executive Director (from 1 October 2025)	Completed	Completed	Completed	None	None	Completed	Confirmed	Confirmed	Confirmed	Confirmed	Confirmed	Confirmed	Completed
Sarkar	Bidesh	Non-Executive Director (from 13 October 2025)	Completed	Completed	Completed	None	None	Completed	Confirmed	Confirmed	Confirmed	Confirmed	Confirmed	N/A	Completed
Sunderland Hay	Claire	Associate Non-Executive Director	Completed	Completed	Completed	None	None	Completed	Completed	Completed	Completed	Completed	Confirmed	N/A	Completed
Totterdell	Jacqueline	Group Chief Executive (to 17 September 2025)	Completed	Completed	Completed	None	None	Completed	Confirmed	Confirmed	Confirmed	Confirmed	Confirmed	N/A	Completed
Blythe	James	Interim Group Chief Executive Officer (from 18 September 2025)	Completed	Completed	Completed	None	None	Completed	Confirmed	Confirmed	Confirmed	Confirmed	Confirmed	N/A	Completed
Alabaster	Elizabeth	Interim Group Chief Finance Officer (from 1 December 2025)	Completed	Completed	Completed	None	None	Completed	Confirmed	Confirmed	Confirmed	Confirmed	Confirmed	Confirmed	Completed
Bagnall	Mark	Group Chief Officer Facilities, Infrastructure and Estates	Completed	Completed	Completed	None	None	Completed	Completed	Completed	Completed	Completed	Confirmed	N/A	Completed
Clancy	Elaine	Interim Group Chief Nursing Officer (from 15 September 2025)	Completed	Completed	Completed	None	None	Completed	Completed	Completed	Completed	Completed	Confirmed	Confirmed	Completed
Grimshaw	Andrew	Group Chief Finance Officer (to 30 November 2025)	Completed	Completed	Completed	None	None	Completed	Confirmed	Confirmed	Confirmed	Confirmed	Confirmed	Confirmed	Completed
Jennings	Richard	Group Chief Medical Officer	Completed	Completed	Completed	None	None	Completed	Confirmed	Confirmed	Confirmed	Confirmed	Confirmed	Confirmed	Completed
Jones	Stephen	Group Chief Corporate Affairs Officer	Completed	Completed	Completed	None	None	Completed	Confirmed	Confirmed	Confirmed	Confirmed	Confirmed	N/A	Completed
Michell	Ralph	Group Chief Transformation Officer (from 1 April to 31 August 2025)	Completed	Completed	Completed	None	None	Completed	Confirmed	Confirmed	Confirmed	Confirmed	Confirmed	N/A	Completed
Pantlin	Michael	Group Deputy Chief Executive Officer (from 22 April 2025 (interim) and 1 September 2025 (substantive)	Completed	Completed	Completed	None	None	Completed	Confirmed	Confirmed	Confirmed	Confirmed	Confirmed	N/A	Completed
Slemeck	Catriona	Managing Director - St George's	Completed	Completed	Completed	None	None	Completed	Confirmed	Confirmed	Confirmed	Confirmed	Confirmed	N/A	Completed
Smith	Victoria	Group Chief People Officer	Completed	Completed	Completed	None	None	Completed	Completed	Completed	Completed	Completed	Completed	Confirmed	Completed
Wellman	Arlene	Group Chief Nursing Officer (to 31 August 2025)	Completed	Completed	Completed	None	None	Completed	Confirmed	Confirmed	Confirmed	Confirmed	Confirmed	Confirmed	Completed

** Matthew Shaw started as Group Chief Executive Officer on 7 April 2026, having satisfied all FPPT checks. Dr Shaw's FPPT compliance will be incorporated as part of 2026/27 FTTP reporting.*

gesh

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

Epsom and St Helier University Hospitals NHS Trust - Fit and Proper Persons Test Annual Compliance 2025/26

Last Name	First Name	Job Role	Qualifications Check	Occupational Health Check	References Check	Open/Upheld Disciplinary Case	Open/Upheld Grievance Case	Social Media Date Checked	Not Disqualified as a Charitable Trustee	Not Disqualified from Directors Register	No Employment Tribunal Judgements Found	DBS Requirements	Not Found on Insolvency Register	Prof Reg Check	Self-Declaration
Lowcock	Mark	Chair	Completed	Completed	Completed	None	None	Completed	Confirmed	Confirmed	Confirmed	Confirmed	Confirmed	N/A	Completed
Armstrong	Natalie	Non-Executive Director (from 1 January 2025)	Completed	Completed	Completed	None	None	Completed	Completed	Completed	Completed	Completed	Confirmed	N/A	Completed
Beasley	Ann	Non-Executive Director (to 12 October 2025)	Completed	Completed	Completed	None	None	Completed	Confirmed	Confirmed	Confirmed	Confirmed	Confirmed	N/A	Completed
Davé	Pankaj	Non-Executive Director (from 1 October 2025)	Completed	Completed	Completed	None	None	Completed	Confirmed	Confirmed	Confirmed	Confirmed	Confirmed	N/A	Completed
Jones	Chiew Yin	Non-Executive Director (from 1 January 2025)	Completed	Completed	Completed	None	None	Completed	Confirmed	Confirmed	Confirmed	Confirmed	Confirmed	N/A	Completed
Kane	Peter	Non-Executive Director (to 30 September 2025)	Completed	Completed	Completed	None	None	Completed	Confirmed	Confirmed	Confirmed	Confirmed	Confirmed	N/A	Completed
Murray	Andrew	Non-Executive Director	Completed	Completed	Completed	None	None	Completed	Confirmed	Confirmed	Confirmed	Confirmed	Confirmed	Confirmed	Completed
Penna	Leonie	Associate Non-Executive Director (from 1 October 2025)	Completed	Completed	Completed	None	None	Completed	Confirmed	Confirmed	Confirmed	Confirmed	Confirmed	Confirmed	Completed
Sarkar	Bidesh	Non-Executive Director (from 13 October 2025)	Completed	Completed	Completed	None	None	Completed	Confirmed	Confirmed	Confirmed	Confirmed	Confirmed	N/A	Completed
Wilbraham	Phil	Associate Non-Executive Director	Completed	Completed	Completed	None	None	Completed	Confirmed	Confirmed	Confirmed	Confirmed	Confirmed	N/A	Completed
Totterdell	Jacqueline	Group Chief Executive (to 17 September 2025)	Completed	Completed	Completed	None	None	Completed	Confirmed	Confirmed	Confirmed	Confirmed	Confirmed	N/A	Completed
Blythe	James	Managing Director ESTH (1 April 2025 to 17 September 2025); Interim Group Chief Executive Officer (from 18 September 2025)	Completed	Completed	Completed	None	None	Completed	Confirmed	Confirmed	Confirmed	Confirmed	Confirmed	N/A	Completed
Alabaster	Elizabeth	Interim Group Chief Finance Officer (from 1 December 2025)	Completed	Completed	Completed	None	None	Completed	Confirmed	Confirmed	Confirmed	Confirmed	Confirmed	Confirmed	Completed
Bagnall	Mark	Group Chief Officer Facilities, Infrastructure and Estates (from 27 August 2024)	Completed	Completed	Completed	None	None	Completed	Completed	Completed	Completed	Confirmed	Completed	N/A	Completed
Clancy	Elaine	Interim Group Chief Nursing Officer (from 15 September 2025)	Completed	Completed	Completed	None	None	Completed	Completed	Completed	Completed	Completed	Confirmed	Confirmed	Completed
Grimshaw	Andrew	Group Chief Finance Officer (to 30 November 2025)	Completed	Completed	Completed	None	None	Completed	Confirmed	Confirmed	Confirmed	Confirmed	Confirmed	Confirmed	Completed
Jennings	Richard	Group Chief Medical Officer	Completed	Completed	Completed	None	None	Completed	Confirmed	Confirmed	Confirmed	Confirmed	Confirmed	Confirmed	Completed
Jones	Stephen	Group Chief Corporate Affairs Officer	Completed	Completed	Completed	None	None	Completed	Confirmed	Confirmed	Confirmed	Confirmed	Confirmed	N/A	Completed
Michell	Ralph	Group Chief Transformation Officer (from 1 April to 31 August 2025)	Completed	Completed	Completed	None	None	Completed	Confirmed	Confirmed	Confirmed	Confirmed	Confirmed	N/A	Completed
Pantlin	Michael	Group Deputy Chief Executive Officer (from 22 April 2025 (interim) and 1 September 2025 (substantive)	Completed	Completed	Completed	None	None	Completed	Confirmed	Confirmed	Confirmed	Confirmed	Confirmed	N/A	Completed
Sawtell	Thirza	Managing Director - Integrated Care	Completed	Completed	Completed	None	None	Completed	Confirmed	Confirmed	Confirmed	Confirmed	Confirmed	N/A	Completed
Shaw	Alex	Interim Managing Director – ESTH (from 18 September 2025)	Completed	Completed	Completed	None	None	Completed	Confirmed	Confirmed	Confirmed	Confirmed	Confirmed	N/A	Completed
Smith	Victoria	Group Chief People Officer	Completed	Completed	Completed	None	None	Completed	Completed	Completed	Completed	Confirmed	Completed	Confirmed	Completed
Wellman	Arlene	Group Chief Nursing Officer (to 31 August 2025)	Completed	Completed	Completed	None	None	Completed	Confirmed	Confirmed	Confirmed	Confirmed	Confirmed	Confirmed	Completed

** Matthew Shaw started as Group Chief Executive Officer on 7 April 2026, having satisfied all FPPT checks. Dr Shaw's FPPT compliance will be incorporated as part of 2026/27 FTTP reporting.*