Group Board

Agenda

Meeting in Public on Thursday, 09 July 2026, 12:45 – 16:40

Barnes, Sheen and Richmond Rooms, Queen Mary's Hospital, Roehampton, SW15 5PN

Feedback from Board visits					
Time	**Item**	**Title**	**Presenter**	**Purpose**	**Format**
12:45	-	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

Priority Matters for the Board					
Time	**Item**	**Title**	**Presenter**	**Purpose**	**Format**
13:05	2.1	Interstitial Lung Disease: Report from the Royal College of Physicians	GCMO	Review	Report
13:30	2.2	Water Safety in St Helier E Block	MD-ESTH	Review	Report

Group Leadership and Performance					
Time	**Item**	**Title**	**Presenter**	**Purpose**	**Format**
13:40	3.1	Group Chief Executive Officer's Report	GCEO	Review	Report
13:50	3.2	Integrated Finance Report – Month 2	IGCFO	Review	Report
14:00	3.3	Integrated Quality and Performance Report	GDCEO	Review	Report
14:10	3.4	Urgent and Emergency Care Improvement Plan – ESTH	MD-ESTH	Approve	Report
14:15	3.5	Maternity Services Report: • Perinatal Quality Oversight Model Exception Report • Briefing on Ockenden And Amos Maternity Reports	GCNO	Assure	Report
14:30	-	*Break*			

Committee Assurance and Oversight					
Time	**Item**	**Title**	**Presenter**	**Purpose**	**Format**
14:45	4.1	Quality Committees Report	Committee Chair	Assure	Report
14:55	4.2	Finance and Performance Committees Report	Committee Chair	Assure	Report
15:05	4.3	People Committees Report	Committee Chair	Assure	Report
15:15	4.4	Infrastructure Committees Report	Committee Chair	Assure	Report

Strategy and Risk					
Time	**Item**	**Title**	**Presenter**	**Purpose**	**Format**
15:25	5.1	Group Strategy Update	GDCEO	Review	Report
15:35	5.2	Group Surgery Strategy	GDCEO	Approve	Report
15:50	5.3	Group Digital Strategy	GDCEO	Approve	Report
15:55	5.4	Group Board Assurance Framework	GCCAO	Approve	Report

Closing items					
Time	**Item**	**Title**	**Presenter**	**Purpose**	**Format**
16:05	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	Review	Verbal
	6.4	Any Other Business	All	Note	Verbal
16:15	6.5	Patient Story	GCNO	Discuss	Verbal
16:40	-	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 and SGUH	NA
Pankaj Davé	Non-Executive Director – ESTH and SGUH	PD
Richard Jennings	Group Chief Medical Officer	GCMO
Stephen Jones*^	Group Chief Corporate Affairs Officer	GCCAO
Yin Jones	Non-Executive Director – ESTH and SGUH	YJ
Khadir Meer^	Non-Executive Director – SGUH	KM
Andrew Murray	Non-Executive Director – ESTH and SGUH	AM
Michael Pantlin*^	Group Deputy Chief Executive Officer	GDCEO
Leonie Penna*	Non Executive Director – SGUH and ESTH (Associate)	LP
Bidesh Sarkar	Non-Executive Director – ESTH and SGUH	BS
Alex Shaw	Interim Managing Director – ESTH	MD-ESTH
Kate Slemeck^	Managing Director – SGUH	MD-SGUH
Victoria Smith*^	Group Chief People Officer	GCPO
Claire Sunderland Hay^	Associate Non-Executive Director – SGUH	CSH
Phil Wilbraham	Associate Non-Executive Director – ESTH	PW
In Attendance		
Kelly Brown	Senior Corporate Governance Manager	SCGM
Anna Macarthur	Group Chief Communications Officer	GCCO
Theresa Matthews	Site Chief Nursing Officer – SGUH	SCNO-SGUH
Nicola Shopland	Site Chief Nursing Officer – ESTH	SCNO-ESTH
Apologies		
Mark Bagnall*^	Group Chief Officer – Facilities, Infrastructure and Estates	GCOFIE
Elaine Clancy	Interim Group Chief Nursing Officer	IGCNO
Thirza Sawtell*	Managing Director – Integrated Care	MD-IC
Observers		
Mamta Joshi	Inclusion Board Member, Consultant Physician in Diabetes, Endocrinology & GIM (ESTH)	MJ
Dee Kapfunde	Inclusion Board Member, Divisional Director of Nursing and Governance	DK
Karyn Richards-Wright	Inclusion Board Member, Group Freedom to Speak Up Guardian	KRW
Alfredo Benedicto	SGUH Appointed Governor, Merton Healthwatch	AB
John Hallmark	SGUH Public Governor, Wandsworth	JH
Shuile Syeda	SGUH Appointed Governor, Merton Council	SS

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

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

Minutes of Group Board Meeting

Meeting in Public on Friday, 08 May 2026, 12:30 – 15.50

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

PRESENT		
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 – SGUH & ESTH	NA
Mark Bagnall*^	Group Chief Facilities, Infrastructure and Environment Officer	GCFIEO
James Blythe*	Managing Director – ESTH	MD-ESTH
Elaine Clancy	Interim Group Chief Nursing Officer	IGCNO
Pankaj Davé	Non-Executive Director – SGUH and ESTH	PD
Richard Jennings	Group Chief Medical Officer	GCMO
Stephen Jones*^	Group Chief Corporate Affairs Officer	GCCAO
Yin Jones	Non-Executive Director – ESTH and SGUH	YJ
Khadir Meer^	Associate Non-Executive Director – SGUH	KM
Andrew Murray	Non-Executive Director – SGUH and ESTH	AM
Leonie Penna*	Non-Executive Director – SGUH and ESTH (Associate)	LP
Bidesh Sarkar	Non-Executive Director – SGUH and ESTH	BS
Thirza Sawtell*	Managing Director – Integrated Care	MD-IC
Kate Slemeck^	Managing Director – SGUH	MD-SGUH
Victoria Smith*^	Group Chief People Officer	CPO
Claire Sunderland-Hay^	Associate Non-Executive Director – SGUH	CSH
IN ATTENDANCE		
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

** 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

Members of the Inclusion Board joined Board members on their visits across the St Helier Hospital site. The Board provided the following feedback from their respective visits to a number of wards and departments:

- Neonatal & Postnatal Services (GCMO and Pankaj Davé)**:** Board members observed a calm, well-led service with high levels of staff engagement and effective multidisciplinary working between neonatal, transitional care and maternity teams. Members noted that the neonatal unit had successfully adapted its model of care by reducing commissioned cot capacity and expanding transitional care, helping to improve patient flow whilst maintaining quality of care. Staff described excellent teamworking and high levels of retention. The Board also noted significant estate constraints, including limited storage, cramped clinical accommodation and temperature control issues, together with ongoing fire compartmentation risks which were being actively managed. The Birth Centre was observed to provide a welcoming, patient-centred environment with consistently higher utilisation and lower transfer rates than comparator services.

- Frailty Hub (Group Chair, GCEO, GCNO): Board members met the multidisciplinary frailty team and observed a collaborative model of care focused on supporting older people with complex needs. Members noted evidence that the service had reduced average patient length of stay by around two days and welcomed the team's focus on service development, integration with community services and improving patient pathways. Discussions with patients and families were positive regarding the care they had received, although concerns were raised about delays in discharge pathways and onward care, reinforcing the importance of continuing work with system partners to improve patient flow.

- Validation Team (Non-clinical) (Natalie Armstrong, GCOO, GCTO): Board members recognised the Validation Team as a key contributor to elective recovery, supporting the quality of waiting lists and patient access to treatment. Members observed a highly engaged team with a strong patient-centred culture and clear commitment to continuous improvement. Staff highlighted the continuing impact of data quality issues following implementation of the electronic patient record, together with capacity pressures and the need to ensure that future AI-enabled solutions were developed collaboratively with frontline teams to support, rather than disrupt, existing ways of working.

- Emergency Department (ED & UTC) (GCFO, GCCAO, Andrew Murray, Yasmin Mullick): Board members observed a busy clinical environment operating under sustained operational pressure but characterised by strong teamwork and visible clinical leadership. Staff described the positive impact of the Urgent Treatment Centre-first model and the deployment of senior emergency physicians within the Urgent Treatment Centre in supporting earlier clinical decision-making and improving patient flow. Members also noted the continuing challenges associated with discharge delays and recognised the limited staff welfare facilities available within the department. The visit also highlighted opportunities to share learning across the Group by drawing on the experience of clinicians working across both hospital sites.

- Estates Workshop (MD-ESTH, GCOFIE, Khadir Meer, Claire Sunderland Hay, Amol Joshi): Board members met the in-house estates team and observed a highly motivated workforce with a strong sense of pride in maintaining the hospital estate. Members welcomed the team's commitment to developing future capability through apprenticeship programmes and recognised the benefits of undertaking maintenance work in-house wherever possible. Staff spoke positively about the increasing certainty provided by multi-year capital investment, whilst recognising the continuing challenges associated with maintaining an ageing estate and supporting increasingly complex infrastructure requirements.

The Board thanked all colleagues who had hosted the visits for their openness, professionalism and willingness to discuss both the strengths of their services and the challenges they faced.

1.0	INTRODUCTORY ITEMS
1.1	**Welcome, introductions and apologies**
	The Chair welcomed members, observers and members of the public to the meeting. Apologies for absence were noted as set out above. The Chair also welcomed Ralph Michell, who was deputising for the Group Deputy Chief Executive Officer, and members of the Inclusion Board – Yvette Boamah, Amol Joshi and Yasmin Mullick – who were attending the meeting to present feedback from their discussions.
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 5 March 2026 were approved as a true and accurate record.
1.4	**Action Log and Matters Arising**
	The Board reviewed the Action Log and received the following updates: • GB26.01.08/02 – Information on recurrent and non-recurrent Cost Improvement Plans: The IGCFO provided a verbal update on the balance between recurrent and non-recurrent cost improvement programme delivery during 2025/26 and the implications for the 2026/27 financial plan. The Board noted the update and agreed that future finance reports should incorporate this analysis as requested. The action would therefore remain open pending implementation through routine reporting. • PUBLIC20250901.1 – Mandatory and Statutory Training (MAST): The Board noted that work to review mandatory training requirements across the Group remained aligned to the forthcoming national review being undertaken by NHS England, with proposals to be brought forward once national guidance had been clarified. The Board agreed that the action would be kept open pending completion of the review of MAST training across the Group. • PUBLIC20241107.2 - Speaking Up and Interstitial Lung Disease: The Board further noted that work to strengthen the Group's speaking up culture continued as part of the organisational response to the SGUH CQC Well Led Review and the 2025 Staff Survey results for both Trusts. The Board also noted that further discussion would take place later in the meeting through the Audit and Risk Committee report and the Freedom to Speak Up Guardian's report. The action would remain open pending presentation of the wider Group FTSU strategy and CQC Wel Led improvement plan.
1.5	**Feedback from the Inclusion Board**

	The Board welcomed three members of the newly established Inclusion Board to the meeting: Yvette Boamah, Amol Joshi and Yasmin Mullick. The Board noted that the Inclusion Board forms part of a six-month inclusive leadership development programme, bringing together colleagues from across the Group to strengthen inclusive leadership and provide staff perspectives on selected Board agenda items. The programme is intended to broaden participation in Board discussions, support leadership development and enable Board decision-making to be informed by a wider range of experiences from across the organisation. The Board received feedback from the Inclusion Board's discussion on the 2025 NHS Staff Survey and Freedom to Speak Up reports. The Inclusion Board members highlighted three key observations: • Firstly, Inclusion Board members considered that the Group should adopt a more aspirational approach to tackling bullying, harassment and discrimination, recognising that whilst national benchmarking was useful, the organisation should articulate an ambition of zero tolerance. • Secondly, Inclusion Board members reflected on the forthcoming merger, recognising the opportunities it presented to share learning and best practice across the Group, whilst also highlighting the need for proactive staff engagement to mitigate the risk of uncertainty and disengagement during the transition. • Thirdly, Inclusion Board members suggested that future reports should include comparison with previous years to demonstrate progress over time and better recognise improvements achieved. In discussion, Board members welcomed the insight provided by the Inclusion Board and explored the extent to which the Staff Survey findings reflected colleagues' lived experience across the organisation. Inclusion Board members recognised both the positive culture experienced within some teams and the significant challenges highlighted through the survey, particularly in relation to burnout, speaking up and staff experience. Members also discussed the opportunity presented by the merger to bring colleagues together, share best practice and strengthen organisational culture across the Group. The GCEO welcomed the establishment of the Inclusion Board and encouraged members to continue providing constructive challenge and insight as part of their leadership development, recognising the value of bringing wider staff perspectives into Board discussions. The Group Chair thanked the Inclusion Board members for their thoughtful contribution and looked forward to hearing from future cohorts throughout the programme. The Board welcomed and noted the feedback from the Inclusion Board and noted the observations made.
1.6	**Group Chief Executive's Officer (GCEO) Report**
	The Board received the GCEO's first report since taking up post on 7 April 2026 and welcomed the opportunity to discuss his initial reflections and priorities for the Group Executive. The Group Chief Executive highlighted a number of key issues, including: • Interstitial Lung Disease (ILD): The Board noted that the independent review by the Royal College of Physicians had now been received and that all recommendations had been accepted. Members noted the commitment to publish the report once all affected patients and families had been contacted, statutory Duty of Candour obligations had been fulfilled where appropriate, and patients had been given the opportunity to discuss the findings with the Trust. The expectation was that the RCP report would be published in full as part of the Board papers for the next Board meeting on 9 July 2026. The Board further noted that the review would be extended beyond the original sample of patients to provide

assurance that all affected patients had been appropriately identified and supported. The Group Chief Executive acknowledged the anxiety experienced by patients and families and apologised on behalf of the organisation for the failings identified.

- Capital Investment: Members welcomed confirmation of the proposed £55 million capital investment to redevelop the Emergency Department at St Helier Hospital and noted progress in discussions regarding the Renal Development Programme.
- Organisational Culture: The Board noted the findings of the 2025 NHS Staff Survey and welcomed the GCEO's clear commitment to improving organisational culture, strengthening leadership and tackling violence and aggression towards staff, recognising these as fundamental to attracting, retaining and supporting the workforce needed to deliver high-quality patient care.
- Merger: Members noted that planning for the proposed merger of the two Trusts was progressing towards a proposed implementation date of April 2028, with work now commencing on development of the Full Business Case.

In discussion, Board members welcomed the GCEO's early focus on visibility, culture and staff engagement. Members sought assurance regarding staff sentiment towards the proposed merger and the increasing integration of the Group. The Board noted that Executive engagement with colleagues indicated growing recognition of the benefits of collaboration across the Group, with examples of successful clinical integration already emerging. Members also recognised the importance of maintaining the distinct identity and culture of individual hospitals as merger planning progressed, acknowledging that successful integration would depend upon balancing the benefits of operating as a Group with preserving strong local leadership and identity at each site.

The Board **noted** the report and the updates provided.

2.0 QUALITY AND SAFETY

2.1 Quality Committees Report

The Board received the report from the Quality Committees summarising the key issues considered at the March and April 2026 meetings.

Andrew Murray, Chair of the Quality Committees, highlighted the principal areas of discussion, including:

- Quality Governance Improvement Plan: The Committee welcomed the progress being made but considered that further work was required to articulate more clearly the purpose of the programme, the cultural changes it sought to achieve and how success would be measured over the next six months.
- Quality Priorities 2026/27: The Committee had reviewed the proposed Quality Priorities and agreed that progress against their delivery should be monitored throughout the year.
- Maternity Services: The Committee welcomed the strengthening of the maternity leadership team and supported proposals to establish a dedicated Maternity Board to provide more detailed oversight of statutory maternity reporting, enabling the Quality Committees and Group Board to focus on the principal risks, assurances and areas requiring oversight.
- Interstitial Lung Disease: The Committee noted that the recommendations arising from the Royal College of Physicians' Invited Review had been accepted and were being implemented, with further detail provided through the Group Chief Executive Officer's report.

In discussion, Members welcomed the Committee's observation that maternity services were continuing to move in a positive direction, recognising in particular the strengthening of the senior midwifery leadership team. Members also acknowledged the Committee's view that, whilst the

	current reporting arrangements contained substantial information, future Board reporting should provide a clearer narrative of the key risks, progress and actions being taken to support more effective Board assurance. The Board therefore welcomed the proposed establishment of a dedicated Maternity Board as a means of strengthening governance and improving the quality of assurance provided to both the Quality Committees and the Group Board. The GCEO advised that NHS England was developing a standardised maternity Board reporting template to support more consistent reporting and assurance across NHS organisations. Members welcomed this development and recognised the opportunity to strengthen the quality and consistency of maternity reporting across the Group. The Board: • **noted** the report of the Quality Committees and the key areas of assurance and escalation; • **received and noted** the Quality Committees' Annual Report for 2025/26; and • **approved** the revised Terms of Reference for the Quality Committees.
2.2	**Maternity Services Report**
	The Chair formally welcomed Michelle Cudjoe, Group Chief Midwifery Officer, to her first meeting of the Group Board and invited her to present the quarterly Maternity Services Report. The Group Chief Midwifery Officer (GCMidO) outlined the key developments since taking up post, including work to strengthen maternity governance arrangements, establish a Group Maternity Board, develop a standardised maternity reporting framework and introduce a core set of maternity metrics to support consistent oversight and assurance across both Trusts. The Board noted the continued progress being made across maternity services, including the full recruitment of the senior midwifery leadership team and ongoing work to strengthen governance, quality and safety. Members also noted: • the establishment of a Task and Finish Group to address health inequalities, following analysis of maternal mortality and perinatal outcomes which demonstrated disproportionate impact on women from Black ethnic backgrounds; • progress towards compliance with the revised CNST Year 8 standards, recognising that additional work would be required to meet the new national requirements; • the recent Level 1 Maternity Outcomes Signal System (MOSS) trigger at St Helier Hospital, noting that the subsequent critical safety review had identified no common themes across the cases reviewed and that the required actions had been implemented or were in progress; and • the continued focus on learning from patient safety incidents, mortality reviews and national guidance to support improvement across maternity services. In discussion, Board members warmly welcomed Michelle to the Group and recognised the positive impact of the strengthened maternity leadership arrangements now in place. Members sought assurance regarding the priorities identified during her first weeks in post and welcomed her early observations of strong multidisciplinary working across both Trusts, whilst recognising opportunities to reduce unwarranted variation in practice, strengthen health equity and consolidate existing improvement work into a single, coherent programme of delivery. The Board also welcomed the emphasis being placed on improving governance, consistency and organisational learning across maternity services. The GCMO welcomed the clarity and focus that Michelle had already brought to maternity services, particularly in relation to maternal mortality and health inequalities, and expressed

	confidence in the strengthened clinical leadership now in place. The GCNO similarly welcomed Michelle's expertise and leadership as the Group continued its maternity improvement journey. The Board **noted** the report and welcomed the continued progress in strengthening maternity leadership, governance and quality improvement across the Group.
2.3	**Quality Governance Improvement Plan**
	The Board received an update on the Quality Governance Improvement Plan, which set out the next phase of work to strengthen quality and safety governance across the Group. The GCMO outlined the proposed quality governance arrangements, including clearer organisational accountabilities, strengthened site and Group quality governance structures, and the development of a quality governance toolkit to support more consistent quality governance arrangements across divisions and services. Members noted that the programme sought to simplify quality governance, improve organisational learning and strengthen the flow of quality and safety information from ward to Board. In discussion, Board members welcomed the progress being made and focused their discussion on the effectiveness of the proposed arrangements. Members emphasised that successful implementation would depend upon embedding the right organisational culture and behaviours alongside the strengthened quality governance framework. In particular, Members discussed: • the importance of fostering a problem-sensing culture, in which colleagues felt confident to raise concerns openly and where quality governance arrangements supported learning; • ensuring that the revised quality governance arrangements simplified organisational processes, enabling discussion to focus on the issues requiring Executive and Board attention; • the importance of identifying clear measures by which the Board could assess whether quality governance arrangements were becoming more effective over time; • continuing to improve the quality, consistency and presentation of quality and safety information provided to the Board to support effective scrutiny and assurance. In response, the GCMO emphasised that the programme sought not simply to introduce revised quality governance structures, but to strengthen organisational culture, clarify accountability and create quality governance arrangements that enabled earlier identification of risk, more effective organisational learning and better quality assurance. Members also noted that progress would continue to be monitored through the Quality Committees and would be informed by staff feedback, governance effectiveness and wider organisational indicators. The Board **noted and endorsed** the direction of travel set out within the Quality Governance Improvement Plan and noted that further updates would be provided through the Quality Committees.
3.0	**FINANCE AND PERFORMANCE**
3.1	**Finance and Performance Committees Report**
	The Board received the report from the Finance and Performance Committees summarising the key issues considered at the March and April 2026 meetings. Bidesh Sarkar, Chair of the Finance and Performance Committees, highlighted the following matters:

	• Financial Performance: The Committee welcomed the successful delivery of the agreed 2025/26 financial position, recognising the significant effort across the organisation to achieve the year-end outturn. Members noted, however, that delivery had been supported by a level of non-recurrent measures and recognised that the financial challenge facing the Group in 2026/27 remained substantial, requiring continued focus on recurrent financial improvement and delivery of the Medium Term Financial Plan. • Financial risks: The Committee recognised the continuing delivery risks associated with cost improvement programmes and commissioner contract alignment, and emphasised the importance of maintaining close oversight of financial performance and delivery. • Financial governance: The Committee welcomed the continued strengthening of financial governance and oversight arrangements across the Group. • Operational Performance: The Committee continued to oversee operational performance across the Group, recognising the progress being made in a number of areas whilst noting that sustained focus would be required to deliver the Group's operational priorities and support delivery of the 2026/27 financial plan. In discussion, Members welcomed the successful conclusion of the 2025/26 financial year whilst recognising that the focus now needed to shift to delivery of the significantly more challenging financial plan for 2026/27. The Board emphasised the importance of strengthening recurrent financial improvement, ensuring that cost improvement programmes remained deliverable and aligned to operational priorities, and maintaining robust financial governance throughout the year. The Board also approved the revised Terms of Reference for the Finance and Performance Committees, noting the changes made to strengthen the Committee's oversight of finance, operational performance and transformation. The Board: • **noted** the report of the Finance and Performance Committees and the key areas of assurance; • **noted** the improving financial position whilst recognising the continuing focus required on recurrent financial sustainability; and • **approved** the revised Terms of Reference for the Finance and Performance Committees.
3.2	**Finance Report – Year End 2025/26**
	The IGCFO presented the year-end financial position for 2025/26, advising that both Trusts had achieved their agreed financial plans and Capital Departmental Expenditure Limits (CDEL), reflecting a significant organisational achievement following a challenging financial year. Members noted, however, that delivery had relied upon a level of non-recurrent measures and that the underlying financial position remained challenging as the Group entered 2026/27. In discussion, Board members welcomed the successful delivery of the 2025/26 financial position and recognised the considerable effort by colleagues across the organisation in achieving the agreed year-end outturn. Members acknowledged that the financial discipline demonstrated during the year provided a strong platform for the future, whilst recognising that the demanding financial environment for 2026/27 would require sustained organisational focus and difficult decisions. Members discussed the balance between recurrent and non-recurrent savings, recognising the importance of continuing to increase the proportion of recurrent improvements over time to strengthen the Group's underlying financial position. The Board also emphasised the importance of ensuring that financial recovery remained aligned with operational performance and quality of

	care, recognising that delivery of the 2026/27 financial plan would depend upon successful delivery of transformation and cost improvement programmes. The Group Chair thanked colleagues across the Group for their contribution to achieving the 2025/26 financial position, recognising the significant organisational effort required throughout the year. The Board **noted** the report.
3.3	**Integrated Quality and Performance Report (IQPR)**
	The Board received the Integrated Quality and Performance Report, providing an overview of quality, operational and performance metrics across the Group. The report highlighted continued improvement in operational performance across both Trusts. Members welcomed the significant progress made by St George's in reducing long waits, resulting in the Trust exiting NHS England Tier 1 oversight for elective recovery. The Board also noted that Epsom & St Helier remained in Tier 1 oversight for elective recovery and Tier 2 oversight for urgent and emergency care, reflecting the continuing operational challenges facing the Trust. The Board noted that: • both Trusts continued to exceed the national 77% Faster Diagnosis Standard for 28-day cancer performance; • St George's achieved 72.4% against the 62-day cancer standard, with continued work underway to address capacity pressures within thoracic services; • Epsom & St Helier achieved 80.8% against the 62-day cancer standard, with ongoing recovery actions focused on gastrointestinal pathways, endoscopy capacity and anaesthetic workforce constraints; and • the South West London FIT testing incident had resulted in increased lower gastrointestinal referrals, creating additional pressure on outpatient and endoscopy services across the system. In discussion, Members recognised the improving trajectory of operational performance across the Group and recognised the significant effort by colleagues in achieving progress against a number of national performance standards. Members particularly acknowledged St George's exit from Tier 1 oversight as an important milestone, whilst recognising that Epsom & St Helier continued to make progress against a backdrop of sustained operational pressures. The Board acknowledged the actions underway to improve elective recovery, urgent and emergency care and cancer performance, recognising that maintaining momentum and sustaining improvement throughout 2026/27 would be critical. Members emphasised the importance of ensuring that operational improvements were sustained over time rather than representing short-term gains. The Board recognised the close interdependence between operational performance, transformation and financial recovery, noting that successful delivery of the Group's objectives would depend upon continued progress across all three areas. The Board further recognised that, whilst NHS England oversight provided an important external measure of progress, the organisation's primary objective remained the delivery of safe, timely and high-quality care for patients. Members agreed that success should ultimately be judged by sustained improvements in patient outcomes, access to services and patient experience, rather than regulatory status alone.

	The Board **noted** the report and welcomed the improving trajectory of performance across the Group whilst recognising the continuing operational challenges requiring sustained organisational focus.
3.4	**Audit and Risk Committee Report**
	The Board received the report from the Audit and Risk Committees summarising the principal matters considered at the April 2026 meetings. Pankaj Davé, Chair of the Audit and Risk Committees, highlighted the following matters: • External Audit: The Committees had reviewed the external audit plans and timetable for completion of the 2025/26 annual reports and accounts, together with the proposed accounting policies for both Trusts. • Internal Audit: The Committees welcomed the significant improvement in delivery of the 2025/26 Internal Audit Plan, noting that the draft Head of Internal Audit Opinion for both Trusts remained Reasonable Assurance. The Committee had also reviewed internal audit reports relating to International Recruitment and Raising Concerns, recognising that the latter reinforced the need to continue strengthening organisational speaking up culture. • Risk Management: The Committees welcomed continued progress in strengthening the Group's risk management framework, including improvements to the quality and alignment of the Corporate Risk Registers and ongoing development of the Group Board Assurance Framework. In discussion, Board members welcomed the improved delivery of the internal audit programme but expressed concern regarding the number of overdue internal audit actions across both Trusts. The GCEO acknowledged that stronger collective Executive team grip was required to ensure that agreed actions were implemented promptly and that overdue actions did not remain outstanding for extended periods. Members welcomed this commitment and emphasised the importance of clear Executive ownership, timely delivery and regular monitoring of progress. The Board emphasised the importance of ensuring that agreed management actions were implemented promptly and that Executive Directors maintained clear ownership and accountability for timely delivery. Members also welcomed the improving maturity of the Group's risk management arrangements and recognised the progress being made in developing a consistent Group-wide approach to strategic and operational risk management. The Board: • **noted** the report of the Audit and Risk Committees and the assurance provided; • **received and noted** the Audit and Risk Committees' Annual Report for 2025/26; and • **approved** the revised Terms of Reference and Forward Plan for 2026/27.

4.0	PEOPLE
4.1	**People Committees Report**

The Board received the report from the People Committees summarising the principal matters considered at the April 2026 meeting.

Yin Jones, Chair of the People Committees, highlighted the following matters:

- NHS Staff Survey 2025: The Committee had reviewed the Staff Survey results, recognising that whilst staff engagement remained above the national average, both Trusts continued to perform below national benchmarks across a number of the NHS People Promise themes. The Committee welcomed the emerging organisational response, focused on strengthening leadership, organisational behaviours, equality, diversity and inclusion, and staff recognition.
- Talent Management and Leadership Development: The Committee had considered the Group's approach to talent management, succession planning and leadership development, recognising the importance of developing a sustainable pipeline of future leaders and strengthening inclusive leadership capability across the Group. Members also welcomed the continued development of the Inclusion Board as part of the Group's wider leadership development offer.
- People Function Transformation: The Committee welcomed progress in implementing the People Function Target Operating Model, including the introduction of a single front door for People Services, the rollout of the new gesh People Management Programme and the development of a refreshed approach to performance and development focused on continuous conversations, coaching and leadership development rather than annual appraisal processes alone.

In discussion, Board members welcomed the progress being made in modernising the People function and recognised the importance of ensuring that the transformation delivered tangible improvements for colleagues rather than simply changes to organisational structures or processes. The GCEO emphasised that improving staff experience and organisational culture would depend not only upon changes to people systems, but upon consistent leadership behaviours across the organisation, recognising that responsibility for culture rested with every leader.

Members discussed the importance of supporting managers through the changes, recognising that leadership capability, coaching and development would be fundamental to improving staff engagement, organisational performance and patient care. The Board welcomed the move towards continuous performance and development conversations, recognising the opportunity to move away from a compliance-based approach towards one focused on meaningful feedback, learning and development.

The Board further emphasised the importance of evaluating the impact of the People Function transformation, leadership development programmes and talent management initiatives, seeking assurance that these programmes would deliver measurable improvements in staff experience, organisational culture and leadership effectiveness. Members noted that the detailed discussion regarding the NHS Staff Survey findings would take place under the following agenda item.

The Board:

- **noted** the report of the People Committees and the key areas of assurance; and
- **approved** the revised Terms of Reference and forward plan for the People Committees.

4.2	NHS Staff Survey Report

The Board received the report setting out the results of the 2025 NHS Staff Survey across the Group.

The GCPO highlighted that, whilst both Trusts continued to achieve staff engagement scores above the national average, the results demonstrated significant challenges in staff experience, organisational culture and leadership. Members noted that St George's ranked 17th and Epsom & St Helier 13th of the 17 London acute and community Trusts against the NHS People Promise themes. The report also highlighted inequalities in the experiences of Black, Asian and Minority Ethnic and Disabled colleagues, alongside concerns relating to workload, burnout, leadership behaviours, bullying and discrimination. The GCPO outlined the proposed organisational response, centred on four priority themes: leadership, organisational behaviours, equality, diversity and inclusion, and staff recognition, supported by local action planning and increased leadership visibility across the organisation.

The GCPO emphasised that the proposed response deliberately focused on a small number of priorities capable of delivering meaningful change, rather than developing extensive action plans that were difficult to implement consistently. She highlighted the importance of local ownership, regular engagement with staff through "Conversations that Matter", and ensuring that colleagues saw tangible evidence that their feedback was informing improvement through a clear "You Said, We Did" approach.

In discussion, Board members recognised the continued commitment and professionalism of colleagues across the Group but acknowledged that the survey results demonstrated the need for sustained organisational improvement. Members discussed the importance of triangulating the Staff Survey findings with other sources of organisational intelligence, including Freedom to Speak Up, employee relations, workforce metrics and qualitative staff feedback, to provide a richer understanding of organisational culture and to monitor whether improvement actions were delivering measurable change over time.

The GCEO emphasised that improving organisational culture represented one of the Group's highest strategic priorities, recognising that the organisation should not accept its current position in the Staff Survey rankings. He emphasised that meaningful improvement would depend upon consistent leadership behaviours, visible leadership and greater accountability at every level of the organisation, rather than additional centrally owned action plans. He further emphasised that responsibility for improving staff experience rested with all leaders across the Group and that success would ultimately be measured by whether colleagues experienced genuine improvements in their day-to-day working lives.

The Board agreed that improving staff experience was fundamental to improving patient care, organisational performance and the Group's long-term success. Members supported the proposed approach, recognising the importance of sustained leadership focus, clear accountability and regular reporting of progress against the agreed priorities.

The Board:

- **noted** the results of the 2025 NHS Staff Survey;
- **supported** the proposed organisational response and engagement approach;
- **endorsed** the focus on a small number of high-impact priorities, delivered through visible leadership and local ownership; and
- **requested** regular updates on progress and demonstrable improvements in staff experience and organisational culture.

4.3	**Freedom to Speak Up Report**
	The Chair welcomed Karyn Richards-Wright, Group Freedom to Speak Up Guardian, to the Group Board. The Board received the Freedom to Speak Up Report. The Group Freedom to Speak Up Guardian presented a thematic overview of concerns raised during the second half of 2025/26, highlighting that the report focused on the themes emerging from concerns, organisational learning and the actions being taken in response, rather than solely the number of cases received. Members noted that the most common themes continued to relate to behaviours, working relationships and organisational culture, reinforcing the importance of ensuring that colleagues felt confident to raise concerns and that those concerns resulted in meaningful organisational learning and improvement. In discussion, Board members reflected on the close alignment between the themes emerging through Freedom to Speak Up, the NHS Staff Survey and other sources of workforce intelligence. Members recognised the value of triangulating these different sources of assurance to provide a richer understanding of organisational culture and to identify recurring themes requiring organisational action. The Board discussed the importance of creating an environment in which colleagues felt confident to speak up, recognising that the number of concerns raised should not be viewed in isolation but alongside staff confidence to raise concerns, the quality of the organisational response and the extent to which learning was translated into sustained improvement. Members agreed that Freedom to Speak Up should continue to be considered alongside Staff Survey findings, employee relations information and wider workforce indicators as part of the Board's overall assessment of organisational culture. The GCEO welcomed the report and emphasised that strengthening organisational culture, psychological safety and leadership behaviours remained one of the Group's highest priorities. He reiterated that responsibility for creating an environment in which colleagues felt able to speak up rested with leaders throughout the organisation and that the Board should continue to monitor evidence that staff confidence and organisational learning were improving over time. The Board **noted** the report**.**
5.0	**ITEMS FOR NOTING**
5.1	**Fit and Proper Persons Test Annual Compliance Report 2025/26**
	The Board received the annual Fit and Proper Persons Test (FPPT) Compliance Report, providing assurance that appropriate arrangements remained in place across both Trusts to comply with the NHS England Fit and Proper Person Test Framework. The GCCAO advised that all Executive and Non-Executive Directors had successfully completed the required fit and proper person checks during 2025/26 and that the necessary declarations and supporting evidence were in place to support the annual submissions to NHS England. Members welcomed the assurance provided and recognised the importance of maintaining robust arrangements to support ongoing compliance with the national Framework and high standards of Board governance. The Board **noted** the report, confirmed its assurance that all Directors continued to meet the requirements of the NHS England Fit and Proper Person Test Framework, and the Chair thanked the GCCAO and colleagues for the work undertaken to maintain compliance with the Framework.

6.0	CLOSING ITEMS
6.1	**New Risks and Issues Identified**
	The Chair invited members to identify any new risks or issues arising from the meeting that were not already reflected within the Board Assurance Framework. Members noted that the discussions throughout the meeting had reinforced the significance of existing strategic risks, particularly those relating to organisational culture, workforce and operational delivery. No new strategic risks requiring escalation to the Board Assurance Framework were identified.
6.2	**Reflections on meeting**
	At the invitation of the Chair, Khadir Meer reflected on the meeting. He observed that the Board had considered a number of significant and challenging issues and welcomed the opportunity for constructive scrutiny and discussion throughout the meeting. He also recognised the appointment of the new GCEO and welcomed the clear priorities and direction set out within the Chief Executive's report. Members reflected that the discussion on the Quality Governance Improvement Plan had been particularly important, recognising that the success of the programme would ultimately be judged by the quality of assurance provided to the Quality Committees and the Board, and by the improvements achieved in practice over the coming months. The Board noted that this was James Blythe's last Board meeting before taking up the role of Chief Executive Officer at Royal Berkshire NHS Foundation Trust. The Board also acknowledged the contribution made by James during his period as Interim Group Chief Executive Officer and in his substantive role as Managing Director at Epsom and St Helier over the last four years.
6.3	**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: • Marion Parkes, member of the public, submitted a number of questions regarding the Picture Archiving and Communication System (PACS). Ms Parkes stated: "Following the comments made by the interim CEO at the 5th March 2026 meeting, I have referred the Optum (formerly known as Change Healthcare) PACS contract to the NHS Fraud Agency together with any relevant documentation I have in my possession from my time as the SWL Programme manager for this implementation. The Contract was signed in November 2021. The system was deemed clinically unsafe after extensive testing concluded in February 2024. In November 2024 the SWL Programme Team including the former GESH Director of Finance, stated in papers seen by me, that a new go live date was targeted in Spring/summer 2026 implying therefore that implementation work would re-start and a £900K of NHS funding had been secured. Without any indication as to why there is a delay, the former GESH Director of Finance announced at the 6th November 2025 Board that the go live was now targeted for November 2027, a potential go live date some SIX years post contract signature for a contract due to expire in 2031." ○ *Question 1: What is the reason for this delay and is it acceptable?* *Response: This is a complex service implementation. The reasons for the delay have previously been reported to the Board, including the rationale for pausing the earlier implementation. Since then, the Interim Group Chief Executive Officer has been working closely with programme teams and the supplier to prepare for the next phase of mobilisation. The Interim Group Chief Executive Officer recently*

	chaired a meeting with radiology clinical leaders to support engagement with the programme and the next stage of implementation. ○ *Question 2: Is this delay permitted under Public Sector/NHS Procurement rules?* *Response: The programme team has sought legal advice throughout the programme to ensure that the procurement and implementation continue to comply with the relevant legal and procurement requirements.* ○ *Question 3: How much of the further £900K has been expended* *Response: Approximately £34,000 has been expended to date.* ○ *Question 4: Who in SWL under the auspices of GESH is being held accountable for this?* *Response: The programme is overseen by the Imaging Network Board and the Acute Provider Collaborative, which is jointly accountable to all South West London NHS Trusts.* • An employee from the Estates and Facilities Department expressed concerns regarding equal pay and pension arrangements. The Group Chief People Officer thanked the member of staff for raising these concerns and gave assurance that they would be taken seriously. It was agreed that the matters raised would be followed up outside the Board meeting.
CLOSE	
The meeting closed at 15:50.	

DRAFT

Group Board (Public) - 9 July 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.	~~08/05/2026~~ July 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~~ Autumn 2026	GCPO	Update: 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~~ Autumn 2026	GCCAO	Update: The report on ILD (agenda item 2.1) sets out the steps taken by the organisation to strengthen speaking up within the respiratory team at ESTH in response to the issues identified, as well as summarising the wider steps being taken across the organisation to improve organisational culture including in relation to speaking up. The wider steps to strengthen speaking up culture are being taken forward through the CQC Well Led Improvement Plan for SGUH, which will be presented to the Board in September 2026, as well as through the development of a new Group-wide FTSU strategy, which will be presented to the Board in November 2026.	NOT YET DUE

Group Board

Meeting in Public on Thursday, 09 July 2026

Agenda Item	2.1	
Report Title	Interstitial Lung Disease (ILD) & RCP Invited Review - Update	
Executive Lead(s)	Richard Jennings, Group Chief Medical Officer	
Report Author(s)	Richard Jennings, Group Chief Medical Officer Rebecca Suckling, Site Chief Medical Officer – ESTH	
Previously considered by	Group Executive Committee	07 July 2026
Purpose	**For Review**	

Executive Summary

This paper provides the Board with an update on the issue of patients with Interstitial Lung Disease having received in the past poor and unsafe care from an individual consultant at St Helier Hospital.

“Interstitial Lung Disease” (ILD) is a term covering a range of conditions: the diagnosis in the majority of patients referred to in this paper is Idiopathic Pulmonary Fibrosis (IPF), a form of ILD that is progressive and for which, until some years ago, the median life expectancy was only 3-3.5 years after diagnosis. The introduction of new treatments in recent years, however, enables the slowing of disease progression in some patients.

The Board last discussed this issue at the Group Board meeting in Public on 24 November 2024 (a link to that Board paper is provided below). Since that time, the Board has received updates on this issue through the reports of the Quality Committee.

The timing of this update to the Board is prompted by the receipt of the final Report of the Royal College of Physicians (RCP) Invited Review on 24 March 2026, which is appended to this paper.

In November 2024 it was made clear to the Board that the individual consultant (referred to in the RCP Report as “*Dr X*”) had not kept up with evolving best practice and it was recognised that this was likely to have caused significant harm.

The scale of that harm is, however, now much more evident. The RCP Panel reviewed the care given to a sample of 28 patients with ILD looked after by Dr X, and of those 28, the review found that in seven cases, patients had experienced moderate clinical harm, in 12 cases, patients had experienced severe clinical harm and in three cases, failings in care may have contributed to premature death.

When the Board discussed this issue in November 2024, the Terms of Reference for the RCP Invited Review were made public, and a commitment was made to make the final RCP Report public as well. Between receiving and publishing this Report, including its findings in 28 individual cases, it was clearly right and essential for us to contact all 28 of those patients or, in cases in which the patients have died, their bereaved next of kin, to let them know what the RCP panel found in their individual cases. We have now done this, and we have offered all those patients or their families the opportunity to come and meet us to discuss the findings and any other concerns in more detail should they wish to.

Although this paper covers a substantial amount of detail around many different aspects of this issue, it is important to recognise, at the centre of this, the immense distress that this has caused to our patients and families. They had every right to expect safe and excellent care but have instead been let down and, in many cases, harmed. In our Board meeting in November 2024 our then-Chief Executive and Chair opened with a heartfelt and profound apology for this, and now, particularly in the light of the RCP's findings, we reiterate our deepest apology to every person who has been affected.

The work of assessing harm is not complete. The fact that the RCP found harm in such a substantial proportion of cases (including ten cases that, on the RCP's recommendation, were selected at random) clearly suggests that there will be other cases in which harm has occurred, and although some of these cases may have already been recognised (for instance, through the investigation of complaints or of specific concerns that have been raised), it is likely that there are instances of harm that have not yet been recognised. Patients and families have a right to be told when harm has occurred through poor care, and NHS organisations have a statutory Duty of Candour to inform patients of moderate or severe levels of harm. For this reason, we have decided to review the care given to all our patients with ILD from 2019 until 2023 (when Dr X stopped working clinically at the Trust). This review will be carried out internally, using the same methodology as the RCP used. It will be a substantial piece of work because it will review the care of over 200 patients, and we estimate that it will take between six months and one year. We have now written to all the patients whose cases will be included in this review to explain this, and in those cases where the patient has died, we have written to their next of kin. When this further review has been complete, the findings will be reported back to the Group Board in Public, and any further steps can then be discussed.

The RCP Report makes a number of Recommendations (19 in total) and this paper describes our progress in acting upon them (they have all been accepted). The RCP provided immediate feedback after their review in March 2025, and provided a draft of the Report, with its Recommendations, in September 2025, so by the time the final Report was received in March 2026 many of the recommended actions had already been completed. Some remain underway, and this is described in this paper.

The Board received assurance in November 2024 that all patients with ILD looked after by ESTH were now on the correct treatment. It is clearly important that the Board and our patients and public can be assured that the ESTH respiratory department is continuing to provide safe care. This paper sets out the assurance that this is indeed the case, and the RCP Report makes the observation, in its conclusion to the Executive Summary (p8), that "*the review team expressed their confidence that with sustained support from the trust, the current respiratory team is well-positioned to drive meaningful improvements to the ILD service going forwards*".

In our Terms of Reference, we asked the RCP to review the degree to which we had responded appropriately to the initial concerns raised about Dr X, and we included this because, as we highlighted in the November 2024 Board meeting, we recognised that we had not responded effectively enough at the time. The RCP Report says on this question (in the executive summary under the heading of Responding to concerns, p7), "*The review team considered that concerns about Dr X's practice raised between 2019 and 2022 were not adequately addressed… However, the review team were reassured that recent leadership and departmental changes have led to improvements in governance, morale and team dynamics*".

Although the RCP acknowledges this improvement, one of the most important areas of learning from the harm that has been caused is the crucial importance of successfully fostering a culture where staff believe they can raise concerns without fear of negative consequences, and with confidence that their concerns will be heard and acted upon. This was not always the case for the whistle-blowers involved, some of whom have fed back directly to the GCMO and the then-GCNO as well as the RCP. This

remains one of the most challenging areas for this organisation to address. This paper reaffirms our commitment to improving and sets out some of the measures we have taken and will continue to take.

Although Dr X was restricted by the Trust from seeing patients from January 2023, it is clear in retrospect that this should have been done sooner. An obvious and important question is how confident we can be in the gesh Group that no other clinicians are departing so significantly from accepted standards and putting patients at risk of harm. There are a great many safeguards in place to minimise the risk of this, including local and national auditing against benchmarked outcomes, regular appraisal of all doctors and regular meetings to consider concerns about individual practice. Without doubt, these safeguards prevent and address departures from good care in many instances, but they were not sufficient to prevent this instance of significant harm arising from poor care provided by one individual. For this reason, this paper also describes a major programme of work to increase our ability to detect poor individual care sooner, and this programme is fully integrated into the ongoing Group-wide Quality Governance Improvement Programme that the Board already oversees.

The improvements we have made, and the work that is ongoing to improve further, can never put things right for those patients who have been harmed, or for families who have been bereaved, but it is very important that they should be able to see how seriously we have taken this issue, how much we have reflected on it as an organisation, and what we are doing to prevent it happening again.

In summary, the purpose of this paper is:

- To recognise and profoundly apologise for the harm done to patients and their families through the poor care described in the RCP Report;
- To commit to the extension of the work done by the RCP, in order to identify other cases of harm that have occurred;
- To describe in what way we are trying to do the right thing in our communication with patients, families and stakeholders;
- To describe what steps we have taken to improve the respiratory service at ESTH, particularly in response to the RCP recommendations, and what assurance we now have that the service now gives good and safe care;
- To acknowledge that this organisation did not respond as well as it should have done to act promptly and effectively as soon as concerns were raised, or to fully and successfully support all whistle-blowers, and to describe the improvements both made and ongoing to create a better culture to support the raising of concerns;
- To describe the specific steps being taken to strengthen safety governance and oversight across the whole gesh Group in such a way as to enable poor or unsafe practice by individual clinicians to be identified, escalated and effectively acted upon earlier, thereby minimising a risk similar harm occurring again; and
- To reiterate the commitment given by the Board in November 2024 to continue to be completely open and transparent with patients, families, staff and the public about harm that has occurred, recognising that it is morally right to do so and that it will also drive us to continually improve the safety of the care we provide.

gesh

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

Action required by Group Board

The Board is asked to:

a. Note the RCP Invited Review Report and the information provided in this paper.
b. Decide the level of assurance provided that patients and families have been communicated with appropriately and that Statutory Duty of Candour has been discharged where the information is available to do so.
c. Decide the level of assurance provided that appropriate next steps are being taken to identify further instances of harm.
d. Decide the level of assurance provided that the RCP Recommendations have been, or are being, appropriately acted upon.
e. Decide the level of assurance provided that the ESTH respiratory service is now safe.
f. Decide the level of assurance provided that appropriate steps are being taken across the Group to strengthen the ability of staff to speak up.
g. Decide the level of assurance provided that appropriate steps are being taken across the Group to detect earlier any clinicians who depart from safe standards of practice.

Committee Assurance

Committee	Quality Committees
Level of Assurance	N/A

Appendices

Appendix No.	Appendix Name
Appendix 1	Royal College of Physicians Invited Review – March 2026

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 unless these actions are carried out in a timely and organised way, the Group will fail to meet its statutory obligation to discharge Duty of Candour with regard to communications with patients and families.

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

Key financial implications (past, present & future) include the cost of resourcing the original internal review, the cost of commissioning the independent RCP Invited Review, the cost of implementing respiratory department

service improvements including new staff appointments, the cost of resourcing a further extended review of care and any harm, and the cost implications of any legal claims related to this issue.
Legal and / or Regulatory implications
The programme of work described within this paper carries significant legal implications, including the discharge of statutory duty of candour obligations, engagement with the Coroner where relevant, management of potential litigation and regulatory risk, and the need to ensure all communications and review processes are conducted in line with confidentiality requirements and established governance processes.
Equality, diversity and inclusion implications
We will consider EDI implications in all engagement with patients, families and staff on this matter, to ensure that in carrying out this programme of work we are adhering to the Group's EDI principles, ensure nobody is unfairly treated, and making reasonable adjustments where needed.
Environmental sustainability implications
There are none identified in this paper.

Interstitial Lung Disease Update

Group Board, 09 July 2026

1.0 Purpose of paper

1.1 This paper presents the Group Board with the Royal College of Physicians commissioned review of the treatment of Interstitial Lung Disease at St Helier Hospital between 2019-2024.

1.2 This paper includes a summary of the key findings of the report, and an update on relevant actions completed and underway in response to the findings and recommendations of the RCP.

1.3 This paper also includes a summary of how we have managed the patients, and the patients' families, with regard to this report – including offering our full apologies and discharging duty of candour where appropriate to do so. We also discuss the care we have taken in managing the Respiratory clinical teams at Epsom and St Helier Trust.

1.4 The review of the treatment of ILD at St Helier relates to the care provided by one consultant at St Helier Hospital, who now no longer works at the Trust.

1.5 The overall purpose of the paper is summarised within the Executive Summary, above.

2.0 Background and Context

2.1 The background to this issue has been previously summarised in the paper discussed at Group Board in Public in November 2024.

2.2 The link to the November 2024 paper is here: Group-Board-Public-7-November-2024-V2.pdf

2.3 As reported previously, multiple sources reported perceived departures from recognised best medical practice in the management of patients with Interstitial Lung Disease by one respiratory consultant (referred to in the RCP report and hereafter as "Dr X"), who was primarily based at St Helier Hospital from 1996 until leaving the Trust in 2023. Concerns included that patients under the care of this consultant were not discussed in the multidisciplinary team meetings, may have not received disease modifying treatment and had not received consistent specialist input from Tertiary referral centres. It was recognised that this thereby may have led to avoidable degrees of disease progression and possibly significant truncation of life expectancy for some patients.

2.4 "Interstitial Lung Disease" covers a broad spectrum of conditions which are characterised by inflammation of fibrosis of the alveolar wall, leading to lowering oxygen levels. There are multiple different types of ILD; they are chronic, progressive conditions which require collaborative expertise including a consultant respiratory physician, a chest radiologist and specialist nurses to reach a consensus for diagnosis and management. Most patients with ILD referred to in this paper are patients diagnosed with Idiopathic Pulmonary Fibrosis (IPF), for which the median survival after diagnosis (as given in the NHS England Service Specification for ILD) was quoted as 3-3.5 years. This median survival estimate was determined by research that pre-dated the introduction and widespread use of the antifibrotic medications described in paragraph 2.5, which can slow disease progression in a proportion of patients.

2.5 As previously described to Quality Committee and the Group Board, best practice guidelines for people with ILD are set out in national guidelines published by the British Thoracic Society 2008, which recommended a multi-professional approach, and NICE 2013 (*Idiopathic Pulmonary Fibrosis in Adults diagnosis and management* CG183 2013) which outlines the multidisciplinary team involved in the diagnosis of ILD and the most appropriate medical management including identifying therapies that were not indicated previously. This was supported by the Quality Standard for Idiopathic pulmonary fibrosis QS79 which specified that diagnosis should be made by a multidisciplinary team with expertise in Interstitial Lung Disease. Subsequent technical updates outlined anti-fibrotic therapies and indications for use in the treatment of ILD (Nintedanib NICE 2016 TA379; Pirfenidone NICE 2018 TA50).

2.6 The Trust commissioned an external independent assessment of the quality of care provided to patients with ILD under the care of the consultant, and this assessment was undertaken by the Royal College of Physicians. The initial draft report of this review was received for factual accuracy checking on 22 September 2025. The draft report made a series of key recommendations to the Trust which were all formally accepted at the Group Executive Committee on 7 October 2025.

2.7 The final report was received by the Trust on 24 March 2026.

2.8 The RCP's report found that there were many instances in which the care provided to patients fell short of the expected standard, caused harm, and in some cases, through failing to offer timely disease-modifying treatments, may have contributed to premature death.

2.9 This report has been received with utmost seriousness and the RCP's recommendations have been accepted in full and have either been implemented already, or are underway.

3.0 Being open with our patients and discharging statutory duty of candour

Background

3.1 All affected or potentially affected patients with ILD looked after by Dr X since 2019, or their bereaved families, received a letter from Richard Jennings, the Group Chief Medical Officer, as described in the Public Board paper of November 2024, explaining the issue, apologising, providing the details of an advice line, explaining what was being done to ensure future safety and to learn and improve, including the commissioning of the RCP Invited Review.

3.2 The patients' General Practitioners (GPs) were sent copies of these letters with an explanatory cover letter.

3.3 The Group CMO committed in those letters to write again to patients and bereaved families once the final outcome of the external review was available.

Statutory Duty of Candour

3.4 Statutory duty of candour is triggered when patients suffer moderate or severe harm as a result of failings in care. The findings of the RCP report trigger statutory duty of candour obligations in 22 cases.

3.5 The following actions have now been taken in response to the final RCP Report:

i. Duty of candour letters have been sent to all patients and bereaved families of patients included in the RCP's review (28 letters). These letters included the summary of the

RCP's specific findings of their case and included full quotation of the relevant patient-specific RCP text. Individual patients, or bereaved families, have been offered to face to face or virtual meetings with us to discuss these findings or any other related issues or concerns

ii. A separate letter has been sent to all other patients receiving care for ILD from Dr X since 2019 who were not selected as part of the RCP's review (203 letters). The Group Chief Medical Officer wrote to these patients or families, as previously promised, with a summary of the RCP findings, and an update that a comprehensive, internal, second harm review would be conducted, based on a similar structure as the RCP review. It has been explained that this review will necessarily include their care, and the purpose of this comprehensive review is to assess the quality of care provided to all ILD patients and identify all instances of harm, and to be open and transparent with all patients and families where this is the case. Individual patients, or bereaved families, have been offered to face to face or virtual meetings to discuss any concerns ahead of this further review.

iii. Communication has also been made with all the key whistleblowers who raised the initial concerns, either through departmental or individual meetings, or by letter, highlighting the actions that have been taken and highlighting the imminent publication of the RCP Report.

3.6 These letters have all been sent, ensuring that impacted patients and their families where appropriate have had the opportunity to receive the news, before the RCP Report is made public at this Group Board meeting on 9 July 2026.

4.0 An Overview of Patient Communication Since the RCP Report Was Received

4.1 We have taken steps to ensure that all relevant patients, who have either been reviewed by the RCP as part of the selected 28 cases, or are ILD patients who were not selected as part of the RCP review, have been contacted before the RCP report is published into the public domain, both by telephone and in writing. Where those patients are now deceased, we have contacted their next of kin. We have offered avenues of support, including the offer of clinician-led meetings to talk through the RCP's findings in specific cases and in general, and any other concerns patients or families may wish to raise. The purpose of these communications has been to take extra care to ensure that any distressing news can be managed as sensitively and appropriately as possible.

The 28 ILD Patients Selected as Part of the RCP Review

4.2 All patients, or bereaved families of decease patients, whose care has been reviewed as part of the RCP invited review, have been contacted. 28 patient cases were selected and reviewed by the RCP panel. A team dedicated to managing the Trust's response to the RCP Review has put principles and processes in place to ensure patients, or patients' families, are treated with care, sympathy and respect in receiving distressing news.

4.3 The Trust has discharged statutory duty of candour to all patients, or the families of patients, whose cases were reviewed by the RCP panel. Statutory duty of candour is legally triggered where the RCP has made a finding of moderate or severe harm or death, but the Trust's responsibility to be open and transparent extends to every patient and family, and so the same approach has been used in all 28 cases. In each case, the patient, or their next of kin where the patient is deceased, were contacted by telephone to offer a meeting with a clinician to talk

through the findings, or the option of receiving a letter first, containing all the detail of the RCP's findings in their individual case. Following this telephone contact, (or, if contact could not be made, following a further two attempts), a letter has been issued.

4.4 The letters have been written to provide the RCP's findings specific to that patient, and to offer the Group's utmost apologies for the care which fell short of what patients expect of the NHS – and in some cases caused significant harm.

4.5 The letters also included an explanation regarding next steps, including the fact that the RCP Report would be published in full at this Board Meeting, on 9 July 2026. The letters made clear that follow up appointments were available to all to discuss any concerns patients or families may have, and an enquiries email address and telephone advice line were made available. It was also noted in the letter that a senior group of clinicians reviewed all patients who were being treated for ILD at St Helier, in 2024, and the care of every ILD patient was corrected where necessary. The letter also noted that, whilst we cannot undo what has been done, the RCP's recommendations for ensuring that this will not happen again, have been accepted in full – and have either been implemented already, or are being implemented.

The 203 ILD Patients not included in the RCP Review Sample of 28

4.6 We have also issued letters to all other ILD patients who were treated at St Helier between 2019 and 2023 but who were not among those reviewed as part of the RCP report. That cohort constitutes 203 patients, some of whom are now deceased.

4.7 We have issued letters to the patients, or the patients' next of kin where the patient is deceased. The purpose of the letters is to:

- Refer back to the previous letter sent to each of these patients or their next of kin by the Group CMO in November 2024.
- Explain that the RCP Invited Review Report is now available to read from 09 July. 2026, and that its recommendations have been accepted and acted upon.
- Explain that the Trust is undertaking a further review of care provided in the treatment of ILD at St Helier 2019-2024 (more details are below in Section 7.0).
- Provide and explanation regarding the purpose and scope of the process.
- Explain how individuals will be updated if concerns are identified.
- Provide contact routes for questions and support.

4.8 The communications approach is intended to meet the key obligation of transparency and openness while at the same time avoiding causing unnecessary distress or anxiety. Communications are therefore being carefully developed with input from clinical, patient experience and communications teams.

4.9 The communication provides assurance that in 2024, a senior group of clinicians reviewed the care of all patients being treated for ILD at St Helier, and corrected their care, where necessary.

5.0 Engagement with Regulatory Bodies and Stakeholders and Whistleblowers

5.1 The Care Quality Commission (CQC) has been kept informed of this issue since 2023 and has received updates through the CQC/St George's regular engagement meetings. The RCP Invited Review report has been shared with the CQC, in April 2026.

5.2 The General Medical Council (GMC) has been kept informed through regular contact between the Site CMO, the Responsible Officer (RO) and the GMC Employment Liaison advisor (ELA). Dr X was referred to the GMC as described above. The RCP Invited Review report has been shared with the GMC, in April 2026.

5.3 NHS Resolution has been kept informed and the RCP Invited Review report has been shared with NHS Resolution on 30 June 2026.

5.4 NHS England (London Region) has been kept informed and the RCP Invited Review report has been shared with the Regional Medical Director on 26 March 2026. The Regional Postgraduates Dean has also been updated.

5.5 The Coroner for London South (Croydon) and the Coroner for Surrey were informed of the issue by the GCMO on 7 November 2024, and received an update, with a copy of the RCP Invited Review Report, and other relevant details, ahead of this Group Board meeting in July 2026.

5.6 Briefings have also been provided to:

- Surrey & Sussex Integrated care board (ICB)
- South West London Integrated Care Board (ICB)
- The Local GP Network
- Local Members of Parliament
- The Chair of Merton Overview and Scrutiny Committee
- The gesh Freedom to Speak Up Guardians
- The staff of the ESTH Respiratory Department
- The original whistle-blowers (in accordance with the local gesh Freedom to Speak Up Policy (2025), the local Whistleblowing Policy and the National Whistleblowing Standards, April 2025)

6.0 The actions taken with regard to Dr X, including with the General Medical Council

6.1 Below is a summary of the actions taken regarding Dr X, including those involving the General Medical Council (GMC):

- Dr X was formally locally restricted in their clinical practice (meaning they were not permitted to see patients or supervise resident doctors) from January 2023, as reported in the MHPS paper to Group Board in Private on 5 May 2023.

- Dr X left ESTH through pre-planned retirement on 28 April 2023 and ceased to be an employee of the Trust from that time.

- Dr X was discussed by the Site CMO and Responsible Officer (RO) with the GMC Employment Liaison Adviser and was formally reported by the Trust to the GMC in 2023.

- Because Dr X was not taking up a new clinical job, no Responsible Officer RO-to-RO communication could be made. The GMC referral, however, also ensured that any future RO would be made aware, by the GMC, of the concerns about her practice

- The draft RCP Invited Review Report was shared by the trust with the GMC in January 2026.

- The GMC asked the Trust for the details of the patients whose care was reviewed by the GMC, and the Trust is providing this information.

- The GMC placed conditions on Dr X's registration, which are set out in the GMC Register and in the public domain. The register confirms that Dr X is "*not currently connected to a Designated Body*." From 22 February 2026 the conditions are, in summary, that Dr X must inform the GMC before taking up any new post, and that Dr X must personally ensure all relevant people are notified of Dr X's conditions, and that Dr X must be supervised by a clinical supervisor appointed by Dr X's RO, and that Dr X must provide the GMC with a report from the supervisor "*in advance of or at her next review hearing*" and that Dr X "*must only do clinical work at consultant level in a non-acute setting*".

- The Trust informed Dr X, and Dr X's representative, of the upcoming public Board discussion that took place in November 2024, and similarly informed Dr X and Dr X's representative ahead of this paper and discussion in public Board.

7.0 The initial internal review of Dr X's patients from 2019, and the plan and rationale for further internal harm review (both ILD and non-ILD cases) following the RCP Report

7.1 The purpose of this section of this paper is to provide a description of the degree to which Dr X's patients have had a care and harm review already, apart from the RCP Invited Review of 28 cases that is described in the attached RCP Report. In this section we provide clarity on the numbers of patients, the methodology, the membership of the review teams and the depth of the analysis of reviews that have taken place, and are planned.

7.2 When it became apparent in 2024 that it was necessary to review the care given by Dr X to all ILD patients since 2019, and to course-correct the treatment of all patients whose treatment needed correcting, an initial internal review was conducted.

7.3 The primary purpose of this 2024 initial internal review was to identify every patient Dr X had looked after with Interstitial Lung Disease. 2019 was chosen as the start date because that was when a ILD MDT became available to doctors at St Helier Hospital, and from when up-to-date national best practice could have been readily followed. 2023 was chosen as the end date because the was when Dr X stopped looking after patients. This Internal Review included all patients who had a Dr X clinic code. This review was conducted by four ESTH respiratory consultants and one final year respiratory specialist registrar.

7.4 The number of patients in this initial review was 1608.

7.5 Of these 1608, the number of patients who had ILD was 231.

7.6 The review was carried out by four ESTH respiratory medicine consultants and a ESTH respiratory final year SpR.

7.7 The 231 patients with ILD were prioritised for detailed scrutiny.

7.8 The remaining 1377 of the 1608 (i.e., those who were looked after by Dr X between 2019 and 2023 but who did not have ILD), a review was also conducted. If the reviewers had no

concerns about the care, the record of this review was brief, but in cases in which the reviewers did have concerns, these were set aside for more detailed scrutiny, which was carried out. The number of these patients was 36, and this is discussed further in the relevant section below.

7.9 More detailed Internal Review of all Dr X's patient with ILD seen between 2019 and 2023

7.10 The 231 patients with ILD were prioritised for detailed scrutiny.

7.11 At the time of the review of those 231 cases, 216 were identified as having had care that in some ways did not meet best practice guidance, and of those 216, 91 (42%) were deceased and 125 (58%) were living.

7.12 Departures from best practice were noted, and all patients received a course-correction of their treatment where that was required. This process has been described in Section 4.0 of the November 2024 paper for the Group Board in Public.

7.13 Written narratives were created for all 231 patients with ILD through this Internal Review process. These narratives show clearly where the reviewers had concerns about the care, but do not contain a standardised and pre-determined assessment of the degree of harm caused, because at that stage we were commissioning the RCP to convene an external panel of experts to assess the degree of harm in a selected number of case note reviews.

7.14 It is therefore probable that within the cohort of 216 ILD patients whose care did not meet best practice guidance, there are some instances of moderate or severe harm which have not yet been identified. It is clearly necessary to identify those cases to be open and transparent with these patients and families, and if and where applicable, to meet our statutory duty of candour obligations. The approach to rectifying this, in the light of the RCPs findings on the degree of harm caused by such departures from best practice, is to conduct a further, comprehensive review, as discussed in the relevant section below.

External RCP Review of selected cases

7.15 Of the 231 patients with ILD, the RCP was provided with 30 sets of case notes. Some of these were selected because there were already concerns highlighted about the care given, but some (at the RCPs request) were selected randomly. Two cases were subsequently excluded from the RCP review, and 28 were reviewed. The findings are described in the RCP Report.

7.16 In the course of the Internal Review of 1608 cases of Dr X's patients who did **not** have ILD (1377 of the 1608), an additional 36 patients were identified whose cases gave cause for concern, who hadn't already been identified through prescribing records (for oxygen and roflumilast), clinical trial data, or DATIX during routine clinical interaction.

7.17 Those concerns have been categorised by theme and have informed the choice of cases to be selected or sampled for an expansion of the clinical care reviews already undertaken (see the section below).

7.18 The themes identified are:

- **Nocturnal hypoventilation**

  Some patients were prescribed oxygen for nocturnal hypoventilation when this may not have been appropriate, and may have carried the risk of causing deterioration. These patients

were not referred to a sleep service for consideration of non-invasive ventilation which is standard of care.

At this timepoint we believe that the care of all these patients who received nocturnal oxygen has been course-corrected, but this is currently being reconfirmed.

In addition, further patients were identified with obstructive sleep apnoea or nocturnal hypoventilation who were not prescribed inappropriate oxygen but were also not referred onwards appropriately to a sleep service.

There is a risk that there are other patients with nocturnal hypoventilation that we have not yet found who should have been referred to a sleep service but have not been.

- **Roflumilast treatment**

  This treatment, licensed for Chronic Obstructive Pulmonary Disease (COPD), was prescribed by respiratory nurses to 14 patients under the direction of Dr X in 2023. Some of these patients had COPD which was the correct indication, but the monitoring and delivery did not meet best practice. In two cases patients were prescribed Roflumilast in conditions for which the drug was not licensed. It is the use of this medication in preference of other treatments, as well as the high side effect profile, which gave rise to concern.

  The respiratory team reviewed, and course-corrected all patients who were receiving Roflumilast in 2023 but there may be additional patients who were not receiving it at that time point, but who had received it prior to 2023, and who are not yet identified. Work to clarify this is underway.

- **Patients undergoing bronchoscopy**

  It has been identified through the Internal Review that bronchoscopies were undertaken for indications not recommended in guidelines, giving rise to risk of avoidable harm.

- **Patients entered into research studies conducted by Dr X**

  There were two research studies which Dr X ran at the Trust. Patients entered into these studies may not have had access to established therapy recommended by NICE. Work to clarify this is underway.

- **Patients given respiratory diagnoses without clear reference to contemporaneous diagnostic standards**

  A high number of patients in Dr X's clinic were given respiratory diagnoses such as asthma and COPD without clear reference to contemporaneous diagnostic standards. These patients may have received inappropriate treatments (for example inhalers), or the un-evidenced diagnosis may have obscured a different serious underlying diagnosis (such as bronchiectasis or restrictive lung defects).

- **Poor record keeping and failure to make best practice recommendations**

  The internal review and the RCP Review both showed that Dr X's diagnostic and record keeping standards were not good. Dr X also recommended alternative treatments which were available over the counter, and whilst this did not carry a risk of

harm, these were suggested in preference to established recommendations including vaccination for potentially serious infections such as influenza and Covid 19.

The choice of cases to be selected for an expansion of the clinical care reviews already undertaken.

7.19 Informed by the above, we will expand the clinical care reviews already undertaken, to include the following:

- Nocturnal hypoventilation – all patients from 2019 to 2023 with nocturnal hypoventilation, and all patients prescribed oxygen.
- Roflumilast treatment - all patients from 2019 to 2023 prescribed roflumilast.
- Patients undergoing bronchoscopy – a sample of patients from 2019 to 2023 undergoing bronchoscopy.
- Patients entered into research studies for which Dr X was the Principle Investigator– a sample of patients entered into research studies from 2019 to their cessation before 2023.
- Patients given respiratory diagnoses without clear reference to contemporaneous diagnostic standards – a sample of patients from 2019 to 2023 diagnosed with asthma and COPD.
- Poor record keeping and failure to make best practice recommendations – a random sample of patients from 2019 to 2023.

7.20 In addition to this, the findings of each original 2024 internal review of the 231 ILD patients described above will be again reviewed (excluding the 28 cases now reviewed by the RCP), along with all other cases of ILD looked after by Dr X since 2019, to ensure that statutory duty of candour has been fulfilled, and to discharge this duty where it has not already been discharged. These reviews will be informed by the RCP Review team's approach to gradings of harm.

8.0 Recommendations from the Royal College of Physicians' Invited Review

8.1 The table below sets out the recommendations made by the Royal College of Physicians within immediate feedback and the final report. The Trust accepted all recommendations in full, and the table below encloses our detailed progress. Significant work has been completed, with the majority of recommended actions either completed or partially completed. Recommendations for further development as a tier 2 centre where antifibrotic therapy is delivered are currently not required but should be considered in the context of departmental development in the medium term.

8.2 Key highlights of improvements made include:

- Established standardised approach to the diagnosis and treatment of ILD through multiprofessional care, supported by:
  - Established diagnostic and treatment pathways to ensure a standardised approach which meets best practice

- MDT following NICE best practice guidelines for constitution with tertiary specialists embedded and outcomes tracked
- Investment in the respiratory clinical workforce to improve the ability of the team to deliver high quality clinical care.

- **Table 1:** Recommendations from Draft Report from Invited Review of the Royal College of Physicians – Analysis of Progress

Recommendation	Timelines	Trust Response	Update position
Recommendation a. **This report should be considered by the Trust Board or relevant subcommittee, and oversight of an action plan should be provided to a nonexecutive board member to ensure these recommendations are completed.**	Immediate (0–3 months)	Agree - completed	The draft report was considered at Quality Committee on Thursday 26 March 2026 and is being considered at the Trust Board on 9 July 2026.The action plan will be monitored through Quality Committee which is chaired by a non-executive board member.
Recommendation b. **The healthcare organisation should share the outcome of this report with their GMC employment liaison officer as part of the ongoing updates in relation to Dr X's clinical practice. The trust should also share this report with the Care Quality Commission (CQC).**	Short term (0–6 m)	Agree - completed	The final report was shared with the GMC in April 2026. The final report was also shared with the Care Quality Commission in April 2026.
Recommendation c. **Review outcomes of internal ILD patient review since 2019 and consider expansion; ensure transparent communication and duty of candour.**	Medium term (6–12 months)	Agree – underway-	The Trust identified all ILD patients looked after by Sr X since 2019 as part of the case identification process with a view to undertaking any necessary course correction of treatment (and this was completed in 2024). The outline as to how the Trust will now undertake an internal review of all ILD patients looked after since 2019 to assess harm, and include a sample of cases with other respiratory diagnosis is detailed within this paper.
Recommendation d. **Review all patients prescribed roflumilast by Dr X for clinical oversight and prescribing compliance.**	Medium term (6–12 months	Agree - underway	All patients prescribed roflumilast historically have been identified by pharmacy records. All patients for whom this is prescribed are now brought into routine consultant clinic for ongoing consultant-led prescription led by the COPD team. Their care will be reviewed as part of the wider harm review.

Recommendation	Timelines	Trust Response	Update position
			An audit of relevant practice will be arranged by December 2026 to ensure quality standards.
Recommendation e. 1. Respiratory teams to collaboratively develop ILD assessment and referral pathways.	Immediate (0–3 months	Agree - completed	The ILD diagnostic pathway has been approved at divisional governance and is in practice. There is national guidance that this should be a 10-week timed pathway from referral to diagnosis. This timeframe remains challenging to meet due to clinic capacity, MDT capacity and waits for diagnostics including lung biopsy but performance is continuously under review and further actions will be considered as necessary. Treatment pathways (steroids / Disease Modifying Anti-Rheumatic Drugs - DMARDs) have been written and will be reviewed at the site medicines optimisation committee on July 8th, which will then go to divisional governance for ratifying. Adherence to pathways is monitored through routine audit and where deviation is found, action is taken.
Recommendation e. 1. i. Ensure all lung biopsy patients are discussed in regional ILD MDT.	Immediate (0–3 months	Agree - completed	All lung biopsy patients with ILD are discussed in the regional MDT. Compliance is assessed through annual audit.
Recommendation e. 2. ii. Create clear referral pathway from local ILD MDT to GSTT regional MDT; introduce annual audit; audit treatment schedules vs MDT outcomes.	Immediate (0–3 months)	Agree - completed	This is included in the ILD diagnostic and treatment pathways and is reviewed via annual audits. The next annual audit will begin in October 2026.
Recommendation e. 2. iii. Establish SOP for referral to CNS-led clinics with escalation and named consultant oversight.	Immediate (0–3 months)	Agree – partially completed and underway	The lead Clinical Nurse Specialist (CNS) undertakes regular meetings and supervision with respiratory nursing staff. A log is kept up to date of all ILD patients known to the CNS team. CNS have Standard Operating Procedures to support practice including, for example, therapeutic drug monitoring. There is consultant oversight through weekly MDT. We will assign individual consultant leads to CNS clinics with the increased consultant establishment which

Recommendation	Timelines	Trust Response	Update position
			will be in place by September 2026.
Recommendation e. 2. iv. Develop pathways for smoking cessation, PR, oxygen services, palliative care referrals.	Immediate (0–3 months)	Agree – initiated and partially completed	A gap analysis is required and has been initiated for all areas: Smoking cessation pathways locally are provided locally and not by the acute Trust at this time. gesh is reviewing the in-house smoking cessation service for acute services as there is no local in-house service at ESTH. We are taking part in the national British Thoracic Society BTS smoking cessation audit this year, the findings from which will inform our approach. Developing clear pathways for community Pulmonary Rehabilitation and Oxygen services require proactive discussion and planning, which has been initiated. A palliative care pathway is in place and will form part of the annual audit in respiratory medicine.
Recommendation f. Support ILD CPD for consultants and CNSs including MDT attendance and national/regional education.	Immediate (0–3 months)	Agree - underway	Expectations of the educational requirements for all clinicians delivering ILD care will be defined by the ILD lead and will be monitored through appraisal. MDT attendance is routinely recorded.
Recommendation g. Support additional respiratory workforce recruitment across both sites.	Short term (0–6 months)	Agree - completed and under review	Consultants have been appointed to all vacant positions in substantive roles. Additional resilience in the respiratory service has been achieved through the appointment of two substantive consultants in April 2026.
Recommendation h. Invest in specialist ILD nursing and pharmacy support for antifibrotic/immunosuppressive monitoring.	Short term (0–6 months)	Agree – partially completed	The department has recruited additional Band 7 staff to support the ILD pathway and nurses now work cross site to cover the service, improving resilience. Although the Trust has ambitions to become a tier 2 provider(in tier 2, antifibrotics commenced in regional centres are continued closer to home), this is more a medium-term ambition, and antifibrotics are currently delivered and monitored at the regional centre (GSTT). There

Recommendation	Timelines	Trust Response	Update position
			remains a need for dedicated ILD pharmacy support which is currently not in place. Options to address this are being reviewed.
Recommendation i. **Establish dedicated ILD clinics at Epsom and St Helier led by ILD-interested consultants and specialist nurse.**	Short Term (0-6 months)	Agree - completed	Both sites have ILD clinics in place led by consultants with respiratory CNS's undertaking ILD clinics
Recommendation j. **Develop cross-site ILD MDT with SOP; include rheumatologist input; embed MDT in job plans; enable remote access; create referral SOP to tertiary MDT.**	Immediate (0–3 months)	Agree - completed	ESTH ILD MDT runs fortnightly and is attended by ESTH respiratory / ILD consultants, ESTH specialist radiologist, respiratory CNS, ESTH rheumatologist, and tertiary GSTT ILD consultant. Diagnostic and treatment SOPs include referral pathways to tertiary MDT.
Recommendation k. **Develop cross-site respiratory departmental meeting; incorporate into job plans; use Datix only for patient safety issues.**	Immediate (0–3 months)	Agree - completed	Departmental meeting established cross site. The divisional quality team is supporting with an audit of Datix usage with completion for this by September 2026.
Recommendation l. **Ensure regular clinical governance including M&M with ToR, wide MDT engagement, and dissemination of learning.**	Immediate (0–3 months)	Agree – completed and remains under review	A full review of governance has been undertaken and is established within the department including monthly multidisciplinary departmental meetings which have recorded minutes; monthly consultant meetings with minutes; quarterly governance half-days; job planned timed for governance lead in respiratory department; Monthly Mortality & Morbidity meeting
Recommendation m. **Provide timely departmental feedback on inquiries, Datix investigations, appreciative inquiry outcomes**	Immediate (0–3 months)	Agree – partially completed and ongoing	Established communication process delivers feedback through the departmental meetings by executives, site leadership team, divisional and departmental teams as appropriate. A further (third) executive and SLT-led AI feedback meeting is being arranged. Feedback from Datix is established through quarterly governance meetings.
Recommendation n. **Develop system for monitoring ILD patients on immunosuppressive therapy and prepare for devolved antifibrotic prescribing.**	Immediate (0–3 months)	Agree - completed	There is no immediate plans to become a tier 2 centre for devolved antifibrotic prescribing although this is an ambition. Although there is presently no

Recommendation	Timelines	Trust Response	Update position
			dedicated pharmacy support, SOPs for currently prescribed immunosuppressive therapy have been developed.
Recommendation o. **Evaluate current mechanisms for raising/responding to concerns; ensure accessibility and a clear escalation plan.**	Short term (0–6 months)	Agree – partially completed and under review	The Appreciative Inquiry identified gaps in the ability of individuals to raise concerns. The division, with support of the Freedom To Speak Up team have undertaken, listening events with the residents and junior doctor forums and monitoring end of placement feedback, but there is more required in this area for other staff groups.
Recommendation p. **Improve research governance: implement learning from trial breach audit, review all trials, provide feedback to Quality Committee.**	Short term (0–6 months)	– completed and remains under review	Epsom and St Heliers University Hospitals NHS Trust no longer act as a sponsor for Trials. All trials previously sponsored by Epsom and St Helier have closed prior to 2023. All trials undertaken at the Trust now are overseen by their relevant steering groups and trial sponsors who oversee the trail governance. Governance of research across gesh is now managed in an integrated structure with accountability held by the Group Chief Medical Officer.
Recommendation q. **Support nurse-led respiratory clinics with clinical leadership, escalation procedures, and integration into governance structures.**	Short term (0–6 months)	Agree – completed and ongoing	SOPs for nurse led respiratory care including competency frameworks have been developed, with a clear process for referring patients back into consultant clinic and in the process of being implemented. The outcomes of these SOPs will be audited to evaluate effectiveness, this will be done within 6 months of all being fully implemented.
Recommendation r. **Review of local leadership arrangements.**	Immediate (0–3 months)	Agree - completed	Respiratory leadership was reviewed in the broader context of a full review of senior leadership in the medicine division with the creation of more senior deputy divisional medical director posts within the department.
Recommendation s. **Provide confidential emotional/psychological support for all respiratory staff via external provider.**	Immediate (0–3 months)	Agree – partially completed and ongoing	External pastoral support for staff is being provided by the gesh Group Staff Support service, which is external to the respiratory service but not external to the organisation. A

Recommendation	Timelines	Trust Response	Update position
			prioritisation agreement with the service is in place which will be valuable to ensure that the staff have the real-time support required following the impact of the outcome of the invited review. This will overlap with support to strengthen psychological safety to speak up.

9.0 Engagement with the ESTH Respiratory Team

9.1 The RCP Report, in its conclusion to the Executive Summary (p8) notes that "*the review team expressed their confidence that with sustained support from the trust, the current respiratory team is well-positioned to drive meaningful improvements to the ILD service going forwards*".

9.2 The RCP Report also observes, however, that tensions in the team in the past created a challenging environment, and it was in recognition of this fact that the Trust commissioned the Appreciative Inquiry described below.

9.3 It was members of the ESTH respiratory department who carried out the very substantial piece of work to carry out the initial internal review in 2024 of all patients looked after by Dr X since 2019, and likewise it was members of this team who then recalled every patient with ILD who needed a course correction of their treatment so that we could then be assured that every ILD patient is now being safety and correctly looked after. It has been important for the respiratory team to know that this work has been recognised and greatly appreciated.

9.4 As the RCP Report observes, this has been a difficult time for all members of the ESTH respiratory department and ILD team, and senior leaders have engaged and continue to engage with the team to offer information and support, to listen to concerns and to help foster a continuing improved departmental culture.

9.5 Senior leaders continue to engage proactively with the ESTH respiratory team regarding the external review findings and next steps.

9.6 A series of meetings, both in person and virtual, have been held since 2024 between members of the executive team, the ESTH senior leadership team, and all members of the department. Recent meetings, attended by the GCEO, the GCMO and the Site CMO, have taken place in May and June this year to:

- Provide updates on the Group and Trust response to the RCP Invited Review Report.
- Discuss support arrangements for team members.
- Reinforce expectations regarding openness, professionalism and patient-centred engagement.
- Enable team member questions and feedback.

9.7 Fortnightly engagement sessions have been scheduled from 02 July and will focus on:

- Listening and responding to staff concerns ahead of and beyond 09 July
- Ongoing staff support and wellbeing.
- Learning and improvement actions.

- Clinical governance improvements.
- Opportunities for staff involvement in improvement activity.
- Discussion of the future review of harm approach for the 203 ILD patients not within the scope of the RCP review

9.8 The Trust recognises the importance of maintaining psychologically safe and professionally supportive engagement throughout this process. Staff counselling has been made available to staff to access immediate support. Divisional Tri fortnightly touch point meetings have been diarised with the respiratory team as an additional means of support.

10.0 Respiratory department teamworking & psychological safety

10.1 As previously described, following the commissioning by the Trust of an Appreciative Inquiry (AI) to adopt a supportive and restorative approach to departmental team working, feedback of the key findings was provided through a number of workshops led by the Group CMO and Group CNO and Site Managing Director on the 14 August 2024 and 30 September 2024. The final AI report was shared with the Senior Leadership Teams and the Divisional Leadership Team who developed an action plan with 11 actions which covered the various areas of concern, of which seven are closed.

10.2 The following four actions remain open:

i. Divisional leadership being more visible amongst the team. Although the members of the divisional Triumvirate (Tri) have increased their visibility across wards and administration areas, this still requires further work to ensure that there is an open, psychologically safe environment where concerns can be raised. The appointment of deputy divisional medical director for specialist services in March 2026 has increased divisional leadership capacity at a senior level to increase senior leadership. This will be monitored through triangulation of feedback through the Freedom to Speak Up guardian, staff survey and GMC survey and delivery of engagement plans on both sites.

ii. Enabling staff to speak up – with support of Freedom to Speak Up (FTSU) through staff listening events, listening events with the residents and junior doctor forums and monitoring end of placement feedback, the division has worked to enable and encourage staff to speak up. However, staff are reporting concerns regarding this through the FTSU Guardian which suggests that staff still do not always feel confident or comfortable to approach management teams. The divisional management team is reviewing the staff survey to further strengthen the ability of staff to speak up and share their concerns. As this remains an ongoing concern, the division will now provide training to clinical leaders and operational managers in managing concerns and whistleblowing as this is essential for safeguarding including ensuring early detection of risks, promoting a psychologically safe environment, and protecting workers from retaliation or detriment.

iii. Facilitated discussion is being arranged between the senior consultant colleagues in the department to develop a professional culture which is shared, compassionate and where consultants work together with civility and respect. A facilitator has now been found for this discussion to take place within gesh and will take place in Autumn 2026. In the meantime, the Site CMO and Group CMO have met individually with consultants

to make clear the Trust's expectations and requirements regarding civility, respect and teamworking behaviour. These Trust expectations are grounded in signed behavioural agreements that the team members themselves co-created in a constructive and collegiate manner in the past, providing reason to be optimistic that positive teamworking behaviours will be maintained in the future, aided by additional support as described above.

iv. Peer review visits across Southwest London Trusts has not been achieved due to capacity of other Trusts to support the peer review visits. Options continue to be explored and will be focused on arranging peer review of improved pathways for clinical care delivery.

11.0 ESTH Respiratory Department: Sources of assurance on current quality of ILD care

11.1 Structural change and strategic investment have led to significant improvements in the delivery of care to patients with interstitial lung disease. Through improved medical and nursing staffing and cultural change including empowerment of nursing staff to refer to the MDT, supported by an agreed ILD pathway, training and education, initial audit has shown compliance with MDT referral and management.

11.2 The ESTH ILD MDT is multiprofessional and includes tertiary consultants within its structures. Currently, all patients with ILD are discussed in this forum and this includes patients referred by nurses and other medical specialists and includes patients for whom there is radiological suggestion of ILD even where the clinician feels this may not be the primary diagnosis. This ensures that ILD is robustly diagnosed and that an MDT decision is made where there is diagnostic uncertainty and it is felt that ILD is not likely to be present. Additionally, an ESTH respiratory consultant attends the tertiary MDT weekly at GSTT which is a separate MDT where patients under tertiary management led by GSTT are discussed, allowing early access to specialist opinion in cases where patients are deteriorating rapidly.

11.3 An audit program of outcomes is embedded in the ESTH ILD service. The audit evaluates compliance with NICE/British Thoracic Society guidelines for ILD Management.

11.4 Audit in 2025 led to immediate actions to address findings where there were gaps or areas for improvement. Overall, the audit findings were significantly assuring, as follows:

i. Diagnostic delays: referral to first appointment was 120 days. Respiratory consultants now directly triage ILD to urgent new appointments. Although 95% of patients have pulmonary function tests, there is considerable delay of 155 days due to the separate issue of the fragility of the ESTH respiratory physiology service (which is on the risk register, and for which options are being set out under the leadership of the gesh Clinical Strategy & Standards Group (CSSG)). All patients have CT chest within an appropriate time frame.

ii. Multidisciplinary team meeting frequency has been increased to 2 weekly and quorate standards are maintained through a register. 100% of meetings meet the standard required assuring that all patients who meet criteria for tertiary referral services are identified. Although there is a backlog of MDT discussions due to availability of chest radiology, additional meetings have been arranged to ensure patients whose disease is worsening are identified ,and MDT triage ensures that the backlog is reviewed regularly.

iii. Referral of eligible and consenting patients with Idiopathic Pulmonary Fibrosis (IPF) or progressive pulmonary fibrosis referred to tertiary centre is at 100%.

11.5 A further audit of practice will be completed by Q2 2026 to review the impact of pathway development.

11.6 In addition to making and auditing improvements in clinical standards and pathways, the respiratory department has taken steps to more meaningfully incorporate the experience of patients and their carers into the provision of high-quality care. To this end, a local support group has now been established for those affected by pulmonary fibrosis, which is open to both patients and their carers.

12.0 Current challenges to the ESTH ILD service and associated improvement activity

12.1 The current challenges to the ESTH ILD service and associated improvement activities are:

i. Limitations of specialist radiological support. Currently there is a single chest radiologist in position and where there is annual leave or sick leave the MDT cannot go ahead which leads to delays in the pathway. A new full time respiratory specialist radiologist has been appointed in June 2026, which will significantly improve this situation

ii. Demand and capacity in the MDT is currently being reviewed with assessment to ensure that those who will most benefit from specialist MDT input are seen in a timely manner. The team are looking at processes to review cases virtually where primary ILD is less likely through utilising MDT triage processes.

iii. Clinic capacity has improved through additional substantive consultants (now 11 consultants) who work across ESTH at both sites. ILD patients are directly triaged to ensure they are not impacted by clinic capacity.

iv. Respiratory Physiology is a fragile service recognised on the Trust risk register and impacts the pathway for interstitial lung disease as this is a key investigation for monitoring and diagnostic purposes. A business case to support this service is being presented to the senior leadership team imminently, supported by the new gesh Clinical Strategy and Standards Group (CSSG).

13.0 Organisation-wide improvement measures to detect individual practice concerns

13.1 Poor practice by an individual consultant can clearly, if it continues unchecked, cause significant harm, and so a key question must be how the gesh Group, which has over a thousand consultants practicing in over forty different specialties, ensures that no other clinicians are practicing in an unsafe way.

13.2 Work to strengthen our safeguards around this across the organization has focused on four main areas, namely:

- Promoting a culture in which staff feel safer to speak up
- Strengthening our system for escalating and responding to concerns
- Strengthening Multidisciplinary Team Meetings (MDTs) to prevent continuing practice in isolation

- Strengthening Morbidity & Mortality Meetings (M&Ms) to identify poor practice outside accepted standards

13.3 These four things are not the only things that can be strengthened to make care safer and poor practice less likely, but they are particular areas of focus and are covered in this section in turn.

13.4 These areas of improvement are also related to other broader initiatives to strengthen quality and safety, which the Board has discussed in the past and continues to focus on, including the Quality Governance Improvement Programme.

13.5 This work also supports the focus on safety culture, learning and the better use of data, all of which is highlighted in the agreed gesh Quality and Safety Strategy 2024-2028.

13.6 **Work done to strengthen the ability of staff to speak up:**

- Strengthened speaking up arrangements within the Respiratory Service at ESTH: This has been done drawing on the findings of the appreciative inquiry and has been described in previous papers.

- Strengthened organisational framework for concern raising at ESTH: Over the past two years, we have strengthened the framework for FTSU Guardian Service at Epsom and St Helier. In May 2024, the FTSU Guardian Service was brought together on a Group-wide basis across the St George's, Epsom and St Helier University Hospitals and Health Group, under the leadership of a single Group-wide FTSU Guardian. This has ensured there are common standards, systems and processes for supporting staff to raise concerns to the Guardian across the Group. Supporting this is a new Group-wide Freedom to Speak Up policy, developed in line with the national guidance, which was approved by the Group Board in January 2025. The new policy sets out clear routes and contact details for staff to raise concerns and standards and expectations relating to how concerns should be responded to. To support the active tracking and management of cases raised to the FTSU Guardian, in 2024 Epsom and St Helier adopted the existing St George's FTSU case management system, and from April 2026 both Trusts have adopted a new case management system which supports staff raising concerns anonymously to the FTSU Guardian.

13.7 **Work done to strengthen the executive and site-level oversight and response to concerns**

- Strengthened executive and site level oversight of concerns: Over the past two years, we have strengthened both executive and site-level oversight of concerns raised both through the Freedom to Speak Up Guardian Service and directly to executive and site leads. This enhanced oversight has helped to promote better visibility of concern raising at executive and site level and has also supported improvements in the resolution of concerns in a more timely way. Alongside this, we have developed a new Insights Dashboard, which the executive and site leadership teams use to triangulate multiple sources of intelligence to identify services and teams with challenges and proactively agree support needed. This dashboard has already been used to prompt deep dives into specific services and teams where the intelligence points to potential challenges that require early intervention.

- Response to the NHS Staff Survey: We know from our NHS Staff Survey 2025 that our staff at both Trusts do not always feel safe and supported to raise concerns and that staff lack confidence that where they raise concerns, the organisation will respond to their concerns. In response to the NHS Staff Survey, we are prioritising work on management conduct, leadership development, equality diversity and inclusion which will address key themes in concerns raised by staff.

13.8 **Work underway to strengthen the impact of MDTs on preventing isolated working or poor practice**

- It is well recognised that MDTs play a central role in ensuring that care provided to patients is multidisciplinary, with input from a range of clinicians are care-givers and is based in accepted standards and best practice. If MDTs are well-run and overseen, with systematic communication between MDT chairs and clinical leaders, they also provide a major opportunity to identify isolated practice that may depart from accepted standards, and to ensure that such departures are flagged early, escalated and not permitted to continue. Failure of individual clinicians to engage with MDTs or adhere to MDT working is a recognised theme when investigating concerns about poor individual practice (as is indeed the case in the current RCP Report, e.g. RCP Section 3.2.3).

- St George's commissioned an external governance review (April 2019) focusing on M&Ms and MDTs, and all St George's M&Ms were mapped. The number of MDTs identified was 103 (St George's has 44 Care Groups covering a very wide range of specialities), excluding Imaging and Pharmacy, which were involved in 59 and 21 specialty MDTs respectively. Work was done based on this 2019 governance review to provide guidance on the standards an MDT should follow.

- A new improvement programme is now being undertaken to strengthen the assurance that can be taken from these MDTs that clinicians are providing care in accordance with accepted standards.

- This MDT improvement programme is being fully integrated with the Quality Governance Improvement Programme that is already being tracked by the Group Board, and being implemented across the Group.

- The Group CMO and Group CNO, alongside clinical site leadership, have written to all MDT Chairs, via their Divisional Medical Directors (ESTH) or Divisional Chairs (SGUH), describing the quality governance standards for MDTs. As part of the Quality Governance Improvement Programme, a Divisional MDT Assurance review will be conducted in September 2026 for each Division, led by the Group Director of Quality & Safety Governance, supported by the GCMO and Site CMOs and Site CNOs.

- In this same letter from the Group CMO and the Group CNO, the MDT Chairs have been asked to share any immediate concerns about any poor clinical practice. The letter points out that the substantial harm that has occurred at St Helier through individual unsafe practice is a powerful reminder of the crucial importance of identifying, raising, and acting on unsafe practice quickly.

- As part of this MDT improvement programme, the map of St George's MDTs is being updated, with an updated list of MDT Chairs and their contact details, and a similar action is being undertaken at ESTH. This work will continue through Q2 and Q3 of 2026/7 with the intention that all MDT Chairs will then have a collective robust means of communicating and escalating

concerns about poor clinical practice promptly with Site senior leadership teams and the Group Executive.

- Through this work, all MDTs will be mapped across the organisation and benchmarked against best practice to ensure consistent standard of structure and recording of outcomes.

- The initiation of this MDT improvement work, and the failings in care that have prompted it, were also shared by the Group CMO at the Group All Consultants Meeting in May 2026

- The Group CMO is also liaising with the Group Chief Information Officer to explore the potential role of Ambient Voice Recognition technology and Artificial Intelligence in supporting the contemporaneous documentation and sharing of information from MDTs and M&Ms, and the possibility of improving the ease of access to MDT records on the iClip Cerner electronic patient record, which would substantially increase the ability of clinicians to see what MDT recommendations have been made and whether they have been followed.

13.9 Work done and underway to strengthen the impact of M&Ms in identifying poor practice or departure from accepted standards

- Morbidity and Mortality (M&M) meetings are a well-recognised and nationally expected way of learning from deaths and complications, and improving care. They provide an important way of meeting the standards set out in the *NHS National Guidance on Learning from Deaths (March 2017)*, and the Royal College of Surgeons has produced a detailed guide – *Morbidity and Mortality Meetings: A Guide to Good Practice (November 2018)*.

- For historical reasons, the oversight and governance of M&Ms is more mature at St George's than at ESTH – as noted above, St George's commissioned an external governance review (April 2019) focusing on M&Ms and MDTs (at that time there were 39 different M&Ms at St George's – there are now 47). Based on the recommendations of this review, a team was recruited to support St George's M&Ms. That team became a Group-wide team in 2024 with the integration of corporate services, and now sits under the Group head of Mortality & Effectiveness, who reports to the GCNO.

- Work is being done now to strengthen our ability to address early any repeated departure from best practice standards or any care associated with a pattern of poor outcomes. M&Ms are, and should remain, a psychologically safe space to learn without blame from things that go wrong, including instances of recognised complications of treatment. This learning-focused approach can still be maintained, however, while recognising that M&Ms are also a forum in which persistently poor or non-standard care by individuals can first become evident – the improvement work now is directed towards detecting, escalating and acting on such signals early.

- The M&M support team has built on the work that it has done at St George's, and has created clear guidance and standards for good M&Ms across the Group. These standards have been integrated into the ongoing Quality Governance improvement programme that the board continues to track.

- The M&Ms at ESTH have been mapped – there are 34 in total – and in March 2026 a gap analysis was completed to determine what support those M&Ms required. Engagement from those M&Ms with the improvement work has steadily increased through 2026 and is positive overall.

- M&M Quality Assurance information, including the recording and dissemination of learning) is now being routinely collated and tracked at St George's, and work is being done to create the same level of Quality Assurance information at ESTH.

- An up-to-date contact list of the Chairs of all 47 M&Ms at St George's is maintained, and a similar list is being complied for ESTH.

- Through Q2 2026/7 the GCMO and Site CMOs will be working with the M&M chairs, through their Divisional leaders, to establish robust regular communication that will enable concerns about individual practice that are detected at M&Ms to be reliably highlighted and escalated, and appropriate action taken. Appropriate action will often be supportive, focused on learning, training and mentoring, but will also include the imposition of restrictions on practice where necessary, through the existing governance mechanism that is reported regularly to Group Board in Private.

13.10 The governance and reporting of the M&M and MDT Improvement Programme.

- The GCMO is the Senior Responsible Officer (SRO) for this programme, which will be led by the Group Head of Mortality & Effectiveness, working closely with the Group Director of Quality and Safety Governance and the Site CMOs and CNOs.

- The work of the M&M support team has been reported to the Mortality Monitoring Group at St George's and at RADAH at ESTH, and then through each Site's Patient Safety & Quality Group (PSQG) and thence to the Group's Clinical Safety Action Group (CSAG), which is co-chaired by the GCNO and the GCMO. Kay developments have been reported to Quality Committee and to the Group Board through the Learning from Deaths Report. Reporting to CSAG, and on to Quality committee and the board, will continue, but will from now reflect the broader improvement programme for both M&Ms and MDTs described in this section. By this means, the Group Board will be able to maintain appropriately regular oversight of this programme through Quality Committee.

14.0 Future governance oversight and reporting through to Group Board

14.1 The programmes of future work described in this paper can be summarised as follows:

- Communicating and meeting with patients and families of patients whose care has been reviewed by the RCP.

- Completing the further internal harm review of all patients with ILD looked after by Dr X since 2019.

- Completing the further internal harm review of a sample of patients with conditions other than ILD looked after by Dr X since 2019.

- Discharging Statutory Duty of Candour, and transparency and openness, as this arises through the conducting of those further internal harm reviews.

- Completing the delivery of actions arising from the RCP Recommendations.

- Continuing to monitor, engage with and support the ESTH respiratory team.

- Continuing to engage with key stakeholders, including whistleblowers.
- Continuing to take Group-wide actions to strengthen the ability of staff to speak up about concerns.
- Delivering the Group-wide MDT and M&M improvement programme as part of the overall Quality Governance Improvement Programme.

14.2 These programmes of work will be monitored at the Group Clinical Safety Action Group (CSAG), co-chaired by the GCNO and the GCMO. CSAG will report on this work through the Group executive Committee to Quality Committee and thence to the Group Board.

14.3 It is proposed that the first assurance update is discussed at Quality Committee in Q3 2026/7.

15.0 Recommendations

15.1 The Board is asked to:

a. Note the RCP Invited Review Report and the information provided in this paper;
b. Decide the level of assurance provided that patients and families have been communicated with appropriately and that Statutory Duty of Candour has been discharged where the information is available to do so;
c. Decide the level of assurance provided that appropriate next steps are being taken to identify further instances of harm;
d. Decide the level of assurance provided that the RCP Recommendations have been, or are being, appropriately acted upon;
e. Decide the level of assurance provided that the ESTH respiratory service is now safe;
f. Decide the level of assurance provided that appropriate steps are being taken across the Group to strengthen the ability of staff to speak up; and
g. Decide the level of assurance provided that appropriate steps are being taken across the Group to detect earlier any clinicians who depart from safe standards of practice.

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Setting higher standards

Invited Reviews

Report of the individual review for

St George's, Epsom and St Helier University Hospitals and Health Group on 11–12 February and 24–25 March 2025

This report is the property of the healthcare organisation responsible for the commission of this invited review

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1 Glossary

Term	Definition
AI	Autoimmune screening
AIP	Acute interstitial pneumonia
Alveoli	Small air sacs within the lungs
Avian precipitants	Antibodies that react to antigens found in birds
Azithromycin	An antibiotic used to treat various bacterial infections
Basal-associated ILD	ILD affecting the lower portion or bases of the lung
Bronchiectasis	Bronchiectasis is a chronic lung condition characterised by the permanent widening and damage of the airways, leading to mucus build up and frequent infections.
Carbamazepine	Carbamazepine is an anticonvulsant medication primarily used to treat epilepsy and neuropathic pain.
CCP antibody	Anti-cyclic citrullinated peptide (CCP) antibodies are important markers used to diagnose rheumatoid arthritis (RA) and can indicate the severity of the disease.
Charles Bonnet syndrome	Charles Bonnet syndrome is a condition that causes visual hallucinations in individuals with significant vision loss, often resulting from eye diseases.
Co-trimoxazole	Co-trimoxazole is a fixed-dose combination of two antibiotics: sulfamethoxazole and trimethoprim and is used to treat various bacterial infections, also known as Septrin.
CPAP	A continuous positive airway pressure (CPAP) machine is a device used primarily to treat sleep apnoea. It works by delivering a continuous stream of air through a mask worn over the nose and/or mouth, which helps keep the airways open during sleep.
CTD-ILD	Connective tissue disease-associated interstitial lung disease (CTD-ILD) is a lung condition that may develop in individuals with connective tissue diseases. It is characterised by interstitial lung disease (ILD) evidenced by various imaging findings, such as reticulation and ground-glass opacities, often occurring in conditions like rheumatoid arthritis (RA), systemic sclerosis (SSc), and idiopathic inflammatory myopathies (IIM). The distinction between CTD-ILD and idiopathic ILD is clinically significant, as their baseline lung function and treatment approaches differ.
Crepitation	The abnormal crackling sound of lungs (heard through a stethoscope) where airways or air sacs are opening and closing, potentially because of fluid, scarring or inflammation.
Cutaneous scleroderma	Cutaneous scleroderma primarily affects the skin and is characterised by thickening and hardening of the skin due to excessive collagen production. It is an autoimmune condition, meaning the immune system mistakenly attacks the body's own tissues. While there is no cure for cutaneous scleroderma, treatments are available to ease symptoms, slow progression and improve quality of life.
Cyclophosphamide	Cyclophosphamide is a chemotherapy medication used to treat various types of cancer, including lymphoma, leukaemia, breast cancer and ovarian cancer. It works by slowing the growth of cancer cells and is also used to suppress the immune system in certain conditions.
Datix	Datix is an online tool for staff to report and incidents and risks.
Desquamative interstitial pneumonia	Desquamative interstitial pneumonia (DIP) is a rare lung disease characterised by the accumulation of pigmented macrophages in the alveoli, primarily associated with smoking.
DLCO	A lung diffusion test (DLCO) is a type of pulmonary function test that assesses how well your lungs are working. It uses a gas containing carbon monoxide to measure how much oxygen moves from your lungs to your blood when you inhale.
EBUS	Endobronchial ultrasound scan and biopsy is a minimally invasive procedure that allows doctors to view the airways and lungs while obtaining tissue samples for diagnosis. It uses a bronchoscope equipped with ultrasound technology to sample lymph nodes and other tissues without the need for surgical incisions. This procedure is particularly useful for staging lung cancer and diagnosing various lung conditions, as it carries less risk compared to traditional surgical biopsies.
Echocardiography	Echocardiography is a non-invasive test that uses sound waves to produce live images of the heart, allowing healthcare professionals to assess its structure and function. The images generated are called echocardiograms.

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Individual review report

Term	Definition
Emphysema	Emphysema is a chronic lung condition that is part of chronic obstructive pulmonary disease (COPD). It causes shortness of breath due to damage to the air sacs (alveoli) in the lungs, which impairs the exchange of oxygen and carbon dioxide. The most common cause of emphysema is smoking, but it can also result from long-term exposure to irritants such as air pollution and chemical fumes. While the damage caused by emphysema cannot be reversed, symptoms can be managed through treatments such as medications, pulmonary rehabilitation and lifestyle changes.
Eosinophilic pneumonia	A condition characterised by the accumulation of eosinophils, a type of white blood cell in the lungs, leading to inflammation and damage.
FNSIP	A subtype and more serious form of NSIP characterised by chronic inflammation and significant fibrosis (scarring), leading to reduced lung function and difficulty breathing.
FEV1/FVC ratio	The FEV1/FVC ratio is the ratio of the forced expiratory volume in the first one second to the forced vital capacity of the lungs. The normal value for this ratio is above 0.75-85, though this is age dependent.
Folic acid	Folic acid, also known as vitamin B9, is a crucial nutrient that supports red blood cell production, DNA synthesis, and foetal development during pregnancy.
Fostair	Fostair is a type of inhaler and indicated in the regular treatment of asthma.
Furosemide	Furosemide is a loop diuretic medication used primarily to treat fluid retention (oedema) associated with conditions such as congestive heart failure, liver disease, and chronic kidney disorders. It is also effective in managing high blood pressure. Furosemide works by inhibiting the absorption of sodium and chloride in the kidneys, leading to increased urine production. Common side effects may include dehydration, electrolyte imbalances and low blood pressure.
GMC	General Medical Council
Ground glass	Ground glass refers to the hazy grey areas that can show up in CT scans of the lungs. These areas show increased density inside the lungs which could indicate infection, inflammation or other respiratory disorders
GSST	Guy's and St Thomas'
Hydroxychloroquine	Hydroxychloroquine is a medication used to treat autoimmune conditions such as rheumatoid arthritis and lupus, as well as to prevent and treat malaria.
Hypercalcaemia	Hypercalcaemia refers to high levels of calcium in the blood
Hypercholesterolaemia	Hypercholesterolaemia refers to high levels of cholesterol in the blood
ILD	Interstitial lung disease
Induced sputum	A sputum induction test involves producing a fresh sample of sputum to be analysed. Sputum is a type of mucus that is coughed up from the lower airways, specifically the trachea and bronchi.
IPAF	Interstitial pneumonia with autoimmune features (IPAF) is a term given for patients with interstitial lung disease (ILD) who show some features related to autoimmunity but without meeting the full criteria for a defined connective tissue disease.
IPF	Idiopathic pulmonary fibrosis is a condition in which the lungs become scarred making it difficult to breathe.
Itraconazole	Itraconazole is an antifungal drug used to treat various infections
MDT	Multidisciplinary team
Methacholine challenge	The methacholine challenge test is a diagnostic procedure used to evaluate airway hyperreactivity and help diagnose asthma by measuring lung function after inhaling methacholine, a substance that can cause airway constriction.
Methotrexate	Methotrexate is a medication used to treat autoimmune conditions
MMF	Mycophenolate mofetil is an immunosuppression drug and is used to treat autoimmune disorders.
MPHS	Maintaining High Professional Standards in the NHS –a national policy framework for doctors and dentists
MRI	Magnetic resonance imaging

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Term	Definition
Myositis screen	Tests that can help diagnose an autoimmune disease that causes muscle inflammation and weakness
Nintedanib	An oral medication used for the treatment of IPF and other ILD's.
NIV	Non-invasive ventilation
Non-caseating granulomas	Non-caseating granulomas are clusters of immune cells that form in response to chronic inflammation, often associated with conditions like sarcoidosis and Crohn's disease.
Obesity hyper ventilation syndrome	Obesity hypoventilation syndrome (OHS) is defined as the combination of obesity (body mass index [BMI] of 30 kg/m^2 or more), raised arterial or arterialised capillary carbon dioxide (CO_2) level when awake, and breathing abnormalities during sleep, which may consist of obstructive apnoea and hypopnea, or hypoventilation, or a combination of both. OHS is a specific form of chronic ventilatory failure.
Obstructive sleep apnoea	Obstructive sleep apnoea (OSA) is a sleep disorder characterised by repeated interruptions in breathing during sleep, leading to disrupted sleep and various health risks.
Overnight oximetry	Overnight oximetry is a non-invasive test that measures and records the oxygen saturation levels in your blood while you sleep. This test helps evaluate your breathing and can identify potential sleep disorders, such as sleep apnoea, or serious lung conditions like emphysema. During the test, a small device is typically worn on the finger to track changes in oxygen levels throughout the night, including drops that may occur during periods of interrupted breathing.
Pirfenidone	A drug used to treat mild to moderate IPF.
Pleural adenocarcinoma	Pleural-based cancers are malignancies that develop in the thin, double layer of tissue that surrounds the lungs. Pleural tumours may arise in both lung cancer and mesothelioma.
Pleuroparenchymal fibroelastosis (PPFE)	Pleuroparenchymal fibroelastosis (PPFE) is a rare lung disease, usually associated with scarring (fibrosis) of the lungs. It tends to affect the upper lobes of the lungs and cause scarring to the area beneath the lung lining (the pleura) and the lung (parenchyma) itself.
Positive Jo antibody	Anti-Jo-1 antibody is a myositis specific autoantibody most commonly found in patients with idiopathic inflammatory myopathies (IIM).
Psoriatic arthropathy	Psoriatic arthropathy is a chronic inflammatory condition that affects the joints and is associated with psoriasis. It can cause joint pain, swelling and stiffness, and may also present with skin and nail lesions, dactylitis (swelling of fingers or toes) and enthesitis (inflammation where tendons attach to bones). Approximately 30% of individuals with psoriasis may develop psoriatic arthritis, which can significantly impact their quality of life. Treatment options typically include medications to manage symptoms and inflammation.
QI	Quality improvement
Pulmonary fibrosis	A lung disease characterised by damage and scarring of lung tissue
RA-ILD	Rheumatoid arthritis-associated interstitial lung disease
Raynaud's syndrome	A medical condition where small arteries cause episodes of reduced blood flow. It typically affects the fingers and, less commonly, the toes.
RBH	Royal Brompton Hospital
Retrosternal	Retrosternal refers to the area located behind the sternum (breast bone)
Roflumilast	Roflumilast is a medication primarily used to treat chronic obstructive pulmonary disease (COPD).
Septrin	Septrin is a combination antibiotic medication containing sulfamethoxazole and trimethoprim also known as co-trimoxazole.
Solar keratoses	Solar keratoses (also called actinic keratoses) are rough, scaly patches of skin that have been damaged by the sun and may turn into skin cancer.
SSA antibody	SSA antibodies, also known as anti-SSA or anti-Ro antibodies, are autoantibodies associated with autoimmune diseases like Sjögren's syndrome and systemic lupus erythematosus (SLE).
Subpleural cystic changes	Refers to the presence of cysts (small air-filled holes) in the lung that are positioned at the edges of the lungs.
TLC	TLC is the total lung capacity or the sum of all volume compartments. A high TLC may coexist with a very poor FEV1 and FVC in emphysema. A very high TLC suggests hyperinflation. A low TLC suggests restrictive lung disease, such as pulmonary fibrosis.

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Term	Definition
Trimethoprim	Trimethoprim is an antibiotic primarily used to treat urinary tract infections (UTIs), including bladder and kidney infections. It may also be used for other infections, such as ear infections and certain types of pneumonia, particularly in immunocompromised individuals.
Type 1 respiratory failure	Type 1 respiratory failure is characterised by hypoxemia (low blood oxygen levels) with normal or low carbon dioxide levels.
Type 2 respiratory failure	Type 2 respiratory failure is characterised by hypoxemia (low blood oxygen levels) with high carbon dioxide levels.
UIP	Usual interstitial pneumonia is a radiological description of a form of lung disease characterised by progressive scarring in both lungs.

2 Executive summary

Background

This RCP individual review was commissioned by St George's, Epsom & St Helier University Hospitals and Health Group (GESH) to provide an external independent assessment of the quality of care provided to patients with interstitial lung disease (ILD) under the care of Dr X between 2019 and 2022. The review considered 30 patient case records and addressed concerns about clinical decision making, adherence to evidence-based treatment, and MDT engagement, in addition to an independent assessment of the degree of potential clinical harm. The review also addressed whether there were potential missed opportunities by the trust to respond to concerns raised about Dr X's practice.

At the time of this review, Dr X had retired from clinical practice. The medical practice tribunal service (MPTS) interim orders tribunal, first imposed interim conditions in November 2023.

Case review outcomes

Of the 30 cases reviewed:

- two cases were graded as 'good practice'
- seven cases were graded as 'room for improvement' for clinical reasons
- no cases were graded as 'room for improvement' for organisational reasons
- one case was graded as 'room for improvement' for both clinical and organisational reasons
- 18 cases were graded as 'unsatisfactory'
- one case was graded as 'insufficient information' and therefore excluded from the review
- one case was graded as 'not applicable' and therefore excluded from the review.

The review team identified frequent variability in clinical history taking, delays in referrals of patients for MDT discussion and to tertiary centres, and inaccuracies in the reporting of diagnostic results by Dr X. Significant concerns were raised by the review team about Dr X's interpretation of investigations, missed opportunities for appropriate MDT discussions and delayed or absent initiation of ILD guideline-based treatment, initiation of non-evidence-based therapies for patients with ILD, and governance of the local ILD co-trimoxazole clinical trial.

Clinical harm assessment

Of the 28 applicable cases:

- five cases were graded as 'no clinical harm' (ie impact was prevented, or impact was not prevented but no harm occurred)

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- one case was graded as 'low clinical harm' (ie minimal harm – the patient required extra observation or minor treatment)
- seven cases were graded as 'moderate clinical harm' (ie short term – the patient required further treatment or procedure(s) or was not given treatment which may improve quality of life)
- 12 cases were graded as 'severe clinical harm' (ie permanent or long-term harm– the patient did not have access to treatments which are evidenced as standards of care to improve quality of life or was given treatment(s) which have limited or no evidence of clinical benefit)
- three cases were graded as 'death' (ie the patient did not have access to treatments which are evidenced to potentially extend life).

The review team concluded that in a substantial number of cases, Dr X's delays to or deviations from guidelines-based care potentially contributed to the patient's irreversible lung damage, poor quality of life or premature death.

Key findings

Clinical practice and treatment decisions

The review team found that Dr X frequently initiated non-evidence-based and off-label treatments for ILD (eg rapeseed oil avoidance, co-trimoxazole, trimethoprim and flu/COVID-19 vaccine avoidance), with such interventions not consistently supported by a documented clinical rationale nor clear evidence of informed patient consent. The review team observed that Dr X did not actively recommend approved therapies for idiopathic pulmonary fibrosis (IPF) or immunosuppressive treatments for other ILD conditions. Additionally, Dr X demonstrated poor interpretation of lung function test results, which the review team felt lacked the diagnostic insight necessary to guide appropriate treatment regimes.

MDT engagement and decision making

The review team identified Dr X's limited and inconsistent use of local and regional MDTs and that they did not attend either meeting as expected. Poor documentation and lack of structured MDT input were recurring issues, which contributed to delays in diagnosis, decision making and access to timely treatment.

Clinical documentation

The review team found that Dr X's clinical letters often lacked structure and coherence, with poor articulation of diagnoses and inadequate documentation of investigations. Evidence of collaborative decision making was lacking, potentially impacting the clarity of clinical communication and continuity of care.

Supportive services

The review team identified limited evidence of appropriate referrals for ambulatory oxygen, pulmonary rehabilitation or palliative care. For patients with advanced disease, this potentially resulted in missed opportunities to improve quality of life.

Responding to concerns

The review team considered that concerns about Dr X's practice raised between 2019 and 2022 were not adequately addressed, in part due to the strained relationships among clinical leads, geographical separation of the two departments, poor escalation pathways for concerns to be responded to and the

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pandemic-related disruption to governance processes. However, the review team were reassured that recent leadership and departmental changes have led to improvements in governance, morale and team dynamics.

New areas of concern highlighted during the review

Co-trimoxazole clinical trial

The review team were informed of concerns regarding a co-trimoxazole clinical trial managed by Dr X between 2012 and 2021. These related to decisions around patient eligibility, *Good clinical practice*[1] breaches and the management of patients after the trial was terminated. When reviewing the cases, the review team expressed concern regarding apparent lack of informed consent, lack of prescription of evidence-based medication in favour of trial medication, and continuation of trial medication after the trial period had terminated in several patients. The review team made a series of recommendations relating to improvements in the oversight and conduct of future clinical trials at GESH.

Nurse-led clinics

The nurse-led respiratory clinics appeared to accept new undifferentiated 'general respiratory' referrals from primary care and were found to lack consultant oversight, escalation processes and external governance. This, the review team felt, posed risks to patient safety and overall accountability, particularly in complex cases.

Workplace culture

A historical lack of integration between the St Helier and Epsom sites and tensions within the clinical leadership created a challenging environment for staff to raise and respond to concerns. Recent staff changes, the review team felt, had improved cross-site working and morale.

Conclusions

In conclusion, while the review identified recurring and significant concerns related to Dr X's clinical decision making, lack of MDT engagement and the trust's clinical governance processes, they also acknowledged the trust's proactive steps in addressing these issues. In addition to commissioning this invited review, the trust initiated internal reviews and is implementing associated recommendations. The trust has communicated with patients with ILD who were treated by Dr X, in line with the duty of candour. A new departmental lead has been appointed, and the review team expressed their confidence that with sustained support from the trust, the current respiratory team is well-positioned to drive meaningful improvements to the ILD service going forwards.

[1] MHRA. *Good clinical practice for clinical trials*. https://www.gov.uk/guidance/good-clinical-practice-for-clinical-trials

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3 Overall conclusions

3.1 Terms of reference A

3.1.1 To assess the clinical management and quality of care of 30 patients diagnosed with ILD since 2019 who were treated by Dr X.

Initial assessments and reporting

The review team identified that Dr X and their colleagues frequently undertook appropriate initial assessments and investigations. However, the quality of comprehensive history taking was variable. Concerns were raised by the review team regarding instances of inaccuracies within clinical correspondence, particularly relating to the interpretation and reporting of diagnostic results by Dr X.

In some cases there were delays in, or a complete absence of, onward referral to tertiary centres for specialist input. Some patients were discharged without undergoing further necessary investigations, even when test results indicated that such steps were warranted.

The review team acknowledged that there were aspects of good initial assessment, however, they felt that Dr X's interpretation of clinical results and limited referral of patients to the tertiary centre for advice often compromised their ability to reach accurate diagnoses and therefore management plans.

They concluded that significant gaps in diagnostic and referral pathways warranted improvements to the ILD referral processes as well as consistency across diagnostic testing and reporting of results for patients with ILD.

MDT collaboration and consensus in clinical decision making

The review team flagged the importance of MDT discussion for achieving consensus diagnoses and informing appropriate treatment options. However, in most cases reviewed, they found that the discussion of these patients at a local radiology meeting did not constitute an MDT discussion, and the outcomes of such meetings were often unclear or inadequately recorded. They also identified delays in referring patients to be discussed at regional MDT meetings or, in several cases, no referral was made.

The review team were of the view that in many cases standard treatments for ILD were not considered at an early enough stage in the patient's care pathway due to the lack of timely MDT discussion. This was despite clinical indications that may have warranted such early intervention.

The review team concluded that the lack of, or delayed, referral of patients to the regional MDT ultimately resulted in delays in initiating timely collaborative decision making, planning and implementing recognised treatment options such as immunosuppressive or antifibrotic therapies.

The consistent lack of documented recognition of the need for timely treatment in the management of ILD by Dr X, the review team felt, highlighted issues with clinical management and prioritisation. They have made recommendations regarding the development of ILD referral pathways to ensure that patients in need of regional MDT advice are appropriately captured and are in receipt of timely specialist advice where clinically appropriate.

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Non-evidence-based treatment regimes

The review team noted that many patients were treated by Dr X with therapies lacking an evidence-based rationale. A specific example included the use of roflumilast for ILD, a drug indicated for severe COPD. In some cases, patients were advised to avoid rapeseed oil or vaccination for flu or COVID-19 – contrary to advice supported by guidelines for ILD. In several cases, Dr X initiated enrolment of patients into a co-trimoxazole clinical trial without first confirming (or documenting) patient eligibility through a formal ILD MDT discussion.

The review team observed from the clinical notes that Dr X's treatment decisions were not consistently supported by clinical guidelines and were not always clearly documented as having been discussed with the patient or colleagues. The review team expressed concern that deviations from evidence-based practice may pose a potential risk to patient safety, particularly when the effectiveness and safety of the chosen treatments are uncertain or lack supporting evidence.

The review team identified gaps in clinical oversight and inconsistent adherence to prescribing guidelines. They have made specific recommendations to develop and improve the governance of clinical research trials. Additionally, the review team have recommended a review of patients who were prescribed roflumilast under the care of Dr X, to ensure appropriate clinical management of those patients.

Oxygen assessments and palliative care

The review team identified limited evidence of ambulatory oxygen, pulmonary rehabilitation or oxygen therapy where clinically indicated. Additionally, there was a significant lack of documented discussions regarding palliative care for patients with advanced disease. The review team felt that these omissions in care highlighted missed opportunities to improve patients' quality of life, particularly for those with complex or progressive symptoms.

Interactions with the patient and their family

The review team found that despite many patients receiving non-evidence-based treatments, their views and preferences were not consistently recorded in the clinical notes. The review team felt that there were gaps specific to informed consent (for non-evidence-based treatment options over standard practice treatment). They also identified limited evidence that MDT opinions were communicated to or discussed with the patient or their family. The review team concluded that the gaps in information sharing by Dr X with their patients highlighted the need for improvements to shared decision making and transparency. They were of the view that refinements to consent processes are needed to improve this aspect of patient centred care. Very few clinic letters were copied to the patients and no clinic letters were addressed to the patient or copied to the relevant healthcare professionals (as per current guidance).

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Clinical record keeping

The review team identified that clinic letters frequently lacked structure and coherence and failed to convey a clear clinical narrative. Key omissions included incomplete history and examination findings. ILD diagnoses were poorly articulated with non-specific or absent diagnoses, absence of rationale for non-evidence-based treatments and limited detail of MDT input. Objective data such as CT findings, lung function trends, and 6-minute walk test results were sometimes misinterpreted or poorly documented. Additionally, there was no evidence of smoking cessation support offered to patients.

The review team concluded that the deficiencies in Dr X's documentation practices could pose risks to continuity of care and informed decision making.

3.1.2 To provide an independent assessment of the degree of clinical harm

No clinical harm – impact was prevented, or impact was not prevented but no harm occurred
In the five cases graded as no clinical harm the review team identified decisions for: an observational approach, to withhold antifibrotic therapy given the patients' age and comorbidities, and a change in management plan from antifibrotics to palliative care. The review team found that the patients' management plans prioritised safety and individualised care, balancing treatment benefit against potential risk. In each case, the review team concluded that the clinical approach ensured optimal clinical outcomes without unnecessary intervention.

Low clinical harm – minimal harm – the patient required extra observation or minor treatment
In the one case graded as low clinical harm the review team identified a missed opportunity for a CT scan. While the review team recognised the patient was frail and older (90 years old), they were of the view that a CT scan could have been performed to give an indication for the cause of his breathlessness. The review team acknowledged that any ILD-specific therapy would have had minimal benefit given the patient's age and comorbidities.

Moderate clinical harm – short term, the patient required further treatment or procedure or was not given treatment which may improve quality of life
In the seven cases graded as moderate clinical harm the review team identified four cases where earlier intervention with evidence-based treatment options may have improved the patient's quality of life. In one case the review team thought that an ILD MDT/cancer/rheumatology team discussion may have prompted a consideration of cyclophosphamide or an increased dose of mycophenolate as the most appropriate treatment. In another case, more timely palliative care could have been enacted for a patient to improve their overall experience of their final stages of life. In the remaining case the review team thought that the patient was inappropriately discharged from care without ILD-specific follow-up and key interventions such as smoking cessation and ILD work up were not pursued.

The review team were of the view that within these cases earlier intervention with evidence-based treatments and timely MDT discussions may have potentially improved patient outcomes and quality of life.

Severe clinical harm – permanent or long-term harm – the patient did not have access to treatments which are evidenced as standards of care to improve quality of life or was given treatment(s) which have limited or no evidence of clinical benefit
In the 12 cases graded as severe clinical harm, the review team identified the following aspects of suboptimal care. In several cases the review team found that the rate of disease progression could potentially have been slowed through the initiation of appropriate immunosuppressive or antifibrotic

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therapy. Delays in recognising autoimmune-related ILD and initiating targeted treatments were also more likely than not to have contributed to irreversible lung damage and reduced lung function in one case. The review team considered that in some cases the prolonged absence of immunosuppressive therapy and missed opportunities to introduce treatment had the potential to contribute to respiratory decline. In one case, there was a lack of any treatment despite documented disease progression.

The review team were of the view that in these cases, patients potentially experienced permanent or long-term harm because of delayed or absent access to treatments that are recognised as standard care. These treatments, which are supported by evidence to improve quality of life and slow disease progression, were either not considered or not initiated soon enough. In some instances, patients received therapies with limited or no proven clinical benefit, instead of treatments established as standards of care, contributing potentially to the risk of harm. The lack of appropriate treatment regimens was likely to have contributed to irreversible lung damage and a decline in overall prognosis for these patients.

The patient did not have access to treatments which are evidenced to potentially extend life and the outcome was strongly linked to their premature death
In the three cases where patient outcomes were graded as strongly linked to a premature death, the review team identified significant delays in the initiation of evidence-based treatments for fibrosis, which were likely contributing factors to clinical deterioration and potential premature death.

In one case the review team identified a 2-year delay in commencing immunosuppression for fibrotic non-specific interstitial pneumonia (FNSIP), and treatment with trimethoprim was noted instead. Despite ongoing clinical decline, appropriate therapy was not initiated until advanced disease and complications had developed. In another case, a 1-year delay in referring the patient to a specialist ILD MDT resulted in missed opportunities for earlier intervention and by the time antifibrotic therapy was recommended, the patient's disease was too advanced for it to be effective. In the third case, progressive decline in lung function was neither adequately recognised nor integrated into treatment decisions. Symptoms were misattributed to poor general fitness and management deviated from guideline-based care involving trimethoprim and dietary advice rather than immunosuppressive or antifibrotic therapy. At no point was there documented consideration or discussion of appropriate disease-modifying treatments.

The review team were of the view that across all three cases, the delays and deviation from best practice highlighted the lack of timely recognition of disease progression, adherence to established treatment guidelines, and early specialist input to improve outcomes in those patients with ILD. The review team concluded that the lack of appropriate treatment regimens potentially contributed to these patients' premature deaths.

3.2 Terms of reference B

3.2.1 Activity and outcomes

The review team identified areas for improvement related to Dr X's working conditions, the structure of their role and the appraisal process. Dr X had responsibility for general medicine, general adult respiratory medicine and had a subspecialist interest in ILD for a population of 490,000.

Dr. Concerns were also raised about vacancies in consultant posts, and that a high volume of respiratory referrals from multiple specialties further impacted on their workload. Four complaints involving Dr X were noted. These were primarily related to nursing, ward staffing issues and discharge processes but not related to their management of patients with ILD. The review team identified that the appraisal process did

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not include items specific to MDT meeting participation, ILD QI projects, discussion of Datix submissions and any findings, and CPD was lacking ILD-specific training.

The review team concluded that at the time of this review, having eight respiratory consultants across two sites with such a large catchment area posed clinical, leadership and organisational challenges. They were of the view that the trust should continue its efforts to address workforce challenges through consultant and allied healthcare professional recruitment. Moreover, the trust's appraisal processes should ensure that respiratory physicians with an interest in ILD can adequately demonstrate ILD-specific continued professional development (CPD) and participation at the ILD MDT meeting.

3.2.2 Clinical decision making and implementation of treatment plans

The review team identified areas for improvement related to non-evidence-based treatment regimens.

During the interviews, some interviewees expressed support for Dr X's approach to clinical decision making, noting that their interest in immunology appeared to inform and justify their treatment choices. Some patients were documented to have described Dr X as kind and caring in their clinical interactions.

However, concerns were raised by others regarding aspects of practice that were not evidence based, including recommendations of a rapeseed oil-free diet and advising against flu and COVID-19 vaccination. It was also noted that some patients had been enlisted in a co-trimoxazole clinical trial and treated with co-trimoxazole often at the expense of not being considered for evidence-based treatments. However, this trial was terminated in 2021 due to breaches in Good clinical practice (GCP).[2] Additionally, there was feedback indicating a lack of urgency in initiating antifibrotic therapies and making referrals to pulmonary rehabilitation, which raised concerns about timely access to standard treatments.

The review team noted that these findings were consistent with those recurring themes identified within the clinical record review. They were of the view that assessment and referral pathways for ILD patients should ensure that all patients receive appropriate clinical oversight that is evidence based. The pathways should include formalising the process of referrals from local to regional ILD MDT, referrals of respiratory patients to clinics run by clinical nurse specialists (CNSs) with appropriate escalation pathways as well as timely patient access to supporting services (ie pulmonary rehabilitation, oxygen therapy and smoking cessation services).

3.2.3 MDT working and interactions with members of the wider medical and nursing team

The review team found that historically the radiology meeting at St Helier was informally referred to as the 'X-ray/lung meeting' and was primarily used as a forum to discuss diagnoses and management plans for ILD patients. However, the team noted a lack of robust documentation or formal reporting of outcomes from these meetings.

From 2019, there was an expectation by the trust leadership for a single unified ILD MDT meeting to be held jointly between St Helier and Epsom and based at Epsom Hospital. In practice, the review team heard that this was not fully achieved with colleagues from St Helier not actively participating. There was therefore a lack of formalised ILD MDT discussion involving relevant specialties at St Helier. The review team also queried the quality and inclusiveness of the ILD MDT based at Epsom, which they felt did not

[2] GCP is the agreed international standard for conducting clinical research: https://www.nihr.ac.uk/career-development/clinical-research-courses-and-support/good-clinical-practice

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foster a supportive environment for involvement of St Helier clinicians, nor were management plans robustly documented.

It was noted that Dr X did not attend the Epsom ILD MDT meetings. Instead, Dr X occasionally sought advice from radiology colleagues at the Royal Brompton Hospital (RBH), which was a historical arrangement. However, the review team found no evidence of a systematic approach to these interactions with RBH.

These findings were consistent with recurring themes identified within the clinical record review, namely a lack of Dr X discussing their ILD patients at a formal ILD MDT to inform diagnoses and clinical management. The review team considered that the lack of integration of St Helier colleagues to the ILD MDT at Epsom and lack of formal outcome reporting had limited the effectiveness of collaborative decision making. Dr X's decision to seek external radiological input, while well-intentioned, contributed further to the lack of cohesive, local and collegiate MDT approach.

The review team were of the view that the trust needs to establish a consistent, appropriately chaired, well-documented, and fully integrated ILD MDT, using multi-media modalities, that ensures inclusive participation for its members.

3.3 Terms of reference C

3.3.1 Management of concerns about Dr X's practice and to give a view on whether opportunities to respond at an earlier stage were missed.

The review team identified barriers which resulted in missed opportunities to respond to concerns at an earlier stage. These barriers included the COVID-19 pandemic, strained interpersonal relations between clinical leads, inadequate clinical governance systems regarding Datix system review and actioning, limited research trial governance, and a lack of monitoring for MDT working.

The review team were informed that when concerns were raised again in July 2022, an internal fact-finding review and a rapid review were initiated in January 2023 and a new respiratory lead was appointed in March 2024.

The review team acknowledged that the COVID-19 pandemic disrupted governance and oversight structures at the trust, resulting in fewer governance meetings and streamlined appraisals. They recognised the challenges faced and were of the view that this contributed to the missed opportunities for earlier detection and intervention in response to the concerns raised about Dr X.

Datix reporting and feedback

The review team identified longstanding concerns regarding Dr X's non-evidence-based treatment of ILD patients raised between 2019-2022. Multiple Datix reports were submitted during that time, but further investigation and/or definitive outcomes were lacking. Staff reported limited feedback and action following these concerns being raised.

Culture

Issues with workplace culture and behaviours were highlighted to the review team including a lack of confidence in some clinical leads (and unresolved interpersonal issues), which the review team thought fostered an unsupportive environment for raising and responding to concerns.

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The review team heard repeatedly of the lack of a supportive and open culture, commonly attributed to leadership tensions and poor communication styles of certain clinical leaders which, on balance they felt prevented earlier resolution and collaborative problem solving.

Ceasing non-evidence based treatments

Dr X was reportedly instructed to cease non-evidence-based ILD treatments, though whether this was adhered to was unclear. In particular, the review team were unsure about how those patients enrolled in the co-trimoxazole trial were managed with respect to their eligibility and consent for enrolment and ongoing open label treatment after the trial was ceased.

Even after instructions were issued to Dr X to cease non-evidence-based ILD treatments, the practice reportedly continued. The lack of monitoring at this point was a missed opportunity to ensure compliance and patient safety.

Contemporary ILD management and leadership arrangements

The review team were impressed with the new ILD and respiratory department lead, who has approached the case reviews with compassion, professionalism and rigor, supported effectively by the CD. The review team acknowledge that the trust has taken several positive steps in response to its internal review with many of the recommendations to support the respiratory department already underway. The review team have confidence in the current respiratory clinical leadership team's ability to continue this progress, provided they receive sustained support from the trust.

The review team were of the view that provisions should be made by the trust to ensure that their processes for raising and responding to concerns are robust and transparent and have made recommendations to facilitate this.

3.4 Terms of reference D

3.4.1 Highlight any new area of concern that arises during the invited review.

The review team identified three new areas of concern outside of the terms of reference. These were specific to the treatment of ILD patients with co-trimoxazole as part of a clinical trial for which Dr X was the principal investigator, the organisation of nurse-led clinics to support the respiratory service and the behaviour and culture of clinical leads.

Co-trimoxazole clinical trial

The review team received supportive feedback from former colleagues of Dr X, highlighting their research capabilities and expertise in publishing peer reviewed articles. However, concerns were identified during the review regarding the single centre nature of the study, the prolonged recruitment period, the eligibility criteria for patient enrolment into the trial and the overall robustness of these processes. It was noted that the trial was closed due to GCP breaches and there was insufficient information about the subsequent management of those patients including whether treatment with co-trimoxazole continued outside of the trial setting. The review team appreciated that this aspect was outside of the scope of the current review and therefore was not fully explored.

The review team concluded that the clinical trial highlighted processes that lacked rigor and transparency which further raised concerns about compliance with standard research practices. The review team were of

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the view that the Trust needs to examine its research governance framework to ensure that clear and robust protocols are in place to support and monitor eligibility criteria in future studies.

Nurse-led clinics

The review team were made aware of the need for improvements to the structure and support of the nurse-led respiratory clinics. They found that there was an absence of a named consultant, limited escalation pathways and a lack of external governance. The case reviews showed examples of patients with undifferentiated 'general respiratory' problems referred from primary care being solely assessed and managed by specialist nurses, resulting in patients receiving mis-diagnoses and subsequent mis-management with no or limited medical consultant input.

The review team were of the view that while the model of nurse-led care can be highly effective when supported by the appropriate framework, in this instance the clinics appeared to have unclear referral criteria, insufficient oversight and escalation processes.

The lack of a named consultant with defined responsibilities for the clinics potentially poses risk to accountability, particularly in complex or deteriorating cases where consultant input is essential. Moreover, the absence of clear escalation protocols further compounds this issue, leaving nursing staff without formalised pathways to seek timely intervention or a medical review.

Team dynamics and morale

The review team were made aware of a historical tension between the St Helier and Epsom sites. However, they were reassured that with new staff appointments, cross-team collaboration has significantly improved.

It was reported that Dr X's practice and circumstances around this has had a notable impact on staff wellbeing. The review team considered that the findings from the appreciative inquiry should be shared by the trust executive team with the respiratory teams to support them through this difficult time.

The review team heard from several interviewees that the leadership styles of historical and current clinical leaders resulted in conflict and one leader was repeatedly referred to as having a 'direct' approach which got things done 'but was also referred to as 'bullying' on several occasions. This tension was, likely, a contributory factor to a review of Dr X's practice being delayed.

Encouragingly, the review team heard that departmental meetings are now having a positive influence on staff morale, contributing to a more supportive and cohesive working environment.

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4 Recommendations

Key for timelines for implementing recommendations:

- **Immediate (0–3 months)** – action should be completed within 3 months of receipt of the invited review report.
- **Short term (0-6 months)** – action should be completed within 6 months of receipt of the invited review report.
- **Medium term (6-12 months)** – action should be completed within 12 months of receipt of the invited review report. Planning for actions resulting from these recommendations should start as soon as possible.
- **Long term (12-24 months)** – action should be completed within 24 months receipt of the invited review report. Planning for actions resulting from these recommendations should start as soon as possible.

Trust board	
Recommendation	**Timelines**
a. This report should be considered by the Trust Board or relevant subcommittee, and oversight of an action plan should be provided to a non-executive board member to ensure these recommendations are completed.	**Immediate (0–3 months)**
b. The healthcare organisation should share the outcome of this report with their GMC employment liaison officer as part of the ongoing updates in relation to Dr X's clinical practice. The trust should also share this report with the Care Quality Commission (CQC).	**Short term (0–6 months)**

TOR 1: Clinical record review	
Recommendation	**Timelines**
c. At the conclusion of the trusts internal review of all patients treated for ILD by Dr X since 2019, the trust should consider whether further expansion of patient review is required. Transparent discussions with relevant patients and/or families affected is key as well as ensuring that duty of candour is performed.	**Medium term (6–12 months)**
d. The trust should undertake a comprehensive review of all patients who have been prescribed roflumilast under the care of Dr X to ensure appropriate clinical oversight and adherence to prescribing guidelines.	**Medium term (6–12 months)**

TOR 2: Activity and outcomes (pathways)	
Recommendation	**Timelines**
e. The respiratory teams (at the Epsom and St Helier sites) should collaboratively develop the following assessment and referral pathways: 1. Assessment pathways:	**Immediate (0–3 months)**

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TOR 2: Activity and outcomes (pathways)	
Recommendation	**Timelines**
i. If patients are deemed to require a lung biopsy, they must be discussed in the regional ILD MDT. 2. Referral pathways: ii. Local to regional ILD MDT: > A clear pathway is needed for referral of ILD patients from the local ILD MDT at GESH to the regional Guy's and St Thomas' (GSTT) ILD MDT. The pathway should be developed in conjunction with the GSTT regional ILD service and should have clear referral criteria. > The number of referrals to the GSTT tertiary ILD MDT should be audited on an annual basis so that trends can be identified in the future. > Regular audit of ILD patients' treatment schedules to ensure that ILD MDT recorded outcomes are actioned or justification is documented for an alternative strategy (eg frailty, patient choice) with resource allocated to deliver these ILD specific audits. iii. Respiratory patients to nurse-led clinics: > Clear standard operating policy to clarify pathways for referral of respiratory patients to CNS clinics with appropriate escalation pathways and a named supervising respiratory consultant. iv. Access to supportive services: > Clear pathways should be developed for referral to smoking cessation, pulmonary rehabilitation, oxygen assessment (ambulatory and long-term therapy) and palliative care services.	

TOR 2: Activity and outcomes (CPD)	
Recommendation	**Timelines**
f. The trust should support its respiratory physicians with an interest in ILD to demonstrate ILD-specific ongoing continued professional development (CPD). For example: > The ILD team should be supported to attend educational events related to ILD updates at a regional and national level as part of CPD and supporting professional activities (SPA). > The above recommendation also applies to CNSs working in these roles, who should be able to demonstrate appropriate CPD and engagement with regional/national education. > Respiratory physicians with an interest in ILD should attend local and regional ILD MDTs and detail this in their appraisal supporting evidence.	**Immediate (0–3 months)**

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TOR 2: Activity and outcomes (workforce)	
Recommendation	**Timelines**
g. The trust should support the need for resourcing within the respiratory department. It is challenging for eight respiratory consultants across two sites to cover such a large catchment area. The trust should continue efforts to meet these workforce challenges with consultant and allied healthcare professional recruitment.	**Short term (0-6 months)**
h. The trust must invest in the recruitment of a specialist ILD nursing team and pharmacy support for monitoring patients on antifibrotic and immunosuppressive therapies.	**Short term (0-6 months)**
i. The trust should support the development of dedicated ILD clinics at each of the Epsom and St Helier sites. The clinics should be led by respiratory physicians with an interest in ILD and supported by an ILD specialist nurse across both sites.	**Short term (0-6 months)**

TOR 2: Multidisciplinary team working	
Recommendation	**Timelines**
j. The trust should support the development of a cross-site interstitial lung disease multidisciplinary meeting (ILD MDT) with a defined standard operating policy (SOP) and include the following: > All patients with suspected ILD should be referred to the ILD leads within the Epsom and St Helier sites and be discussed in the cross-site ILD MDT meeting. > A rheumatologist should be invited to attend the ILD MDT meeting when patients with suspected systemic autoimmune rheumatic diseases (SARD-ILD) or connective tissue disease (CTD-ILD) are presented. If the rheumatologist is unable to attend, an alternative option may be that the rheumatologist provides a letter/statement in time for the ILD MDT. > The ILD MDT meeting should be incorporated into the job plans and appraisals of the ILD lead physicians and allied healthcare professionals. > The ILD MDT should be accessible, equitably, for all ILD interested clinicians on both sites > There should be a clear pathway (SOP) for referral of local ILD patients to the regional (tertiary) ILD MDT > The facility for staff to dial in (via MS Teams/teleconference) to discuss all relevant ILD patients.	**Immediate (0–3 months)**
k. The trust should support the development of the current respiratory departmental meeting with consideration of the following: > All respiratory team members should have the weekly cross-site departmental meeting incorporated into their job plans. > Datix reporting should be reserved for incidents affecting patient safety. All other departmental concerns should be openly and transparently discussed in the cross-site respiratory departmental meetings.	**Immediate (0–3 months)**

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TOR 3: Management of concerns (governance)	
Recommendation	**Timelines**
l. The trust should ensure that regular departmental clinical governance meetings take place including: > Mortality and morbidity (M+M) meetings with clear terms of reference for those patients who should be discussed. These meetings should encourage and support engagement from all members of the multidisciplinary team, with pathways for timely dissemination of good practice and learning from audit, Datix reports, case reviews and service evaluation projects, to the wider team. There should be a designated M+M clinical lead.	**Immediate (0–3 months)**
m. The trust should ensure the timely feedback to the department regarding updates of inquiries and meetings. For example: > The review team heard from several staff that the appreciative inquiry has not been fed back to the respiratory directorate and the review team recommend this happens as soon as possible by the trust executive team. > All Datix reports and investigations should be fed back to the reporter and wider respiratory team in a timely, accurate and sensitive manner.	**Immediate (0–3 months)**
n. The trust should support the development of a system for establishing and monitoring ILD patients starting and established on immunosuppressive therapy and future planning for the proposed national devolvement of prescribing of antifibrotic therapies to local centres.	**Immediate (0–3 months)**
o. The trust should undertake a comprehensive evaluation of the current mechanisms in place for raising and responding to concerns. This should include: – an assessment of the accessibility and responsiveness of current mechanisms in place – a clearly defined and well communicated escalation plan. This escalation plan should outline the steps to be followed when concerns are not resolved at the initial level, including clear roles, responsibilities and timelines to support timely and appropriate resolution.	**Short term (0–6 months)**

TOR 4: Highlight any new areas of concern (clinical trials)	
Recommendation	**Timelines**
p. The trust should put in place mechanisms to support and maintain oversight of research governance activities. For example, ensure that: > lessons are learnt from the research audit report into Dr X's GCP trial breaches and a framework is put in place for embedding good clinical practice for clinical trials going forwards. > the trust research portfolio as a whole is reviewed to determine whether there are other trials that need external independent assessment. > all findings are fed back to the Group Executive Committee and to the Quality Committee (a sub-committee of the Group Board) .	**Short term (0–6 months)**

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TOR 4: Highlight any new areas of concern (nurse clinics)	
Recommendation	**Timelines**
q. The trust should support the development of its nurse-led respiratory clinics. This should include: > the appointment of a named consultant to provide clinical leadership and oversight > development and implementation of clear escalation procedures > the integration of nurse-led clinics into the broader governance and quality assurance frameworks of the trust.	**Short term (0–6 months)**

TOR 4: Highlight any new areas of concern (leadership)	
Recommendation	**Timelines**
r. The Trust must consider if the clinical director's leadership role should be focused on other areas of the specialty medicine portfolio but not respiratory medicine going forwards.	**Immediate (0–3 months)**
s. All members of the respiratory department require the provision of confidential emotional and psychological support provided by an external body during what is a difficult time.	**Immediate (0–3 months)**

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5 Introduction

On 7 July 2024, Dr Richard Jennings, GESH Group chief medical officer, and Dr Rebecca Suckling, chief medical officer at Epsom and St Helier University Hospitals NHS Trust, contacted the Royal College of Physicians (RCP) regarding concerns about a retired consultant respiratory physician's practice. Dr Jennings discussed the concerns with Dr Adam de Belder, medical director for invited reviews (IRs) at the RCP. Following discussion, it was agreed that an individual review would be undertaken on 24 and 25 March 2025.

5.1 The terms of reference for this individual review

1. Background

On 1 February 2022 Epsom and St Helier University Hospitals NHS Trust and St George's University Hospitals NHS Foundation Trust formed a hospital group: St George's, Epsom & St Helier University Hospitals and Health Group (GESH). They remain two separate trusts but share an executive team. Dr Richard Jennings, GESH Group chief medical officer, and Dr Rebecca Suckling, chief medical officer at Epsom and St Helier University Hospitals NHS Trust, approached the Royal College of Physicians (RCP) invited review team to request a review in response to concerns about the clinical practice of a recently retired consultant respiratory physician (Dr X). Dr X has a subspecialty interest in interstitial lung disease (ILD) and also contributed to adult general medicine.

Concerns over Dr X's clinical practice were raised from different sources over several years without any objective determination. There was a concern that Dr X's care of ILD patients has not developed in line with modern practice and that some patients may not have been offered appropriate life-enhancing and potentially life-prolonging treatments, including anti-inflammatory ILD medications.

NICE guidelines[1] on the management of ILD recommend multidisciplinary team (MDT) engagement to ensure that these patients have a plurality of opinion on what is a complex condition. A weekly local MDT and monthly regional MDT (run from Guy's and St Thomas' NHS Foundation Trust) were established, but Dr X did not attend or contribute to these meetings, nor did they have their patients discussed. Dr X is described as having a longstanding professional relationship with colleagues providing the ILD service at the Brompton Hospital, but the nature and documentation of this arrangement is unclear.

In response to these concerns GESH is undertaking a review of all patients with a diagnosis of ILD from 2019 (as that was when the local MDT became available to clinicians at Epsom and St Helier University Hospitals NHS Trust). It has informed the GMC liaison officer and the CQC about the concerns (there is an interim order in place for Dr X). As Dr X was retiring, an MHPS investigation did not appear to be the practicable way forward.

The internal review will seek to identify if there are concerns about the care provided and/or adherence to guidelines, and whether any patients require an urgent recall[3].

The purpose of requesting an external RCP invited review is to have an independent assessment of whether the management of some patients with ILD by Dr X has led to any harm, and if so, to determine the degree of harm. These 'index' patients have been identified both through concerns previously raised and the

[3] *Since the development of the terms of reference for this review, the findings and arrangements for the recall of patients were described and discussed at the meeting in public of the Group Board in November 2024.*

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internal review process. The review team will also determine whether there have been missed opportunities with respect to the handling of the concerns raised about Dr. X.

2. Objectives

To undertake an invited review of the care of patients with a diagnosis of ILD at St George's, Epsom & St Helier University Hospitals and Health Group. The medical specialty is respiratory medicine.

3. Expertise required

- 1 x chair (medical director for invited reviews)
- 3 x consultant respiratory physicians (2 general respiratory consultants with expertise in ILD, and 1 tertiary centre ILD expert)
- 1 x nurse specialist in ILD
- 1 x lay reviewer

4. Methodology

The findings of this review will be based on interviews with key individuals and a review of patient medical records to be conducted by appropriate specialists, using structured judgement review methodology. The review will take place both virtually using teleconference facilities (for the clinical record review) and in person (for the interviews).

In undertaking the review, the review team will consider whether care is in line with national good practice and guidelines, and/or what would be considered by the view of a body of clinical professionals in a similar situation.

5. Issues to be explored

a) To conduct an independent clinical record review of the medical records of patients with a diagnosis of ILD since 2019 who received care from Dr X, to include:

- 20 index patients identified by the internal review conducted by GESH
- 10 randomly selected patients from the list of those included in the internal review: every 10th new patient diagnosed with ILD starting from 2019.

Consideration will be given to:

- Assessment, investigations and initial treatment plans
- Ongoing care and treatment
- Communication with colleagues and MDT working
- Interactions with patients and their family
- Clinical record keeping

b) To consider concerns about the clinical work of Dr X with specific reference to activity and outcomes, clinical decision making, implementation of treatment plans, MDT working and interactions with members of the wider medical and nursing team. This will include determining the professional relationship with colleagues at the Royal Brompton Hospital.

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c) To review the management of concerns about Dr X's practice by St Helier University Hospitals NHS Trust and by GESH and give a view on whether opportunities to respond to them at an earlier stage were missed.

d) Highlight any new area of concern that arises during the invited review.

6. Reporting

The review team will prepare a report that makes recommendations, as relevant, for the consideration of the requesting healthcare organisation. Once issued the final report becomes their property.

7. Date of agreement

The above terms of reference were agreed by the Royal College of Physicians and the healthcare organisation on 11 September 2024.

5.2 Approach to this review

The RCP consulted with the British Thoracic Society, who nominated specialist reviewers. The RCP convened a review team, as set out in Section 4.4.

In advance of the interviews, the specialist reviewers received 30 clinical records to review (methodology described in Section 4.3) and documentation provided by the healthcare organisation was examined for the insights it offered in respect of the terms of reference. The review team held interviews with staff virtually via MS Teams. The interview with Dr X was, at their request, held in person at the RCP's London office. The interviews took place on Monday 24 and Tuesday 25 March 2025. Details of these interviews have been included in the appendix.

The findings contained in this report are outlined in Section 6 and represent a summary of the information gathered by the review team during both the interviews and from the documentation submitted. The findings are organised under the headings of the agreed terms of reference. The information presented sometimes reflects the viewpoints of those individuals being interviewed and where this is the case it will be made clear; it will not necessarily reflect the views of the healthcare organisation, the RCP or its reviewers. The views of the review team are provided in the overall conclusions (Section 2.0). The recommendations (Section 3.0) were made considering these conclusions.

5.3 Clinical record review methodology

The RCP was provided with clinical records for 30 patients, as detailed in the terms of reference (Section 4.1). Twenty index cases (five considered cases of concern as identified by the internal clinical review and identified as patient complaints and 15 considered cases of concerns as identified by the internal clinical record review). Ten cases were a randomly selected sample of every 10th new patient diagnosed with ILD from 2019. Each of the 30 cases were considered independently by at least two specialist reviewers – see Section 4.4 for details of the review team. Each reviewer used a structured form adapted from the RCP National Mortality Case Record Review (NMCRR) programme[1] to independently examine phases of care that the patient received. These were graded by the reviewers as **1 = very poor care; 2 = poor care; 3 = adequate care; 4 = good care, or 5 = excellent care**. The reviewers also utilised a grading system[2] developed by the National Confidential Enquiry into Patient Outcome and Death (NCEPOD)[3] to give an overall perspective on the quality of care provided. This considers both clinical and organisational care. The overall gradings were as follows: **good practice, room for improvement – clinical,**

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room for improvement – organisational, room for improvement – clinical and organisational, unsatisfactory, insufficient information.

The review team also gave their opinion on whether the care and treatment provided to the patient by Dr X resulted in potential harm.

The degree of harm was graded as follows: **no harm** (impact prevented, or impact not prevented but no harm occurred), **low harm** – minimal (eg patient required extra observation or minor treatment), **moderate harm** – short term (eg patient required further treatment or procedure or was not given treatment which may improve quality of life), **severe harm** – permanent or long-term harm (eg the patient did not have access to treatments which are evidenced as standards of care to improve quality of life or was given treatment(s) which have limited or no evidence of clinical benefit) , **death** (eg the patient did not have access to treatments which are evidenced to potentially extend life).

Having independently reviewed the cases, the reviewers presented them at a virtual meeting on 11 and 12 February 2025. The meeting was co-chaired by the medical director for invited reviews and the immediate past deputy director of invited reviews and supported by the RCP review manager. Each case was considered in turn, the specialist reviewers presented their views, followed by a 'confirm and challenge' discussion to agree the grading of phases of care and the overall care. In making judgements about the overall care provided to the patient, the review team considered national good practice and guidelines.

5.4 Invited review team

Role
Co-chair and medical director of invited reviews
Co-chair and immediate past deputy director of invited reviews
Consultant respiratory physician, Northern Ireland
Consultant respiratory physician, West Midlands
Consultant respiratory physician, Southeast England
Respiratory nurse specialist, Southwest England
Consultant respiratory nurse specialist, East of England
Lay reviewer
Review manager

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6 Context and background

6.1 Interstitial lung disease (ILD)

Interstitial lung disease (ILD) is an umbrella term for a large group of rare lung conditions that result in inflammation and scarring of the lung. In ILD, the interstitium (the tissue between the small air sacs (the alveoli)) becomes inflamed and scarred (fibrosed) making it difficult for the alveoli to expand sufficiently to allow enough oxygen to enter the bloodstream. As part of this process the lung tissue thickens and so common symptoms of ILD include shortness of breath and persistent cough.

ILD can have many causes, including exposure to asbestos. Some types of autoimmune disease (eg rheumatoid arthritis) can cause ILD. Once lung scarring occurs it generally isn't reversible and so treatment focuses on keeping more scarring from occurring, managing symptoms and improving quality of life.

6.1.1 Types of ILD

ILD is a complex subspecialty of respiratory medicine. ILD comprise a heterogenous group of more than 200 pulmonary disorders of which the most common are listed below. For the reader to understand this report, we refer to defining commonly used terms throughout the clinical record review:

Idiopathic pulmonary fibrosis (IPF) – this is the most common form of pulmonary fibrosis – the cause is unknown. It is irreversible and progressive. There are drugs, called antifibrotic agents, which can slow the rate of fibrosis and scarring. The two drugs approved for treatment are nintedanib and pirfenidone. As with all drugs, there are potential side effects, which can limit their use in some patients.

Hypersensitivity pneumonitis (HP) – this is inflammation of the lungs after inhaling an allergen. If the allergen can be identified, it should be avoided, and the inflammation is treated with immunosuppressant agents. The allergen can be a micro-organism, plant or animal proteins – eg farmer's lung from mould on hay, straw, or grain, or bird fancier's lung (the allergen is particles from feathers/droppings of many species of bird), humidifier lung is from fungus, humidifier/air conditioner/ heating systems etc.

Non-specific interstitial pneumonia (NSIP) – is generally rarer than IPF and more common in younger patients and female patients. Sometimes the cause is unknown (idiopathic), but can be related to a connective tissue disease, such as rheumatoid arthritis and systemic sclerosis. Some drugs can lead to this condition, eg amiodarone, methotrexate, chemotherapeutic drugs, some antibiotics (such as nitrofurantoin). The gold standard for diagnosis is characteristic changes seen on a high-resolution CT scan (HRCT). It is a complex condition, usually requiring multiple health professionals to obtain the best outcomes. As it is responsive to treatment, NSIP needs to be differentiated from IPF.

Fibrotic non-specific interstitial pneumonia (FSNIP) – a subtype and more serious form of NSIP characterised by chronic inflammation and significant fibrosis (scarring), leading to reduced lung function and difficulty breathing.

Usual interstitial pneumonia (UIP) – this is the most common form of interstitial fibrosis, hence the term 'usual' and is diagnosed by HRCT (high-resolution computed tomography scan) where the commonest finding is 'honeycomb' change in the periphery and lower portions of the lungs and/or histologically. The underlying pathology is more fibrosis than inflammation affecting the supporting framework of the lung.

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The cause is usually unknown and is consistent with a diagnosis of IPF but can relate to autoimmune disease, asbestosis and other rare causes.

(Cryptogenic) Organising pneumonia (OP) – this is less common but again has typical changes on HRCT and histopathology of a lung sample – it can happen with some autoimmune illnesses, eg lupus, systemic sclerosis, rheumatoid arthritis. The condition is often responsive to immunosuppression and treatment may include long term steroids. It has a better prognosis than other interstitial conditions.

Drug-induced interstitial lung disease – can produce all histopathological patterns of interstitial pneumonia including HP, OP diffuse alveolar damage, NSIP, eosinophilic pneumonia. A vast range of drugs have been shown to cause this reaction.

Antisynthetase syndrome – a rare chronic disorder affecting multiple organs (muscles, joints, interstitial lung disease, Raynaud's, mechanic hands). It is an immune-mediated reaction leading to widespread inflammation caused by an antibody against an aminoacyl transfer RNA synthetase (an enzyme). It is responsive to anti-inflammatory medication and usually involves multiple specialists to manage.

Sarcoidosis –a rare condition that causes small patches of inflammation, called granulomas, which can develop in different parts of the body. This is usually the lungs, lymph nodes and the skin. Up to 20% of patients develop fibrotic lung disease.

Other respiratory conditions that can be associated with ILD

Obesity hypoventilation syndrome – a breathing disorder that affects some overweight patients. The under breathing leads to a rise in the carbon dioxide in the blood stream and insufficient oxygen leading to shortness of breath.

Pulmonary hypertension – a term used for higher-than-normal blood pressure in the pulmonary circulation. It is a serious condition that can reduce life expectancy. In severe lung disease, where there is a shortage of oxygen, pulmonary hypertension can be a secondary effect. In most patients accurate estimates of pulmonary blood pressure can be measured with echocardiography. There are treatments available from specialist units, so regular checks with echocardiography are required in patients with ILD.

Honeycombing/ground glass/mosaicism – these are common descriptions used in the reporting of high resolution CT (HRCT) scans of the lung. Their presence and distribution can be characteristic of the different types of ILD.

6.1.2 Diagnosing ILD

There are several tests and assessments used in the diagnosis of ILD and are referenced in clinical guidelines.[4,5]

History taking – it is vital that the patient's assessment is structured to include questions about symptoms, quality of life, current medications, medical conditions, smoking history, working life, hobbies and pets, plus general home life.

[4] https://www.nice.org.uk/guidance/cg163/chapter/recommendations

[5] https://www.england.nhs.uk/wp-content/uploads/2018/08/Interstitial-lung-disease-service-adult.pdf

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Chest auscultation – when a clinician listens to the patient's chest, they may hear bilateral inspiratory crackles. These are sounds caused by the opening of small airways and alveoli that have become collapsed due to fibrosis or inflammation.

Spirometry – a simple test used to help diagnose and monitor certain lung conditions by measuring how much air you can breathe out in one forced breath. It's carried out using a device called a spirometer, a small machine attached by a cable to a mouthpiece. In ILD, you may see a restrictive spirometry pattern. This is because the volume of the lungs is reduced, and less air is breathed in. Therefore, vital capacity and forced vital capacity will be reduced. The FEV1/FVC ratio will be normal, unless the patient also has some obstruction in addition to restriction, in which case the ratio will be reduced.

Shuttle walk test – the incremental shuttle walk test is designed to measure how the patient's heart and lungs respond to an increasing walking pace.

Oxygen saturation may be reduced because the fibrosis or inflammation makes it harder for oxygen to pass from the alveoli into the blood. It is important that O_2 saturations are measured while the patient is moving as well as at rest. Desaturation on movement is a key sign of ILD and occurs because the damaged alveoli can't meet the increased oxygen demand during activity. Saturations below 88% and a decrease during exercise of 4% or more is significant and should prompt referral for oxygen assessment.

Blood tests –these include a full blood count, autoimmune screening tests, serum angiotensin-converting enzyme, C-reactive protein and erythrocyte sedimentation rate, liver function tests, urea and electrolytes, b-type natriuretic peptide, vitamin D and calcium levels.

Chest X-ray and/or high-resolution CT scan – fibrosis is not always evident on chest X-ray in early disease but may have a hazy or patchy appearance. HRCT provides detailed images of the lung parenchyma and can reveal patterns of fibrosis, inflammation or ground-glass opacities, which are key for diagnosing the specific types of ILD and assess the extent of lung damage.

Bronchoscopy – this procedure uses a bronchoscope, which is a thin, lighted tube with a tiny camera to view images of the patient's airways.

Bronchoalveolar lavage (BAL) – a small telescope (bronchoscope) is passed into the lungs and a measured amount of fluid is injected into the deep structures of the lung and then collected. The collected fluid can be inspected under a microscope to determine if there are inflammatory cells present, which may help to decide on whether specific treatments might help the condition.

ILD multidisciplinary team meetings – as there are >200 different types of ILD an accurate diagnosis precedes appropriate treatment. Often onward referral to a tertiary centre is necessary to access specialist treatment and to confirm diagnosis in some cases.

NICE guidance for the management of IPF states that 'At each stage of the diagnostic care pathway the multidisciplinary team should consist of a minimum of the healthcare professionals listed in table 1, all of whom should have expertise in interstitial lung disease'. These are:

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Stage of diagnostic care pathway	MDT composition
After clinical evaluation, baseline lung function and CT	Consultant respiratory physician, consultant radiologist, interstitial lung disease specialist nurse, multidisciplinary team coordinator, specialist pharmacist
When considering performing bronchoalveolar lavage, and/or transbronchial biopsy or surgical lung biopsy only some patients will have bronchoalveolar lavage or transbronchial biopsy but they may be being considered for surgical lung biopsy	Consultant respiratory physician, consultant radiologist, consultant histopathologist, thoracic surgeon as appropriate, interstitial lung disease specialist nurse, multidisciplinary team coordinator
When considering results of bronchoalveolar lavage, transbronchial biopsy or surgical lung biopsy	Consultant respiratory physician, consultant radiologist, consultant histopathologist, interstitial lung disease specialist nurse, multidisciplinary team coordinator, specialist pharmacist

6.1.3 Treatments for ILD

Treatments for ILD will vary depending on the type of disease and are based on diagnostic tests (as described above) informed by clinical guidelines and expert consensus, in addition to multidisciplinary team (MDT) meeting consensus which is imperative to diagnosis.

- NICE clinical guideline: Idiopathic pulmonary fibrosis in adults: diagnosis and management (23 May 2017)
- NICE technology appraisal guidance – nintedanib for treating progressive fibrosing interstitial lung diseases (17 November 2021)

Immunosuppression therapy – these are widely used in medicine to combat illnesses that have an inflammatory component. Examples include steroids, azathioprine, mycophenolate and cyclophosphamide. They have significant side effects in some patients, which needs to be considered when making decisions about patient care.

Antifibrotics – nintedanib is recommended as an option in NICE technology appraisal guidance for treating idiopathic pulmonary fibrosis in people with forced vital capacity (FVC) above 80% predicted (approved in February 2023. Nintedanib is recommended as an option in NICE technology appraisal guidance for treating patients with non IPF progressive fibrosing interstitial lung diseases (approved in November 2021). Pirfenidone is recommended by NICE as an option for treating idiopathic pulmonary fibrosis in adults only if the person has a forced vital capacity (FVC) between 50% and 80% predicted

The NICE clinical guideline for idiopathic pulmonary fibrosis in adults: diagnosis and management states that ambrisentan, azathioprine, bosentan, co-trimoxazole, mycophenolate mofetil, prednisolone, sildenafil and warfarin should not be used to modify disease progression in idiopathic pulmonary fibrosis.

Pulmonary rehabilitation – for a condition that has limited therapeutic options for treatment, patients need to optimise their restricting breathlessness with programmes of rehabilitation. This will include support with exercises to strengthen breathing muscles, breathing retraining, airway clearance, education, mental health, and nutrition.

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Oxygen therapy –as the process of interstitial scarring progresses, the ability to transport sufficient oxygen into the bloodstream becomes limited, and supplemental oxygen can be delivered in a number of ways (eg nasal tubes, face mask) attached to oxygen tanks or concentrators.

Lung transplant – this can be considered in patients with ILD including IPF although long-term results are less favourable than lung transplants for other conditions. There are six units in the UK providing this service. There were 106 lung transplants performed in the UK in 2021/2022.

6.2 Description of the service

Overview

The Epsom and St Helier University Hospitals NHS Trust serves a population of approximately 490,000 people in Southwest London and Northeast Surrey. The trust operates two general hospitals, Epsom Hospital and St Helier Hospital. The respiratory department offers inpatient and outpatient care at Epsom and St Helier Hospital sites for patients with respiratory conditions. Respiratory clinics are held at both hospitals daily. The trust also holds links to tertiary centres at the Royal Marsden Hospital, St George's Hospital, The Royal Brompton Hospital, Queen Victoria Hospital and Guy's & St Thomas' Hospital.

On 1 February 2022 Epsom and St Helier University Hospitals NHS Trust and St George's University Hospitals NHS Foundation Trust formed a hospital group: St George's, Epsom & St Helier University Hospitals and Health Group (GESH). They remain two separate trusts but share an executive team.

Staffing

At the time of this review there were five substantive consultant respiratory physicians, two locum consultant respiratory physicians and three specialty doctors in respiratory medicine. Of the three substantive consultants, one was the clinical lead for the respiratory department, one was the clinical director for specialist medicine (which included respiratory medicine as part of the portfolio) and one was the clinical lead for lung cancer.

During the period 2019–2020 there were four respiratory consultants at Epsom Hospital and four respiratory consultants plus one SAS at St Helier Hospital. In 2021 there were four respiratory consultants at Epsom Hospital and three respiratory consultants, plus one SAS and one agency consultant at St Helier Hospital.

At the time of this review there was a team of respiratory clinical nurse specialists led by one lead nurse for respiratory services plus an associate lead nurse for respiratory services. The respiratory team was also supported by a physiologist and several physician associates.

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Dr X

Dr X joined the trust in 1996 as a substantive consultant respiratory physician. From 1996 up to Dr X's retirement (in 2023) they had responsibilities to the general medical ward, general respiratory medical support to acute admissions plus ILD clinics. Dr X had one programmed activity (PA) to run the ILD clinic.

From 2012 to 2021, Dr X was principal investigator for a local clinical trial based at St Helier Hospital. The clinical trial was a single centre, double-blind, randomised, placebo-controlled study of co-trimoxazole in advanced pulmonary fibrosis.[6] Dr X was also lead investigator for several other research trials, but these trials were considered outside of the scope for this review as they were not all specific to ILD.

ILD MDT pathways

At the time of this review, the trust ran a local ILD MDT meeting based at the Epsom Hospital (established in 2019) and which provided referrals to the tertiary centre ILD MDT at GSST. There was no formalised MDT pathway to the regional service from St Helier's prior to 2019.

7 Findings

7.1 Terms of reference A

a) To conduct an independent clinical record review of the medical records of patients with a diagnosis of ILD since 2019 who received care from Dr X, to include:

- 20 index patients identified by the internal review conducted by GESH
- 10 randomly selected patients from the list of those included in the internal review: every 10th new patient diagnosed with ILD starting from 2019.

Consideration will be given to:

- Assessment, investigations and initial treatment plans
- Ongoing care and treatment
- Communication with colleagues and MDT working
- Interactions with patients and their family
- Clinical record keeping

An independent assessment of whether the management of some patients with ILD by Dr X has led to any harm, and if so, to determine the degree of harm.

7.1.1 Clinical record review

Thirty clinical cases were reviewed as part of terms of reference A. Twenty were index cases (RCP 1–20) and ten were randomly selected (RCP 21–30). Two cases were excluded from the review; the review team were of the view that one case (RCP 26) was not relevant for this review having had no input from Dr X and the other case (RCP 29) had insufficient information to inform an overall grading.

[6] https://www.isrctn.com/ISRCTN87032740

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7.1.2 Overall rating for quality of care

NCEPOD gradings

The review team's overall ratings for the quality of care provided in the 28 cases were as follows (a full breakdown of gradings by phase of care can be found in Appendix 4):

NCEPOD gradings:

- 2 graded 'good practice'
- 7 graded 'room for improvement' for clinical reasons
- 0 graded 'room for improvement' for organisational reasons
- 1 graded 'room for improvement' for both clinical and organisational reasons
- 18 graded 'unsatisfactory'
- 1 graded 'insufficient information' and was excluded
- 1 'not applicable' and was excluded

7.1.2.1.1 Good practice

Two of the 28 cases were graded by the review team overall as 'good practice' (RCP 27 and RCP 30).

Key themes identified by the review team within those two cases were:

- Appropriate and timely initial assessment and investigations including CT scans, lung function tests, blood tests, chest X-rays and autoimmune screening.
- Appropriate initial and ongoing treatment plans, informed by a secure diagnosis and with plans either for an observational approach or for referral to the local ILD MDT with further discussion documented at the regional ILD MDT.
- There was communication between the healthcare professional and the patient clearly evidenced within the clinical notes, including advice on the patient's management plan and evidence for patient information leaflets provided.
- There was no harm identified in either of the two cases.
- Of note Dr X was not involved in the care of case RCP 27 and was involved only in the initial management of case RCP 30.

7.1.2.1.2 Room for improvement (clinical factors)

Seven of the 28 cases were graded by the review team overall as 'room for improvement with respect to clinical factors' (RCP 5, RCP 8, RCP 12, RCP 14, RCP 19, RCP 21, RCP 28).

Key themes identified by the review team within those seven cases were:

- An incorrect diagnosis or no definitive diagnosis recorded (RCP 5, RCP 14).
- Recognition for the deteriorating patient and ILD progression was lacking (RCP 5, RCP 14, RCP 28).
- Delays in requesting clinical advice from the regional ILD MDT (RCP 5, RCP 19) or no MDT discussion documented (RCP 14, RCP 18, RCP 21).
- No discussion or consideration for referral to smoking cessation services (RCP 5), pulmonary rehab (RCP 5) or oxygen therapy (RCP 19, RCP21).
- Delay in commencing antifibrotics (RCP 5).
- Prescribing asthma treatment for a patient without clinical evidence for asthma (RCP 19).

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- Non-evidence-based treatment recommended by Dr X:
  - nocturnal oxygen prescribed as a replacement for NIV (RCP 12)
  - patient enlisted in a trial for co-trimoxazole (RCP 14, RCP 18)
  - balsamic vinegar advised for headache (RCP 19)
  - rapeseed oil avoidance advised (RCP 8, RCP 21),
  - avoidance of the flu vaccine and COVID-19 vaccine advised (RCP 19)
  - roflumilast prescribed for treatment of patient's ILD (RCP 19).
- Palliative care not discussed with the patient and/or family (RCP 8, RCP 21).

7.1.2.1.3 Room for improvement (clinical and organisational factors)

One of the 28 cases was graded by the review team as 'room for improvement with respect to clinical and organisational factors' (RCP 18).

The organisational aspect of this case was underpinned by the involvement of three different respiratory clinicians who advised on the care of this patient. There was evidence of inadequate communication and conflicting management approaches among the clinicians without an appropriate collaborative MDT forum of discussion documented. The clinical factors have been described in section 7.1.2.1.2 above.

7.1.2.1.4 Unsatisfactory

Eighteen of the 28 cases were graded by the review team as 'unsatisfactory', (RCP 1, RCP 2, RCP 3, RCP 4, RCP 6, RCP 7, RCP 9, RCP 10, RCP 11, RCP 13, RCP 15, RCP 16, RCP 17, RCP 20, RCP 22, RCP 23, RCP 24, RCP 25).

Key themes identified by the review team within those 18 cases were:

- Lack of recognition by Dr X for the deteriorating patient (ie ILD progression, decline in lung function, increased breathlessness).
- Delays to or no referral to the regional ILD MDT for assessment, to formalise a diagnosis and support the patient's treatment plan.
- Insufficient investigation(s) to secure an accurate diagnosis. As a result, these patients were denied timely access to immunosuppression.
  In two cases there were missed diagnoses:
  - antisynthetase syndrome
  - anti-neutrophil cytoplasmic antibodies (ANCA) positive vasculitis

  both of which should have been identified within a specialised clinic.
- Colleague management recommendations (tertiary centre/local) not enacted.
- Evidence for steroid/immunosuppressive responsive ILD but no immunosuppression or antifibrotics were considered.
- Advice and prescription for antibiotic use in idiopathic pulmonary fibrosis (IPF) (eg trimethoprim and Septrin), often within the local Epsom & St Helier trial, and usually without other proven standard of care treatment options being considered.
- Deteriorating patient symptoms or results were often linked to other factors, including: breathlessness due to anxiety, breathlessness due to lack of weight reduction, hypoxaemia due to Raynaud's phenomenon, reduced lung function due to exercise prior to testing
- Use of non-evidence-based treatments for FSNIP and IPF: trimethoprim, co-trimoxazole, folic acid, rapeseed oil-free diet, roflumilast, advising patients against flu and COVID-19 vaccination.
- Recruitment to a co-trimoxazole clinical trial without a formalised ILD MDT meeting to consider patients eligibility.

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- No referral to pulmonary rehabilitation as per NICE quality standards.
- No referral for ambulatory oxygen despite demonstrable desaturation.
- Frequent follow up with investigations (lung function and shuttle tests) but there was a lack of understanding linking the patients ongoing symptoms with CT findings and lung function impairment and which necessitated treatment initiation or change in treatment.
- Diagnosis or focus on asthma/airways disease with bronchodilator prescription/airway management when the clinical features and lung function tests were not consistent with these diseases and the patient was unlikely to benefit from these treatments.
- Lung imaging (radiology) and reporting were detailed and provided in a timely fashion but the results were misinterpreted by Dr X.
- Incorrect reporting within the clinical notes (ie diagnosis, test results).
- Lack of documented discussion with the patient regarding non-evidence-based treatment options.
- Diagnosis of IPF without being discussed at an ILD MDT as per NICE guidance suggestion that all IPF diagnoses, and treatment plans should be discussed at an ILD MDT.

7.1.3 Assessment of clinical harm

The review team provided an independent assessment of whether the management of patients with ILD by Dr X resulted in any clinical harm, and if so, what degree of harm (see Table 1. Degree of harm).

Table 1. Degree of clinical harm

Grade	**Degree of clinical harm**	**No.**	**RCP no.**	**Dr X's involvement in the care of the patient** (a key has been provided at the end of this table)
No clinical harm	Impact was prevented, or impact was not prevented but no harm occurred	5	RCP 8	C/Dr X
			RCP 12	C/Dr X
			RCP 21	Dr X/C
			RCP 27	C
			RCP 30	Dr X/C
Low clinical harm	Minimal harm – the patient required extra observation or minor treatment	1	RCP 28	Dr X
Moderate clinical harm	Short term – the patient required further treatment or procedure or was not given treatment which may improve quality of life	7	RCP 5	Dr X
			RCP 7	C/Dr X/C
			RCP 14	Dr X
			RCP 18	C/Dr X
			RCP 19	Dr X
			RCP 22	Dr X
			RCP 24	Dr X
Severe clinical harm	Permanent or long-term harm – the patient did not have access to treatments which are evidenced as	12	RCP 3	Dr X
			RCP 6	Dr X
			RCP 9	Dr X
			RCP 10	C/Dr X
			RCP 11	C/Dr X

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Grade	Degree of clinical harm	No.	RCP no.	Dr X's involvement in the care of the patient (a key has been provided at the end of this table)
	standards of care to improve quality of life or was given treatment(s) which have limited or no evidence of clinical benefit		RCP 13	Dr X
			RCP 15	Dr X
			RCP 16	Dr X
			RCP 17	Dr X
			RCP 20	C/Dr X
			RCP 23	Dr X
			RCP 25	Dr X
Death	Death – the patient did not have access to treatments which are evidenced to potentially extend life	3	RCP 1	C/Dr X
			RCP 2	C/ Dr X
			RCP 4	Dr X
KEY: Dr X = Dr X's was responsible for the care and management of the patient C/Dr X = Dr X's colleagues were responsible for the initial assessments and Dr X was responsible for the treatment and ongoing care of the patient Dr X/C = Dr X was responsible for the initial assessment and Dr X's colleagues were responsible for the treatment and ongoing care of the patient C = Dr X's colleagues were responsible for the care and management of the patient				

7.1.3.1 Death – the patient did not have access to treatments which are evidenced to potentially extend life

Findings (RCP 1):

In case RCP 1, the patient was diagnosed with FNSIP in 2017 by GSST following a referral by Dr X's colleague to the regional ILD MDT. A diagnosis of IPAF was made by the regional ILD MDT in the context of SSA antibody and with a note for a treatment plan of induced sputum, prednisolone and mycophenolate mofetil (in 2018). There was no record in the notes to suggest this recommendation from the tertiary centre had been actioned at that time. The clinical notes documented that the patient was on azithromycin but not tolerating this well, and in May 2019 a rapid decline in weight and increased breathlessness were reported. In 2019 the patient was discussed with Dr X with an incorrect diagnosis documented in the clinical notes by Dr X's colleague (IPF instead of FNSIP). The patient was started on trimethoprim (an antimicrobial agent without evidence-based efficacy for FNSIP). Despite a request to start the patient on immunosuppression by GSST (in 2018), this was not actioned between the period 2018–2021. In 2020 the patient was discussed at the local ILD MDT with a recommendation for discussion at the regional ILD MDT, which occurred. The regional ILD MDT outcome was that the patient had chronic HP progressive over 5 years with a suggestion for prednisolone treatment and withdrawal of trimethoprim which occurred. The patient was admitted in 2021 with ILD exacerbation/progression and type 1 respiratory failure, developed HAP and palliative care was involved and the end of life (EOL) pathway enacted, the patient died at home 4 weeks later.

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Review team's independent assessment (RCP 1) – death:

Based on the review of clinical records, there is evidence to suggest that the 2-year delay to treat this patient with immunosuppression for FNSIP may have contributed to their deterioration and eventual death.

The tertiary centre provided a clear diagnosis and treatment plan recommending immunosuppressive therapy. Despite this, the advice was not followed. Instead, the patient was treated with trimethoprim. When the patient eventually received immunosuppression, there was a demonstrable positive response indicating that earlier use of this treatment might have altered the disease trajectory.

The review team noted that the treatment choice (trimethoprim) was inconsistent with the standard clinical management of fibrotic ILD, particularly in patients with inflammatory or steroid responsive features. Over time, clinical deterioration was documented within the clinical notes but no significant change in treatment strategy occurred. By the time appropriate treatment was initiated the disease had progressed and the patient developed complications (including respiratory failure and infection), which the review team raised as known risks in progressive ILD without adequate disease control.

The review team were of the view that while the patient's comorbidities (type 2 diabetes and age-related frailty) may have increased their vulnerability. The delay in initiating immunosuppressive treatment may have been a contributing factor in the progression to respiratory failure and premature death.

Findings (RCP 2):

In case RCP 2, between the period 2016–2019 the patient was under the care of Dr X's colleagues. In 2019 a referral was made to Dr X for the patient with a diagnosis of probable FNSIP and for possible recruitment to the co-trimoxazole trial. Despite a lung function report that documented impairment (DLCO (diffusing capacity of the lungs for carbon monoxide) 48%) and a HRCT that demonstrated extensive ground glass changes with traction bronchiectasis in both lower lobes and subpleural fibrosis bilaterally in the upper lobes consistent with NSIP thus severe fibrotic lung disease. Dr X subsequently advised for a treatment plan of co-trimoxazole twice a day (via recruitment to the local clinical trial), folic acid three times a day and a rapeseed oil-free diet. There was no ILD MDT discussion documented for this patient's eligibility for recruitment into the trial, nor discussion of bronchoalveolar lavage (BAL) or prednisolone therapy. Between the period 2019 and 2023 the patient continued this treatment plan despite there being evidence within the clinical notes for the patient's decline, both symptomatically and from a lung function perspective. The decline in lung function was demonstrated within the lung function test results, but the interpretation of the decline was not detailed within Dr X's clinical letters to the GP or consultant colleagues. A HRCT report in 2022 identified significant progression from October 2020 and March 2022 with further diffuse ground glass and traction bronchiectasis and honeycombing (HC) – Differential of FNSIP UIP AIP. At this point the patient was advised to double the dose of Septrin (co-trimoxazole), to undergo a spirometry test and to see whether they were eligible for antifibrotics. One year later the patient was discussed at the regional MDT and the recommended treatment was prednisolone, mycophenolate mofetil and nintedanib.

Review team's independent assessment (RCP 2) – death:

Based on the review of clinical records, the review team identified evidence for a critical delay of over 1 year in initiating disease-modifying treatments for this patient – specifically mycophenolate mofetil and nintedanib.

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Following diagnosis, the patient was enrolled in a clinical trial for co-trimoxazole therapy. However, this approach was maintained for a prolonged period of time, without adequate reassessment and despite evidence of clinical deterioration and radiological progression on HRCT. Instead of initiating immunosuppressive or antifibrotic therapy the patient was managed with folic acid and rapeseed oil avoidance – interventions lacking clinical justification for FNSIP. Notably there was no BAL to reassess or clarify underlying inflammatory activity, nor was prednisolone trialled at an earlier stage despite worsening lung function.

The review team considered that the significant decline in lung function and radiographic findings were not escalated in a timely manner. A 1-year delay occurred before referral to a regional ILD MDT, which appropriately recommended mycophenolate mofetil, prednisolone and nintedanib. However, by this point the patient's disease had progressed substantially and the patient's condition was no longer amenable to these interventions.

The review team were of the view that the failure to initiate timely and appropriate immunosuppressive and antifibrotic therapy was more likely than not, a contributing factor in the progression of lung disease and premature death.

Findings (RCP 4):

In case RCP 4, there were frequent and timely lung function and shuttle tests, but questionable interpretation of results for these (2016–2021). In 2020, the patient was started on trimethoprim (a non-evidence-based medication for this indication) and with no clinical rationale documented. In 2021, the patient demonstrated the need for ambulatory oxygen (with no referral documented). Despite the evidence of progressive decline in lung function and shuttle tests and CT results, there were no referrals documented to pulmonary rehabilitation (as per NICE quality standards) and the patient was advised to walk more. The patient was referred by Dr X to the RBH for nintedanib, but the patient declined this opportunity, and it was documented that the patient preferred to continue trimethoprim.

Review team's independent assessment (RCP 4) – death:

A review of the clinical records revealed multiple missed opportunities for treatment interventions, largely driven by misinterpretations of objective clinical data and the use of non-evidence-based treatment approaches.

Despite lung function and shuttle walk tests showing a clear and measurable decline, these results were not adequately integrated into Dr X's treatment decisions. Symptoms of breathlessness and reduced exercise tolerance were incorrectly attributed to general fitness rather than being recognised because of worsening lung disease. The patient was managed with trimethoprim and advised to avoid rapeseed oil, neither of which is supported by current clinical guidelines for the treatment of FSNIP. The patient accepted treatment with trimethoprim. However, it was unclear how guideline based treatment options were communicated to and discussed with the patient.

Importantly, the patient had a delayed ambulatory oxygen assessment despite meeting likely clinical criteria which could have improved quality of life and functional status at an earlier stage. A referral for nintedanib was advised at a later stage but the patient declined this. The review team considered that this decision may have been driven by Dr X's false reassurance to the patient that the treatment they were receiving was appropriate. If the patient had been fully informed about the progression of their disease and the lack of evidence for their current therapy (trimethoprim), they might have made a different decision

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regarding antifibrotic treatment. These management failures represent a departure from accepted standards of care for fibrotic ILD.

The review team were of the view that these missed opportunities for timely evidence-based treatments were potentially contributing factors to the patient's decline and premature death.

7.1.3.2 Severe clinical harm

Twelve of the 30 cases were graded by the review team as severe clinical harm (RCP 3, RCP 6, RCP 9, RCP 10, RCP 11, RCP 13, RCP 15, RCP 16, RCP 17, RCP 20, RCP 23, RCP 25). Within these 12 cases there was evidence for permanent or long-term clinical harm, ie the patient did not have access to treatments that were evidenced as standards of care to improve quality of life or was given treatment(s) that have limited or no evidence of clinical benefit.

Findings (RCP 3):

In case RCP 3, the patient was diagnosed with HP and managed by Dr X from 2018 to 2023. During this period, there was evidence of frequent follow up with investigations (lung function and shuttle walk tests) but limited reporting of the patient's symptoms with CT findings and lung function necessitating treatment initiation with steroids. Instead, the clinical notes documented that the patient's symptoms were attributed to high weight and asthma. Thus, the management plan focused on losing weight and increased activity. This patient had ongoing interstitial lung changes as defined by pulmonary function tests with no objective evidence of asthma. There was deterioration and fibrosis documented in the clinical notes between CT scans carried out from August 2021 to January 2023 suggestive of progressive pulmonary fibrosis (scarring). The referral to seek specialist advice from the regional ILD MDT for the consideration of antifibrotic treatment did not occur at that point. In 2024 the patient was referred to the regional ILD MDT where nintedanib was recommended.

Review team independent assessment (RCP 3) – severe clinical harm:

The patient was diagnosed with HP and despite clinical surveillance there was limited reporting and integration of key investigative findings into the patient's management plan. Treatment was focused primarily on weight loss and asthma management (although there was no objective evidence supporting a diagnosis of asthma). Overtime, the patient's condition deteriorated with CT imaging showing progression of pulmonary fibrosis.

The review team were of the view that investigations such as CT imaging indicative of fibrotic progression were not adequately reported, communicated or acted upon. The patient's underlying ILD was therefore not appropriately reassessed despite worsening symptoms. The referral to a tertiary centre occurred only after significant disease progression had been recognised. Earlier referral could have facilitated timely initiation of immunosuppressive and antifibrotic therapy.

The review team classified this as severe clinical harm due to the rate of disease progression, which could potentially have been slowed if the deterioration had been recognised earlier. It is likely that the harm could have been mitigated by earlier re-evaluation of the diagnosis and initiation of appropriate therapy.

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Findings (RCP 6):

In case RCP 6, the patient was assessed by Dr X from 2014–2016. During this period, the patient's clinical assessments evidenced deteriorating lung function. The interpretation of the lung function decline was not reported by Dr X in their correspondence to the GP nor to consultant colleagues. The patient was documented to have been discussed at the 'big X-ray meeting' and later in 2016 referred to a radiology colleague at the RBH. In 2015, Dr X documented a treatment plan of vitamin D and azithromycin. Between 2014–2016 there was no evidence for instituting steroid treatment and several entries documenting cold and cough symptoms attributed to pollen count/hay fever and with multiple short course steroids prescribed for asthma. There was no recorded recognition of the need for the timely treatment of ILD. An accurate diagnosis and therefore management plan was not instigated until the involvement of the team at the RBH in 2016. For 2 years the patient was not treated on immunosuppression (2014–2016). From 2016 onwards the review team graded care as 'good' as the patient appropriately received a lavage and CTD screen and commenced on prednisolone therapy with symptomatic benefit. The patient was kept under review by the RBH team and subsequently prescribed mycophenolate and itraconazole. Monitoring of bloods following commencement of mycophenolate mofetil and anti-fungal medication occurred locally.

Review team's independent assessment (RCP 6) – severe clinical harm:

This patient had a history of asthma, HP and fibrosis-related ILD and experienced progressive decline in lung function over a period of 2 years. This was characterised by worsening respiratory function, which was initially attributed to asthma and fibrotic HP. The interpretation of this patient's continued decline was not adequately communicated by Dr X to colleagues. Consequently, there was a failure to recognise the need for more specialised treatment of ILD. Instead, the patient was treated with intermittent short courses of oral steroids, long-term azithromycin and vitamin D (non-evidence-based treatments).

The review team were of the view that the failure to treat this patient for their ILD over an extended period may have amounted to severe harm. The review team thought that the prolonged absence of immunosuppressive therapy may have accelerated the patient's respiratory decline. On balance, the delay in treatment may have had implications for the patient's long-term prognosis (ie irreversible lung damage, reduced lung function and increased risk of complications such as respiratory failure) and their quality of life.

Findings (RCP 9):

In case RCP 9, the patient demonstrated features of CTD-ILD and PPF. The patient received co-trimoxazole as well as some treatment strategies for asthma and COPD. The clinical notes did not detail recognition of positive anti-Jo-1 antibodies, nor adaptation of the management plan for this patient with the potential for antisynthetase syndrome. Diagnostic tests for antisynthetase syndrome were available but not evidenced within the clinical notes to have been requested. The patient was documented to have continued with treatment for asthma and COPD. A referral to the regional ILD MDT was made in 2023.

Review team's independent assessment (RCP 9) – severe clinical harm:

The review team identified several missed opportunities to diagnose and treat this patient in accordance with recognised clinical standards for positive anti-Jo-1 antibodies and antisynthetase syndrome. The delayed diagnosis of positive anti-Jo-1 antibodies meant that the patient had a 3-year delay in the timely receipt of treatment for their condition. The review team were of the view that co-trimoxazole should not have been continued (with very weak evidence of its benefit). Moreover, nintedanib was licensed from November 2021 for this indication and therefore care under a specialist team would have allowed access to

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this medication at an earlier point and potentially delayed progression of this patient's disease. On balance, the review team were of the view that earlier immunosuppression for the patient's CTD-ILD could have delayed deterioration and PPF.

Findings (RCP 10):

In case RCP 10 the patient was referred to the respiratory service having had a 1-year history of cough, an abnormal chest X-ray suggestive of early ILD and lung function tests showing stable results but with reduced gas transfer (in 2013). In 2015 the patient was treated with (high-dose) steroids, with radiological improvement documented in 2016. Between 2017 and 2018 the patient was treated for airways disease. Dr X oversaw the care of this patient from 2018 at which point the treatment plan documented (by Dr X) included enrolment into the co-trimoxazole trial. The treatment plan of this patient was guided by a diagnosis that was not explored at an ILD MDT, no auto-antibody review was documented, and long-term immunosuppression was not considered.

The patient demonstrated lung function decline (FVC 81% and DLCO down to 38% predicted) in April 2019. The clinical letters to the GP by Dr X detailed that the patient was stable, however, a CT report suggested progressive FNSIP (albeit mild progression). The patient had a further CT scan in March 2021 which was confirmed as stable 'by Dr X. The patient continued with the asthma medications, co-trimoxazole and the patient was continued in the clinical trial. It was noted that the patient desaturated on exertion (shuttle test), but there was no referral for ambulatory oxygen documented. From September 2022 a new diagnosis of ANCA-positive vasculitis was recorded in the clinical notes and the patient's care was directed from St George's Hospital. In November 2022, there was discussion regarding the role of nintedanib "if the CT showed progression". The review team noted that progression is not the only criteria to access nintedanib. Other criteria include worsening patient symptoms and declining lung function.

Review team's independent assessment (RCP 10) – severe clinical harm:

The patient's ILD was identified at an early stage and initially treated with steroids resulting in radiological improvement. Despite this, the patient went on to receive co-trimoxazole, which the review team felt was not in line with ILD treatment best practice or the patient's actual diagnosis. The review team considered that this approach did not appropriately address the ILD's progressive nature and positive response to steroids.

The review team were of the view that the failure to provide optimal treatment over a period of 4 years 2018–2022 and the missed ANCA-positive diagnosis may have exacerbated the progression of the disease. The review team considered that timelier diagnosis of an autoimmune component may have significantly influenced treatment decisions and led to a more targeted immunosuppressive therapy. Earlier targeted treatment may have slowed inflammation or fibrosis.

Findings (RCP 11):

In case RCP 11, the patient was referred to the respiratory service having had an abnormal chest X-ray in 2019, and a diagnosis of FNSIP was made. The patient was referred to Dr X, who documented an initial management plan for enrolment into the co-trimoxazole trial. There was no MDT discussion documented for this patient's eligibility for recruitment into the trial. Treatment continued with co-trimoxazole, rapeseed oil avoidance and vitamin D (non-evidence-based treatments). The patient was documented to have been reviewed regularly in clinic with spirometry rather than formal pulmonary function tests. Dr X's clinical letters attributed lung deterioration to the patient's anxiety, low mood and insomnia to the point where the patient was referred to a liaison psychiatrist.

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Review team's independent assessment (RCP 11) – severe clinical harm:

The review team were of the view that this patient would have qualified for nintedanib for PPF secondary to NSIP, although was unlikely to have tolerated this well. The patient was treated with non-evidence-based treatments. The review team considered that these diseases are life limiting and deterioration is common and appropriate symptomatic treatment should be considered. While low mood and anxiety are common phenomena in patients with chronic lung disease, this patient's increased symptom burden, which was associated with deteriorating objective measures of lung function, was attributed to anxiety and low mood as primary causes rather than as secondary to the physical decline and was not offered appropriate end-of-life care planning and symptom management.

Findings (RCP 13):

In case RCP 13, the patient was diagnosed with sarcoidosis in 1990 (not by Dr X) and managed by Dr X between 2019 and 2023. The initial treatment plans in 2019 detailed airway management with intermittent increased doses of prednisolone, and vitamin D, was advised. The rationale for alternatives to steroids (such as methotrexate) was not considered nor discussed at an ILD MDT meeting. The CT scan reported the patient as stable, but lung function demonstrated deterioration. Consideration of the patient's original pulmonary hypertension was not reported within the clinical notes – there was no further cardiac imaging requested. The clinical notes did not record this patient to have received any pulmonary hypertension agents. Dr X's colleague sought opinion from the GSST ILD MDT in 2023. Pulmonary hypertension was picked up by Dr X's colleague in 2024.

Review team's independent assessment (RCP 13) – severe clinical harm:

The patient had follicular lymphoma in addition to their ILD. Early on when Dr X established fibrosis, there was incomplete investigation and symptom management, and progression could have been slowed. Nintedanib wasn't available until 2021 but other alternatives to steroids such as methotrexate could have been considered but were not. Recognition and strategies to manage the patient's pulmonary hypertension, which is associated with a worse prognosis, were not considered until 2024.

Findings (RCP 15):

In case RCP 15, the patient was diagnosed with hypersensitivity pneumonitis by the RBH in 2019. Overnight oximetry was performed in February 2019, which noted low oxygen saturations down to 75% overnight and therefore oxygen was prescribed. The patient commenced on overnight oxygen for the possibility of obstructive sleep apnoea (OSA) or obesity hypoventilation syndrome (OHS). The patient was not obese (80 kg with a BMI of 27.9 kg/m^2). The diagnosis was put forward as either OSA or OHS. Overnight oxygen is not the standard treatment option for OSA/OHS. In 2020 Dr X commenced the patient on roflumilast, which is indicated for severe COPD (of note the patient was never a smoker). The clinical notes recorded multiple overnight oximetry and shuttle walk tests between 2018 and 2023. Following a CT scan review by RBH radiology, features consistent with acute hypersensitivity pneumonitis were reported. The patient commenced on oral steroids for suspected HP in April 2019. The dose of steroids was 10 mg once daily. The patient continued with regular nurse-led review with no formal consensus diagnosis documented. The poor results on spirometry were noted and it was recorded that the patient felt stable. A repeat CT was deemed stable and the option for referral to the RBH was discussed but a decision was made by Dr X and the patient to continue care at St Helier and to review in 2 months. Symptomatic deterioration was reported in November 2019 (the patient did not attend appointments in between) and steroids were increased. In

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January 2020, the patient received roflumilast and between the period 2020 to 2023 showed variable lung function with a plan for a repeat CT in 2022. In August 2023, the patient was discussed at the GSST ILD MDT, where a diagnosis of fibrotic HP was made.

Review team's independent assessment (RCP 15) – severe clinical harm:

The review team were of the opinion that the patient's investigations were not interpreted appropriately, the diagnosis was missed, and management options were misguided. The patient would have benefited from evidence-based treatment. The review team were concerned that no treatment was provided to a patient whose disease was progressing. The review team were unsure from the clinical notes whether the patient died, hence the severe harm score.

Findings (RCP 16):

In case RCP 16, lung function decline and progression of ILD reported on CT scans did not prompt Dr X to document treatment options. Dr X instead focused on axillary lymph node biopsy and haematology referral. It was noted that a CTPA demonstrated right heart strain. An ECHO was requested. Despite a haematology letter documenting severe breathlessness, there was no documentation for breathlessness or exercise tolerance. At this point steroid therapy due to the progression of this patient's ILD was not considered. The patient commenced low-dose furosemide, 20 mg, (despite having severe pulmonary hypertension) and was started on ambulatory oxygen in December 2020 (which was instituted by the respiratory nurse during admission). The patient experienced recurrent admissions with syncope, potentially due to severe pulmonary hypertension, but this was not acted on in terms of clinical management strategy. Between 2019 to 2021 there was no consideration within the clinical notes for ILD treatment with immunosuppression despite evidence of progressive ILD. Palliative care options were not documented to have been discussed.

Review team's independent assessment (RCP 16) – severe clinical harm:

The patient was not appropriately investigated from the outset and therefore the diagnosis was missed. As a result, the patient's management options were misguided. It is likely that the patient would have benefited from alternative treatments.

Findings (RCP 17):

In case RCP 17, a referral was made by the rheumatology team to the respiratory service for this patient with previous pulmonary fibrosis whose CT showed ILD. The patient had high CCP antibody, but no symptoms related to rheumatoid arthritis. The lung function results demonstrated impaired lung function, but this was not outlined by Dr X in their clinical notes. A reversible element was documented on CT imaging and lung function impairment without consideration for steroid therapy. No initial treatment plans were documented for this patient, who had a DLCO of 36% (albeit asymptomatic).

Review team's independent assessment (RCP 17) – severe clinical harm:

The review team identified evidence within this case of an inflammatory component which required treatment but was not acted on for a period of 4 years (delay in treatment between the period 2019 – 2023). Sulfasalazine was documented as a treatment choice, which the review team felt was a non-standard option for a patient with this presentation. This patient's lung disease had the potential for

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significant improvement with appropriate treatment, in contrast to patients with progressive fibrotic lung disease (IPF) where there are limited therapeutic options to make patients feel better and reverse lung function. This patient had an inflammatory ILD and the review team were of the view that there was severe harm as the patient may have benefited from treatment.

Findings (RCP 20):

In case RCP 20, the patient was diagnosed with IPF in 2017 (seen by Dr X's colleagues). Dr X reviewed the patient in 2018 and documented a management plan for trimethoprim and rapeseed oil avoidance (non-evidence-based treatments). The CT scans reported fibrotic lung disease (UIP pattern) progression. The pulmonary function noted an FVC of 70% predicted. A tertiary referral was not made, and antifibrotic medication was not considered. The patient was not offered palliative care measures during the outpatient review between 2018 and 2022, nor pulmonary rehabilitation nor oxygen assessment.

Review team's independent assessment (RCP 20) – severe clinical harm:

The review team were of the view that an accurate diagnosis may have potentially guided the treatment of antifibrotic medication with an aim to slow disease progression. The review team felt that agencies such as palliative care were not offered at an early enough point in this case. Pirfenidone was approved in 2013 and with NICE updated guidance in 2018, hence was available but was not considered. As per IPF guidelines pending review in an ILD MDT the patient would have been eligible for antifibrotics. The review team acknowledged that it is known that this age group poorly tolerate this treatment but felt that it should have been explored as an option.

Findings (RCP 23):

This patient (RCP 23) was referred by gastroenterology to the respiratory team in 2021 for retrosternal burning pain and cough (for 1 year). The CT was reviewed at the 'X-ray meeting' and the CT was reported as stable (compared to the CT in 2018) with fibrotic peripheral changes subpleural, not confined to bases, not IPF nor NSIP. Dr X detailed a management plan for this patient as annual CT and for lung function testing. Despite there being knowledge of pulmonary fibrosis, further history of exposures and blood tests (including precipitants and connective tissue disease markers) to inform a treatment plan were not undertaken. There was no treatment plan documented for this patient. The patient demonstrated signs of ILD and was offered annual CT and pulmonary function test.

Review team's independent assessment (RCP 23) – severe clinical harm:

The review team were of the view that the patient's underlying inflammatory and fibrotic lung disease was not fully investigated and therefore a consensus diagnosis from an ILD MDT was not reached. The patient has benefited since commencing treatment which suggests earlier intervention would have been useful. An observational approach was taken instead. The review team were of the view that timelier diagnosis may have significantly influenced treatment decisions and led to a more targeted therapy. Earlier targeted treatment may have slowed inflammation or fibrosis.

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Findings (RCP 25):

In case RCP 25, the patient was referred to the respiratory service for chronic dry cough, crackles on chest auscultation and a chest X-ray that showed non-specific basal opacities with right apical pleural thickening. There was documentary evidence for adequate 'initial assessments and investigations' for this patient who received a CT scan but no documented immunology screen. Dr X's initial treatment plan did not document consideration for immunosuppression as first-line treatment and instead the patient was recruited to the co-trimoxazole trial without ILD MDT discussion of their eligibility. There was no consensus diagnosis documented for this patient (FNSIP vs NSIP) as the case was not discussed at an ILD MDT.

Review team's independent assessment (RCP 25) – severe clinical harm:

The review team were of the view that this patient should have commenced antifibrotics to stabilise the disease. Instead, the patient remained on co-trimoxazole (a non-evidence-based treatment) for 4 years. The review team were of the view that timelier targeted therapy may have slowed inflammation or fibrosis and improved quality of life for this patient.

7.1.3.3 Moderate clinical harm

Seven of the 28 cases were graded by the review team as moderate clinical harm (RCP 5, RCP 7, RCP 14, RCP 18, RCP 19, RCP 22, RCP 24). Within these seven cases there was evidence for short-term clinical harm, ie the patient required further treatment or procedure or was not given treatment which may have improved their quality of life.

Findings (RCP 5):

In case (RCP 5), between the period 2019 – September 2022, the patient was referred to the respiratory team by a consultant rheumatologist, who arranged a CT scan following bilateral crackles being heard on auscultation. The CT showed upper lobe emphysema and subpleural cystic changes. Dr X carried out the initial review of the patient and documented that the CT scan was discussed at the 'X-ray MDT' showing COPD/emphysema with basal-associated ILD and with a plan for this patient's care to remain with the GP and the COPD clinic.

Between September 2022 and November 2023, the clinical notes documented a 10-month timeframe for a regional ILD review for antifibrotic therapy, despite this patient's rapid deterioration. No regular follow up occurred during this period and there was no consideration for oxygen provision or pulmonary rehabilitation. While a referral to the RBH was considered, the only action taken was the provision of nintedanib leaflets to the patient.

Following review by a consultant colleague of Dr X (in October 2023), the patient was diagnosed with progressive ILD and a high priority ILD MDT discussion occurred, which prompted an oxygen assessment and urgent referral to the RBH ILD MDT. The patient was subsequently seen at the GSST ILD/rheum MDT clinic and commenced treatment (rituximab, oxygen and nintedanib) and was under regular follow up.

Review team's independent assessment (RCP 5) – moderate clinical harm:

The review team identified a 10-month delay in requesting a regional ILD review for antifibrotics in a patient who demonstrated rapid deterioration. Of note, the review team were unsure of the reason for the delay (as this was not documented within the clinical notes). The review team were of the view that

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between September 2022 and November 2023, there were missed opportunities to escalate this patient for discussion at the regional ILD MDT. the review team considered that starting antifibrotics at an earlier stage may have improved the patient's quality of life.

Findings (RCP 7):

In case RCP 7, a diagnosis of FNSIP was made (in 2019) for this patient with a previous history of cutaneous scleroderma (under care of a rheumatologist). The initial treatment plan documented by Dr X (in 2021) included trimethoprim and folic acid (non-evidence-based treatments for ILD) despite the patient's lung function being severely impaired. The patient was noted to have developed left pleural thickening and was reviewed by a ESTH lung cancer team and diagnosed with pleural adenocarcinoma. The patient was referred to the Royal Marsden team for chemotherapy (in February 2022). At this point there was no documented consideration of the high-risk nature of chemotherapy in the context of severe ILD and the need for follow up regarding potential complications of pneumonitis. No ILD MDT was documented to have occurred. The patient was admitted in October 2022 with pneumonia and died a week after admission.

Review team's independent assessment (RCP 7) – moderate clinical harm:

The review team identified aspects of suboptimal care for this patient who was initially treated with trimethoprim (a non-evidence-based treatment) despite demonstrating impaired lung function. The patient was diagnosed with pleural adenocarcinoma and commenced chemotherapy but without consideration for treatment of their ILD. The review team were of the view that there were missed opportunities by Dr X to discuss treatment options with their ILD, rheumatology and cancer colleagues. Discussion with those teams may have prompted a consideration of cyclophosphamide or an increased dose of mycophenolate as treatment options to improve this patient's quality of life.

Findings (RCP 14):

In case RCP 14, the patient was recruited into a co-trimoxazole in fibrosis trial having been diagnosed with FNSIP. The patient's spirometry results remained normal but had impaired gas transfer (2019–2020) documented. The patient's ongoing care and treatment was documented in the clinical notes as co-trimoxazole, 'referral to ENT for ear wax issues' and to dermatology for 'solar keratosis'. No other treatment options were documented for this patient with FNSIP. A follow up CT in 2020 reported progression of FNSIP. There were no clinical notes available to the review team after 2020.

Review team's independent assessment (RCP 14) – moderate clinical harm:

The review team acknowledged that no clinical notes were available beyond 2020 and therefore they were unable to comment on the care provided to the patient during that period. The review team were of the view that the care for this patient as recorded in the notes available to them was suboptimal, as the patient was recruited into a trial which may not have benefited their diagnosis of FNSIP and without an ILD MDT consensus discussion for eligibility documented. It was unclear to the review team whether reversible abnormality on the CT had been considered as this may have warranted more aggressive therapy such as immunosuppression. While the patient had normal spirometry over a 1-year period (between 2019 and 2020), progression of FNSIP was demonstrated in 2020. There may have been missed opportunities during this period for Dr X to discuss immunosuppression with the patient and, on balance, the review team considered that starting immunosuppression at an earlier stage may have improved the patient's quality of life.

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Findings (RCP 18):

In case RCP 18, the patient's ongoing care and treatment was documented in the clinical notes as recruitment to the co-trimoxazole trial. The patient was recruited to the trial without ILD MDT discussion nor discussion with a rheumatologist to confirm a consensus diagnosis. Dr X documented a plan to wean steroid therapy and RA-ILD was not explored as an alternative diagnosis. A diagnosis of RA-ILD was later confirmed by the GSST ILD MDT team and with a plan for steroid therapy.

Review team's independent assessment (RCP 18) – moderate clinical harm:

Dr X's colleague noted the patient responded well to steroid therapy from a breathlessness perspective, yet a decision was made to wean steroids without a clear rationale documented. The review team could not find evidence of any ILD/rheumatology MDT discussion to consider a diagnosis of RA-ILD. At a later stage in the patient's care a diagnosis of RA-ILD was confirmed by the GSST ILD MDT. While the outcome for this patient may not have changed, the review team thought that the patient should not have been weaned off steroids having previously responded well. Palliative care could have been enacted for this patient to improve their overall experience of their final stages of life.

Findings (RCP 19):

In case RCP 19, the patient was referred for breathlessness (ongoing for several weeks), crepitations were heard at the lung bases and fibrosis on a chest X-ray. At that point a CT scan reported a possible diagnosis of HP. Screening for connective tissue disease and avian precipitants were not evidenced in the clinical notes. A diagnosis of carbamazepine-induced hypersensitivity pneumonitis was made without other putative causes documented. In 2018 Dr X detailed a treatment plan for the withdrawal of carbamazepine and to replace with an alternative (gabapentin), balsamic vinegar (for the management of headache), acupuncture and regular vitamin D (no documented vitamin D level was recorded in the notes). The rationale for the non-evidence-based treatments was not detailed within the clinical notes. In 2021, the patient was discussed with a radiologist at the RBH who advised consideration for antifibrotics. The patient received frequent follow up and lung function tests by Dr X. The results of the lung function tests were interpreted in the clinical letters as within the normal range. However, the results from those tests were demonstrated to have been outside of normal range. Between the period 2018 to 2021 there was evidence detailed within the clinical notes of a decline in lung function that did not prompt evidence-based treatment. Of note, the patient was documented to be asymptomatic. An ambulatory oxygen assessment was not performed despite evidence of desaturations on lung function. The patient was strongly advised not to take advantage of flu or COVID-19 vaccinations. The patient commenced nintedanib in 2022.

Review team's independent assessment (RCP 19) – moderate clinical harm:

The patient was commenced on nintedanib in 2022 after a 3-year delay from the initial indication for antifibrotic therapy. The review team acknowledged that nintedanib was not available until 2021, but other evidence-based treatments were not considered or discussed at the regional ILD MDT from 2018 until 2022. The review team were of the view that earlier intervention and earlier involvement of a regional MDT meeting could have mitigated the delay in treatment and may have slowed disease progression and improved quality of life.

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Findings (RCP 22):

In case RCP 22, the patient was referred to the respiratory service for an assessment of frequent exacerbations of asthma in 2019. There was evidence in the clinical notes of a normal spirometry function test and improvement in breathlessness and cough after the prescription of Fostair (an inhaler used to help manage asthma or COPD symptoms). In the following 3 months it was documented that the patient suffered with breathlessness and a cough, with a 4–5-day course of antibiotics making no difference to their symptoms. A HRCT was performed, and bronchiectasis was noted. Eight months later Dr X requested a repeat CT and reported this as stable with 'old asbestos marks on chest X-ray'. Despite the repeat CT showing asbestosis, bronchiectasis and fibrosis, the patient was discharged without further discussion about potential diagnosis or prognosis.

Review team's independent assessment (RCP 22):

The patient experienced ongoing respiratory symptoms without a definitive care plan. The review team identified a lack of diagnosis and management options. There was evidence in the notes of missed opportunities to deliver timely, evidence-based care for bronchiectasis and possible asbestos-related lung disease. The review team were of the view that earlier intervention and earlier involvement of a regional MDT meeting could have mitigated the delay in treatment and may have improved the patient's quality of life.

Findings (RCP 24):

In case RCP 24, the patient was a known smoker (30–60 cigarettes per day) with asthma, emphysema, bronchiectasis, inflammatory arthritis and osteopenia and was seen by Dr X in 2018. In 2018 spirometry and CT investigations were performed. The CT report indicated smoking-related ILD – desquamative interstitial pneumonitis. At this point there was no evidence within the clinical notes to suggest discussion with the tertiary centre ILD MDT. The patient was reviewed the following year in 2019 and Dr X noted within the clinical letters that the patient had emphysema-related ILD . An internal 'X-ray meeting' determined that the diagnosis was not IPF. The patient was discharged with the plan for a yearly review in the nurse COPD clinic. There was no evidence within the clinical notes of referral to a smoking cessation service (although the review team was not aware of the arrangements in place for this service at the time), and there was no mention of rheumatoid arthritis in the initial letter by Dr X. Later that year the patient presented on admission with community-acquired pneumonia on a background of ischaemic heart disease and COPD. The patient was discharged with a plan to finish a course of steroids and for a CT to follow up on significant weight loss over the previous 6 months. The initial treatment plans were focused on COPD treatment and ongoing smoking. There was no evidence within the clinical notes of blood tests or tests related to ILD/pulmonary fibrosis. In 2022 the patient was referred for pulmonary rehabilitation and assessed for oxygen therapy. However, the patient would not have fulfilled the criteria for this, in addition to being documented as a smoker.

Review team's independent assessment (RCP 24) – moderate clinical harm:

The review team were of the view that this patient experienced multiple missed opportunities for early diagnosis, smoking cessation support and specialist intervention. Disease progression may have occurred without appropriate monitoring or treatment. The lack of a clear plan, prognosis discussion and specialist tertiary centre intervention may have contributed to avoidable morbidity. The review team noted that the patient was inappropriately discharged from care without ILD-specific follow up and key interventions such as smoking cessation and ILD work up were not pursued. The review team were of the view that if a clear

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pathway for this patient with complex lung disease was pursued it may have contributed to improvement to their quality of life.

7.1.3.4 Low clinical harm

One of the 28 cases was graded by the review team as 'low clinical harm' (RCP 28). Within this case there was minimal clinical harm identified, ie the patient required only extra observation or minor treatment.

Findings (RCP 28):

In case RCP 28, the patient was referred to the respiratory team with breathlessness, raised inflammatory markers and abnormal chest X-ray (report compared to 2018 X-ray demonstrating widespread reticular shadowing with volume loss, suggestive of progressive fibrosis). The patient had a background of severe frailty, Charles Bonnet syndrome, arthritis, psoriatic arthropathy, transient cerebral ischaemia, chronic kidney disease stage 3 and asthma. The patient was prescribed an inhaler and vitamin D and discharged from follow up.

Review team's independent assessment (RCP 28) – low clinical harm:

While the review team recognised that the patient was frail and older (90 years old), they were of the view that a CT scan could have been performed to give an indication for the cause of his breathlessness. The review team acknowledged that any ILD-specific therapy would have had minimal benefit given the patient's age and comorbidities. A GP reference to the patient also noted that they were on an end of life care pathway.

7.1.3.5 No clinical harm

Five of the 28 cases were graded by the review team as 'no clinical harm' (RCP 8, RCP 12, RCP 21, RCP 27 (not Dr X), RCP 30). Within these five cases either the impact of clinical harm was prevented, or the impact of clinical harm was not prevented but no harm occurred.

Findings (RCP 8)

In this case (RCP 8), the patient was managed by Dr X's colleagues (in May 2022) having demonstrated fibrosis on their chest X-ray. A comprehensive history was taken detailing asbestos exposure. The clinical notes documented that the patient would not be an appropriate candidate for antifibrotics given their frailty (aged 90) and comorbidities (hypertension, ischaemic heart disease, cognitive impairment) and a referral was made for pulmonary rehabilitation along with advice provided on financial compensation (for asbestos exposure). Dr X managed the patient's ongoing symptoms.

Review team's independent assessment (RCP 8) – no clinical harm

The review team identified aspects of care that did not meet good practice standards regarding Dr X's management of the patient's ongoing symptoms. For example, increased bowel frequency and faecal elastase was investigated and Creon proposed as a treatment option and rapeseed oil avoidance was recommended to reduce coughing. Palliative care was not discussed with the patient despite their frailty and weight loss. While the review team identified opportunities for improved symptom control and earlier liaison with palliative care, they considered the decision not to treat this patient with antifibrotics entirely appropriate given his age and comorbidities.

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Findings (RCP 12):

In this case (RCP 12), the patient was initially referred by the RBH to St Helier in 2014 having experienced obstructive sleep apnoea and with a background of type 2 diabetes, hypertension, hypercholesterolaemia and a BMI of 47 kg/m^2. In 2014, the consensus diagnosis was that of constrictive bronchiolitis and the patient was managed with a combination of methotrexate and hydroxychloroquine. Dr X reviewed this patient in 2019, and the clinical records noted a diagnosis of pneumonia, pulmonary hypertension and heart failure (during the period 2021–2022). The review team graded the initial assessments and treatment plans by Dr X as 'good'. The ongoing care was graded as 'adequate' as Dr X documented a non-standard treatment strategy (nocturnal oxygen) in place of pressure support ventilation. The patient was documented to have gone on to receive CPAP.

Review team's independent assessment (RCP 12) – no clinical harm:

The review team identified both good and adequate aspects of care in relation to Dr X's ongoing treatment strategy. The patient received nocturnal oxygen as a substitute for non-invasive ventilation. The review team was of the view that the clinical outcome for this patient was not affected by this treatment choice. Ultimately, the patient received the appropriate standard of care in the form of CPAP treatment.

Findings (RCP 21):

This patient (RCP 21) had previously been assessed for pulmonary fibrosis and was found to have early ILD. The patient presented to Dr X in 2020 with a cough and a chest X-ray showing fibrosis. In 2020, Dr X detailed a treatment plan for pulmonary fibrosis documented as rapeseed oil avoidance, flight socks and regular walking. No clinical rationale was documented for those non-evidence-based treatments. The patient was discharged back to the GP and thus not observed between 2020–2023. From 2023, the patient was under the care of Dr X's colleagues. Multiple A&E attendances were documented (in 2023) and the patient was treated for COPD. A decline in the patient's spirometry test results were documented but not acted on within a period of 4 years. In 2023 the patient was identified as having advanced ILD and there was no evidence within the clinical notes to suggest that the palliative care pathway was enacted.

Review team's independent assessment (RCP 21) – no clinical harm:

The review team identified aspects of care that could have been improved for this patient who was advised non-evidence-based treatment for their pulmonary fibrosis (documented in Dr X's initial treatment plans). The patient's ongoing care was subsequently managed by Dr X's colleagues. While the review team identified aspects of treatment planning that could have been improved, the patient had a slowly progressing form of interstitial lung disease and was unlikely to have benefited from the option of antifibrotic medication.

Findings (RCP 27):

This patient (RCP 27) presented to Dr X's colleagues at the respiratory clinic having had a 1-year history of increased breathlessness on exertion (in 2020) with a background of being an ex-smoker, right upper lobectomy and chest wall reconstruction for non-small-cell lung cancer (in 2017) with a chronic discharging wound (the patient was under thoracic follow up at that time). Clinical standards were followed with respect to the initial investigations and a consensus-based (ILD MDT informed) diagnosis of IPF was made. Antifibrotics were offered and ambulatory oxygen recommended. The patient received nintedanib but

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there was no improvement to their disease progression and so nintedanib was discontinued. The patient was subsequently referred to palliative care.

Review team's independent assessment (RCP 27) – no clinical harm:

The review team identified all aspects of this case as 'good practice' as the patient was treated in line with national clinical guidelines for IPF. The review team believed the patient was appropriately treated with antifibrotics in the first instance and the change in management plan from treatment to palliative care was considered appropriate.

Findings (RCP 30):

This patient (RCP 30) presented to Dr X with night sweats and hilar lymphadenopathy on chest X-ray. An endobronchial ultrasound scan (EBUS) was performed confirming non-caseating granulomas and sarcoidosis. Lung function was normal, and the patient was monitored from January 2019 to May 2021. The patient was asymptomatic with 100% normal lung function, a stable chest X-ray and subsequently discharged.

Review team's independent assessment (RCP 30) – no clinical harm:

The review team identified most aspects of this case as 'good care'. The patient received appropriate investigations and tests to inform their diagnosis of stage 1 sarcoidosis. The patient remained asymptomatic and with no concerns regarding their lung function. Therefore, the review team were of the view that an observational approach for this patient was entirely appropriate.

7.2 Terms of reference B

To consider concerns about the clinical work of Dr X with specific reference to activity and outcomes, clinical decision making, implementation of treatment plans, MDT working and interactions with members of the wider medical and nursing team. This will include determining the professional relationship with colleagues at the Royal Brompton Hospital.

7.2.1 Activity and outcomes

7.2.1.1 Documentation review

7.2.1.1.1 Activity

Job plans and clinical activity

Job plans:

The trust provided Dr X's *job plans* to the review team for the following years:

- March 2019 – March 2020
- No job plans were provided for the period April 2020 – March 2022
- April 2022 – March 2023
- April 2023 – March 2024

Each *job plan* (listed above) indicated that Dr X was contracted for 10 PAs of core activity.

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In March 2019 to March 2020, Dr X's PAs were recorded as:

- 1.3 PAs for administrative work directly related to clinical care
- 0.62 PA for clinical diagnostic work, 0.5 PA for MDT meetings
- 2.0 PAs for outpatient activities, 1.0 PA for predictable emergency work
- 3.0 PAs for ward rounds
- 0.25 PA for appraisals
- 0.5 PA for revalidation/appraisal (audit/CPD/job planning/journal club/statutory and mandatory training).

There was no reference to PAs for the specific ILD clinic responsibilities and no PAs listed for research activity.

Clinical activity

An *ILD case finding presentation* document provided by the trust noted that Dr X held 'Home visits and Saturday group sessions outside of [their] agreed job plan and/or activity'. There was no further detail provided by the trust to confirm whether this was for clinical or research purposes.

An executive team meeting (ETM) report titled *Care concerns into the management of interstitial lung disease (ILD)* referred to Dr X's clinical activity, noting some out-of-hours clinic consultations with patients that lacked documented episodes in the hospital booking systems. There was no further information about how Dr X recorded the outcomes of these consultations.

These additional out-of-hours clinic consultations did not appear to have been included within Dr X's appraisals as part of any discussion regarding clinical activity. The review team appreciated that information related to additional clinical activities (ie those outside of Dr X's agreed job plans) may have been incorporated within Dr X's supporting documentation, however, this was unavailable for the review team to access.

7.2.1.1.2 Appraisals

The trust provided an *appraisal summary* to the review team for the period May 2022. The *appraisal summary* outlined key areas including personal development plans (PDP), 360 feedback reports, PDP proposals, CPD, complaints, quality improvement activity, significant events, and research activity. Findings from these documents are detailed below, however, some items contained supporting information as embedded documents. While the trust provided some supporting information as separate files, not all embedded content could be accessed.

Personal development plans:

Dr X's PDPs were listed and catalogued into two key areas, including job plans and publications. Dr X raised concerns at the time about their job plan, which included an allocation 0.5 SPA that they felt was unsafe. Dr X reported this concern to the relevant senior leads and escalated to the executive team. The second area listed for PDP considered Dr X's publications, listed as hypersensitivity pneumonitis and the use of methylprednisolone in COVID-19. There was no reference to the co-trimoxazole study in the PDP document. The review team acknowledged that the information may have been incorporated as a supporting document, which they did not have access to.

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Complaints:

A total of four complaints were recorded with Dr X's reflections on those incorporated. The complaints centred around nursing, staffing and discharge.

Friends and family feedback:

Eight items were presented from the family and feedback section which described Dr X as an excellent doctor who was kind, caring and compassionate.

Personal development plan proposal:

In May 2022, Dr X noted that one consultant post had remained unfilled since October 2021, and that daily respiratory referrals from multiple specialties were significantly impacting on their workload. Bronchoscopy frequency was noted to have increased and with only two consultants providing bronchoscopy (Dr X being one of the two). Dr X indicated that providing electronic advice and guidance also consumed time daily, particularly in reviewing CT scans and chest X-rays as well as vetting referrals.

Personal development plan audit tool:

The trust's appraisal process utilised the Appraisal Summary and Personal Development Plan Audit tool to quality assess appraisals. The tool provided a framework consisting of three specific domains. These have been listed below, with details specific to Dr X's appraisal.

- *Domain 1: Knowledge skills and performance* which reported that Dr X was up to date with adequate CPD and had achieved most PDP objectives, despite some difficulty with workload and staffing.
- *Domain 2: Safety and quality* noting that Dr X had been keeping up to date with CPD and attended conferences. No SIs had been documented but there was reference to complaints made regarding issues with nurses and discharge plans.
- *Domain 3: Communication, partnership and teamwork* noted that feedback from Dr X's patients and colleagues was very positive.

While the trust had a personal development plan audit tool in place for annual appraisals, it did not include elements related to clinical decision making or aspects of multidisciplinary team meeting attendance or participation.

7.2.1.2 Comments from interviewees

Activity

The review team were informed that Dr X was appointed to St Helier Hospital in 1996 as a respiratory physician. Dr X went on to become clinical lead in 2010 and stepped down from that post shortly after due to some difficulties experienced with colleagues. Dr X was employed as a consultant respiratory physician and was given 1 PA to provide the local ILD service. They had responsibilities to general medical ward admission patients as well as providing general respiratory medical support to acute admissions. The review team were informed that since 2018, there was a daily general medical intake and consultant-led ward round with approximately 30 inpatients to be reviewed. After the COVID-19 pandemic this increased to around 44 inpatients.

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The review team was informed by two interviewees about out-of-hours meetings with Dr X and staff at weekends, specifically discussing the co-trimoxazole trial. The review team was not informed of any clinical consultations with patients outside of regular hours.

7.2.2 Clinical decision making and implementation of treatment plans

7.2.2.1 Documentation review

The trust provided an *ESTH update report on interstitial lung disease (ILD) for the quality committee in common* to the review team. The document outlined the findings of an internal case note review which aimed to identify patients with ILD under the care of Dr X. The case finding process was documented to have identified patients who 'required a change in treatment and/or a review by specialists.' Of the 231 patients with ILD identified, 216 were recorded as having 'care in some way not meeting best practice.' With respect to Dr X's clinical decision making, the report noted the following areas of clinical concern, including: lack of investigation, lack of referral to available ILD MDT, no treatment provided, and inappropriate treatment provided.

The trust provided an ETM report titled *Care concerns into the management of interstitial lung disease (ILD) resulting in a possible severe level of patient harm* to the review team. The document outlined the concerns escalated by Dr X's colleagues to the executive team regarding Dr X's clinical practice. With respect to clinical decision making – themes documented within the report included: incomplete diagnostic assessments, patients not referred to tertiary centres for opinion or treatment opportunities, local MDT or tertiary MDT discussions not consistently requested, the use of unlicensed medications for ILD, advice against vaccination, advice on exclusion diet management.

The trust provided an *ILD case finding presentation* (dated November 2023) to the review team. Several themes were highlighted with respect to Dr X's implementation of treatment plans, these included: concerns regarding the interpretation of test results, information provided to patients, ie no evidence of consenting patients to be excluded from standard care, vaccine avoidance, off guidance medications prescribed, advice about eligible treatments, missed diagnosis of the patient.

The trust provided a *rapid review report* (dated January 2023) to the review team. The document presented evidence for eight patients under the care of Dr X (since 2019) where concerns had been raised via the Datix process. The Datix concerns were related to Dr X's treatment plans, which consisted of trimethoprim given to a patient against NICE guidance and non-approved medication prescribed for ILD – rapeseed oil avoidance as treatment for ILD and co-trimoxazole as treatment for ILD.

The trust provided a paper titled *Roflumilast and O2 review* to the review team. The document highlighted key findings, which identified three patients who were commenced on roflumilast in the context of having ILD and not COPD.

7.2.2.2 Comments from interviewees

Supportive statements

The review team discussed aspects of Dr X's clinical decision making with interviewees. Several interviewees (ie those interviewed virtually and those who provided written statements) were supportive of Dr X's approach to clinical decision making. Those interviewees were impressed by Dr X's immunology interest, including quoting basic science 'pathways' to corroborate their rationale for treatment strategies,

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which they felt supported and justified their treatment choices. Dr X was described by those colleagues as having expert knowledge with a sound, evidence-based clinical judgement.

Non-evidence-based treatment (rapeseed oil and flu vaccine avoidance)

Concerns regarding Dr X's clinical decision making were raised by several other interviewees. The review team was informed that Dr X could at times be forceful in expressing their clinical opinion. The review team also heard that Dr X recommended a rapeseed oil-free diet for ILD and flu vaccine avoidance, citing research that was based on animal studies but not recognised by NICE. Some interviewees described Dr X's clinical decision making as outside standard practice for the diagnosis and management of ILD patients (ie outside of British Thoracic Society (BTS), NICE and other national guidelines).

Patient consent

Concerns were raised by some interviewees that not all patients had been appropriately consented for treatment with off-label medication for their ILD diagnosis. However, responses varied among interviewees and the review team was unable to determine whether appropriate consent had been obtained in all cases. Despite this, the review team was informed by some interviewees that patients recruited into the co-trimoxazole trial were appropriately consented.

Co-trimoxazole clinical trial

The review team were informed that Dr X was the principal investigator of a local clinical trial for the use of co-trimoxazole in advanced pulmonary fibrosis (2012–2021). They were told that Dr X's clinical rationale for prescribing co-trimoxazole in UIP/IPF and FNSIP was based on several international human and animal studies, in addition to anecdotal evidence (of a cohort of approximately 9–20 patients). Of note, the clinical trial was terminated in 2021 due to good clinical practice (GPC) breaches. Aspects of the clinical trial are discussed further in Terms of reference D – other issues highlighted.

Antifibrotic treatment

The use of antifibrotic treatment for ILD patients was discussed with interviewees. Some reported a lack of urgency and delayed consideration for antifibrotic treatment by Dr X for their patients. Dr X expressed concerns about complications and side effects associated with antifibrotic medication and indicated a preference for other medications in the first instance followed by nintedanib over pirfenidone for these reasons. In some cases, delays in initiating antifibrotic treatment were attributed to patient choice.

Oxygen and pulmonary rehabilitation

The review team were informed about Dr X's lack of consistent referral to pulmonary rehabilitation and oxygen services for patients who might have benefited. Interviewee responses regarding these services varied. The review team also heard that at the time of this review, there was a good network for oxygen provision locally and regionally and the trust guidance noted that oxygen support was readily available within 2 weeks. It was unclear to the review team whether this guidance was in place when the concerns were raised regarding Dr X's limited and/or delayed referrals for oxygen support.

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7.2.3 MDT working and interactions with members of the wider medical and nursing team

7.2.3.1 Documentation review

Several documents provided by the trust detailed Dr X's lack of, or delays in referring to the local ILD MDT (established in 2019) and the tertiary centre (GSST) for consideration of immunosuppression therapy or antifibrotic treatment.

The trust provided an *ILD pathway flowchart* to the review team. The document was developed in 2020 and outlined a pathway for diagnostic investigations, MDT referral pathways and opportunities for specialist consultant and nurse review.

7.2.3.2 Comments from interviewees

Local ILD MDT

The review team were informed of the historical local ILD MDT meeting arrangements. Prior to 2019, ILD patients were discussed at a weekly respiratory radiology meeting at St Helier Hospital – attended by consultant respiratory physicians, respiratory nurses, junior doctors and two chest radiologists. Both radiologists had a special interest in ILD, with one being an internationally experienced radiologist in that field. The review team heard that there was good attendance from colleagues, including Dr X, and this meeting was used a forum to review patient scans and seek colleagues' advice. While cases were peer-reviewed within this forum by Dr X and their colleagues, the review team were informed that discussions and outcomes were not always captured in a systematic way.

In 2019, an ILD MDT meeting was established at Epsom Hospital and the review team were told that this meeting was intended to replace any existing ILD MDT meetings across the two sites. A proforma was developed to ensure outcomes were properly documented. Some interviewees expressed concerns about the newly established ILD MDT, primarily relating to delays in receiving advice. As a result, some colleagues reportedly chose not to attend and referred patients directly to the tertiary centre instead. One interviewee noted that these concerns were escalated to the clinical director at the time and raised in departmental meetings. However, the review team heard that the concerns remained unresolved.

The review team were informed by clinicians who had been based at St Helier, that the local ILD MDT at Epsom did not function well, and interpersonal relationships became strained creating an 'unhealthy atmosphere' to the point where several colleagues left the trust and there was a breakdown in collaboration and collegiate MDT working with a lack of integration. The review team were told that Dr X did not attend the ILD MDT at Epsom (in person, nor virtually). The review team heard that the local ILD MDT provision changed during the COVID-19 pandemic lockdown (2020–2021) as the consultant teams were not seeing any new patients. It was unclear to the review team whether the local ILD MDT meeting ceased or continued but at a reduced capacity. The review team also heard that Dr X did not use multi-media modalities and was averse to emails, mobile phones and teleconferencing.

Regional ILD MDT

The regional ILD MDT based in GSST was discussed and the review team heard that on average the MDT received approximately 50 new referrals per month from referring centres.

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The process for a district general hospital (DGH) to gain access to antifibrotics was explained: for the patient to receive antifibrotics they would need to be referred to the GSST ILD MDT for discussion and consensus agreement for antifibrotics would be made.

Since the trust's internal review of Dr X's management of ILD cases, the GSST ILD MDT has supported the process of duty of candour to those patients treated by Dr X since 2019.

The review team heard that within the region there is a good ambulatory oxygen support with guidance specifying support to be received within 2 weeks.

Links with the Royal Brompton Hospital

The historical links and referral pathway from St Helier Hospital to the RBH was described to the review team. Dr X joined the trust in 1996 and at that time the regional referral area was Southwest Thames (which included the Royal Brompton Hospital). Dr X having previously worked at the RBH self-referred their ILD patients from St Helier to the RBH. The review team were informed that historically the process for this involved a referral letter from Dr X to an expert chest radiologist at the RBH to seek their opinion following discussion at the St Helier's respiratory radiology meeting. After the St Helier's respiratory meeting was replaced with the ILD MDT at Epsom, Dr X continued to refer to the RBH radiologists and without prior discussion at the local ILD MDT. Patients of Dr X were not routinely discussed at the RBH ILD MDT and review of referrals into this MDT revealed that fewer than 10 patients from St Helier had been formally registered and discussed at the RBH ILD MDT over a period of approximately 10 years. There were no minuted formal referrals going through a recognised pathway.

Interactions with the wider medical team

The review team was informed of communication issues involving Dr X, as raised by resident doctors. At times, communication with Dr X was described as challenging, partly because Dr X was not always available via mobile phone or email. As a result, the review team were told that support available to resident doctors was not always reliable.

7.3 Terms of reference C

To review the management of concerns about Dr X's practice by St Helier University Hospitals NHS Trust and by GESH and give a view on whether opportunities to respond to them at an earlier stage were missed.

7.3.1 Management of concerns about Dr X's practice and opportunities to respond

7.3.1.1 Documentation review

Chronology

A chronology of concerns raised about Dr X's practice was provided by the trust to the review team during the invited review interviews.

The document outlined the following timeline of events:

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- **1999:** Epsom and St Helier Hospitals merge but remained largely separate with respect to services on each site.
- **October/November 2019:** incident 1 Datix regarding the management of a patient with ILD by a locum consultant (not Dr X). During the same period there was an Epsom/St Helier restructure of respiratory services.
- **February 2020:** incident 1 presented to a panel, and an RCA was completed in July 2020 with recommendations including the need for a cross-site ILD SOP.
- **March 2020 – April 2021:** the COVID-19 pandemic imposed pressures on the respiratory service and the focus was shifted to responding to those pressures. Governance meetings stopped during this period. Several experienced consultant respiratory physicians and radiologists left the service. Further Datix reports were submitted between 2020–2021 (concerns regarding Dr X's practice).
- **April – July 2021:** A Maintaining High Professional Standards (MHPS) process was enacted regarding Dr X prescribing of trimethoprim and co-trimoxazole for COVID-19 during the second wave of the COVID-19 pandemic (not for the off-licence use in ILD).
- **February 2022:** ESTH became part of a group structure with St Georges – GESH. There was a change in leadership roles and management structures.
- **July 2022:** Five Datix investigations (raised between 2019–2021) had been closed, these cases were then escalated in July 2022 to be reconsidered and for discussion with executive teams.
- **October 2022:** Executive team discussed the ILD Datix cases regarding Dr X.
- **January – February 2023:** Concerns about Dr X's practice were escalated by the clinical director to the executive team. Dr X was restricted from all clinical duties and an internal fact-finding review was initiated. This internal review was led by an internal consultant urologist.
- **February 2023**: the medicine division at St Helier's entered a GMC enhanced monitoring process. During this time a Higher Education England visit revealed trainees concerns about Dr X.
- **March 2023**: the internal fact-finding review was completed, noting the need for an external independent review.
- **April 2023**: GMC liaison regarding Dr X commenced.
- **May 2023**: May 2023: an investigation into concerns raised about Dr X was initiated. Local restrictions were placed by the organisation on Dr X's clinical practice to ensure patient safety.

Of note, the above timeline refers to five specific Datix reports concerning a cohort of eight patients. These five Datix reports were noted to have been closed by the trust's Quality team. Further details about the management of those Datix concerns are provided within the rapid review report below.

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Individual review report

Rapid review report

The trust provided a *rapid review report* to the review team (dated January 2023). The report identified eight patients who had been under Dr X's care for whom a Datix report had been raised (since 2019).

These were addressed as follows:

- five Datix reports were closed with a generic response provided. The generic response noted that the case(s) had been escalated (to the clinical lead for respiratory services, clinical director for medical specialties and the chief medical officer) and that no further input from the quality team was required at that stage and the incident(s) were closed.
- one Datix was recorded to have been assigned to a member of the Quality team and was closed following 'feedback provided'. There were no further details provided to the review team regarding the details of that feedback.
- one Datix remained open. No further details about the outcome were provided to the review team.
- one Datix received a full investigation.

Trust reflections

The trust provided a *chronology* document to the review team during the interviews. Within this document there were a series of reflections and questions with respect to potential opportunities to respond to concerns regarding Dr X's clinical management of patients with ILD.

These were listed as follows:

- An RCA was completed in 2020, were these recommendations followed and embedded by the respiratory team?
- What was the role of the pandemic in delaying investigations into the Datix reports? Did the devolved governance and medical workforce structures during this time contribute?
- Did historic interpersonal issues between colleagues with leadership roles contribute?
- Appraisal processes during the height of COVID-19
- Performance monitoring

Management of concerns

There were no documented concerns about Dr X provided to the review team for the period 1999 – 2019.

Concerns regarding the respiratory service were initially identified in 2013 – 2014 but were not specific to Dr X. Those concerns were raised by the current clinical director (current at the time of this review) regarding a consultant respiratory colleague's clinical practice. An external invited review took place during this period.

The review team were provided with details of five Datix reports raised between 2020 – 2021 which had been closed with no further investigation. In July 2022, these five Datix cases were escalated to the executive team for investigation.

Between the period March 2020 – July 2022 there was no documented evidence provided to the review team for the escalation nor further investigation into the Datix reports raised with respect to Dr X's practice. Upon escalation of those five Datix cases to the executive team in July 2022 there was documented evidence for an internal fact-finding review and a rapid review initiated in January 2023.

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From the period October 2022 – October 2024 there were several governance reports led by the executive team provided to the review team.

These included actions and progress updates specific to:

- ensuring that the care of existing patients previously under the management of Dr X with a diagnosis of ILD met best practice standards including review within the ILD MDT
- recommendations specific to the ILD diagnostic and treatment pathways
- duty of candour to those patients with ILD treated by Dr X
- an appreciative inquiry to ensure a supportive and restorative approach to cultural challenges faced within the respiratory team
- lessons learned about raising and responding to concerns.

7.3.1.2 Comments from interviewees

Datix reports (2019–2021)

The review team discussed with interviewees, the process of raising concerns about the management of ILD patients. The review team heard that several Datix reports had been raised with respect to Dr X's off-licence and non-evidence-based treatment regimens for ILD (between 2019–2021). A key theme that arose was a lack of clarity regarding the outcome of those Datix reports. The review team were informed that many of the Datix reports were closed without further investigation and without a clear reason provided for their closure. The explanations given by members of the clinical team involved in managing these Datix reports were conflicting and, at times, adversarial.

RCA recommendations (2020)

The review team discussed with interviewees their views on the opportunities available to respond to the concerns raised about Dr X's practice. Some staff queried the process of enacting recommendations from an earlier RCA completed in 2020 and whether there may have been opportunities to address issues around MDT referral pathways and treatment choice with the development of an agreed SOP at an earlier stage. The trust did not provide the RCA document as part of the documentation review. The review team heard that the development of an SOP had since been agreed – led by the new respiratory lead following her appointment in March 2024. The delayed implementation of these recommendations (between 2020 and 2024) was reported to be due to the impact of the COVID-19 pandemic.

Raising concerns about Dr X (2019–2022)

Several interviewees informed the review team that their concerns about Dr X were reported to staff in relevant leadership roles and via other channels including 'Freedom to Speak Up' but without any subsequent urgent action taken (between 2019–2022). Some interviewees informed the review team that despite being told that their concerns were being dealt with, there was no feedback or communication provided about the progress of this.

Several interviewees raised concerns about the culture, attitudes and behaviour of one clinician in a leadership role (not Dr X). Many did not feel confident in their ability to lead – based on their approach to disagreements, conflict and challenge, such that the term 'bullying' was used by some interviewees. The review team were also informed of historic tensions between two consultants in leadership roles (neither including Dr X nor the newly appointed respiratory lead), which potentially contributed to a lack of collaborative and cohesive working. Several staff reported feeling that there was a lack of a supportive

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culture across both sites for raising concerns, as well as a lack of clarity about how such concerns would be addressed.

COVID-19 pandemic (March 2020 – April 2021)

The COVID-19 pandemic was highlighted to the review team by some senior leaders at the trust as a key factor influencing the chronology of events. The review team was informed that the pandemic impacted governance arrangements and oversight. Between the period March 2020 – April 2021, oversight was reportedly reduced due to the reduced frequency of governance meetings. Appraisal processes were also streamlined as resources were redirected to other priorities.

Post COVID-19 restrictions (June 2021 – 2024)

The review team were told that during a respiratory team meeting (held in summer 2021), all staff (including Dr X) were advised with immediate effect to stop any use of non-evidence-based treatment for ILD. Two interviewees informed the review team that the practice did not stop at this point. It was unclear to the review team how the process regarding those patients on co-trimoxazole within the clinical trial were managed up until its closure and afterwards. Themes related to the clinical trial were considered outside of the terms of reference for this review and raised under terms of reference D.

The review team were informed that since the concerns were escalated to the executive team in July 2022 a rapid review and an internal fact-finding review were implemented in January 2023 and a new respiratory lead was appointed in March 2024.

Implementation of the findings from the trust's internal reviews (2023 up until the time of this invited review)

At the time of this RCP invited review, the newly appointed respiratory lead was overseeing the implementation of the recommendations identified in the internal reviews. The review team was informed that since the respiratory lead's appointment in 2024, initiatives aimed at improving the ILD service had been making progress.

The review team were informed of:

- an ILD specific task and finish group to implement recommendations from internal reviews
- a recent audit of the ILD service
- better cross-site working following formalised fortnightly ILD MDTs with attendance from general respiratory nurses (one nurse takes an interest in ILD), radiologists, consultant respiratory colleagues, the GSST ILD MDT lead and a specialist nurse from GSTT. The review team were told that a rheumatologist with ILD interest also attends. The ILD MDT doesn't currently have pharmacy input but there have been discussions with the pharmacy teams to recruit in a 0.5 WTE to the local ILD service
- duty of candour processes for all patients with ILD treated by Dr X between 2019 –2022
- a formalised mycophenolate mofetil pathway in development (at the time of this review patients were referred to the tertiary centre for mycophenolate mofetil treatment).

7.4 Terms of reference D

Highlight any new area of concern that arises during the invited review.

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7.4.1 Clinical trials

7.4.1.1 Documentation review

The trust provided the review team with research audit reports relating to two clinical trials for which Dr X was the principal investigator. One related to a single centre, double-blind, randomised, placebo-controlled study of co-trimoxazole in advanced pulmonary fibrosis and the other study assessed the benefit of modafinil in COPD with type 2 respiratory failure. The review team did not consider the documentation relating to the modafinil study as this was outside the remit for this invited review and not related to ILD.

The trust provided a *Good clinical practice audit report* to the review team that highlighted 10 major findings with respect to the co-trimoxazole trial (with one of the findings noted as borderline critical). The key themes included breaches with respect to essential documentation, patient consent, staff training records, pharmacy dispensing guide and investigational medicinal products reconciliation, sponsor oversight, site standard operating procedures and case report forms. Key recommendations included a more frequent review of research standard operating procedures, the development of a working practice guideline, development of a SOP covering document version control of study source data, a database to reflect study status and study amends, periodic staff training on good documentation practice, and that patient information sheets and informed consent documentation should have the same version number, date, IRAS identification.

The review team were not provided with current good clinical practice updates, or whether these recommendations had been enacted as this item was not specific to the agreed terms of reference.

7.4.1.2 Comments from interviewees

Supporting statements

Supporting statements provided by Dr X's former consultant colleagues referenced the co-trimoxazole trial for which Dr X was the principal investigator. Dr X's former consultant colleagues praised Dr X's research skills highlighting their expertise and experience of publishing peer reviewed articles. One interviewee noted that Dr X's initial results showed improvement in the clinical outcomes of the patients on co-trimoxazole and as a result, a larger national trial was conducted. The review team could not triangulate supporting evidence for this assertion within the documentation provided by the trust.

Eligibility criteria

Concerns were raised regarding the eligibility criteria for those patient's recruited to the co-trimoxazole trial. It was noted by one interviewee that many patients did not have a differentiated ILD diagnosis and were labelled as 'unclassified ILD', apart from Dr X's patients many of whom had idiopathic pulmonary fibrosis (IPF).

Closure of the trial

The review team were informed that the co-trimoxazole clinical trial was halted in 2021 due to the GCP breaches and that patient recruitment ceased at that point. It was unclear to the review team how these patients were managed following the termination of the study, and whether any patients were treated with co-trimoxazole outside the scope of the clinical trial.

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7.4.2 Nurse-led clinics

7.4.2.1 Documentation review

No documentation specific to nurse-led clinics was requested from or received by the trust, as this was outside the review team's terms of reference.

7.4.2.2 Comments from interviewees

The review team were informed of the process for patient's referred via GP to the Epsom and St Helier respiratory service. Those patients who presented with respiratory symptoms were filtered to either a nurse-led or consultant-led clinic, historically this occurred via an administrator and sometimes an automatic filter system would facilitate this process. The review team heard that the filtering processes required improvement. Nurse-led clinics were described to the review team. Within the nurse-led clinics a CNS would perform spirometry, and based on the patient's test results (spirometry, X-rays etc) the patient would be seen by a respiratory clinician.

In general, the patient would be under the care of one consultant rather than multiple consultants. However, the review team learned that there was no named consultant, nor where there any external governance arrangements to oversee this part of the service.

7.4.3 Behaviours, culture and clinical leadership

7.4.3.1 Documentation review

No documentation specific to behaviours, culture and clinical leadership was requested from the trust or received by the review team, as this was outside the review team's terms of reference.

7.4.3.2 Comments from interviewees

Behaviours and culture

The review team was informed of a historical tension between the Epsom and St Helier sites, with previous poor working relationships described. However, the review team was reassured by several interviewees that, with new staff in post, cross-team working had significantly improved.

The review team heard that the trust-led review of Dr X's practice had a significant emotional impact on the respiratory teams, and particularly the nursing teams. An appreciative inquiry was carried out by the trust to support the respiratory department through this difficult time; however, the review team was informed that the feedback from the inquiry had yet to be disseminated. It has subsequently been clarified that two feedback sessions had been held with the respiratory department in 2024, led by the relevant executives and the person who conducted the appreciative inquiry. Other methods of support were raised – including monthly departmental meetings, which some interviewees indicated had a recent positive effect on morale.

Clinical leadership

The current specialty medicine clinical director (CD) did not have the full support of the respiratory department. There was a division of opinion among interviewees. While the review team was informed

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that their leadership style and support were effective in terms of decision making and clarity of thought, others did not feel empowered to approach them for advice or to raise concerns.

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8 References

[1] Royal College of Physicians. National Mortality Case Record Review Programme. https://www.rcp.ac.uk/improving-care/resources/national-mortality-case-record-review-nmcrr-programme-resources/ [Accessed 25 July 2025]
[2] National Confidential Enquiry into Patient Outcome and Death. NCEPOD grading system for use by case reviewers. http://www.ncepod.org.uk/grading.html [Accessed 25 July 2025]
[3] National Confidential Enquiry into Patient Outcome and Death. https://www.ncepod.org.uk/ [Accessed 25 July 2025]

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9 Appendices

9.1 Appendix 1: Documents received and reviewed

Clinical record review	
To conduct an independent clinical record review of the medical records of patients with a diagnosis of ILD since 2019 who received care from Dr X.	• 20 index patients identified by the internal review conducted by GESH • 10 randomly selected patients from the list of those included in the internal review: every 10th new patient diagnosed with ILD starting from 2019.

Individual review documentation
Organisational-level information
GESH quality committees in common report October 2024
Corporate structure 2023
Medicine leadership structure April 2023
Medicine organisational chart May 2023
Trust structure 2018
Executive's team meeting (ETM) report for ILD
ETM report timeline
Dr X
Dr X's job plans March 2020 – March 2024
Dr X's appraisal summary May 2022
Dr X's personal development template 2022
Dr X's certificate of attendance BSACI 2022
Dr X's CPD diary 2022
Details of concerns raised with the trust about Dr X
ILD original case finding November 2023
Dr X's ILDlist October 2022 to March 2023
Rapid review report ILD January 2023
Roflumilast and O2 review
Complaints 2022
ILD specific complaints
Incident policy

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Individual review report

360 feedback analysis
Friends and family feedback 2022
Patient feedback 2022
Fact-finding report in relation to the care provided to ILD patients
GMC query regarding Dr X
Doctors in training
Medicine respiratory training feedback 2021–2022
Activity and outcome data for Dr X
Inpatient and outpatient activity data 2019 to 2023
Example medicine mortality review summary February 2019
ILD MDT operational policy
ILD pathway map
Clinical governance
Risk management policy
Policy for mortality reporting and mortality peer review process
ILD audit January 2025
Trust clinical audit policy 2018
Audit co-trimoxazole CI response May 2021
Audit Modafinil CI response May 2021
Audit report co-trimoxazole in APF January 2021
Audit report Modafinil January 2021
Audit reports from MHRA and associated letters
Audit and quality meetings 2022
Clinical audit policy
Confirmation to close studies May 2021
Notification of serious breach form
Research activity 2022
Significant events 2022
Sponsor report March 2021 (co-trimoxazole)
Sponsor report modafinil March 2021
Governance policy

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Statements received prior to interviews
A total of three written statements were received from Dr X's former colleagues
A total of two written statements were received from interviewees prior to the interviews
Documents received during interviews
ILD timeline/chronology

9.2 Appendix 2: Interviews

Monday 24 March 2025 (day 1)	
REDACTED	REDACTED
REDACTED	REDACTED
REDACTED	REDACTED
REDACTED	REDACTED
	REDACTED
	REDACTED
REDACTED	REDACTED
REDACTED	REDACTED
	REDACTED

Tuesday 25 March (day 2)	
Nurses	REDACTED
REDACTED	REDACTED
	REDACTED
	REDACTED
REDACTED	REDACTED

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Individual review report

Tuesday 25 March (day 2)	
REDACTED	REDACTED
REDACTED	REDACTED
REDACTED	REDACTED

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9.3 Appendix 3: Letter summarising initial feedback dated 11 April 2025

Dr Richard Jennings
Group Chief Medical Officer
St George's, Epsom and St Helier
University Hospitals and Health Group

BY EMAIL ONLY

PRIVATE AND CONFIDENTIAL

11 April 2025

Dear Dr Jennings,

Royal College of Physicians Invited Review: St George's, Epsom and St Helier University Hospitals and Health Group (GESH), respiratory medicine individual review

We are writing to confirm the immediate feedback that was provided to you and your colleagues Mr James Blythe, ESTH managing director and Dr Becky Suckling, ESTH chief medical officer at the verbal feedback session on Tuesday 25 March 2025, the final day of the invited individual review of the respiratory medicine practice of 'Dr X'.

The review team gathered a substantial amount of information from reviewing the 30 clinical case records, the interviews held and the documentation provided and is now considering these against the agreed terms of reference. The review team summarises its immediate feedback below.

Terms of reference A: To conduct an independent clinical record review of the medical records of patients with a diagnosis of ILD since 2019 who received care from Dr X.

This concerned the review of 30 clinical case records (20 index patients identified by the internal review conducted by GESH and 10 randomly selected patients from the list of those included in the internal review: every 10th new patient diagnosed with interstitial lung disease (ILD) starting from 2019).

The review team used a structured judgement review (SJR) form adapted from the RCP National Mortality Case Record Review (NMCRR) Programme to independently examine the care that each patient received, in addition to a grading system originally developed by the National Confidential Enquiry into Patient Outcome and Death (NCEPOD) to give an overall perspective on the quality of care. The review team also included an independent assessment of whether the management of these patients with ILD by Dr X resulted in any harm, and if so, to what degree of harm (see Table 1. Degree of harm).

Table 1. Degree of harm

Grade	Degree of harm
No harm	Impact was prevented, or impact was not prevented but no harm occurred
Low harm	Minimal harm – the patient required extra observation or minor treatment
Moderate harm	Short term – the patient required further treatment or procedure or was not given treatment which may improve quality of life

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Severe harm	Permanent or long-term harm – the patient did not have access to treatments which are evidenced as standards of care to improve quality of life or was given treatment(s) which have limited or no evidence of clinical benefit
Death	Death – the patient did not have access to treatments which are evidenced to potentially extend life

Clinical record review results

Table 2. Quality of care (30 cases)

NCEPOD grade	Number
Good practice	2[7]
Room for improvement (clinical factors)	7
Room for improvement (organisational factors)	0
Room for improvement (clinical and organisational factors)	1
Unsatisfactory	18
No grading	2[8]

Table 3. Assessment of harm (28 cases)

Harm	Number
No harm	5
Low harm	1
Moderate harm	7
Severe harm	12
Death	3

The RCP IR final report will provide a comprehensive analysis of the cases reviewed. High-level themes are listed below.

Dr X's initial assessment and investigations

The review team found that:

- Dr X's respiratory history taking was inconsistent and lacked important detail, particularly with respect to relevant respiratory symptoms, functionality and occupational history.
- Dr X's clinical examination was limited or lacking at initial assessment.
- There was evidence of access to comprehensive cardio-respiratory function testing including full lung function tests, oxygen assessment, 6-minute walk tests and echocardiography. However, there was highly selective reporting of these test results by Dr X.
    - There was reference to decision making being influenced by handheld spirometry rather than the formal lung function tests.

[7]Dr X managed the patient's initial stage of care (ie investigations and assessments) in one of the two cases graded as good practice, in the other case graded as good practice Dr X was not involved. The care of that patient was overseen by Dr X's consultant colleagues.

[8] The review team felt that one case was not relevant for this review having had no input from Dr X nor having a clear diagnosis of ILD and the other case had insufficient information to inform an overall grading. These two cases were excluded from the clinical record review.

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  - Some patients had pulmonary hypertension identified but this was potentially ignored, these patients had no follow up and, in some cases, presented with severe pulmonary hypertension at a later stage.
  - The review team identified that the lung imaging (radiology) and reporting was of high quality with comprehensive detailed reports provided in a timely fashion. However, for some patients, the review team found that the radiology scans and reports were often misinterpreted by Dr X.
- Common and complex respiratory cases were not referred for regional ILD multidisciplinary team (MDT) assessment to confirm and formalise their diagnosis and aid treatment planning.
- Some cases were insufficiently investigated to secure an accurate diagnosis. In two cases there were missed diagnoses; one of antisynthetase syndrome and another of anti-neutrophil cytoplasmic antibodies (ANCA)-associated vasculitis, which should have been identified within a specialised clinic. As a result, these patients were denied timely access to immunosuppression.
- It was noted during an inpatient stay that occupational therapy/physiotherapy/respiratory nurses were available for this cohort of patients, yet no reference to their involvement was made by Dr X in the outpatient setting.

Dr X's treatment plans

The review team found that:

- Within the expected framework of providing a comprehensive specialised ILD service, there were elements missing, including a lack of referral for patients requiring smoking cessation, pulmonary rehabilitation, oxygen assessment, and timely referral to palliative care when appropriate.
- Several patients had clear objective evidence for steroid/immunosuppressive responsive ILD but no immunosuppression was given. For example, in one case a HRCT scan was consistent with hypersensitivity pneumonitis showing 'extensive ground glass appearance' in 2009, but no immunosuppression was started until 2023.
- Dr X frequently advised and prescribed antibiotic use in idiopathic pulmonary fibrosis (IPF) (eg trimethoprim and Septrin), often within the local GESH trial, and usually without other proven standard of care treatment options being considered.
- There was frequent use of non-evidence-based treatments for fibrotic non-specific interstitial pneumonia (NSIP) and IPF (roflumilast, folic acid, rapeseed free diet, advising patients against flu and COVID-19 vaccination).
- There was evidence within the clinical notes of a diagnosis of asthma/airways disease with bronchodilator prescription when the clinical features and lung function tests were not consistent with these diseases and thus the patient was unlikely to benefit from these treatments.
- Dr X performed appropriate monitoring respiratory function and/or radiology imaging but commonly attributed deteriorating patient symptoms or results to other factors, including:
  - breathlessness due to anxiety
  - breathlessness due to lack of weight reduction
  - breathlessness due to lack of engagement with Dr X's exercise recommendations
  - reduced lung function due to the patient having done it on a 'cold day', 'hot day' or 'following exertion'
  - exercise or resting hypoxaemia due to Raynaud's phenomenon
  - intercurrent infection or allergy
  - technical issues with lung function equipment.

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The review team accept that breathlessness, for example, is multi-factorial but for these patients there was clear evidence of deteriorating lung function and/or radiology due to the ILD as the main reason for their deteriorating symptoms.

Evidence of communication with colleagues

Across the sample of cases reviewed there was limited evidence of communication with colleagues about patient care for the ILD cases reviewed by the IR team. Dr X was preferentially referred patients with ILD by their colleagues at St Helier Hospital and was allowed to manage these patients independently.

Within the clinical notes Dr X referred to a 'lung MDT', however, the MDT meeting proforma was not fully completed and it was unclear to the review team who was present or what the clinical outcomes were. The review team determined this was a local St Helier's respiratory radiology meeting.

When the local GESH ILD MDT meeting was established at Epsom Hospital in 2019, Dr X did not contribute to it, nor were their patients discussed there. However, the review team determined that this was held exclusively at the Epsom site and had no teleconferencing/MS Teams facility initially.

Occasionally, Dr X's patients were discussed at the Guy's and St Thomas' (GSTT) regional ILD MDT meeting chaired by Dr. Alex West, ILD clinical lead at GSTT. The review team were informed that the meeting had teleconferencing facility. Dr X never attended (physically or virtually) or contributed to that meeting and in some of the cases reviewed, the review team found that Dr X did not implement the management recommendations from the GSTT ILD meeting.

Dr X had a longstanding arrangement with respiratory radiology consultants working at the Royal Brompton Hospital (RBH), whose advice about relevant lung imaging they would request by letter, often with a comprehensive reply. The review team found that, on occasion, Dr X did not action the outcome from these RBH radiology assessments. Dr X's cases were not systematically referred to or discussed at the RBH ILD MDT meeting.

In cases requiring input from other specialists, such as rheumatologists or oncologists, there was limited evidence that this was sought directly by Dr X.

The review team consistently found that they were unable to determine the primary ILD diagnosis and treatment plan from Dr X's letters and thus believe that primary and secondary care colleagues would similarly be unclear what the outcome of each consultation with Dr X entailed.

Interactions with patients and their family

The review team found that Dr X was readily available to see patients and their letters demonstrated their willingness to give an opinion on non-respiratory conditions. Dr X's letters, however, were not routinely addressed to the patients or copied to them.

Dr X's letters contained advice which reflected their strongly held opinions, but which was not sufficiently supported by evidence, eg prescription of trimethoprim and Septrin, avoidance of rapeseed oil, the influenza vaccine 'causing fibrosis', the COVID-19 vaccine having a similar effect. In those cases, the advice provided to patient's was contrary to public health guidance, potentially putting vulnerable patients at risk.

Clinical record keeping

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The review team found that Dr X's letters lacked organisational structure – there was often a 'stream of consciousness' offering the reader little understanding of the relevant clinical narrative.

Observations made in the cases reviewed included:

- Relevant findings (positive and negative) from history and examination were not recorded.
- Frequently ILD diagnoses were not well explained with no specific diagnosis recorded.
- Lack of explanation for decision making, many of which were non-standard and non-evidence-based.
- Limited reference to MDT engagement and discussions.
- Limited recording of therapeutic history of previous treatments, rationale for stopping treatment and management plans.
- Letters did not accurately reflect evidence of radiological progression identified by CT scans, deteriorating lung function or implications of desaturations on 6-minute walk tests (ie misinterpreting objective trends).
- No documentation to suggest that patients were supported to give up smoking, eg patients were not referred to local smoking cessation services.

Terms of reference B: To consider concerns about the clinical work of Dr X with specific reference to activity and outcomes, clinical decision making, implementation of treatment plans, MDT working and interactions with members of the wider medical and nursing team. This will include determining the professional relationship with colleagues at the Royal Brompton Hospital.

- Dr X was given 1 PA (programmed activity) to provide the local ILD service. They had responsibilities to general medical ward admission patients as well as providing general respiratory medical support to acute admissions.
- There was no meaningful MDT engagement by Dr X, either locally or regionally, by them or for their patients with ILD. Often patients were denied a timely referral to be discussed at the regional ILD MDT meeting.
- The arrangements with the RBH have been described in TOR A above.
- The review team heard that Dr X contributed to a St Helier respiratory radiology meeting. There was no documentation available from this meeting about who was present, the cases under discussion, or the clinical management plan agreed.
- The review team found that all the written statements from Dr X's respiratory colleagues at St Helier were positive stating that they were a good colleague, who cared about their patients, were supportive to their consultant colleagues and were viewed as the local ILD expert with no concerns regarding their practice.

Terms of reference C: To review the management of concerns about Dr X's practice by St Helier University Hospitals NHS Trust and by GESH and give a view on whether opportunities to respond to them at an earlier stage were missed.

The review team heard various accounts about the raising of concerns in relation to the ILD service over several years including differing accounts of how matters raised using the Datix system were managed.

The RCP IR final report will include reflections on whether opportunities to respond to concerns at an earlier stage were missed.

Terms of reference D: Highlight any new area of concern that arises during the invited review

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Clinical trial

Dr X was the principal investigator (PI) in a single centre research trial, which had local ethics approval. A recent external audit identified several protocol violations of this trial resulting in its closure.

The RCP IR final report will include some reflections on this trial and its supervision and management.

Nurse-led clinics

The IR team noted that at least two of the cases reviewed were seen as 'new' patients referred from primary care in a nurse-led clinic as 'general' undifferentiated respiratory referrals and were treated initially, incorrectly as asthma. These clinics appeared to have limited consultant support, with no named consultant, limited escalation and external governance.

The RCP IR final report will include reflections on nurse-led clinics and their supervision and management.

Behaviour

Throughout the interviews the review team consistently heard accounts of the challenging relationships with unprofessional behaviours being demonstrated within the Epsom and St Helier respiratory department, including terms such as 'undermining' and 'bullying' being used. This has not contributed to good patient care and will be discussed further in the RCP IR final report.

The current specialty medicine clinical director (CD) does not have the full support of the respiratory department. The review team were told that his leadership style was effective in terms of decision making and clarity of thinking, but the review team felt that his approach did not foster an open and supportive atmosphere whereby team members felt empowered and safe to raise any potential future problems.

Recommendations to commence and/or implement prior to the issue of the report to address any potential patient safety concerns

The review team were very impressed with the new ILD and respiratory department lead Dr Jennifer Martinovic. Dr Martinovic has led the review of the ILD cases with great compassion and professionalism supported by the CD. The review team believe that the trust has made several positive changes in the light of the trust's internal review. Many of our recommendations listed below, to help support the respiratory department, are already starting to be implemented, and the review team had confidence in Dr Martinovic and her team's ability to continue this work if given ongoing trust backing.

Interstitial lung disease (ILD) multidisciplinary team meeting

- The trust should support the development of a cross-site interstitial lung disease multidisciplinary meeting (ILD MDT) with the facility for staff to dial in (via MS Teams/teleconference) to discuss all relevant ILD patients.
- All patients with suspected ILD should be referred to the ILD leads within the Epsom and St Helier sites and be discussed in the cross-site ILD MDT meeting.
- A rheumatologist should be invited to attend the ILD MDT meeting when patients with suspected systemic autoimmune rheumatic diseases (SARD-ILD) or connective tissue disease (CTD-ILD) are presented. If the rheumatologist is unable to attend, an alternative option may be that the rheumatologist provides a letter/statement in time for the ILD MDT.

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- The ILD MDT meeting should be incorporated into the job plans and appraisals of the ILD lead physicians and allied healthcare professionals.

Respiratory departmental meeting

- All respiratory team members should have the weekly cross-site departmental meeting incorporated into their job plans.
- Datix reporting should be reserved for incidents affecting patient safety. All other departmental concerns should be openly and transparently discussed in the weekly cross-site respiratory departmental meetings.

Governance meetings

- The trust should ensure that regular departmental clinical governance meetings take place, including mortality and morbidity (M+M) meetings with clear terms of reference for those patients who should be discussed. These meetings should encourage and support engagement from all members of the multidisciplinary team, with pathways for timely dissemination of good practice and learning from audit, Datixes, case reviews, and service evaluation projects, to the wider team.
- Timely feedback to the department regarding updates of inquiries and meetings is needed. For example, the review team heard from several staff that the appreciative inquiry has not been fed back to the respiratory directorate and the review team recommend this happens as soon as possible.
- All Datix reports and investigations should be fed back to the reporter and wider respiratory team in a timely, accurate and sensitive manner.

Pathways

Assessment pathways:

- If patients are deemed to require a lung biopsy, they must be discussed in the regional ILD MDT.

Referral pathways:

- A clear pathway is needed for referral of ILD patients from the local ILD MDT at GESH to the regional GSTT ILD MDT. The pathway should be developed in conjunction with the GSTT regional ILD service and should have clear referral criteria. The number of referrals to the GSTT tertiary ILD MDT should be audited on an annual basis so that trends can be identified in the future.
- The trust should ensure clear pathways for referral of respiratory patients to CNS clinics with appropriate escalation pathways and a named supervising respiratory consultant.
- Clear pathways should be developed for smoking cessation, pulmonary rehabilitation, oxygen assessment (ambulatory and long-term therapy) and palliative care.

ILD clinic

- The trust should support the development of dedicated ILD clinics at each of the Epsom and St Helier sites. The clinics should be led by respiratory physicians with an interest in ILD and supported by an ILD specialist nurse across both sites.
- The trust should support the development of a system for establishing and monitoring ILD patients starting and established on immunosuppressive therapy and future planning for the proposed national devolvement of prescribing of antifibrotic therapies to local centres.

Continuing professional development (CPD)

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- Respiratory physicians with an interest in ILD should demonstrate continuing professional development (CPD) that is ILD specific within their annual appraisals. For example the ILD team should be supported to attend educational events related to ILD updates at a regional and national level as part of CPD and supporting professional activities (SPA).
- The above recommendation also applies to CNSs working in these roles, who should be able to demonstrate appropriate CPD and engagement with regional/national education.
- Respiratory physicians with an interest in ILD should attend local and regional ILD MDTs and detail this in their appraisal supporting evidence.

Workforce

- It is challenging for eight respiratory consultants across two sites to cover such a large catchment area. The trust should continue efforts to meet these workforce challenges with consultant and allied healthcare professional recruitment.
- The review team support the aims for ongoing cross-site working and having a unified respiratory team.
- The trust must invest in recruitment of a specialist ILD nursing team and pharmacy support for monitoring patients on antifibrotic and immunosuppressive therapies.

Leadership

- The review team were told that the current clinical director had a wide leadership portfolio and considered whether his leadership role should be focused on other areas of the specialty medicine portfolio but not respiratory medicine going forwards.

Wellbeing

- All members of the respiratory department require the provision of confidential emotional and psychological support provided by an external body during what is a difficult time.

I hope this letter is clear and helpful in summarising the review team's immediate feedback on these matters at the conclusion of the review visit. The team will now work to prepare and finalise the RCP IR final report.

Yours sincerely,



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Co-chair of the invited review

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9.3 Appendix 4: Phases of care

9.3.1.1 Initial investigations and assessments

The review team were asked to consider evidence for the appropriateness of the patient's initial assessment and investigations.

The gradings were as follows:

- Excellent care (n=5), RCP 11, RCP 12, RCP 17, RCP 18, RCP 30
- Good care (n=4), RCP 1, RCP 4, RCP 20, RCP 27
- Adequate care (n=8), RCP 3, RCP 5, RCP 7, RCP 8, RCP 14, RCP 16, RCP 19, RCP 25
- Poor care (n=8), RCP 2, RCP 6, RCP 10, RCP 13, RCP 15, RCP 22, RCP 23, RCP 24
- Very poor care (n=1) (RCP 28)
- Four cases were not graded (three due to insufficient information (RCP 9, RCP 21 and RCP 26) and one was not relevant to this review (RCP 29)).

9.3.1.1.1 Good care

Of the nine cases graded as 'excellent care' or 'good care' for the phase 'assessment and initial investigations', Dr X was responsible for three of those patients (RCP 4, RCP 17 and RCP 30). In the remaining six cases, the initial assessments were managed by Dr X's colleagues (RCP 1, RCP 11, RCP 12, RCP 18, RCP 20, RCP 27). Across the nine cases managed by Dr X and their colleagues there was evidence within the clinical notes for a comprehensive range of assessments and investigations performed to evaluate the patients' respiratory health. These included lung function tests, spirometry and shuttle tests to assess lung volume, capacity and gas exchange. Autoimmune (AI) screening through blood testing was also carried out to detect autoimmune disorders. Other diagnostic tests such as CT scanning, high resolution CT scans, BAL and bronchoscopy were requested to assess the presence and progression of ILD.

9.3.1.1.2 Adequate care

Of the eight cases graded as 'adequate' for this phase of care, Dr X was responsible for six of those patients (RCP 3, RCP 5, RCP 14, RCP 16, RCP 19, RCP 25). In the remaining two cases the initial assessments were managed by Dr X's colleagues (RCP7 and RCP 8). Across the eight cases managed by Dr X and their colleagues the review team graded these cases 'adequate' (rather than 'good') as there were potential missed opportunities for connective tissue disease screening, BAL, assessments for avian precipitants, or lung function tests.

9.3.1.1.3 Poor care

Of the eight cases graded poor care, Dr X was responsible for the initial assessment and investigation for six of those patients (RCP 6, RCP 13, RCP 15, RCP 22, RCP 23, RCP 24). Dr X also oversaw the care of case RCP 28, which was graded as very poor for this phase. The remaining two cases were overseen by Dr X's colleagues (RCP 2, RCP 10).

In the six patients overseen by Dr X, the review team identified the following aspects of poor care:

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- In case RCP 6, there was reference to a diagnosis of hypersensitivity pneumonitis made in 2008 and the patient commenced on steroids at that point. The patient was referred in 2014 to Dr X (and remained under the care of Dr X until 2023). In 2014 there was evidence in the clinical notes for allergy, lung function, shuttle and blood tests performed (without an AI screen documented). The lung function tests showed severe impairment, which was not mentioned in Dr X's clinical letters. Between 2014 and 2016 there was no onward referral for consideration of ambulatory oxygen or a myositis screen, despite demonstrable desaturation. There was no referral to a tertiary centre for specialist advice until 2016 when a referral was made to the Royal Brompton Hospital (RBH) (a delay of 2 years). Of note, there was no information within the clinical notes pertaining to the period 2008–2014.

- In case RCP 13, a diagnosis of sarcoidosis was made in 1990 and the patient commenced on steroids at that point. In 2014, the patient had a sarcoid complication of anterior uveitis. The patient had a history of hypertension, glaucoma, asthma and spinal arachnoid cyst. Dr X reviewed the patient from 2019–2023. Between 2017 and 2023 there was one recorded pulmonary function test performed (in 2017), CT scans were performed in 2015, 2018 and 2022 and several basic spirometry tests documented throughout this period (2019–2023). There was no evidence within the clinical notes for a cardiac MRI to assess involvement of the heart with respect to sarcoid disease or regular echocardiograms to assess pulmonary hypertension secondary to sarcoidosis. Between 2019 and 2023 there was no evidence for referral to a tertiary centre for specialist advice.

- In case RCP 15, a referral was made to the respiratory service for this patient with chronic cough and shortness of breath in 2018. Initially, the patient was documented to have been reviewed in the nurse-led clinic. The patient was known to Dr X between 2018 to 2023, although Dr X did not formally review the patient in their designated clinic (there is no documentation outlining the reason for this). There was evidence of discussion between the nursing team and Dr X on many occasions, however, all the documentation provided is from nurse correspondence. There was evidence in the clinical notes of a positive nitric oxide test, positive skin test for allergens and a negative bronchial hyperactivity test. A shuttle walk test noted significant desaturation and prompted discussion between the nurse and Dr X. This resulted in the request for an echocardiogram, HRCT and pulmonary function tests. The CT scan was reviewed by the interstitial lung disease specialist radiologist at the RBH in 2019, which concluded features consistent with hypersensitivity pneumonitis. Bronchoscopy was performed in 2019, but BAL was not undertaken. Of note, there were frequent investigations documented between 2018 to 2023 but without a clear management plan recorded by Dr X.

- In case RCP 22, a referral was made to the respiratory service for an assessment of frequent exacerbations of asthma for this patient in 2019. Initially, the patient was documented to have been reviewed in the nurse-led clinic. There was evidence in the clinical notes of a normal spirometry function test and improvement in breathlessness and cough following the prescription of Fostair (an inhaler used to help manage asthma or COPD symptoms). In the following 3 months it was documented that the patient suffered with breathlessness and a cough, with a 4–5-day course of antibiotics making no difference to their symptoms. A HRCT was performed, and bronchiectasis was noted. Eight months later Dr X requested a repeat CT and reported this as stable with 'old asbestos marks on chest X-ray'. Despite the repeat CT showing asbestosis, bronchiectasis and fibrosis, the patient was discharged without further assessment.

- In case RCP 23, a gastroenterology referral was made to the respiratory team regarding a patient with retrosternal burning pain and cough (for 1 year) in 2021. The patient was reviewed by Dr X between 2022 and 2024. There was evidence in the clinical notes of initial investigations requested,

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including a methacholine challenge (to assess airway responsiveness), a CT and pulmonary function tests. The CT in 2022 demonstrated subpleural reticulations and there was a plan made to follow up the patient in 1 year. The clinical notes also documented a CT scan in 2018, which in retrospect showed ILD changes that hadn't been actioned (it was unclear under which consultant this patient was reviewed in 2018). Given that there was no high-resolution CT scan requested in 2022, the possibility of interstitial lung disease was not raised and therefore there was no further history taken regarding blood testing from a connective tissue perspective.

- In case RCP 24, the patient was a known smoker (30–60 cigarettes per day) with asthma, emphysema, bronchiectasis, inflammatory arthritis and osteopenia. The patient had been under the care of Dr X since 2016. In 2018 spirometry and CT investigations were performed. The CT report indicated smoking-related ILD – desquamative interstitial pneumonitis. At this point there was no evidence within the clinical notes to suggest discussion with the tertiary centre ILD MDT. The patient was reviewed the following year (9 months later) in 2019. Dr X noted within the clinical letters that the patient had emphysema-related ILD. An internal 'X-ray meeting' determined that the diagnosis was not IPF. The patient was discharged with a plan for a yearly review in the nurse COPD clinic. There was no evidence within the clinical notes for referral to a smoking cessation service (although the arrangements for this service at the time were not clear to the review team). There was no mention of rheumatoid arthritis in the initial letter by Dr X.

Dr X's consultant colleagues were responsible for the management of the remaining two cases graded as poor care (RCP 2, RCP 10). The review team identified the following aspects of poor care:

- In 2016, this patient (RCP 2) was referred to the respiratory service after a chest infection and was found to have volume loss, ground glass and reticulation on lung imaging. The patient was asymptomatic and was discharged without further investigation. During the first respiratory consultation (in 2016) there was no evidence of an AI screen, lavage or further monitoring. The patient was re-referred in 2019 due to weight loss and incidental findings on CT (ground glass in upper mid lobes). There was evidence of Dr X's colleagues' requests for further imaging and lung function tests, but no evidence of immunology, BAL or myositis screening performed. The patient was then referred to Dr X for recruitment into the co-trimoxazole trial, without discussion at an ILD MDT regarding eligibility.

- In 2013–2015, this patient (RCP 10) was referred to the respiratory service having had a 1-year history of cough and an abnormal chest X-ray suggestive of early ILD. Lung function tests showed stable results but with reduced gas transfer and further investigations including bronchoscopy and CT imaging were performed. There was no evidence documented within the clinical notes for an immunology screen at initial presentation, or HRCT, despite the patient's low gas transfer (documented as 60%).

9.3.1.1.4 Very poor care

Dr X was responsible for the one case considered 'very poor care' by the review team for the phase initial assessment and investigation. The review team identified the following aspects of very poor care:

- In case RCP 28, a referral was made to the respiratory team for a 90-year-old (active) patient with breathlessness, raised inflammatory markers and abnormal chest X-ray (versus 2018), which showed widespread reticular shadowing with volume loss (suggestive of progressive fibrosis). There was contradiction documented between the chest X-ray report (noting progression) and the

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results detailed within Dr X's clinical letter. No CT scan was performed to give an indication of the patient's breathlessness, and the patient was discharged.

9.3.1.2 Initial treatment plans

The review team were asked to consider evidence regarding the appropriateness of the patient's initial treatment plans.

The gradings were as follows:

> Excellent care (n=2): RCP 12, RCP 30
> Good care (n=2): RCP 18, RCP 27
> Adequate care (n=6): RCP 1, RCP 3, RCP 4, RCP 5, RCP 8, RCP 16
> Poor care (n=9): RCP 10, RCP 11, RCP 13, RCP 14, RCP 19, RCP 21, RCP 23, RCP 24, RCP 25
> Very poor care (n=7): RCP 2, RCP 6, RCP 7, RCP 15, RCP 17, RCP 20, RCP 22
> Four cases were not graded due to insufficient information: RCP 9, RCP 26, RCP 28, RCP 29

9.3.1.2.1 Excellent and good care

Of the four cases graded as excellent care or good care, Dr X was responsible for the initial treatment planning for RCP 30, which documented an appropriate observational approach for an asymptomatic patient with stage 1 sarcoidosis. In the remaining three cases, the initial treatment was managed by Dr X's colleagues (RCP 12, RCP 18 and RCP 27). Across the three cases overseen by Dr X's colleagues the review team found evidence in the clinical notes for appropriate treatment plans, including CPAP, smoking cessation and weight loss advice (RCP 12) and referral to the regional (RCP 18) or local ILD MDT (RCP 27).

9.3.1.2.2 Adequate care

Of the six cases graded as adequate care, Dr X was responsible for the initial treatment plans for four of those patients (RCP 3, RCP 4, RCP 5, RCP 16). In the remaining two cases (RCP 1 and RCP 8), the initial treatment plans were managed by Dr X's colleagues. In the six cases graded adequate rather than good care, reasons included the potential missed opportunities to explore other diagnostic tests (RCP 3) or treatment options for example, pulsed steroids without long-term continuation of prednisolone (RCP 1), no supportive care being offered (RCP 8) and failure to consider ambulatory oxygen (RCP 16).

9.3.1.2.3 Poor care

Dr X was responsible for the nine cases graded as poor care for the phase initial treatment plans (RCP 10, RCP 11, RCP 13, RCP 14, RCP 19, RCP 21, RCP 23, RCP 24, RCP 25).

The review team identified the following aspects of care which contributed to this grading:

- In case RCP 10 the patient was referred to the respiratory service having had a 1-year history of cough and an abnormal chest X-ray suggestive of early ILD, with lung function tests showing stable results but with reduced gas transfer (in 2013). The initial assessment and investigations for this patient were managed by Dr X's colleague until 2018 after which Dr X oversaw the patient's care. In 2015 the patient was treated with (high dose) steroids, with radiological improvement documented in 2016. Between 2017 and 2018 the patient was treated for airways disease. Dr X oversaw the care of this patient from 2018. At this point, the initial treatment plan documented (by Dr X) included

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enrolment into the co-trimoxazole trial. The initial treatment plan for this patient was guided by a diagnosis that was not explored at an ILD MDT. No auto-antibody review was documented, and long-term immunosuppression was not documented to have been considered.

- In case RCP 11, the patient was referred to the respiratory service having had an abnormal chest X-ray in 2019. The review team found documented evidence for 'excellent care' demonstrated by Dr X's colleagues for their initial assessments and investigations, which informed a diagnosis of FNSIP. The patient was referred to Dr X, who noted an initial management plan for enrolment into the co-trimoxazole trial. There was no ILD MDT documented to discuss this patient's eligibility for recruitment into the trial.

- In case RCP 13, the patient was diagnosed with sarcoidosis in 1990 (not by Dr X) and managed by Dr X between 2019 and 2023. The initial treatment plans in 2019 detailed airways management with intermittent increased doses of prednisolone. Vitamin D was advised and started on a 1-week basis with a justification documented for 'careful control of vitamin D levels for sarcoidosis.' The recognised rationale for the prescription of vitamin D is generally underpinned by an abnormal calcium level as there is risk of hypercalcaemia in sarcoidosis patients. However, there was no calcium level testing documented at this point. The rationale for alternatives to steroids (such as methotrexate) was not considered nor was the patient discussed at an ILD MDT.

- In case RCP 14, the patient received adequate initial assessments and investigations. While the patient received a CT scan, shuttle walk test and pulmonary function tests, there were missed opportunities to explore the patient's reduced gas transfer. Regarding the initial management plan, the case did not include documentary evidence for a consensus diagnosis (from a radiological perspective) and the patient was recruited into the co-trimoxazole trial without ILD MDT discussion on their eligibility.

- In case RCP 19, the patient was referred for breathlessness (ongoing for several weeks), crepitations at bases and fibrosis on chest X-ray. There was documentary evidence for adequate 'initial assessments and investigations' for this patient who received a CT scan and lung function tests. The CT scan reported a diagnosis of HP and at that point screening of connective tissue disease and avian precipitants were not evidenced in the clinical notes. Despite this, a diagnosis of carbamazepine-induced hypersensitivity pneumonitis was made without other putative causes discussed. Dr X documented a treatment plan for the withdrawal of carbamazepine and replacement with an alternative (gabapentin), balsamic vinegar (for the management of headache), acupuncture and regular vitamin D (no documented vitamin D level was recorded in the notes). The rationale for the non-evidence-based treatments was not detailed within the clinical notes and antifibrotic therapy was not considered nor was the patient discussed at an ILD MDT.

- In 2014, the patient in case RCP 21 had previously been assessed for pulmonary fibrosis and found to have early ILD. The clinical notes documented that the patient presented to Dr X in 2020 with a cough and a chest X-ray showing fibrosis. In 2020, Dr X detailed a treatment plan for rapeseed oil avoidance, flight socks and regular walking with no clinical rationale documented. There was reference to Dr X's justification for regular walking, noting 'if he remains completely inactive this will cause frailty in the future and risk of admission to a nursing home'. The patient was discharged at that point. There was no documentary evidence for a consensus diagnosis or consideration for antifibrotic medication as the case was not discussed at an ILD MDT. Of note, there was no documentation available to the review team for the period 2014–2020.

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- The patient in case RCP 23 was referred by gastroenterology to the respiratory team in 2021 for retrosternal burning pain and cough (for 1 year). The CT was reviewed at the 'X-ray meeting' and was reported as stable (compared to the CT in 2018). It documented fibrotic peripheral changes subpleural, not confined to bases, and a note stating not IPF or NSIP. Dr X detailed a management plan for this patient as annual CT and for lung function testing. Despite there being knowledge of pulmonary fibrosis, further history of exposures and blood tests (including precipitants and connective tissue disease markers) to inform a treatment plan, there was no treatment plan documented for this patient.

- In case RCP 24, the patient had been previously discharged by Dr X with a note for yearly follow up within the COPD clinic. In 2019 the patient presented on admission with community-acquired pneumonia on a background of ischaemic heart disease and COPD. The patient was discharged with a plan to finish a course of steroids and for a CT to follow up on significant weight loss over the previous 6 months. The initial treatment plans were focused on COPD treatment and ongoing smoking. There was no evidence within the clinical notes of blood tests or tests related to ILD/pulmonary fibrosis.

- In case RCP 25, the patient was referred to the respiratory service for chronic dry cough, crackles on chest auscultation and a chest X-ray that showed non-specific basal opacities with right apical pleural thickening. There was documentary evidence for adequate initial assessments and investigations for this patient who received a CT scan but no documented immunology screen. Dr X's initial treatment plan did not document consideration for immunosuppression as first line treatment. Instead the patient was recruited to the co-trimoxazole trial without ILD MDT discussion for regarding their eligibility. There was no consensus diagnosis documented for this patient.

9.3.1.2.4 Very poor care

Dr X was responsible for seven patients who were graded by the review team as having received very poor care for the phase, initial treatment planning (RCP 2, RCP 6, RCP 7, RCP 15, RCP 17, RCP 20, RCP 22).

The review team identified the following aspects of care that supported their judgement of very poor care for this phase.

- In case RCP 2, between the period 2016-2019 the patient was under the care of Dr X 's colleagues. In 2019, a referral was made to Dr X for this patient with a diagnosis of probable FNSIP and for possible recruitment to the co-trimoxazole trial. Lung function results demonstrated impairment (DLCO 48%) and a HRCT that demonstrated extensive ground glass with traction bronchiectasis lower lobes and subpleural upper lobes NSIP (ie severe fibrotic lung disease). Dr X subsequently advised for a treatment plan of co-trimoxazole twice a day (via recruitment to the local clinical trial), folic acid three times a day and a rapeseed oil-free diet. There was no ILD MDT discussion documented for this patient's eligibility for recruitment into the trial, nor was there discussion of BAL or prednisolone therapy.

- In case RCP 6, the patient was assessed by Dr X between 2014–2016. During this period, the patient's clinical assessments evidenced deteriorating lung function. The interpretation of the lung function decline was not evidenced by Dr X in their correspondence to the GP or to consultant colleagues. The patient was documented to have been discussed at the 'big X-ray meeting' and later in 2016 referred to a radiology colleague at the RBH. In 2015, Dr X documented a treatment plan of vitamin D and azithromycin with no clinical rationale detailed, although it was noted

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'azithromycin has an anti-asthma effect and is very good for bronchiectasis and an anti-cytokine effect which might help some of this hypersensitivity settle down'. Between 2014–2016 there was no evidence that steroid treatment was given. Several entries in the record in this period attributed cold and cough symptoms to pollen count/hay fever and multiple short course steroids were prescribed for asthma. There was no recorded recognition for the timely treatment of ILD. An accurate diagnosis and therefore management plan was not instigated until the involvement of the team at the RBH in 2016.

- In case RCP 7, a diagnosis of FNSIP was made (in 2019) for the patient who had a history of cutaneous scleroderma. The initial treatment plan documented by Dr X included trimethoprim and folic acid. The indication for the addition of trimethoprim as treatment for ILD is not an evidence-based therapy. There was no acknowledgment within the clinical notes of lung function, which was documented to have been severely impaired (eg FVC 65% and DLCO 44% and TLC 52% FVC declined again by 350 ml from June 2019 to September 2019). There was no consideration of cyclophosphamide documented or any discussion of this case at the ILD MDT.

- In case RCP 15, the patient was diagnosed with hypersensitivity pneumonitis by the RBH in 2019. Overnight oximetry was performed in February 2019 which noted low oxygen saturations (down to 75% overnight) and therefore oxygen was prescribed (2 litres/minute for nocturnal use). The patient commenced on overnight oxygen for the possibility of obstructive sleep apnoea or obesity hypoventilation syndrome. The patient was not obese as he weighed 80 kg in February 2019 with a BMI of 27.9 kg/m^2. The diagnosis was put forward as either OSA or OHS. Overnight oxygen is not the standard treatment option for OSA/OHS. In 2020, Dr X commenced the patient on roflumilast, which is indicated for severe COPD (of note the patient was never a smoker).

- In case RCP 17, a referral was made by the rheumatology team to the respiratory service for this patient with previous pulmonary fibrosis whose CT showed ILD. The patient had high CCP antibody, but no symptoms related to rheumatoid arthritis. The lung function results demonstrated severe lung function, but this was not outlined by Dr X in their clinical notes. A reversible element was documented on CT imaging and lung function impairment without consideration for steroid therapy. No initial treatment plans were documented for this patient who had a DLCO of 36% (albeit asymptomatic). There was evidence within this case of an inflammatory component which required treatment but was not acted on. No initial treatment plans were instigated for this patient between the period 2019–2023.

- In case RCP 20, the patient was diagnosed with IPF in 2017 (seen by Dr X's colleagues). Dr X reviewed the patient in 2018 and documented a management plan for trimethoprim and rapeseed oil avoidance. There was no documentary evidence for the consideration of NSIP steroids. Pirfenidone was approved in 2018 and available but was not considered.

- In case RCP 22, the patient was referred to the COPD clinic by the GP (in 2019), and was seen by a respiratory nurse and prescribed Fostair. Three months later the patient presented with further breathlessness and cough. A HRCT scan was requested and performed in 2020. The HRCT was noted to have reported bronchiectasis, and Dr X's clinical letter noted 'old asbestos marks on chest X-ray'. The diagnosis for this patient was unclear as they were discharged without further review at an ILD MDT, without a comprehensive history being documented and with no clear management plan detailed for the patient.

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9.3.1.3 Ongoing care and treatment

The specialist reviewers were asked to consider evidence regarding the appropriateness of the patient's ongoing care and treatment.

The gradings were as follows:

- Excellent care (n=0)
- Good care (n=1): RCP 27
- Adequate care (n=2): RCP 12, RCP 30
- Poor care (n=9): RCP 5, RCP 7, RCP 8, RCP 14, RCP 18, RCP 19, RCP 23, RCP 24, RCP 28)
- Very poor care (n=16): RCP 1, RCP 2, RCP 3, RCP 4, RCP 6,* RCP 9, RCP 10, RCP 11, RCP 13, RCP 15, RCP 16, RCP 17, RCP 20, RCP 21, RCP 22, RCP 25.
- Two cases were not graded, one due to insufficient information being available to inform a grading (RCP 26) and the other was excluded from the review as it was not relevant.

9.3.1.3.1 Good care

One case was graded 'good' for the phase ongoing care and treatment (RCP 27). Dr X's colleagues were responsible for the management of this patient who was reviewed at the RBH in 2022. A diagnosis of IPF was made, oxygen therapy was recommended, and the patient was started on nintedanib. The patient stopped nintedanib due to side effects and was referred to palliative care.

9.3.1.3.2 Adequate care

Of the two cases graded adequate care for this phase, Dr X was responsible for the ongoing care and treatment for one of those patients (RCP 12). In case RCP 12, the clinical notes documented nocturnal oxygen prescribed (a non-standard treatment for this patient's indication) and there was no recommendation for CPAP. In case RCP 30, the review team identified a decline in lung function (430 ml, 15%, FVC decline since July 2019, 350 ml, 3% TLC decline, DLCO 7.03 to 5.29), but noted that these results were reported as normal within the clinic letters.

9.3.1.3.3 Poor care

Nine cases were graded as poor care for this phase (RCP 5, RCP 7, RCP 8, RCP 14, RCP 18, RCP 19, RCP 23, RCP 24, RCP 28). Dr X was responsible for the management of eight of those patients (RCP 5, RCP 8, RCP 14, RCP 18, RCP 19, RCP 23, RCP 24, RCP 28). Dr X's colleagues were responsible for the remaining patient (RCP 7).

In the eight patients overseen by Dr X, the review team identified the following aspects of care that contributed to review team's grading:

- In 2019, the patient in case RCP 5 was referred to the respiratory team by a consultant rheumatologist. The consultant rheumatologist requested a CT scan, which demonstrated upper lobe emphysema and subpleural cystic changes. Dr X documented that the CT scan was discussed at the 'X-ray MDT' showing COPD/emphysema with basal associated ILD and with a plan for this patient's care to remain with the GP and the COPD clinic. The patient was already on methotrexate for their longstanding rheumatoid arthritis. From 2019 up to September 2022 there was

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documented discussion with the RBH to review CT images and the potential option of referring to GSST ILD for nintedanib. This period was graded by the review team as 'good'.

The review team were of the view that the ongoing care and treatment from the period September 2022 to November 2023 for this patient was 'poor'. The clinical notes documented a 10-month delay for a request for this patient to be discussed at regional ILD MDT. Therefore, there was a delay for a consensus discussion regarding the potential for antifibrotics, despite this patient demonstrating rapid deterioration (eg the ILD MDT proforma on 25/10/23 noted: FVC in April 21 documented as 97% and in clinic letter documented as 96%). The review team noted: FVC decline from 4% to 5% decline – criteria for prescribing nintedanib is more than 5% FVC decline so this error in documentation is very important. There was no regular follow up documented by Dr X for this patient.

Between the period Dec 2023 – Dec 2024 the review team graded this phase of care as 'good'. In 2023 the patient was reviewed by Dr X's colleague and given a diagnosis of progressive ILD which prompted an ILD MDT discussion. An oxygen assessment occurred and an urgent referral to the RHB ILD was made. At this point the patient commenced on steroids and antibiotics for infection and progression of ILD. The patient was then seen in the GSST ILD/rheum MDT clinic and commenced rituximab, oxygen and nintedanib and was under regular follow up.

- In case RCP 8, the patient demonstrated fibrosis on chest X- ray and was reviewed by Dr X's colleagues in May 2022. A comprehensive history was taken detailing asbestos exposure. The clinical notes documented that the patient would not be an appropriate candidate for antifibrotics given their frailty (aged 93 and comorbidities (hypertension, ischaemic heart disease, cognitive impairment) and a referral was made for pulmonary rehabilitation along with advice on financial compensation (for asbestos exposure). This management plan was documented to have been discussed by Dr X's colleagues with the patient's family. The patient was reviewed by Dr X in November 2022. It was noted the patient had increased bowel frequency and faecal elastase was sent as an investigation with Creon recommended as a treatment option. The patient was advised to avoid rapeseed oil as this may induce coughing. It was reiterated that the patient would not be suitable for nintedanib given their frailty and they were referred for oxygen therapy. Palliative care was not discussed despite this older frail patient (aged 93) losing weight with a fibrotic lung disease.

- In case RCP 14, the patient's ongoing care and treatment was documented in the clinical notes as co-trimoxazole, referral to ear, nose and throat (ENT) for ear wax issues and to dermatology for solar keratoses. No further treatment options were considered such as bronchoalveolar lavage or therapies such as immunosuppressants for FNSIP.

- In case RCP 18, the patient's ongoing care and treatment was documented in the clinical notes as recruitment to the co-trimoxazole trial. The patient was recruited to the trial without ILD MDT discussion or discussion with a rheumatologist to confirm a consensus diagnosis. Dr X documented a plan to wean the steroid therapy without consideration for RA-ILD as an alternative diagnosis. A clinical letter from Dr X's colleague documented that the patient's breathlessness improved when on steroids. The rationale for Dr X's decision to wean steroids was unclear within the clinical notes. A diagnosis of RA-ILD was later confirmed by the GSST ILD MDT team with a plan for steroid therapy.

- In case RCP 19, the patient received frequent follow up and lung function tests. The results of the lung function were interpreted in the clinical letters as within the normal range. However, the

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results from those tests demonstrated some decline (eg DLCO 50% TLC 77%). Between the period 2018 to 2021 there was evidence detailed within the clinical notes for a decline in lung function that did not prompt treatment. Of note, the patient was documented as asymptomatic. An ambulatory oxygen assessment was not performed despite evidence of desaturation on lung function. The patient was strongly advised not to take advantage of flu or COVID-19 vaccinations.

- In case RCP 23, the patient demonstrated signs of ILD and was offered annual CT and pulmonary function tests. No therapeutic options were discussed, and no treatment was provided to the patient.

- In case RCP 24, 4 years after the patient's review with Dr X in 2018, the patient was referred for pulmonary rehabilitation and assessed for oxygen therapy. However, the patient would not have fulfilled the criteria for oxygen prescription given that the patient was a smoker and the associated risk of fire

- In case RCP 28, the clinical notes written by Dr X did not include details about the patient's respiratory compromise and the treatment options for this patient were limited to inhalers. The review team recognised that the patient was 90 years old and so treatment options may have been limited but this was not documented to have been discussed with the patient.

One case was overseen by Dr X's colleagues and the review team identified the following aspects of care that contributed their grading:

- In case RCP 7, the patient was noted to have developed left pleural thickening, reviewed by the lung cancer team (at Epsom and St Heliers) and diagnosed with pleural adenocarcinoma. The patient was referred to the Royal Marsden for chemotherapy (in February 2022). At this point there was no documented consideration for the high-risk nature of chemotherapy in the context of severe ILD and the need for follow up regarding potential complications of pneumonitis. No ILD MDT was documented to highlight ILD as a concern. In May 2022, a CT thorax report demonstrated pleural changes and FNSIP. At this point there was no documentation for the discussion of ILD treatments. Of note there were no reviews by Dr X for this patient during the time spanning December 2021 to July 2022.

9.3.1.3.4 Very poor care

Of the 16 cases graded very poor care for this phase, ongoing care and treatment, Dr X was responsible for the management of 15 of those patients (RCP 1, RCP 2, RCP 3, RCP 4, RCP 6,* RCP 9, RCP 10, RCP 11, RCP 13, RCP 15, RCP 16, RCP 17, RCP 20, RCP 22, RCP 25). Dr X's colleagues were responsible for the remaining patient (RCP 21).

In the 16 patients overseen by Dr X, the review team identified the following aspects of care that contributed to the very poor grading:

- In case RCP 1, the patient was diagnosed with FNSIP in 2017 by GSST following a referral by Dr X's colleague to the regional ILD MDT. A diagnosis of IPAF was made by the regional ILD MDT in the context of SSA antibody and with a note for a treatment plan of induced sputum, prednisolone and mycophenolate mofetil (in 2018). There was no record in the notes to suggest this recommendation from the tertiary centre had been actioned at that time. The clinical notes documented that the patient was on azithromycin but was not tolerating this well, and in May 2019

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a rapid decline in weight and increased breathlessness were reported. In 2019 the patient was discussed with Dr X with an incorrect diagnosis documented in the clinical notes by Dr X's colleague (IPF instead of FNSIP). The patient was started on trimethoprim, a non-evidence-based treatment for FNSIP without a rationale for this treatment choice documented. Despite a request to start the patient on immunosuppression by GSST (in 2018), this was not actioned between the period 2018–2021. In 2020 the patient was discussed at the local ILD MDT with a recommendation for discussion at the regional ILD MDT. The regional ILD MDT outcome was that the patient had chronic HP progressive over 5 years with a suggestion for prednisolone treatment and withdrawal of trimethoprim. A delay of 2 years to start on appropriate immunosuppressive treatment was evidenced within the clinical notes. The patient was admitted in 2021 with ILD exacerbation/progression and type 1 respiratory failure, developed HAP, and palliative care was involved and the EOL pathway enacted. The patient died at home 4 weeks later. Multiple entries were documented in the clinical notes for lung function assessment and 6-minute walk tests but with no detailed description of the results and management plans documented.

- In case RCP 2, the patient was diagnosed with possible FNSIP in 2019 and referred to Dr X, who recommended a treatment plan of co-trimoxazole, folic acid and rapeseed oil avoidance. The patient was enlisted in a trial for co-trimoxazole. Between 2019 and 2023 the patient continued this treatment plan, despite there being evidence in the clinical notes for the patient's decline, both symptomatically and from a lung function perspective. The decline in lung function was demonstrated within the lung function test results, but the interpretation of the decline was not detailed in Dr X's clinical letters to the GP or consultant colleagues. Lung function results in 2021 demonstrated a significant decline (from 2.13 to 1.7, 86% to 68% 18%), but the treatment plan was not modified or adapted at that point, nor were there further imaging tests performed. In 2022, Dr X documented the patient's worsening cough and breathlessness (FVC 1.58), which prompted the request for a CT scan. A HRCT report in 2022 identified significant progression from October 2020 and March 2022 with further diffuse ground glass and traction bronchiectasis and HC – FNSIP UIP AIP. Dr X's clinic letter reports 'small increase in fibrosis' despite the report detailing significant disease progression. At this point the patient was advised to double the dose of Septrin (co-trimoxazole), to undergo a spirometry test and to consider whether they were eligible for antifibrotics. One year later the patient was discussed at the regional MDT and the recommended treatment was prednisolone, mycophenolate mofetil and nintedanib.

- In case RCP 3, the patient's HP was managed by Dr X from 2018 to 2023. During this period, there was evidence of frequent follow-up with investigations (lung function and shuttle walk tests). However, there was limited reporting of the patient's symptoms, despite CT findings and lung function results indicating the need for treatment with steroids. Instead, the clinical notes documented that the patient's symptoms were attributed to high weight and asthma. As a result, the management plan focused on weight loss and increased activity. This patient had ongoing interstitial lung changes as defined by pulmonary function tests with no objective evidence of asthma. There was deterioration of fibrosis documented in the clinical notes between CT scans carried out from August 2021 to January 2023 suggestive of progressive pulmonary fibrosis (scarring). A referral to seek specialist advice from the regional ILD MDT for consideration of antifibrotic treatment should have been made but was not.

- In case RCP 4, there were frequent and timely lung function and shuttle tests, but questionable interpretation of results for these (2016–2021). In 2020, the patient was started on trimethoprim (a non-evidence-based medication for this indication) with no clinical rationale documented. In 2021, the patient demonstrated the need for ambulatory oxygen but no referral was documented. Despite the evidence of progressive decline in lung function and shuttle test and CT, there were no

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referrals documented to pulmonary rehabilitation (as per NICE quality standards) and the patient was advised to walk more. The patient was referred by Dr X to the RBH for nintedanib but the patient declined this opportunity, and it was documented that the patient preferred to continue on trimethoprim. It is unclear whether Dr X explained to the patient the rationale for prescribing trimethoprim versus antifibrotics for the treatment of ILD (see section – communication with patients for further information).

- In case RCP 6, for the period 2014–2016, the review team graded the ongoing care and treatment as 'very poor.' From 2016 onwards this phase of care was graded as 'good'.

  Between 2014–2016, it was not clear from the clinical notes whether a basic respiratory history had been taken, with whom the CT scans were discussed, or in what setting those discussions occurred. In July 2014, the lung function was documented as FEC 64% and gas transfer factor 38% (ie a significant lung function impairment). Despite demonstrable desaturation the patient was not referred for ambulatory oxygen. There was no evidence in the clinical notes that the prognosis was discussed either with colleagues or the patient. As a result, an accurate diagnosis and therefore management plan was not established until the involvement of the respiratory team at the RBH in 2016. For 2 years the patient was not treated with immunosuppression (2014–2016).

  From 2016 onwards, the patient appropriately received a lavage and CTD screen and commenced on prednisolone therapy with symptomatic benefit. The patient was kept under review by the RBH team and subsequently prescribed mycophenolate and itraconazole. Monitoring of bloods following commencement of mycophenolate mofetil and anti-fungal medication occurred locally.

- In case RCP 9, the patient's AI screen reported positive anti-Jo-1 antibodies. The clinical notes did not detail recognition of this finding, nor adaptation of the management plan for this patient with the potential for antisynthetase syndrome. Diagnostic tests were available at that time but not evidenced in the clinical notes. The patient was documented to have continued with treatment for asthma and COPD. There was a delay for this patient to be discussed at the ILD MDT, which occurred in 2023.

- In case RCP 10, the patient demonstrated lung function decline (FVC 81% and DLCO down to 38% predicted) in April 2019. The clinical letters to the GP by Dr X detailed that the patient was stable, however, a CT report suggested progressive FNSIP (albeit mild progression). The patient had a further CT scan in March 2021 which was 'confirmed as stable' by Dr X. The patient continued with the asthma medications and co-trimoxazole following the trial but no other change to treatment (the patient was continued in the clinical trial). In October 2021 the patient was advised against the flu jab with the rationale documented as: 'flu jabs worry me as they can cause exacerbations'. It was noted that the patient desaturated on exertion (via shuttle test) yet there was no referral for ambulatory oxygen documented despite this. From September 2022 a new diagnosis of ANCA-positive vasculitis was recorded in the clinical notes (diagnosis missed by Dr X). In November 2022 Dr X referred the patient to St George's Hospital for consideration of nintedanib for progressive pulmonary fibrosis.

- In case RCP 11, a formal diagnosis was not recorded and the treatment continued was Septrin, rapeseed avoidance and vitamin D. The patient was documented to have been reviewed regularly in clinic with spirometry rather than formal pulmonary function tests. Dr X's clinical letters attributed the patient's lung deterioration to the patient's anxiety, low mood and insomnia to the

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point where the patient was referred to a liaison psychiatrist. The ongoing treatment plan for the patient's ILD was not modified during the time that they were overseen by Dr X.

- In case RCP 13, the patient's CT scan was reported as stable, but lung function demonstrated deterioration. Consideration of the patient's original pulmonary hypertension (PH) was not reported within the clinical notes and there was no further cardiac imaging requested. The clinical notes did not document this patient to have received any PH agents. PH was picked up in 2024. Nintedanib wasn't available until 2021 but other alternatives to steroids such as methotrexate could have been considered. Dr X reviewed the patient from March 2019 – 2023. Dr X's colleague sought opinion from the GSST ILD MDT in 2023.

- In case RCP 15, the clinical notes recorded multiple overnight oximetry and shuttle walk tests between 2018 and 2023 for this patient. Following a CT scan review by RBH radiology, features consistent with acute HP were reported. The patient commenced on oral steroids for suspected HP in April 2019. The dose of steroids was 10 mg once daily. The patient continued with regular nurse-led review with no formal consensus diagnosis documented. The poor results on spirometry were noted and it was recorded that the patient felt stable. A repeat CT was deemed stable and discussion of the option for referral to the RBH was discussed with the patient, but a decision was made by Dr X and the patient to continue care at St Helier and to review in 2 months. Symptomatic deterioration was reported in November 2019 (the patient did not attend appointments in between) and steroids were increased. In January 2020, the patient received roflumilast and between 2020 and 2023 showed variable lung function with a plan for a repeat CT in 2022. In August 2023, the patient was discussed at the GSST ILD MDT where a diagnosis of fibrotic HP was made.

- In case RCP 16, lung function decline and progression of ILD reported on CT scans did not prompt Dr X to document consideration for treatment. Treatment for this patient was focused on axillary lymph node biopsy and haematology referral. It was noted that a CTPA demonstrated right heart strain. There were no further ECHOs requested. Despite a haematology letter documenting severe breathlessness, there was no documentation of breathlessness or exercise tolerance. At this point steroid therapy due to progression of this patient's ILD was not considered. The patient commenced low-dose furosemide, 20 mg, (despite having severe pulmonary hypertension) and was started on ambulatory oxygen in December 2020 (which was instituted by the respiratory nurse during admission). The patient experienced recurrent admissions with syncope, potentially due to severe pulmonary hypertension, but this was not acted on. Between 2019 and 2021 there was no documented consideration in the clinical notes for ILD treatment with immunosuppression despite evidence of progressive ILD. Palliative care options were not documented to have been discussed.

- In case RCP 17, the patient was noted to have extensive inflammation (ground glass). Dr X requested opinion from the RBH in April 2022. In August 2022 Dr X reported that rheumatology reviewed the patient and prednisolone and sulfasalazine 500 mg bd was advised (but not started yet). Dr X's clinical letters documented lung function as stable (FVC 2.5 (predicted 3.5)) to 2019. However, the review team considered this inaccurate (as FVC in 2019 was 3 litres so there had been a 500 ml decline). In December 2022 the patient did not attend spirometry testing and so the plan was to review the patient in 3 months. In March 2023 the patient was admitted and under the care of a consultant colleague and received a referral to the regional service. In April 2023 the patient was treated for severe ILD changes as detailed on the CT scan.

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- In case RCP 20, the patient was treated with a management plan of trimethoprim and rapeseed oil avoidance (in 2018). At this point pirfenidone had been approved for ILD but this treatment was not documented to have been considered by Dr X. The CT scans reported fibrotic lung disease progression (UIP pattern). The pulmonary function tests were available, which noted an FVC of 70% predicted. As per IPF guidelines pending review in an ILD MDT the patient would have been eligible for antifibrotics. A tertiary referral was not made, and antifibrotic medication was not considered. The patient was not offered palliative care measures during the outpatient review between 2018 and 2022, nor was the patient offered pulmonary rehabilitation or oxygen assessment.

- In case RCP 22, the patient was discharged, without further discussion about potential diagnosis or prognosis. There was no support offered about compensation or other financial benefits related to their asbestos exposure.

- In case RCP 25, the patient's lung function tests were monitored closely from May 2017 to November 2017 and FVC remained stable (along with DLCO). No lung function tests were available to the review team from November 2017 to April 2019. An acknowledged drop in FVC was not addressed and did not prompt consideration for the eligibility for treatment and referral for discussion at the ILD MDT (eg the review team's interpretation of lung function was: May 2018, decline from 53% gone down to 46%). The patient was recruited to the co-trimoxazole trial and remained on this treatment for up to 4 years, despite demonstrating lung function decline.

One of the cases graded by the review team as very poor care (RCP 21) , was managed by Dr X's colleague. The review team identified the following aspects of care, that underpinned their grading:

- In this case (RCP 21), the patient had multiple A&E attendances and was treated for COPD, despite showing signs of ILD. The patient demonstrated a decline in their spirometry test results, which was not recognised for a period of 4 years (the patient was discharged to their GP in 2020) and so not fully observed between 2020–2024. From 2023, the patient demonstrated advanced ILD, despite this a palliative care pathway was not enacted.

9.3.1.4 Communication with colleagues

The specialist reviewers were asked to consider evidence of Dr X's communication with colleagues.

The gradings were as follows:

> Excellent care (n= 0)
> Good care (n= 2): RCP 27, RCP 30.
> Adequate care (n= 4): RCP 8, RCP 12, RCP 19, RCP 23.
> Poor care (n= 15): RCP 1, RCP 2, RCP 5, RCP 6, RCP 7, RCP 10, RCP 13, RCP 14, RCP 16, RCP 17, RCP 18, RCP 21, RCP 24, RCP 25, RCP 28.
> Very poor care (n= 7): RCP 3, RCP 4, RCP 9, RCP 11, RCP 15, RCP 20, RCP 22.
> Insufficient information (n=1): RCP 26.
> Not relevant for this review (n=1): RCP 29.

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9.3.1.4.1 Good care

Two of the 28 cases were graded as 'good' for this phase of care (RCP 27 and RCP 30). In case RCP 27 there was evidence for discussion of this case at the local ILD MDT and referral to the regional MDT was made, with clear correspondence from the referring centre documented.

9.3.1.4.2 Adequate care

Four of the 28 cases were graded as 'adequate' for this phase of care (RCP 8, RCP 12, RCP 19, RCP 23). Within these cases there was evidence for communication with other specialties and with nurse colleagues. Some cases referred to discussions with a colleague at the RBH or an X-ray meeting at St Helier's, but these were not documented as formal ILD MDT discussions.

9.3.1.4.3 Poor care

Fifteen of the 28 cases were graded as poor for this phase of care (RCP 1, RCP 2, RCP 5, RCP 6, RCP 7, RCP 10, RCP 13, RCP 14, RCP 16, RCP 17, RCP 18, RCP 21, RCP 24, RCP 25, RCP 28).

Key themes identified were:

> Not acting on recommendations from specialist centres within an appropriate timeframe (RCP 1).

> Delayed MDT referrals for a consensus diagnosis to inform treatment options (RCP 1, RCP 2, RCP 5, RCP 6, RCP 7, RCP 10, RCP 13, RCP 14, RCP 17, RCP 18, RCP 24, RCP 25, RCP 28), no MDT referral (21).

> Limited discussion with other consultant colleagues, ie rheumatology (RCP 5, RCP 24), cancer teams (RCP 7), cardiology (RCP 13), haematology (RCP 16).

> Advice sought from radiologists based at the tertiary centre (RBH), but with no immediate collaborative (MDT) discussion with colleagues to secure a diagnosis and management plan (RCP 5, RCP 6, RCP 16, RCP 17).

> Conflicting management decisions documented (RCP 18).

9.3.1.4.4 Very poor care

Seven cases were graded 'very poor' for this phase of care (RCP 3, RCP 4, RCP 9, RCP 11, RCP 15, RCP 20, RCP 22).

The review team identified the following aspects of care that contributed to their grading:

- In case RCP 3, there was no reference advice sought on the diagnosis or treatment of HP by Dr X and a presumptive diagnosis was made. The patient continued to deteriorate without a second opinion. There is evidence within the clinical notes of two local X-ray meetings, but the outcomes of these were unclear.
- In case RCP 4, there was limited discussion with the tertiary centre MDT (an opinion was sought from a RBH radiologist) but there was no evidence to suggest that the RBH investigation and treatment plans were put in place.

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- In case RCP 9, there was a lack of documentation of ILD MDT discussion and the patient was not discussed with colleagues in rheumatology or radiology (accepting that we don't have 2017–2019 documentation). There was a delayed referral to the specialist ILD MDT. An earlier discussion in a regional MDT should have clarified the diagnosis earlier which may have resulted in immunosuppression being instigated at an earlier point.
- In case RCP 11, an ILD MDT discussion in August 2022 suggested further formal pulmonary function tests and consideration of immunosuppression. This did not occur and instead Dr X referred the patient to psychiatry and offered 'respiratory three-ball lung exerciser'. There was limited evidence for the discussions with the palliative care team.
- In case RCP 15, a referral to a RBH colleague for CT scan review was sent (in 2019). However, there was no evidence within the notes to demonstrate that the results were acted on by Dr X in terms of change of management.
- In case RCP 20, there was a lung MDT discussion of this patient with possible NSIP, however, no clinical notes demonstrate that Dr X acted on those findings. There was no referral to the ILD regional service, despite there being evidence of colleagues recommending referral of this patient.
- In case RCP 22, the patient was discharged without consideration of discussion at the local or regional ILD MDT.

9.3.1.5 Interactions with the patient and their family

The specialist reviewers were asked to consider evidence of Dr X'sinteractions with the patient and their family/carers.

The gradings were as follows:

> Excellent care (n= 0)
> Good care (n= 3): RCP 24, RCP 27, RCP 30
> Adequate care (n= 4): RCP 5, RCP 8, RCP 12, RCP 16
> Poor care (n= 18): RCP 1, RCP2, RCP 4, RCP 6, RCP 7, RCP 9, RCP 10, RCP 11, RCP 13, RCP 14, RCP 15, RCP 17, RCP 18, RCP 19, RCP 20, RCP 23, RCP 25, RCP 28
> Very poor care (n= 3): RCP 3, RCP 21, RCP 22
> Insufficient information (n=1): RCP 26
> Not relevant for this review (n=1): RCP 29

9.3.1.5.1 Good care

Three of the 28 cases were graded as 'good' for this phase of care (RCP 24, RCP 27* and RCP 30). The clinical notes documented interactions with the patient throughout the course of assessments with details regarding diagnosis and management plans, in case RCP 30 it was documented that a patient information letter regarding sarcoidosis was given. *Dr X had no interactions with this patient.

9.3.1.5.2 Adequate care

Four of the 28 cases were graded 'adequate' for this phase of care (RCP 5, RCP 8, RCP 12, RCP 16). Across the four cases there was evidence for the holistic care/communication provided to the patient where Dr X considered other aspects of the patient's health (ie painful joints and their mental health). Information leaflets were noted to have been provided to some patients regarding antifibrotics (although the review

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team graded this as adequate, in one case it was detailed that the patient had not received the leaflet despite it being noted as given).

9.3.1.5.3 Poor care

Eighteen of the 28 cases were graded 'poor' for this phase of care (RCP 1, RCP2, RCP 4, RCP 6, RCP 7, RCP 9, RCP 10, RCP 11, RCP 13, RCP 14, RCP 15, RCP 17, RCP 18, RCP 19, RCP 20, RCP 23, RCP 25, RCP 28).

The review team identified the following aspects of care which contributed to their grading:

- The regional centre's MDT opinion was not discussed with the family (RCP 1).
- The option of referral to the regional MDT was not discussed with the patient/family (RCP 3).
- Dr X commenced the patient on a non-evidence-based treatment for their ILD and without this discussion being fully documented (RCP1, RCP 2, RCP 4, RCP 7, RCP 9, RCP 10, RCP 11, RCP 15, RCP 20, RCP 25). In some cases, there was evidence of a consent form completed by a nurse specialist.
- Patient concerns/frustrations regarding treatment were documented within the notes (RCP 1, RCP 2).
- The patient was not informed about their disease progression and particularly their decline in lung function (RCP 4, RCP 23).
- Some patients were reviewed regularly by Dr X but it was unclear if the management plan (including therapeutic options) were discussed with the patient and the patient's views were not always documented (RCP 6, RCP 7, RCP 9, RCP 10, RCP 13, RCP 14, RCP 17, RCP 18 RCP 19, RCP 28).

9.3.1.6 Clinical record keeping

The specialist reviewers were asked to consider evidence of Dr X'sclinical record keeping.

The gradings were as follows:

> Excellent care (n= 0)
> Good care (n= 2): RCP 8, RCP 30
> Adequate care (n= 8): RCP 4, RCP 5, RCP 7, RCP 12, RCP 16, RCP 17, RCP 18, RCP 27
> Poor care (n= 17): RCP 1, RCP2, RCP 3, RCP 6, RCP 9, RCP 10, RCP 11, RCP 13, RCP 14, RCP 15, RCP 19, RCP 20, RCP 21, RCP 23, RCP 24, RCP 25, RCP 28
> Very poor care (n= 1): RCP 22
> Insufficient information (n=1): RCP 26
> Not relevant for this review (n=1): RCP 29

9.3.1.6.1 Good care

Two of the 28 cases were graded by the review team as good for this phase of care having had appropriately detailed information recorded.

9.3.1.6.2 Adequate care

Eight of the 28 cases were graded by the review team as adequate for this phase of care. Across the eight cases, the review team found evidence of detailed descriptive letters but on occasion the documentation of investigations and symptoms was lacking in detail.

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9.3.1.6.3 Poor care

Seventeen cases were graded by the review team as 'poor' for this phase of care (RCP 1, RCP2, RCP 3, RCP 6, RCP 9, RCP 10, RCP 11, RCP 13, RCP 14, RCP 15, RCP 19, RCP 20, RCP 21, RCP 23, RCP 24, RCP 25, RCP 28).

The review team identified the following aspects of care which contributed to their grading:

- An incorrect diagnosis (IPF) referred to within the clinic letter (of note this was not Dr X in case RCP 1).
- Letters were not concisely written in terms of structure, clinical history, diagnosis, treatment plans, comorbidities, drugs or any changes in treatment plans.
- The rationale for using non-evidence-based treatment was not documented.
- No documentation of respiratory symptoms within the letters.
- Poor documentation/ interpretation of CT images.
- Poor documentation on the lung MDT proforma and outcomes often illegible.
- Unclear in the letters as to whether the spirometry referred to was performed as part of formal lung function tests or handheld spirometry.

9.3.1.6.4 Very poor care

In case RCP 22, there was one letter from Dr X and the documentation available included an incorrect diagnosis, no evidence of history-taking or clinical examination. The CT report was misinterpreted and there was no evidence of discussion with the patient regarding compensation for previous asbestos exposure. No treatment options appeared to have been considered.

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Group Board

Meeting in Public on Thursday, 09 July 2026

Agenda Item	2.2
Report Title	**Water Safety, E block, St Helier Hospital**
Executive Lead(s)	Alex Shaw, Managing Director – ESTH
Report Author(s)	Alex Shaw, Managing Director – ESTH
Previously considered by	n/a
Purpose	**For Noting**

Executive Summary

The Board has previously discussed the water safety risks associated with ageing water infrastructure at E block, St Helier hospital. The Board has agreed that whilst temporary measures make services in the building safe, in the long term a complete refurbishment of the water infrastructure in the building will be necessary. To carry out that refurbishment, it will be necessary to temporarily vacate the building, and the Board has agreed that further work should be carried out to explore the options for doing so – with the priority being to explore options for retaining services elsewhere on the St Helier site.

Given the concern we know this issue will cause for both our patients and affected staff, this paper

a) Reiterates the context and the stage that the Board has reached in its decision-making
b) Provides an update on how we are engaging stakeholders – with our aim being to be transparent and to engage staff and partners on our next steps.

Action required by Group Board

The Group Board is asked to note the report.

Committee Assurance	
Committee	Infrastructure Committee
Level of Assurance	Not Applicable

Appendices	
Appendix No.	**Appendix Name**
Appendix 1	**Actions undertaken in response to the recommendations in the Surman-Lee report**
Appendix 2	**Actions undertaken in response to the recommendations from the IPC Partners audit**
Appendix 3	**IPC Partners Report on Water Hygeine in E Block at St Helier Hospital**
Appendix 4	**Independent Report by Dr Surman-Lee**

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 Trust is insufficiently transparent/engaging as it grapples with water safety issues in E block, which would potentially result in developing a suboptimal way forward and have a harmful impact on our patients and staff. There is equally a risk that the Trust causes unnecessary anxiety by communicating issues at too early a stage, when solutions have not yet been developed or the extent of the challenge is not yet fully clear. The Trust is seeking to balance these risks with its approach.

CQC Theme

☒ Safe	☐ Effective	☐ Caring	☐ Responsive	☐ Well Led

NHS system oversight framework

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

Financial implications

The engagement described above will have some financial implications (e.g. ensuring clinical staff are available to respond to patient queries via an advice line). These are being managed by the Group Executive.

Legal and / or Regulatory implications

The Trust has a responsibility to engage patients/partners/the public as we respond to these changes.

Equality, diversity and inclusion implications

St Helier serves a diverse catchment area. It will be imperative to understand the varying impacts of the challenges we are grappling with, and different options to address them, on different demographic groups. This will be key to the next stage of the Trust's work as we develop options for delivering a safe decant of E block to enable refurbishment of the water infrastructure.

Environmental sustainability implications

n/a at this stage

Water Safety, E Block, St Helier Hospital

Group Board, 9 July 2026

The context and current position with respect to water safety

1.1 St Helier E Block is an originally 1940s built structure housing inpatient maternity and neonatal care, inpatient gynaecology, outpatient antenatal, postnatal and gynaecology care and assisted conception services.

1.2 The building has presented a number of challenges to maintaining a safe and effective environment, for some years. Known risks (outside water safety) include provision of functional and adequately sized lifts, the lack of mechanical ventilation particularly where medical gases are in use, the impact of room sizes on privacy and dignity, electrical infrastructure issues, and repeated issues with the fabric - specifically the roof with rainwater leaking into the labour ward and birth centre.

1.3 In 2024, as part of enhancing the Trusts' surveillance of water safety issues, routine sampling identified increasing concerns in relation to the presence of pseudomonas particularly affecting the neonatal unit in the Block. Concerns were also raised by staff via Freedom to Speak Up. Further monitoring also identified significant legionella bacterial contamination of the water infrastructure within the building

1.4 Subsequent immediate mitigating actions, external advice and surveys have been reported regularly to the Infrastructure Committee.

1.5 A task and finish group was set up, reporting to the site senior leadership team, to monitor immediate remedial actions, including:

- Several Thermal Mixer Values (TMV) were removed or replaced
- Actions were undertaken to improve the water flow to neonatal intensive care unit (NICU) and the Isolation unit
- Hot water temperature was increased following temperature measurements
- Two basins adjacent to a preparation area were removed
- 'Back to back' outlets between the neonatal unit and Ladybird ward were removed
- A number of 'deadlegs' were identified and removed
- A Standard Operating Procedure (SOP), approved by the Water Safety Group, was adopted to clean outlets which had tested positive for Pseudomonas
- Staff Comms were carried out on the safe use of filtered outlets

1.6 Subsequent advice and surveys included independent infection prevention and control advice (commissioned from IPC Partners) and water safety advice (commissioned from Dr Susanne Surman-Lee). Both reports reviewed actions undertaken to date in these respective areas, and recommended further short-term mitigations and long-term solutions. Both are appended.

Major upgrades to improve the quality of the incoming water supply to the whole site have been undertaken including:

- Replacement water tanks
- Schematic drawings were completed for the whole of EBlock
- Risk Assessments for Pseudomonas and Legionella were completed
- A maintenance schedule, in accordance with the Water Safety Plan, was implemented
- A major resampling exercise was undertaken and all positive results were reviewed with a sub Group of the task and finish group, led by infection prevention and control
- All critical appointments (AE, AP, Designated Person etc) were reviewed
- A silver copper dosing system has been installed in EBlock and will be extended site wide shortly
- The borehole chlorine dosing unit has been reactivated
- Booster pumps will be installed to improved the incoming mains water flow
- The fire main will shortly be separated from the incoming water main

These actions are summarised in Appendix 1 and Appendix 2 of this report.

1.7 Oversight to these interventions has been provided by the ESTH Water Safety Group, which includes a senior microbiologist and the Group Director of Infection Prevention and Control or a representative.

Operational and technical mitigations which are currently in place

2.1 The above mitigations have been maintained. In addition:

- All outlets within the building are fitted with Point of Use (POU) filters
- All maintenance activities identified in the Written Scheme are being undertaken and regular flushing is being carried to all outlets, with delivery overseen by the Water Safety Group
- Water pumps have been installed to improve mains flow

2.2 These mitigations, along with the associated surveillance, assure us that services are currently safe. However, they do not provide a long-term solution to the provision of safe water services to the building, with a particular concern remaining the neonatal unit (given patients' increased vulnerability).

2.3 The Surman-Lee report is clear that point of use (POU) filters, which are central to the mitigations currently in place, "should always be regarded as a short-term measure. A more effective long-term solution is required."

2.4 Whilst effective in reducing water safety risks today, POU filters also reduce flow through the building's pipework, which has the effect of increasing the long-term water safety risks.

2.5 The Board has noted that it is not possible to provide an estimate of when these temporary mitigations will cease to be effective, rending the building 'unsafe'. Rather, the longer we rely on temporary mitigations the greater the likelihood of the infection risks materialising.

2.6 This risk increase is not linear. A range of factors (the weather/temperature, levels of activity and therefore water usage/flow in the building, a repeat of water supply issues which the site has experienced previously) could combine to increase the risk.

2.7 The long-term solution, as the Surman-Lee report makes clear, is a complete refurbishment of the existing water infrastructure in order to remove the risk of contamination.

2.8 This will be a significant undertaking, requiring us to vacate E-block (see below). Depending on how we do so, we estimate it could take 6 months or more once a decision and plan of action is agreed. Whilst our assessment, which we have tested with Dr Surman-Lee, is that it should be possible to maintain safe water services to E-block over such a time period, delaying beyond this point would represent a significant risk on what is one of the Board's most important duties – to ensure services are provided in a safe and compliant environment. Proactive, planned action to address the root causes, whilst the building remains safe, is likely to present fewer adverse impacts to patient care than being forced into reactive action at greater speed.

Why a complete refit requires us to vacate E-block

3.1 We have carefully considered whether a rolling decant of services within the building in order to progressively address these concerns is practicable. With other estate safety and improvement works, for example fire compartmentation issues, this would be normal practice. However, this is considered to present too great a risk.

3.2 This is because much of the contaminated pipework is embedded within the building with the location of exact pipe runs unknown. Furthermore the building contains asbestos. This adds additional risk because the precise whereabouts and condition is unclear. It would be impossible to undertake the works in part of the building without a high risk of dust entering other parts of the building.

3.3 Replacement of the pipework in sections would mean that there is a significant risk of re-contamination of the new pipework from the existing pipework as each section is completed and reconnected to the building's water system.

3.4 Undertaking the works in sections means that there is a significant risk that old and contaminated pipework would be missed during the replacement and would end up remaining within the system at the end of the replacement programme. This would be almost impossible to rectify at a later date.

3.5 If the works were to be undertaken in sections then it would vastly lengthen the programme (and associated patient safety risks) and substantially increase the costs of the replacement.

3.6 Based on the above, the Board has previously agreed that a complete refit is required, requiring us to vacate the building.

3.7 It is important here to note that of the two independent reports appended to this paper, one (from IPC Partners) argued that a closure of E block would not be necessary. However, this report was commissioned to provide infection prevention and control advice, and the authors would not have been aware of some of the considerations above (e.g. presence of asbestos) which have led the Executive to the view that vacating the building will be necessary.

Decanting services

4.1 Further work will be required to determine whether the services currently accommodated in that building can be decanted to other parts of the St Helier site, or whether any will need dispersed to other sites in South West London/Surrey, or a mixture of the two. No decisions have yet been made and the Board will need to return to this question at future meetings.

4.2 The gross internal area provided to clinical services within the building is 4,559sqm. For context, the main seven storey A, B and C blocks on site that house the ED, wards, theatres etc constitute 26,000sqm. Evidently a full decant of E Block is a major undertaking.

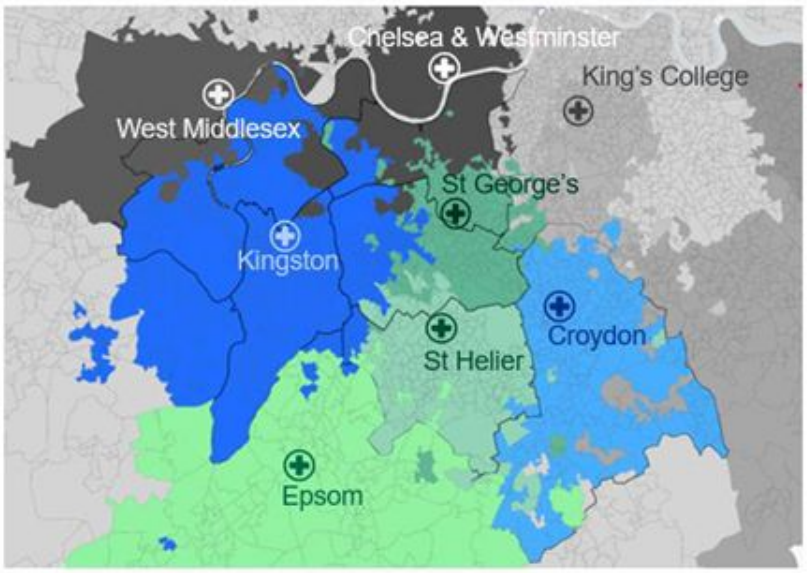
4.3 The Trust is considering a range of options to delivering such a decant in a way that retains services on the St Helier site, including looking at refurbishing/repurposing existing clinical/office space, modular buildings on the site, and reviewing the proposed Emergency Department redevelopment scheme.

The option for temporary dispersal of inpatient maternity and neonatal care

5.1 If services cannot all be decanted from E block and retained on the St Helier site, we may also need to consider the temporary dispersal of some services to other sites. Here it is helpful to note that St Helier's birth rate has reduced by 20% since 2020. Apart from Kingston which has sustained delivery numbers, other units nearby have seen similar drops in their birth rates with the overall compound decline in births across the system being 3.1% since 2020. This means there may be capacity to support increased deliveries in other units.

5.2 The image below illustrates where people giving birth at St Helier come from, and gives a sense of which surrounding units would likely be impacted if births did need to be temporarily dispersed elsewhere. If the Group concludes that a decant on the St Helier site is not possible, and that dispersal to other units is needed, further analysis would be required on the impacts for each unit. At this stage, we expect the biggest impacts would be at Epsom, St George's, and Croydon, with smaller numbers travelling to Kingston.

Map of patient choice for SWL and local non-SWL units
Most chosen unit by each LSOA, deliveries, 2024/25



Source: SWL MH inpatient data
Date updated: 01/09/2025

5.3 If the dispersal route does prove necessary, work would also be required with the South Thames Paediatric Network to assess the impact on NNU capacity. Epsom has a lower level of neonatal

care and will remain limited in what it can take so this would need factoring in to both neonatal and obstetric flow predictions.

5.4 In summary, if we cannot identify safe and effective decant provision for inpatient services on site, there may be capacity within neighbouring units, with outpatient antenatal and postnatal provision maintained locally. If necessary, we may be able to ask our neighbouring units to take on inpatient maternity and neonatal care for the St Helier catchment whilst work on E block is carried out.

The legal context

6.1 If it is not possible to decant services in E block to other parts of the St Helier site and we therefore need to disperse activity to other sites, it would constitute a temporary reconfiguration of services at St Helier.

6.2 Should it be necessary to go down this route, we would need to work with the ICB to consult the relevant local authorities ahead of making a decision. Given that this is a relatively urgent situation, this consultation would be only with local authorities – it would not be a public consultation – and would be limited in scope and duration. We would still need to involve the public by explaining the potential change and how we will maintain effective provision for service users.

6.3 Any such reconfiguration, if required, would have to be temporary and reversible. Given commissioners' previous decision that Epsom St Helier's inpatient maternity services should ultimately be moved to a new hospital in Sutton, with St Helier no longer providing inpatient maternity care, the ICB may subsequently decide to launch a full consultation of the public on a number of options including retaining this configuration until the Sutton hospital is built. This will be a question for the ICB.

6.4 As ever, all decisions would be subject to a number of routes of legal challenge including by patients, the public and local authorities.

The wider St Helier site

7.1 The wider St Helier estate is reliant on pipework of a similar age to that in E Block, and this presents risks as captured on the Trust's risk register.

7.2 However, the water flow is believed to be better in other parts of the site than it is in E Block, and statutory sampling has shown lower levels of contamination. E Block therefore presents a more pressing concern than other parts of the site. Work is underway across the rest of the St Helier site which is expected to reduce the water safety risk for the site as a whole. By contrast, as set out above, the water safety risk at E Block is likely to rise over time.

7.3 An important exception to this point is C block, where sampling has shown more concerning levels of contamination. An action plan for C block has been developed and is being pursued, and further surveys/sampling are being commissioned to better understand this risk.

Stakeholder engagement update

8.1 Given the concern we know this issue will cause for both our patients and affected staff, we have engaged a range of stakeholders since the Board's decision that decanting E block will be necessary.

8.2 We have briefed service user representatives, including the Maternity Neonatal Voice Partnership (MVP), to understand any concerns they have and ensure they have the information they need to relay to the community. We will also be establishing an advice line for patients to seek clarification/assurance.

8.3 Healthcare staff based in the block were briefed in person on 15 June. This was led by the Trust Managing Director, supported by the Women's health leadership team. We will provide regular briefings and further information on the Trust's approach. Messages have also been sent from the Group CEO to all staff across ESTH and Women's Health colleagues at St George's. Information hubs have been set up on both intranets, and a comprehensive FAQ has been published - this will continue to be added to and iterated as more questions are received. The topic has also been included in our all staff briefing, where colleagues can ask the executive team questions

8.4 For external stakeholders, the CEO has met with key stakeholders including nearby hospitals, MPs and Councillors, and there is an ongoing schedule of meetings planned. Key messages and a FAQ are live on both websites. Colleagues in primary care will receive this information via the ICB. We are also posting information on our social media channels and briefing journalists

8.5 This represents a section of the work being undertaken to ensure our staff and local communities are informed and listened to during this process. We will continue to be as open and transparent as we move forward.

Recommendation

9.1 The Board is asked to note the report.

Appendix 1 Actions undertaken in response to the recommendations in the Surman-Lee report

Ref	Recommendation	Action	Status
	Scheme of Control		
1	As soon as possible, the scheme of control should be reviewed and a schedule of tasks drawn up to manage risks effectively and demonstrate compliance with all aspects of water system management to the HSE ACOP L8 and associated guidance HSG 274 (see also Table 1 of HTM 04-01 Part B)	Written Scheme has been developed and approved by WSG	Complete
	Scalding Risk		
2	As soon as possible, the scheme of control should be reviewed and a schedule of tasks drawn up to manage risks effectively and demonstrate compliance with all aspects of water system management to the HSE ACOP L8 and associated guidance HSG 274 (see also Table 1 of HTM 04-01 Part B)	Working with IPC to establish feasibility of removing TMV	Complete
3	As soon as possible, the scheme of control should be reviewed and a schedule of tasks drawn up to manage risks effectively and demonstrate compliance with all aspects of water system management to the HSE ACOP L8 and associated guidance HSG 274 (see also Table 1 of HTM 04-01 Part B)	Written Scheme has been developed and approved by WSG	Complete
	Pseudomonas Auriginosa Risk Assessments		
4	As soon as possible, to conduct *P. aeruginosa* risk assessments within the NICU.	PA risk assessments completed	Complete
5	To contact Sutton Council to seek clarification on its arrangements for assessing the risks associated with the Trust's borehole and the controls required for its safe operation.	Engaged with Environment Agency, Sutton Council to follow	In progress
6	To establish who, within the Trust, is responsible for managing the dosing of the borehole water, details of the dosing regimen are in place, and the competence of those responsible for tasks related to the management of the borehole.	AP identified as the person responsible	Complete
7	To ensure appropriately trained and competent staff manage the water supply effectively, risk assessment actions are completed promptly, and routine temperature and biocide monitoring is initiated immediately	Competent staff carry out these tasks	Complete
8	To ensure that all chemicals, including sodium hypochlorite containers, are stored safely in a suitably bunded area.	All chemicals stored in bunded plant room in line with COSHH	Complete
	Domestic Hot Water		
9	The accuracy of gauges and temperature testing equipment / should be periodically checked, e.g., by using an externally calibrated surface probe thermometer to verify temperatures via the connecting pipework.	All maintenance activities are carried out with appropriate test equipment	Complete
10	These failures (gauge checks) should be addressed as a matter of urgency, principally because there is currently little evidence to show that risks are being managed effectively.s being caried	Certification of test equipment is being carried out	In progress
11	As soon as possible, the scheme of control should be reviewed and a schedule of tasks drawn up to show compliance with all aspects of water system management (see also Table 1 of HTM 04-01 Part B)	Written scheme approved by WSG	Complete
12	Monitoring of temperatures, biocide levels, flushing audits, etc, to be carried out by trained and competent personnel to	Competent Directly Employed and	Complete

	begin as soon as possible for verification that the scheme of control is and remains effective,	Contractor staff are utilised	
13	Records should be maintained as required in HSE ACOP L8.	All maintenance is now recorded	Complete
14	To explore the potential for installing remote monitoring technology across the water systems within the WHB	Explored but not implemented as monitoring checks are carried out by trained staff	Not completed
	Chlorine Dioxide Dosing		
15	To consider recommissioning the existing biocide dosing plant in the plant room	Replacement unit installed and commissioned. To be operational in mid May	In Progress
	EBlock Plant Room		
16	A solution to the plethora of problems associated with the WHB plant room CWST would be to replace it and relocate it.	Water tank was removed as part of mains improvements	Complete
	Pipework labelling		
17	To undertake a comprehensive survey of the pipework supplying the WHB and the pipework within the hot and cold water distribution services.	Work is considered too risky to carry out without decanting the service	Not complete
	Cold Water Storage Tank		
18	To undertake investigations (e.g., level drop tests) to determine the rate of water usage within the CWST serving the WHB, and to ensure that the tank holds no more than 12 hours' supply, as advised in HTM 04-01.	Water tank was removed as part of mains improvements	Complete
19	To consider options to improve the location of the CWST, i.e., to reduce the likelihood of heat gain from the plate heat exchangers, and to allow safe access.	Water tank was removed as part of mains improvements	Complete
	NICU		
20	The WSG should review the risk assessment for filter placement and ensure that, where fitted, they do not pose a risk of breaching the water fittings regulations if the sink is filled or there is a backup following blockages.	RA reviewed by WSG and subsequent sampling for PA negative	Complete
21	There is sufficient activity space to achieve effective handwashing without cross-contamination of the filter outlet, and there is no potential for splash contamination from the drain directly under the filter outlet;	Non Compliant basins removed from NICU	Complete
22	There is a clear policy for how these should be cleaned and for cleaner training.	Cleaning SOP approved by WSG	Complete
23	When decisions are made to fit POU filters, there is a clear exit strategy for their removal.	Clear exit strategy in place but filters are retained where conditions for removal have not been met	Complete
24	New components/fittings/equipment, etc., for installation into the water system should ideally not have been pressure-tested with water. Ideally, leak/pressure testing at commissioning should be carried out as late as possible, using gas or treated water. The specification for new components should require them to be free of contamination. Where this	Compliant parts sourced via supply chain. However it cannot be confirmed that dry testing is carried out	Not complete as this relates to new pipework systems

	is not possible, a validated and WSG-approved disinfection regime should be used before installing fittings, components, etc., and installation should be carried out only by those trained in aseptic technique.		
25	For augmented care, new systems should be filled with disinfected water using an absolute-sterilising-grade microbial filter, as recommended in the NETB 2024/3.	Not actioned, awaiting updated HTM	Not complete as this relates to new pipework systems
26	It is therefore recommended that St Helier consider adopting a phased structured approach to exclude or minimise water and wastewater from direct patient environments in NICU.	Feasibility of water free wards along the Frimley lines is currently being established with IPC	In Progress
27	Evaluate effectiveness at 6- and 12-month intervals, with a view to Trust-wide adoption if results are positive.		Ongoing
28	Whilst there is a gap in the risk assessment process and a lack of schematics for this area, this should be addressed as a priority, as both PArisk assessments and plans for effective real-time actions depend on the veracity of these assessments.	Schematic drawings for EBlock are in place	Complete
29	The asset register should be updated to include items that require PA risk assessments and/or maintenance.	All Eblock water assets have been registered	Complete
30	There have been outbreaks associated with the use of wipes, etc., and these should be included in the risk assessment process to ensure due diligence in procurement and quality assurance processes that ensure they are safe for high-risk patient use.	Cleaning SOP approved by WSG	Complete
31	Assessors should have the competencies and experience needed to identify and assess all applicable systems and/or equipment which might pose a risk of infection in augmented care and be familiar with: the ecology of the target pathogen, the susceptible groups, All relevant modes of exposure, virulence factors, the means of transmission, how to achieve effective control taking into account all relevant factors which can contribute to the risk and consider the consequences of PAinfections and the likelihood of those consequences arising, to derive a measure of harm and to set priorities for action.	PA risk assessments have been completed by Hydrop	Complete
32	Where there is doubt about risk and /or the appropriateness of control measures, manufacturers, installers, and suppliers should be consulted, as necessary. Instructions from manufacturers on safe water uses should constantly be reviewed by the WSG before being implemented, as these have previously been found to be seriously deficient in some cases, leading to patient harm.	Water Safety Plan has been approved by WSG	Complete
33	It is essential that for a meaningful risk assessment, the WSG identify relevant competent and trained staff to assist with the PA risk assessment who understand the activities of the ward/ unit and the patient and staff interactions which may pose risk. The team should include ward managers and IPC teams in each area to assess hand hygiene of both staff, visitors and patients, as well as cleaning regimes, training and understanding of all staff in augmented care areas in particular.	PA Risk Assessment approved by WSG	Complete

34	Consideration should also be given to areas outside of augmented care where high-risk patients may undergo diagnostic tests or treatment, as well as any outpatient areas.	WSG monitors maintenance compliant with the Water Safety Plan	Complete
35	I would further recommend that a WSG subgroup be set up to share information and lead the risk assessment process. Following a suitable training session.	Risk Assessment are monitored by a sub group of WSG including IPC and Micro biology	Complete
36	Where there is a risk of infection from waterborne pathogens other than Legionellae and PA are implicated, those carrying out the risk assessment should have the competencies needed to assess the impact of the relevant hazardson pateitn safety, their ecological niches, modes of transmission and possible sources and assess all applicable systems and/or equipment which might pose a risk of infection and the measures needed to control the risk.	Legionella and PA Risk Assessments have been completed by competent contractors (Hydrop)	Complete
	Training and Competence of Resource		
37	All staff, including estates, contractors, nursing, clinical, medical, ancillary, patient support, and volunteers, should be aware of the risks to patients from waterborne pathogens and the best practices to prevent patient infection. All the above should undergo awareness training during induction and with more detail in augmented care.	Water Safety Awareness training is not currently included in trust induction training	Not Completed
38	All plumbers/ maintenance staff / installers should receive training in water hygiene awareness, how waterborne infections can be transmitted, as well as hand hygiene, aseptic technique, and an understanding of the consequences to patients from poor adherence to Trust-approved practices.	Covered in CP training	Complete
39	Audits are periodically carried out to ensure that no untrained plumbers are used and that Trust protocols are adhered to. Ideally, a lead plumber would be appointed to act as a mentor to create a supported learning environment. Recommendation 40. In addition, plumbers / installers	Annual Compliance Audits are completed by the trust AE	Complete
40	In addition, plumbers / installers working on water systems should have a Watersafe, or equivalent, blue card which shows they have received water hygiene training (see HTM 04-01(21) .	No blue card accreditation is currently undertaken	Not complete
41	Ideally, there should be a separation of those who carry out work on the clean and contaminated areas of the water system. Tools, overalls etc. used for clean and dirty work should be kept separate and disinfected before use.	Our maintenance team is not currently structured to comply	Not complete

Appendix 2 Actions undertaken in response to the recommendations from the IPC Partners audit

Ref	Recommendation	Action	Status
1	Ensure that there is clear temperature profiling for the water system (outlet and riser level) in the E block. The use of continuous water temperature and flow measurement devices could assist here.	Temperature monitoring in line with Water Safety Plan is being carried out No automatic temperature and flow monitoring equipment has been installed currently in place	Complete Not completed
2	Consider the use of in-line thermal disinfection devices close to problematic outlets.	Reviewed and idea discarded due to additional complexity of the installation.	Not Completed
3	Remove TMTs that are supplied by TMVs.	Identified and TMT's removed	Complete
4	Review whether thermostatic protection is required in the CHWBs in the unit.	Ongoing review led by IPC and service	In Progess
5	Service all TMVs in the E block.	All TMVs in EBlock are being serviced	Complete
6	Produce an update schematic for the water system.	Schematics have been updated	Complete
7	Consider identifying *Legionella* spp. to the species level and typing *P. aeruginosa* from future water sampling to understand whether there are dominant clone(s) present.	Legionella and Pseudomonas species identified	Complete
8	Consider sampling water outlets (especially taps) to determine whether they are contaminated.	Major sampling programme has taken place and will be repeated	Complete
9	Ensure that there is clear biocide concentration profiling for the E block.	Copper Silver Dosing system installed	Completed
10	Consider the use of hyperchlorination of the system.	Idea reviewed and discarded due to chlorine risk in NNU	Not Completed
11	Consider undertaking observational audits to provide assurance that point of use filters are in-date, fitted correctly, and not removed by other staff.	A programme of regular Filter inspection and maintenance is conducted in accordance with the Water Safety Plan	Complete
12	Consider sampling the borehole supply water for *P. aeruginosa* contamination.	Part of new monitoring contact	In Progess
13	Consider reducing the number of CHWBs in the bays on the neonatal unit. There is currently more than one CHWB in each bay; this could be reduced to a single CHWB per bay. This would mean that the two problematic back-to-back sinks in adjacent bays could be removed. Consider also moving to "water-free care" and delivering neonatal care without CHWBs in bays	Feasibility study planned to review 'water free' status with Frimley	Complete In progress
14	Replace any non-compliant CHWBs with compliant designs. I	All non compliant CHWB's have been removed to reduce the risk of Pseudomonas contamination	Complete
15	Confirm that the washing machines and other peripheral devices with supply and / or drainage have sufficient Category 5 fluid back-flow protection.		Not completed

16	Consider undertaking observational audits of the sink cleaning process to ensure that housekeeping staff are compliant with the SOP		Complete
17	Retest the neonatal unit outlets for *Legionella* and *Pseudomonas* now that return temperatures have improved following valve work.		Complete
18	Develop a plan for ongoing water testing in the neonatal unit, including implementing asset tracking and an electronic system for monitoring results and trends.	Forward plan in place for ongoing monitoring	Complete
19	Overall, there does not appear to be sufficient evidence to recommend the full closure of the E block or neonatal unit within it to enable temporary relocation of the services and invasive engineering works, particularly in the context of there being no clinical infections (or even colonisation acquisition) in any patients or staff. This suggests the current mitigation measures (primarily the use of POU filters and enhanced flushing regimes) are effective. However, these are not long term sustainable solutions and clearly significant work and resource is required to further investigate the issue and effect long term remediation. *		

*Note this recommendation was written in 2025, by authors commissioned to provide infection prevention and control advice, who did not have access to all the relevant facts on the question of how to deliver a long-term solution to the condition of the water pipes (such as presence of asbestos in the building). This paper sets above out why the Executive have come to a different view.

We have briefed service user representatives, including the Maternity Neonatal Voice Partnership (MVP), to understand any concerns they have and ensure they have the information they need to relay to the community. We will also be establishing an advice line for patients to seek clarification/assurance.

Healthcare staff based in the block were briefed in person on 15 June. This was led by the Trust Managing Director, supported by the Women's health leadership team. We will provide regular briefings and further information on the Trust's approach. Messages have also been sent from the Group CEO to all staff across ESTH and Women's Health colleagues at St George's. Information hubs have been set up on both intranets, and a comprehensive FAQ has been published - this will continue to be added to and iterated as more questions are received. The topic has also been included in our all staff briefing, where colleagues can ask the executive team questions.

For external stakeholders, the CEO has met with key stakeholders including nearby hospitals, MPs and Councillors, and there is an ongoing schedule of meetings planned. Key messages and a FAQ are live on both websites. Colleagues in primary care will receive this information via the ICB. We are also posting information on our social media channels and briefing journalists.

This represents a section of the work being undertaken to ensure our staff and local communities are informed and listened to during this process. We will continue to be as open and transparent as we move forward.

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Report from external review of water hygiene in the E block at St Helier Hospital

27st August 2025, finalised version

1. Summary

The E block at St Helier Hospital, built in the 1940s, houses maternity and gynaecology services (including the neonatal unit). It faces substantial water hygiene challenges due to an aging infrastructure, unclear system configuration, and Estates staff turnover. Recent testing identified contamination with *Pseudomonas* and *Legionella*, though no related infections have occurred. The Trust has a Water Safety Group and has engaged external experts including this review. Key issues include limited assurances around temperature control, chlorination, and poor schematic documentation. The Trust uses point-of-use filters extensively, but lacks audit data to provide assurance that these filters are being deployed and maintained effectively. While current mitigation appears effective, long-term solutions are needed. Our report advises against full closure of the E block due to the absence of clinical infections, recommending targeted remediation and improved monitoring instead. Recommendations include considering the installation of continuous temperature monitoring, removing thermostatic mixing taps, updating schematics, considering hyperchlorination, auditing cleaning practices, and reducing the number of clinical hand wash basins in neonatal unit bays to improve system hygiene and reduce contamination risk.

2. Background

- The E block at St Helier Hospital (part of the St Georges, Epsom, and St Helier Hospital group) was built in the 1940s and houses the maternity services (including the labour ward, neonatal unit, prenatal and postnatal wards) and gynaecology. Only the neonatal unit is considered 'augmented' (as per *HTM 04-01*).
- The Trust draws the majority (90%) of water from a private bore hole , with the remaining approx. 10% made up from a mains supply. The mains supply potentially mixes with the fire hydrant system on the Trust premises. Work is underway to separate the fire hydrant system from the mains supply.
- Concerns about the E block relate to the old water system, lack of understanding about the configuration of the water system, staff turnover in the hospital estates team, and recent water testing that has identified considerable contamination with *Pseudomonas* and *Legionella*.
- The main controls for the system are thermoregulation and chlorination. Assurance for both types of control measure are currently limited.
- An options appraisal has recently been presented to the Trust board. One of the options is to close the block for extensive renovation, and temporarily relocate the clinical services.
- The Trust has commissioned Dr Susanne Surman-Lee as an external and independent advisor related to this issue. Dr Surman-Lee issued a series of recommendations to the Trust in July 2025. In addition, an IPC lead from the ICB visited the Trust and issued a report.
- Dr Simon Goldenberg and Dr Jon Otter had an initial discussion with Prodine Kubalalika, (Group Clinical Director) and Dr Jayakeerthi Rangaiah (Consultant Microbiologist), on 24th June 2025, and have since been commissioned for this external review.

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3. The brief

- The aim of this external review is to understand the issues related to water hygiene in the E block, review the approaches taken to date, and inform the future strategy.

4. The approach

- The external review consisted of a review of documents shared prior to a site visit. The documents that were shared and a summary of the key points from each document are included in the appendix to this document.
- Dr Simon Goldenberg and Dr Jon Otter visited St Helier Hospital on Thursday 7th August 2025.
- The visit included a meeting with Prodine Kubalalika, Dr Jayakeerthi Rangaiah, John Reyes (water hygiene engineer), and Jim Walters (Head of Estates).
- This was followed by a tour of the E block, including the plant room.

5. Findings

Overall approach to water hygiene at the Trust

- Based on the information provided prior to and during the visit, it seems that the Trust has a functional Water Safety Group in place, chaired by the Director of Estates and with a supportive Authorising Engineer for Water.
- The Trust board are briefed as to the water hygiene issues in the E block, based on the options appraisal recently presented to a Trust-level committee.
- The engagement of this external review, the appointment of an external and independent advisor (Dr Susanne Surman-Lee), and the visit and report from an IPC lead for the ICB illustrates transparency and an openness to external challenges around water hygiene.
- The Trust team acknowledge that the Water Safety Group is often 'too reactive', and suffers from the impact of high turnover in Trust Estates staff. These issues are common challenges for Water Hygiene Groups in the NHS in our experience.

Identification of issues with water hygiene in E block

- The issues in the E block are longstanding, and have not been resolved through local outlet remedial work (e.g. descaling, local chlorination, or replacement of outlets), or minor invasive works.
- The decision to sample all outlets in E block in February 2025 goes beyond what would be considered a minimum standard for water sampling, which would include only the neonatal unit (which is classified as augmented care) and sentinel outlets elsewhere in the block.
- There has not been any patient or staff infections related to water linked to the E block.
    - No healthcare-associated *Legionella* infections or *Pseudomonas aeruginosa* bloodstream infections have been linked to the E block, and there have been no *P. aeruginosa* infections in the neonatal unit in recent history.
    - The diagnostic pathway has been reviewed to ensure that all patients with suspected atypical hospital-acquired pneumonia are tested using urinary *Legionella* antigen.

- One staff member claimed a UTI was related to *Pseudomonas* in the E block water, but this seems unlikely.

Investigations and mitigations

- **Temperature**:
  - We don't have a good understanding of how well temperature is controlled in the system based on the information provided. The only temperature profiling we have seen is within the *Legionella* risk assessment from May 2025, which gives an incomplete picture, however there are some outlets that have been recorded as having temperatures in the range that is permissive for the proliferation of microorganisms (20-45°C). As temperature is the primary measure of control against waterborne pathogens, it is critical to obtain good data on this for both cold and hot (flows and returns) prior to any thermostatic controlling devices. If any outlets are not within desired range, measurements should be taken further upstream to the level of the risers.
  - Manual temperature readings based on single timepoints can often give an overly optimistic and misleading impression and there are many remote continuous temperature measurement devices that can be utilised to provide a more accurate and comprehensive understanding of the temperature control (and hydraulic balancing).
  - Where there is persistent difficulty in achieving adequate hot water temperatures of 55°C, despite remedial engineering works, we have found the use of in-line thermal disinfection devices close to the problematic outlets have been helpful. An example of such device: https://www.horne.co.uk/products/water-products/in-line-thermal-disinfection-unit-iltdu/
  - There are several examples of outlets fitted with Thermostative Mixing Taps (TMTs) that are themselves supplied via a Thermostatic Mixing Value (TMV); this likely results in a length of pipework (and fittings) with volumes of water that never rise above 41°C and will support the growth of bacteria. These should be removed.
  - It would also be worth considering whether thermostatic protection is required at all, following a scalding risk assessment. Clearly all showers and baths need to be fitted with a thermal protection device, however other outlets do not require protection by default. By definition neonates themselves do not directly interact with outlets at Clinical Hand Wash Basins (CHWBs), this is done via staff or parents, who it is assumed do not have impaired mental state / capacity or impaired sensitivity to temperature. Therefore thermal protection devices could be removed from CHWBs without breaching the Trust's obligations to protect against scalding under the Health and Safety at Work Act. TMVs and TMTs have been implicated in persistent bacterial contamination that has only been remedied by their removal. Reasonable scalding mitigation can be implemented by use of non-TMT mixer taps and signage warning of very hot temperatures.
  - The TMVs etc do not appear to have been serviced (descaled / cleaned etc) recently, which raises the possibility of biofilm accumulation acting as a persistent source of *Pseudomonas*.
  - We note the concern about elevated cold water temperatures but it is not clear whether the supply (either from the borehole or the mains) at the point of entry is higher than desirable, or whether there is inadequate insulation/unintended mixing of hot and cold water etc which is resulting in a rise in temperature at a more distal

point in the system. The former is clearly more difficult to mitigate, particularly in the summer months, but there are measures that could be taken to limit increase in temperature more distally in the system.

- *Microbiological sampling*:
  - A large number of water testing samples were obtained in February 2025, we have seen the spreadsheet entitled "*St Helier Hospital Women's Health Master 2025 April 2025*" which has almost 400 lines of results. This shows 35 positive results for *Pseudomonas* and 14 with high levels >100cfu/100ml. These high level counts are concentrated on the 1st and 2nd floors, but it is unclear if there is a pattern in terms of positive outlets being supplied by the same problematic riser(s). We note the schematic is not recent and there are doubts about its accuracy.
  - However we also note in the document "*Women's Health Water Sampling Report and Action Plan Rev A*" that there is mention of 53/682 (~8%) *Pseudomonas* positive samples. Of the 53 positives, 12 are from outlets supplied by the borehole and 14 from mains supply, but it's not clear how the remaining 26 failed outlets are supplied. It is possible that some of the tests relate to separate hot and cold or pre and post flush, which would explain the discrepancy in the numbers. If that is the case then there is roughly equal positivity in both borehole and main water derived outlets. This would support the hypothesis of the more distal parts of the distribution system being the source of contamination with *Pseudomonas*. This is also corroborated by the demonstration of a reduction in counts between the pre and post flush samples for some (but not all) outlets e.g. 1F Nursery 003021085, 2F Sluice 003022017 and 2F Delivery Room 2 003022008.
  - There are several examples of an association between positive *Pseudomonas* counts and inadequate temperature control (using the temperatures obtained during the Legionella Risk Assessment, conducted 13-16th May 2025).
  - *Legionella* test results in February 2025 show more widespread issues affecting a larger number of outlets across all floors of the building. The positive *Pseudomonas* and *Legionella* outlets are generally not correlated, however there is a general trend for the numerical counts to reduce in the post flush samples, compared with the pre flush samples. Again this tends to suggest issues affecting the more distal parts of the distribution system.
  - An understanding of whether there are mixed populations of *Pseudomonas* and *Legionella* spp. or a dominant clone(s) might be helpful to differentiate between local and more widespread issues, this could be achieved by identifying the *Legionella* to species level or performing sequencing or other typing of the *Pseudomonas* isolates.
  - There is currently not an electronic system for tracking water microbiology results, which limits oversight of results and trends.
  - Water outlets themselves (especially taps) have not been sampled, which could help to rule them out as a source for *Pseudomonas* contamination.
- *Chemical*:
  - We have not seen any data on biocide concentrations within the system. We note the plan to use silver-copper ion treatment but would note that this can only be effective if the majority of dead-legs and other issues negatively impacting water circulation have been thoroughly addressed. Although this system is reportedly good at penetrating biofilms, we note there are some issues related to water hardness.
  - Hyperchlorination or system pasteurisation have not been considered.
- Risk assessments for the E block were out of data, but have recently been completed.

The Trust team are currently working through recommendations.

- Flushing records are available; flushing is undertaken by Estates staff with some additional flushing from clinical staff and housekeeping staff.
- Accurate schematic diagrams of the water systems in the E block are difficult to produce without invasive investigations.
- Main storage tanks have been inspected; 'settlement tanks' can't be inspected due to access restrictions.
- Calorifiers are in working order, although some are toward the end of their life.
- Point of use (POU) filters have been implemented through the E block.
    - Filters are commonly being removed daily and replaced to allow air to be released, although this action itself may trap air in the filter. Additional handling of the filters may also increase the risk of external contamination and should generally be avoided if possible .
    - POU filters are applied to around 90% of outlets.
    - No audit data available (e.g. around expiry dates, POU filter bypassing, or removal).
- The borehole supply hasn't been specifically tested for *P. aeruginosa*.
    - Although the Drinking Water Inspectorate Standards and Regulations do not specify that wholesome water should be free of *Pseudomonas*, it might be useful to confirm that this is the case as it does not appear to have been tested (only for TVC, coliforms and *E. coli*). *Pseudomonas* contamination is generally said to be an issue with the distal parts (usually last 2 m) of the water distribution network and if the contamination was at the point of the borehole, we would expect to see more widespread and uniform counts at the majority of outlets.
- There is a clear association with inadequate temperature control (primarily hot but also potentially cold) and persistent *Pseudomonas* counts with the back to back CHWBs on the first floor neonatal unit. Some faulty valves have been replaced which appears to have significantly improved the hydraulics and this has resulted in improvement of the temperatures (corroborated subjectively during our visit). This is likely to have had a positive effect on microbial contamination and we recommend testing these outlets now that temperature and flow have improved.
- There is no evidence that uses of water other than outlets (e.g. washing machines, or other equipment or devices) is an unrecognised reservoir of contamination that is seeding the wider system. It may be useful to confirm that the washing machines and other peripheral devices with supply and / or drainage have sufficient Category 5 fluid back-flow protection.
- An SOP for the process by which housekeeping staff clean sinks and outlets is in place. This includes:
    - Training of housekeepers delivered
    - Posters to remind cleaners of best practice
    - Separate microfibre cloths for basin and tap
- Observational audit data, perhaps combined with microbiological sampling of cleaning equipment would provide some assurance that housekeeping staff are keeping to this SOP.
- CHWBs in the E block have a mixture of designs, some of which are non-compliant with the relevant HTM, and blockage is frequent. Poor practice related to the use of CHWBs for tasks other than hand washing has been reported.
- There are no known flexible hoses in the system.

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6. Recommendations

1. Ensure that there is clear temperature profiling for the water system (outlet and riser level) in the E block. The use of continuous water temperature and flow measurement devices could assist here.
2. Consider the use of in-line thermal disinfection devices close to problematic outlets.
3. Remove TMTs that are supplied by TMVs.
4. Review whether thermostatic protection is required in the CHWBs in the unit.
5. Service all TMVs in the E block.
6. Produce an update schematic for the water system.
7. Consider identifying *Legionella* spp. to the species level and typing *P. aeruginosa* from future water sampling to understand whether there are dominant clone(s) present.
8. Consider sampling water outlets (especially taps) to determine whether they are contaminated.
9. Ensure that there is clear biocide concentration profiling for the E block.
10. Consider the use of hyperchlorination of the system.
11. Consider undertaking observational audits to provide assurance that point of use filters are in-date, fitted correctly, and not removed by other staff.
12. Consider sampling the borehole supply water for *P. aeruginosa* contamination.
13. Consider reducing the number of CHWBs in the bays on the neonatal unit. There is currently more than one CHWB in each bay; this could be reduced to a single CHWB per bay. This would mean that the two problematic back-to-back sinks in adjacent bays could be removed. Consider also moving to "water-free care" and delivering neonatal care without CHWBs in bays.
14. Replace any non-compliant CHWBs with compliant designs.
15. Confirm that the washing machines and other peripheral devices with supply and / or drainage have sufficient Category 5 fluid back-flow protection.
16. Consider undertaking observational audits of the sink cleaning process to ensure that housekeeping staff are compliant with the SOP.
17. Retest the neonatal unit outlets for *Legionella* and *Pseudomonas* now that return temperatures have improved following valve work.
18. Develop a plan for ongoing water testing in the neonatal unit, including implementing asset tracking and an electronic system for monitoring results and trends.
19. Overall, there does not appear to be sufficient evidence to recommend the full closure of the E block or neonatal unit within it to enable temporary relocation of the services and invasive engineering works, particularly in the context of there being no clinical infections (or even colonisation acquisition) in any patients or staff. This suggests the current mitigation measures (primarily the use of POU filters and enhanced flushing regimes) are effective. However, these are not long term sustainable solutions and clearly significant work and resource is required to further investigate the issue and effect long term remediation.

7. **Disclaimer:** This report represents an attempt in good faith by the authors to reflect the findings of this review, informed by the review of documents supplied, and offer suggested recommendations based on this information. This report does not reflect the views or opinions of the authors' respective affiliations and organisations.

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Appendix: document shared for review

Document	Key points
Report to the Infrastructure Committee: "Maternity unit water safety update", 25th July 2025	Provides a summary of the current situation with respect to water hygiene in E block, and a summary of the initial recommendations from Dr Susanne Surman-Lee, who has been appointed as an external and independent advisor.
Water Testing at Women's Health Building at St Helier Hospital. Summary of Water Testing and Action Plan, April 2025.	Summary of water sampling microbiology results and an action plan for improvement.
Psuedomonas [sic] Aeruginosa Testing at Women's Health Building at St Helier Hospital, February 2025	Summary of results from Pseudomonas testing in the Women's Health Building, including some short and medium term recommendations.
Options paper: Building and fabric issues within the E-Block and Neo-Natal Unit (NNU).	An options appraisal for how to address water hygiene issues in the E block.
Microbiological testing of water samples from the E block, February 2025.	Overview of the patterns of contamination of water outlets with *Pseudomonas* and *Legionella*
Legionella Risk Assessment, conducted 13-16th May 2025	Detailed risk assessment of the E block, including recommendations.

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2 Limitations

1. This report only reflects the aspects of water system management reviewed to date, as it is based on a short visit to the Women's Health Building (WHB) on 30th October 2025 by Dr Susanne Surman-Lee FRSB, Hon FRSPH, Hon. FWMSoc., FIHEEM, FPWTAG, Consultant HCPC Registered Clinical Scientist (CS02982), and Dr Paul McDermott FRSPH FIHEEM o. Due to time limitations, this consisted of a brief overview of key areas in the WHB only , as identified by Mr Chris Rivers, Director of Estates and Facilities at Epsom & St Helier University Hospitals NHS Trust.

3 Introduction and context

2. This report provides a draft overview of the condition of the water system infrastructure at St Helier Hospital, WHB and is intended to provide initial support to the Trust's Water Safety Group (WSG) in identifying key risks, aligning actions with national standards, and prioritising remedial work to protect patients, staff and visitors based on this short visit

4 Executive Summary

3. This limited review of St Helier Hospital's Water-Safety Plan (WSP) showed there is strong governance intent, but there are several critical gaps in compliance and assurance. The visit focused on the Women's Health Building, including the NICU, and confirmed that immediate patient-protection measures (e.g., POU filtration) are in place, but that infrastructure, documentation, and verification processes require improvement to align with statutory and best-practice standards fully.

4.1 Overall Compliance Position

4. The Water Safety Plan and operational arrangements currently do not demonstrate full compliance with statutory duties under the Health and Safety at Work etc. Act 1974, COSHH Regulations 2002, and the HSE Approved Code of Practice L8 (ACOP L8), nor with mandatory healthcare guidance including HTM 04-01 (Parts A & B) and NETB 2024/3 – Safe Water Systems.

4.2 Key gaps:

5. Whilst there is a Water Safety Group (WSG) and a Water Safety Plan (WSP Books 0–5) in place, which broadly follow BS 8680 (2020) and HTM 04-01, there are some core requirements either incomplete or absent. These omissions collectively represent a failure to evidence compliance with HSE and DHSC-mandated water-safety frameworks, leaving the Trust exposed to enforcement action, infection-prevention risk, and loss of assurance.

6. These include:-

    a. Deficient asset documentation, including schematics, maintenance records, and monitoring verification;

    b. BS 8580-2 Non-Compliance – No formal RA pathway or risk assessments for PA and opportunistic pathogens (BS 8580-2 : 2022) for NICU, which requires a structured, multidisciplinary risk-assessment process for opportunistic pathogens, including *P. aeruginosa*, by a multidisciplinary team, addressing system mapping, sampling strategy, and control verification.

    c. Physical design risks in NICU contrary to HTM 04-01 B 5.8-5.13 and NETB 2024/3 3.3-3.4. Several clinical hand-wash sinks are located within 2 metres of patient cots, equipment and furniture used by parents. This configuration creates a high likelihood of splash-mediated contamination, poses a significant infection-prevention risk to vulnerable neonates, and directly contravenes the design and infection-control principles outlined in HTM 04-01 Part B (5.8–5.13) and NETB 2024/3 (3.3–3.4). HTM 04-01 Part B (5.8–5.13) specifies that hand-wash stations in augmented-care areas must be positioned to avoid splashing into or near patient environments, and that risk assessments should verify compliance. The NETB 2024/3 (3.3–3.4) reinforces this requirement, specifying that design reviews and water-safety validation must ensure that outlets and drainage are located and maintained to eliminate splash- and aerosol-forming pathways.

    d. *Legionella* Management – many failures in compliance with legislation and national standards,

    e. Misinterpretation of *Legionella* action levels; “100 CFU/L acceptable” wording conflicts with HTM 04-01 B 4.15–4.18 and HSG 274 Pt 2 2.138–2.139, which require investigation on any detection.

f. Competence Verification – No evidence of verified competence (EUSR Blue Card or equivalent) as required by HTM 04-01 A 2.31–2.33, 2.48 and NETB 2024/3 §3.1.

g. Absence of Precautionary Principle – Not explicitly stated as required by HTM 04-01 A 2.7, BS 8680 Cl 4, and WHO GDWQ Ch 4.

h. Aged Infrastructure and Incomplete Records – Deficiencies in schematics, TMV and CWST data (HTM 04-01 B Table 1; HSG 274 2.80–2.88).

i. Borehole Governance Gap – No known engagement with the local authority responsible for Private water Supply risk assessment under Private Water Supplies Regs 2016 Reg 6.

j. NETB 2024/3 Cross-Referencing – No explicit mapping or declaration in Book 3.

5 Summary of recommendations

Recommendation 1 As soon as possible, the scheme of control should be reviewed and a schedule of tasks drawn up to manage risks effectively and demonstrate compliance with all aspects of water system management to the HSE ACOP L8 and associated guidance HSG 274 (see also Table 1 of HTM 04-01 Part B)

Recommendation 2 To conduct scalding risk assessments for all outlets within the WHB to determine whether engineering controls are required to manage the identified risks. A TMV is necessary where the risk of scalding outweighs the risk of infection; this is required where there is potential for whole-body immersion, but may not be necessary on WHB, based on risk assessment in non-patient areas or where patients have no access, for example, in the ICU. Kitchens should not have TMVs for hygiene reasons.

Recommendation 3: As scalding is a "never event" in the NHS, it is recommended that the Trust initiate, as a priority, a PPM programme for the calibration and maintenance of TMVs where deemed necessary.

Recommendation 4: As soon as possible, conduct *P. aeruginosa* risk assessments within the NICU.

Recommendation 5: To contact the Local Authority to seek clarification on its arrangements for assessing the risks associated with the Trust's borehole and the controls required for its safe operation.

Recommendation 6: To establish who, within the Trust, is responsible for managing the dosing of the borehole water, details of the dosing regimen are in place, and the competence of those responsible for tasks related to the management of the borehole.

Recommendation 7: To ensure appropriately trained and competent staff manage the water supply effectively, risk assessment actions are completed promptly, and routine temperature and biocide monitoring is initiated immediately.

Recommendation 8 To ensure that all chemicals, including sodium hypochlorite containers, are stored safely in a suitably bunded area.

Recommendation 9 The accuracy of gauges and temperature-testing equipment should be periodically checked, e.g., by using an externally calibrated surface probe thermometer to verify temperatures via the connecting pipework.

Recommendation 10 These PPM failures should be addressed with urgency, principally because there is currently little evidence that risks are being managed effectively.

Recommendation 11 As soon as possible, the scheme of control should be reviewed and a schedule of tasks drawn up to show compliance with all aspects of water system management (see also Table 1 of HTM 04-01 Part B)

Recommendation 12 **Monitoring of temperatures, biocide levels, flushing audits, etc., to be carried out by trained and competent personnel, to begin as soon as possible, for verification that the control scheme is and remains effective.**

Recommendation 13 **Records should be maintained as required in HSE ACOP L8.**

Recommendation 14 **To explore the potential for installing remote monitoring technology across the water systems within the WHB**

Recommendation 15 **To consider recommissioning the existing biocide dosing plant**

Recommendation 16 **A solution to the plethora of problems associated with the WHB plant room CWST would be to replace it and relocate it.**

Recommendation 17 **To undertake a comprehensive survey of the pipework supplying the WHB and the pipework within the hot and cold water distribution services.**

Recommendation 18 **To undertake investigations (e.g., level drop tests) to determine the rate of water usage within the CWST serving the WHB, and to ensure that the tank holds no more than 12 hours' supply, as advised in HTM 04-01.**

Recommendation 19 **To consider options to improve the location of the CWST, i.e., to reduce the likelihood of heat gain from the plate heat exchangers, and to allow safe access.**

Recommendation 20 **"The manufacturer's protocols should be reviewed and approved by the WSG for fitting and cleaning of filters should be followed, and checks made to ensure: -**

a. **Water filters are positioned to avoid or minimise backsplash to the filter outlet when in use,**
b. **There is sufficient activity space to allow handwashing without touching the filter housing and outlet or the basin**
c. **Any containers for connecting filtered water should be place well before the filter outlet point and not in contact with the sink or drain**
d. **The filter should be handled aseptically during installation by trained personnel, touching the filter outlet during installation use must be avoided**
e. **The water filter should not be positioned directly above a drainage point or immersed in collected water placed on the floor in a basin, bath, or in contact with contaminated surfaces**
f. **There is an air gap in compliance with the water fittings regulations"**

Recommendation 21 **Filters must be cleaned only using the IPC/WSG-approved sanitising agents following the Trust protocol**

a. **At no point should the filter be disconnected during cleaning**
b. **Checks should ensure there is no leakage around the filter to the tap connection**
c. **Filters should not be refitted; if removed, they should be replaced by new filters.**

Recommendation 22	**The WSG should review the risk assessment for filter placement and ensure that, where fitted, they do not pose a risk of breaching the water fittings regulations if the sink is filled or there is a backup following blockages.**
Recommendation 23	**There is sufficient activity space to achieve effective handwashing without cross-contamination of the filter outlet, and there is no potential for splash contamination from the drain directly under the filter outlet; and**
Recommendation 24	**There is a clear policy for how these should be cleaned and for cleaner training**
Recommendation 25	**When decisions are made to fit POU filters, there is a clear exit strategy for their removal.**
Recommendation 26	**New components/fittings/equipment, etc., for installation into the water system should ideally not have been pressure-tested with water. Ideally, leak/pressure testing at commissioning should be carried out as late as possible, using gas or treated water. The specification for new components should require them to be free of contamination. Where this is not possible, a validated and WSG-approved disinfection regime should be used before installing fittings, components, etc., and installation should be carried out only by those trained in aseptic technique.**
Recommendation 27	**"For augmented care, new systems should be filled with disinfected water using an absolute-sterilising-grade microbial filter, as recommended in the NETB 2024/3. "**
Recommendation 28.	**It is therefore recommended that St Helier consider adopting a phased structured approach to exclude or minimise water and wastewater from direct patient environments in NICU. This includes:** **a. Conducting pre-intervention risk assessments, baseline environmental sampling, and staff training.** **b. Removing or isolating sinks within patient spaces.** **c. Substituting water-based cleaning with approved alcohol- or detergent-based products.** **d. Reviewing water system design to prevent splash or backflow risks.** **e. Oversight by the Infection Prevention and Control Committee (IPCC) in collaboration with the Water Safety Group (WSG).** **f. Increase environmental and patient surveillance by incorporating pilot monitoring into existing IPC dashboards and HAI surveillance** **g. Collecting data on:** **h. Waterborne organism isolation rates (environmental and clinical).** **i. Device-associated and bloodstream infection rates.** **j. Compliance with hand hygiene and cleaning protocols.**
Recommendation 29.	**Evaluate effectiveness at 6- and 12-month intervals, with a view to Trust-wide adoption if results are positive.**

Recommendation 30. **Whilst there is a gap in the risk assessment process and a lack of schematics for this area, this should be addressed as a priority, as both PArisk assessments and plans for effective real-time actions depend on the veracity of these assessments.**

Recommendation 31. **The asset register should be updated to include items that require PArisk assessments and/or maintenance.**

Recommendation 32. **There have been outbreaks associated with the use of wipes, etc., and these should be included in the risk assessment process to ensure due diligence in procurement and quality assurance processes that ensure they are safe for high-risk patient use.**

Recommendation 33. **Assessors should have the competencies and experience needed to identify and assess all applicable systems and/or equipment which might pose a risk of infection in augmented care and be familiar with: the ecology of the target pathogen, the susceptible groups, All relevant modes of exposure, virulence factors, the means of transmission, how to achieve effective control taking into account all relevant factors which can contribute to the risk and consider the consequences of PAinfections and the likelihood of those consequences arising, to derive a measure of harm and to set priorities for action.**

Recommendation 34. **Where there is doubt about risk and /or the appropriateness of control measures, manufacturers, installers, and suppliers should be consulted, as necessary. Instructions from manufacturers on safe water uses should constantly be reviewed by the WSG before being implemented, as these have previously been found to be seriously deficient in some cases, leading to patient harm.**

Recommendation 35. **It is essential that, for a meaningful risk assessment, the WSG identify relevant, competent, and trained staff to assist with the PA risk assessment who understand the ward/unit's activities and the patient-staff interactions that may pose risk. The team should include ward managers and IPC teams in each area to assess hand hygiene among staff, visitors, and patients, as well as cleaning regimes, training, and the understanding of all staff in augmented care areas, in particular.**

Recommendation 36. **Consideration should also be given to areas outside of augmented care where high-risk patients may undergo diagnostic tests or treatment, as well as any outpatient areas.**

Recommendation 37. **I would further recommend that a WSG subgroup be set up to share information and lead the risk assessment process. Following a suitable training session.**

Recommendation 38. **Where there is a risk of infection from waterborne pathogens other than Legionellae and PA are implicated, those carrying out the risk assessment should have the competencies needed to assess the impact of the relevant hazardson pateitn safety, their ecological niches, modes of transmission and possible sources and assess all applicable systems and/or equipment which might pose a risk of infection and the measures needed to control the risk.**

Recommendation 39. **All staff, including estates, contractors, nursing, clinical, medical, ancillary, patient support, and volunteers, should be aware of the risks to patients from waterborne pathogens and the best practices to prevent patient infection. All the above should undergo awareness training during induction and with more detail in augmented care.**

Recommendation 40. **All plumbers/ maintenance staff / installers should receive training in water hygiene awareness, how waterborne infections can be transmitted, as well as hand hygiene, aseptic technique, and an understanding of the consequences to patients from poor adherence to Trust-approved practices.**

Recommendation 41. **Audits are periodically carried out to ensure that no untrained plumbers are used and that Trust protocols are adhered to. Ideally, a lead plumber would be appointed to act as a mentor to create a supported learning environment.**

Recommendation 42. **In addition, plumbers / installers working on water systems should have a Watersafe, or equivalent, blue card which shows they have received water hygiene training (see HTM 04-01(21) .**

Recommendation 43. **Ideally, there should be a separation of those who carry out work on the clean and contaminated areas of the water system. Tools, overalls etc. used for clean and dirty work should be kept separate and disinfected before use.**

6 Introduction

6.1 Background

7. The St Helier hospital has significant building/maintenance challenges, as it was intended to be replaced under the New Hospital Programme. However, the timetable for the new SECH hospital has slipped, and so the Trust has to manage significant estate deterioration, a backlog of monitoring, remedial actions and maintenance.

8. In addition to the historical design issues, which do not meet current standards for augmented care, recent sampling results show that the water systems pose a potential risk to vulnerable patients, such as those in the NICU unit we visited in the Women's Health Building (WHB).

9. Whilst the risk has temporarily been mitigated in part by the fitting of point-of-use filters, as we understand it, there is no plan for when the filters can be removed safely; longer-term mitigations are needed to ensure the WHB and particularly NICU are safe for all occupants.

6.2 Legionella species and Pseudomonas aeruginosa;

10. *Both Legionella species* and *Pseudomonas aeruginosa (PA)* are natural inhabitants of drinking water, as well as a range of other opportunistic pathogens which may pose a risk of harm to particularly immunocompromised patients, and those who have breaches in their skin's integrity (NETB 2024/3). In healthcare settings, where patients are more susceptible to infections than the general population, especially those who are highly immunocompromised due to illness or treatment, the risk of hospital-acquired infections (HAIs) from bacterial opportunistic pathogens from water and wastewater sources is much higher. Hospital-acquired waterborne infections may occur from contamination of distributed water at the point of use (POU) and other water sources, or from direct or indirect cross-contamination from aerosols and splashes derived from them, to which patients, staff and visitors may be exposed. There is much evidence of outbreaks associated with a variety of healthcare sources other than the drinking water distribution system, including systems and equipment used for diagnosis and treatment, as well as bottled water (1), hydrotherapy pools (2) etc., and the sanitary pipework system, particularly at its periphery, that is from the pipework immediately before the outlet (around 2m), the associated sanitary fittings and pipework, including the drain to the trap. Infections, including multiple antibiotic-resistant strains, can occur from splash contamination that cross-contaminates persons (staff, contractors, patients, and visitors) and surfaces up to 2 m from the outlet.

6.3 Legislative context

11. Ensuring the environment, including the water supply and distribution systems and associated equipment, is safe for all uses and users within the building is a requirement under Health and Safety legislation, Section 21 of the Health and Social Care Act 2008 and associated codes of practice[*] on the prevention and control of infections and related guidance. Whilst ensuring that water systems are compliant with well designed, commissioned and managed, the controls are effective, such as maintaining compliant temperatures, i.e. ≥ 55 °C at the outlets within one minute for the hot water and ≤ 20 °C for the cold within 2 minutes to comply with the HSE ACOP L8 and HTM 04:01. Where target temperatures cannot be consistently achieved, distribution systems supplemented with biocides[†] will effectively manage the risk from *Legionella* infections.

6.4 Managing the *Pseudomonas aeruginosa* risk

12. However, whilst the management of *Legionella* growth is mainly down to engineering and usage interventions, this is not the case for PA. Contamination of outlets by PA can occur through cross-contamination from patients, staff, and visitors, especially when hand hygiene compliance is poor. Retrograde contamination can occur at any time as a result. PA is a formidable foe in the healthcare environment (3) it can multiply in warm conditions, even in low nutrient environments, it can scavenge nutrients from a range of carbon sources, including from the air, sanitisers, plasticizers in pipework and water system fittings, components and associated equipment and where nutrients are deposited on sanitary fittings, e.g from soap dispensers. It grows rapidly within the waste system (4) up towards the sink drain, especially when nutrients are disposed of through the drains of sanitary fittings; splash contamination from sinks and drains has been shown to spread up to 2m from the outlet.

13. Whilst PA rarely causes infections in the normal population, except where it can gain access not normally accessible to it, e.g via cuts, through hair follicles, the urinary tract and ear canal, for example, during submersion in contaminated water. However, for patients with compromised immune systems or conditions that make them more susceptible to infection, including those undergoing interventions that breach the skin

[*] (Department of Health and Social Care (2022). The Health and Social Care Act 2008: Code of Practice, https://www.gov.uk/government/publications/the-health-and-social-care-act-2008-code-of-practice-on-the-prevention-and-control-of-infections-and-related-guidance

[†] (it is rarely possible that temperature control alone is effective in buildings with large complex systems)

barrier and /or provide direct access to tissues and organs, PA infections can pose a serious threat to patient survival.

14. Environmental water and wastewater systems have been recognised as potential reservoirs for a wide range of healthcare-associated waterborne opportunistic pathogens, including *Pseudomonas aeruginosa, Klebsiella* species, *Acinetobacter* species, and carbapenemase-producing *Enterobacterales* (CPE). Traditional clinical environments with sinks and drainage points in close proximity to patient care areas carry a measurable risk of splash, aerosol, or surface contamination.

15. In addition to the harm to patients, waterborne HAIs, especially those resistant to first-line antimicrobials, can significantly increase the length and cost of patients' stays, including in the NICU, ICU, and HDUs, etc.. For the most immunosuppressed patients, PA infections can result in severe illness and death, as occurred in Belfast in 2012 with the loss of 3 neonates due to Pa colonisation of tap inserts.

6.5 Minimizing, not eradicating

16. It is recognised that complete eradication of *PA from* water systems in healthcare environments is not achievable. The objective, therefore, is to identify all potential sources, transmission routes, hazards, hazardous events and risks within the water system, particularly in areas serving highly susceptible patients and to implement proportionate control measures that minimise risk as far as reasonably practicable.

6.6 At-risk groups

17. Those most at risk of infections from a range of waterborne opportunistic pathogens are patients in high-risk augmented care areas, such as those in NICU (as well as ICU / transplant units, haematology oncology). For example, in the NICU, there is an increased risk as the patients have an undeveloped skin barrier (13, 14) and interventions that compromise the skin / tissue integrity and / or venous and bladder /urinary catheters (5-8).

6.7 Importance of Pseudomonas aeruginosa risk assessments

18. Unlike *Legionella*, PA can colonise human skin and intestinal tracts without causing infection and can be transferred to and from other patients, staff, visitors, etc. Transmission of PAcan occur for example, directly from person to person, from a colonised person (skin and / or GI tract) to cause infection in the patient themselves (endogenous transmission), by indirect transmission from a person (patient, staff, contractor, visitor) to water system components and then onwards to other people and indirectly through splash contamination of drinks, food and pharmacy

preparations, especially when prepared on the ward. Whilst there are many potential routes of waterborne infection, including outlets themselves, especially those with inserts, and water dispensed from them, it is increasingly recognised that drains and splash contamination of the surrounding environment can also play a significant role in transmission to patients.

19. The layout and operation of patient areas, the design of sinks and outlets and associated equipment, together with staff and patient practices, including of cleaning equipment (11) can all contribute towards the risk of PA infection in very susceptible patients, such as those in the NICU.

7 Visit findings and recommendations

7.1 Addressing Non-compliances

20. St Helier's ageing fabric and deteriorating water system infrastructure r**equire a high-priority action plan t**o address the risks from poor microbiological control and resilience. There are several non-compliance failures, such as a lack of up-to-date schematics, risk assessments, temperature/biocide monitoring, and record keeping; TMV calibration and maintenance; dead legs leading to stagnation; TMV calibration and performance; backflow protection; materials corrosion; scaling; and flow reduction. Whilst improvements have been made recently, the systems remain a significant risk to those who are more highly susceptible to infection, such as those in the NICU unit. This has been mitigated in part by the fitting of point-of-use filters.

Recommendation 1. **As soon as possible, the scheme of control should be reviewed and a schedule of tasks drawn up to manage risks effectively and demonstrate compliance with all aspects of water system management to the HSE ACOP L8 and associated guidance HSG 274 (see also Table 1 of HTM 04-01 Part B)**

7.1.1 Scalding risk assessments

21. No scalding risk assessments have been conducted in the WHB, as recommended in HTM 04-01 Part B. Many TMVs and TMTs in the building may be unnecessary for managing scalding risks, and their presence increases the risk of colonisation of the valves and exposure to waterborne pathogens such as *PA and* legionellae. The lack of maintenance increases the risk of cold passing into the HWS and of scalding from TMV failure, especially when there have been lapses in TMV maintenance. Conducting scalding risk assessments would also help identify which outlets require engineering controls, such as TMVs, and which do not, reducing infection risks and the maintenance burden on the Trust.

Recommendation 2. **To conduct scalding risk assessments for all outlets within the WHB to determine whether engineering controls are required to manage the identified risks. A TMV is necessary where the risk of scalding outweighs the risk of infection; this is required where there is potential for whole-body immersion, but may not be necessary on WHB, based on risk assessment in non-patient areas or where patients have no access, for example, in the ICU. Kitchens should not have TMVs for hygiene reasons.**

Recommendation 3. **As scalding is a "never event" in the NHS, it is recommended that the Trust initiate, as a priority, a PPM programme for calibration and maintenance of TMVs where these are deemed necessary**

7.2 *Pseudomonas aeruginosa* risk assessments

22. We were informed there were no PA risk assessments for the NICU. This must be addressed as soon as possible, as it is required by regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 and is recommended in HTM04-01 Parts B and C. There is a British Standard Code of Practice BS 8580-2, which will support the process. This must be a multidisciplinary assessment that takes in not just the engineering aspects but also IPC, environmental, and patient surveillance data, as well as the practices of support services, cleaning, flushing, and kitchen staff, and those of staff and visitors. The risk assessment should consider all potential sources through which *PA*could ingress into patient and staff spaces, thereby enabling transmission to patients. Staff training is essential so that all, including physicians, understand the transmission routes, especially the importance of good hand hygiene and how to prevent transmission. Informing patients' families and visitors on how to prevent transmission is also important. Online support can be arranged for this training and assessment if required.

Recommendation 4. **As soon as possible, to conduct *P. aeruginosa* risk assessments within the NICU.**

8 Site plant room and Borehole (Findings of PMD)

23. Both the borehole water and utility mains supply enter the site in the plant room. There appeared to be some uncertainties surrounding the risk assessment and management of the borehole water. During the visit, we were told that there are no known records of any communications with the Local Authority regarding the risk assessment for using a borehole as a safe water supply for the hospital. There is a legal requirement under Regulation 6 of the Private Water Supplies (England) Regulations 2016 (PWS Regulations 2016) for each local authority to undertake a risk assessment of each private water supply system in its area (except certain single domestic supplies) at least every five years.

24. The arrangements for management of the borehole water, which should be treated with sodium hypochlorite at entry, were unclear, i.e., who is responsible for the dosing, monitoring and adjustment of chlorine levels and whether they have been assessed as being competent to do this. This was especially concerning, as recent water testing detected no chlorine.

Recommendation 5. **To contact the Local Authority to seek clarification on its arrangements for assessing the risks associated with the Trust's borehole and the controls required for its safe operation.**

Recommendation 6. **To establish who, within the Trust, is responsible for managing the dosing of the borehole water, details of the dosing regimen are in place, and the competence of those responsible for tasks related to the management of the borehole.**

Recommendation 7. **To ensure appropriately trained and competent staff manage the water supply effectively, risk assessment actions are completed promptly, and routine temperature and biocide monitoring is initiated immediately**

Recommendation 8. **To ensure that all chemicals, including sodium hypochlorite containers, are stored safely in a suitably bunded area.**

25. **Domestic hot water**

26. Domestic hot water for the majority of the site (including parts of WHB) is generated in the plant room via plate heat exchangers served by LTHW, which is generated via CHP. Flow and return temperatures from the PHEs appear to be within recommended values, as are the temperatures within the storage vessels. However, the calibration status of the gauges fitted to the plant has not been established.

Recommendation 9. **The accuracy of gauges and temperature-testing equipment should be periodically checked, e.g., by using an externally calibrated surface probe thermometer to verify temperatures via the connecting pipework.**

27. Although hot water temperatures appear to be good at the point of generation, storage, and flow and return, routine monitoring of distributed hot water temperatures across the site, including the WHB, appears to have lapsed. This is a non-compliance with HSE ACOP L8 and HTM 04 01. The same seems to hold for the monitoring of stored and distributed cold water temperatures.

28. It is concerning that this appears to be the case for a number of other routine PPM activities that should be conducted on the water system at the WHB, e.g., TMV servicing and calibration checks, CWST inspections, etc. This lack of PPM and monitoring activity places the Trust in a vulnerable position should CQC request records to evidence that the Trust is following the guidance set out in HTM 04-01.

Recommendation 10. These PPM failures should be addressed with urgency, principally because there is currently little evidence that risks are being managed effectively.

29. Once effective monitoring of hot and cold-water temperatures is in place, the efficacy of the controls in place can be better assessed. In the first instance, temperature monitoring can be done manually, i.e., using handheld temperature probes to measure hot- and cold-water temperatures at the point of delivery and at strategic points along pipe runs.

30.

31. Ideally, remote monitoring sensors at outlets and across the system to permit an evaluation of how the water systems within the WHB are actually operating on a day-to-day basis, i.e., stored and distributed temperatures in real time, and the frequency of use of outlets (*see Appendix A on relevant standards and factors to consider when retrofitting remote sensors*).

Recommendation 11. As soon as possible, the scheme of control should be reviewed and a schedule of tasks drawn up to show compliance with all aspects of water system management (see also Table 1 of HTM 04-01 Part B)

Recommendation 12. Monitoring of temperatures, biocide levels, flushing audits, etc., to be carried out by trained and competent personnel, to begin as soon as possible, for verification that the control scheme is and remains effective.

Recommendation 13. Records should be maintained as required in HSE ACOP L8.

Recommendation 14. To explore the potential for installing remote monitoring technology across the water systems within the WHB

8.1 Chlorine dioxide dosing equipment

32. There is redundant equipment in the plant room basement, which appears to have been installed to generate chlorine dioxide to dose the site's water supply. We have been informed that plans are to install copper/silver ionisation dosing equipment. Still, it may be prudent to consider recommissioning the existing biocide dosing plant if other monitoring data indicate a need for additional chemical control of the water supplying the WHB.

Recommendation 15. To consider recommissioning the existing biocide dosing plant

8.2 The WHB plant room

8.2.1 Cold water supply and storage

33. Cold water enters the WHB plant room, located on the roof of the building, but it is not clear whether all of the water entering the CWST is derived solely from the mains or is a mixture of mains and borehole water – there is a coupling on the supply

pipework that could indicate that the two supplies are blended prior to entering the CWST.

8.3 CWST

34. The location of the CWST within the WHB plant room is far from satisfactory. It is situated directly above the plate heat exchangers that supply parts of the building. This means that stored water is exposed to a heat source that may cause heat gain, raising its temperature above recommended levels in HTM 04-01 Part B. This may well be a more pronounced issue in the summer months, given the rooftop location of the plant room. Again, there are uncertainties regarding the extent and significance of any heat gain due to the paucity of data on stored cold-water monitoring. Any problems of this nature would be affected by the CWST's turnover rate, but we were informed that water usage is not metered and that drop tests that could indicate turnover rate had not been performed. In addition, the insulation condition for the CWST is poor.

8.4 Access

35. Access to the CWST is problematic and is via an unsecured ladder and some scaffolding. Even with the ladder and scaffolding, access to the interior of the tank for routine examination and testing is extremely difficult due to the close proximity of the ceiling to the top of the tank and the inspection hatches. Space is limited in the plant room, but a smaller tank might suffice and could be sited away from the hot water generating equipment. Reducing the tank's size and increasing its turnover would not only help alleviate heat-gain issues but also facilitate safer, easier routine access. This would require risk assessment and WSG approval

Recommendation 16. A solution to the plethora of problems associated with the WHB plant room CWST would be to replace it and relocate it.

8.5 Pipework labelling

36. Understanding the water distribution network is essential to manage it safely and effectively, and it is a requirement within the HSE ACOP that there is an up-to-date asset register and schematic to facilitate the *Legionella* risk assessment. The lack of informed risk assessments, schematics, and asset registers constitutes non-compliance under the Health and Safety at Work Act and supporting legislation. We were informed that schematic drawings were prepared as part of the Hydrop Legionella risk assessment for WHB, which may assist to some degree. However, it is usually the case that significant assumptions are made in the preparation of this type of schematic drawing – mainly due to access restrictions imposed on the assessor.

However, as this is an old hospital where the pipework has inevitably changed over the decades, a comprehensive survey is needed to fully understand the system and enable effective remedial measures to regain control. It is understood that asbestos poses a problem that must be addressed before the survey can proceed. A priority action plan needs to be in place, agreed by the WSG.

Recommendation 17. **To undertake a comprehensive survey of the pipework supplying the WHB and the pipework within the hot and cold water distribution services.**

Recommendation 18. **To undertake investigations (e.g., level drop tests) to determine the rate of water usage within the CWST serving the WHB, and to ensure that the tank holds no more than 12 hours' supply, as advised in HTM 04-01.**

Recommendation 19. **To consider options to improve the location of the CWST, i.e., to reduce the likelihood of heat gain from the plate heat exchangers, and to allow safe access**.

9 NICU

37. The NICU unit is located within the WHB. I am very grateful to Matron Victoria Hakewell for spending her time and knowledge whilst visiting the unit.

38. There are three rooms allocated for patient use, with one designated as an isolation room not currently in use at the time of the visit. The number and placement of clinical sinks pose a risk to these patients, as there is very little space, and it is not possible to create a 2 m splash zone to reduce the risk of cross-contamination. There were three clinical sinks in the largest room, with one taken out of use, and its back-to-back counterpart in the adjacent room. Whilst a flushing regime was in place, this still posed a risk of biofilm growth within the feed pipework. The sinks and associated drainage systems therefore present a measurable risk of both direct and indirect splash or aerosol transmission from the sanitary fittings and associated drains for these neonatal.

39. The sink in the isolation room, which was not in use, was cramped with insufficient space to provide a patient a safe, splash-free zone.



Figure 1 back-to-back sink in neonatal out of use.



Figure 2 sink in isolation room in proximity to equipment and furniture at risk of splash contamination

9.1 Point of use filters

40. Whilst point-of-use filters are in use to protect patients, staff and visitors in NICU, in some cases, these were fitted so that they breached the water fitting regulations and increased the risk of contamination from splashback as they were very close to the drain and provided insufficient activity space, increasing the risk of cross-contamination of the filter outlet. POU filters should always be regarded as a short-term measure. A more effective long-term solution is required.

9.1.1 Choice and use of POU filters

41. Any filter used in high-risk areas should have sufficient and robust, independently reviewed validation data, preferably which has been published in peer-reviewed journals and not just in manufacturer/distributor publications. However, in very high-risk areas such as neonatal, with highly immunocompromised patients fitting filters alone is not sufficient to protect patients from P. aeruginosa. Filters are just one component of the protective measures required to minimise the risk of hospital-acquired infections.

42. Where these filters are fitted, it is inevitable that the exterior surfaces can become contaminated, especially where there is insufficient activity space, the filter extends below the waterline (breaching the water fittings regulations), or the filter is placed directly over the drain outlet. Slow-draining sinks increase the risk of splash contamination at the filter outlet, leading to colonisation and growth of pathogens.

9.1.2 POU filter fitting and cleaning.

Recommendation 20. The manufacturer's protocols should be reviewed and approved by the WSG for fitting and cleaning of filters should be followed, and checks made to ensure: -

a. Water filters are positioned to avoid or minimise backsplash to the filter outlet when in use,

b. There is sufficient activity space to allow handwashing without touching the filter housing and outlet or the basin

c. Any containers for connecting filtered water should be place well before the filter outlet point and not in contact with the sink or drain

d. The filter should be handled aseptically during installation by trained personnel, touching the filter outlet during installation use must be avoided

e. The water filter should not be positioned directly above a drainage point or immersed in collected water placed on the floor in a basin, bath, or in contact with contaminated surfaces

f. There is an air gap in compliance with the water fittings regulations



Figure 3showing filters in place which could breach the regulatory airgap

43. The extent of any contamination will depend on the local environment and hygiene factors. To minimise the risk of contamination of the dispensed water if the water filter is visibly contaminated or known to have been contaminated, it should be replaced.

44. We did not have the opportunity to speak with cleaners on this visit, so we did not establish if local cleaning WSG-approved protocols are in place for the external surfaces of the filter.

Recommendation 21. Filters must be cleaned only using the IPC/WSG-approved sanitising agents following the Trust protocol

a. At no point should the filter be disconnected during cleaning

b. Checks should ensure there is no leakage around the filter to the tap connection

c. Filters should not be refitted; if removed, they should be replaced by new filters.

***Note**, the use of organic disinfectants such as quaternary ammonium compounds and benzyl ammonium compounds should not be used, as PAcan utilise these as a nutrient source, and there is evidence in peer-reviewed literature of resistance to such products*

Recommendation 22. The WSG should review the risk assessment for filter placement and ensure that, where fitted, they do not pose a risk of breaching the water fittings regulations if the sink is filled or there is a backup following blockages.

Recommendation 23. There is sufficient activity space to achieve effective handwashing without cross-contamination of the filter outlet, and there is no potential for splash contamination from the drain directly under the filter outlet; and

Recommendation 24. There is a clear policy for how these should be cleaned and for cleaner training.

Recommendation 25. When decisions are made to fit POU filters, there is a clear exit strategy for their removal.

9.1.3 Avoidance of Contamination during plumbing works

45. The WSP should include processes to ensure that any additional considerations for refurbishment in the NICU are safe (this includes the associated drains), the design of tap outlets, drains, fixtures and fittings, but also storage, waste disposal, access and risks associated with the use of clean and dirty utility rooms, etc. and comply with the NETB 2024/3.

46. Additionally, contamination of the water system and outlets can occur when remedial and refurbishment works are carried out. New components that have been pressure-tested with water may have been sitting on a shelf for some time. We have experience with several millilitres of contaminated water found in new components. There is also the potential for cross-contamination from plumbers/installers' hands, tools, overalls, and shoes if separate tools, overalls, disinfectant wipes, hand gel, etc., are not available. All personnel installing and maintaining water systems and equipment must be trained in aseptic techniques to ensure that all installation and maintenance tasks are carried out only by personnel who are verified as trained and competent, with up-to-date knowledge of manufacturers' guidance, relevant regulations, guidance, and appropriate standards, and who hold an EUSR Blue Card or equivalent.

Recommendation 26. **New components/fittings/equipment, etc., for installation into the water system should ideally not have been pressure-tested with water. Ideally, leak/pressure testing at commissioning should be carried out as late as possible, using gas or treated water. The specification for new components should require them to be free of contamination. Where this is not possible, a validated and WSG-approved disinfection regime should be used before installing fittings, components, etc., and installation should be carried out only by those trained in aseptic technique.**

Recommendation 27. **For augmented care, new systems should be filled with disinfected water using an absolute-sterilising-grade microbial filter, as recommended in the NETB 2024/3.**

10 Adopting the Precautionary Approach for Managing Risks in NICU

47. NICU is currently overcrowded with clinical sinks in close proximity to furniture used by visitors, patient cots and equipment. This poses an unacceptable risk of HAIs from splash contamination. There's substantial evidence that splashes can reach up to 2 m from a sanitary fitting and can serve as a source of transmission for *PA* and other waterborne pathogens, including AMR. The precautionary approach to microbial risk management, enshrined in the Water Safety Plan, should be followed to reduce this risk. This approach has a proven track record of preventing disease, reducing costs and in the long term, building organisational resilience as WSG team members learn from each other (source WHO) and is supported by national guidance

    a. HTM 04-01 Part A, Section 1.2) states: “The design, installation and operation of water systems in healthcare premises shall adopt a risk-based but precautionary approach, recognising the increased susceptibility of many patients.”

    b. NETB 2024/3 Section 3.2: “Where patient vulnerability is high, design and operational measures should apply the precautionary principle — controlling potential hazards even where the evidence of risk magnitude is incomplete.”

    c. BS 8680 Clause 6.2 (Principles of WSP): “The plan should adopt a preventive and precautionary approach to managing water safety risks.”

48. Evidence from Frimley Health NHS Foundation Trust and from the Netherlands{Hopman, 2017 } demonstrates that a “water-safe” model of care—in which water and wastewater are excluded from the immediate patient environment—can significantly reduce healthcare-associated infection (HAI) incidence while

maintaining patient and staff safety. Surveillance data from Frimley indicate reduced environmental contamination and lower HAI incidence, leading to expansion into other high-risk wards. The Frimley model removes or isolates hand-wash sinks and drainage from direct patient environments, substitutes waterless hand hygiene and alcohol-based cleaning systems, and strengthens environmental surveillance. Frimley reports that this approach is safe, sustainable, and associated with documented reduced healthcare-associated infection (HAI) incidence in high-risk units.

49. A multidisciplinary risk assessment is needed to look at both the engineering and IPC implications. Adopting this approach, if practicable from an engineering perspective, has the potential not only to improve patient safety but also to allow some reconfiguration, giving more space around existing cots and freeing up space for additional needs by placing handwash sinks in the corridors, with clear demarcation that these were for handwashing only and marking out the splash zone space.

Recommendation 28. **It is therefore recommended that St Helier consider adopting a phased structured approach to exclude or minimise water and wastewater from direct patient environments in NICU. This includes:**

- **a. Conducting pre-intervention risk assessments, baseline environmental sampling, and staff training.**
- **b. Removing or isolating sinks within patient spaces.**
- **c. Substituting water-based cleaning with approved alcohol- or detergent-based products.**
- **d. Reviewing water system design to prevent splash or backflow risks.**
- **e. Oversight by the Infection Prevention and Control Committee (IPCC) in collaboration with the Water Safety Group (WSG).**
- **f. Increase environmental and patient surveillance by incorporating pilot monitoring into existing IPC dashboards and HAI surveillance**
- **g. Collecting data on:**
- **h. Waterborne organism isolation rates (environmental and clinical).**
- **i. Device-associated and bloodstream infection rates.**
- **j. Compliance with hand hygiene and cleaning protocols.**

Recommendation 29. **Evaluate effectiveness at 6- and 12-month intervals, with a view to Trust-wide adoption if results are positive.**

10.1 Reducing Antibiotic Resistance

50. Effective clinical, continuous, and systematic surveillance if Watersafe care is implemented should be able to provide timely, accurate and relevant interpreted data to establish the trends of hospital-acquired PAinfections and burden of disease on the Trust and patients. As PA is inherently resistant to antibiotics and can readily acquire additional resistance, including to carbapenamases, the presence of multiple antibiotic-resistant waterborne pathogens is seen as a critical risk to human health by the World Health Organisation (WHO) as a serious health-care threat, including it in the list of the highest priority pathogens (15).

51. Waterborne infection caused by antibiotic-resistant strains is easily identifiable. It is likely to be the tip of the iceberg of the actual burden of infection from waterborne sensitive strains, which are not easily detected. However, it is essential to note that antibiotic profiling alone is insufficient to demonstrate relatedness between clinical and environmental strains.

11 Water Quality Risk Assessments for *P. aeruginosa*

52. Whilst systemic colonization of PA in building water systems has been identified previously, this is rare; it should be assumed that like *Legionella*, PA and other waterborne pathogens will be present in the incoming drinking water distribution system and are likely to be present in small numbers (unless there has been a contamination event or a failure in water treatment), and may be undectable by routine methods (i.e. Viable But Not Culturable) and of low virulence at the cold incoming temperatures. Once within the building, however, they are likely to increase to levels that can cause harm, particularly where warm water temperatures and nutrients are present, which may be derived from the pipework and fittings themselves, as well as from wastewater and other fluids put into the drains.

53. However, PA is more likely to colonise and grow at the periphery of the system from a cross-contamination event, and is usually found within approximately 2 m from the outlet(18), within the outlet itself and associated components (where present) and the wastewater drains and overflows. There is much documented evidence of many possible sources associated with PA infections in healthcare, including equipment used for treatment and diagnosis, personal and clinical items, pharmacy preparations prepared where there is a water outlet in the clean utility, toilets, hydrotherapy pools, plastic bath toys, etc., all of which pose a risk of waterborne infections.

54. Therefore PA risk assessments cannot just rely on engineering and operational assessments (as for *Legionella*) but need to be carried out and reviewed by a

multidisciplinary team which includes for example, Infection Prevention and Control (IPC), Estates, Facilities providers, cleaning supervisors, specialist user group such as dialysis, decontamination, hydrotherapy etc. and microbiologists with knowledge of the hazards, hazardous events and risks associated water and the healthcare environment. External help should be sought where required, from competent public health and/or clinical microbiologists with expertise in water microbiology, epidemiologists, and infection prevention and control specialists. The risk assessment process should build on existing infection prevention and patient safety measures for waterborne infections. As an up-to-date *Legionella* risk assessment is a legal requirement, a starting point then, should be to carry out the pipe survey in NICUas part of the *Legionella* risk assessment and ensure it, the asset register and the schematics are up to date, that it complies with BS 8580-2019, L8, HSG 274 and HTM 04-01, that remedial measures have been completed.

55. When the risk assessment for *Legionella* spp, carried out to BS 8580-1:2019, shows good compliance with the HSE ACoP L8 and associated guidance HSG 274, for the management of *Legionella* risks and the appropriate control measures and systemic engineering components are in place and effective, the risks from systemic *PA* should also be under control.

56. An asset register is a requirement with the ACOP L8 for *Legionella* risk assessments but is unlikely to include all systems and items of equipment, fittings and components which might pose a risk from *P. aeruginosa*; the completeness of the asset register should be verified to ensure it includes all assets which could pose a risk of waterborne infection in addition to those identified in the *Legionella* risk assessment. Input will be required from those with practical experience and knowledge of the buildings, systems, and equipment, as well as the activities and equipment used by and for users of water. Identification of relevant assets

57. The next step is to carry out a gap analysis to see what is missing for PA risk identification and mitigation. Whilst infections from *Legionella* are preventable, as they are primarily caused by inhalation or aspiration of water or aerosols containing Legionella (aspiration is often an underestimated mode of infection, especially in healthcare premises, and is important in patients who have difficulty swallowing), the control of PA infections is much more complex. For example, infection can occur as a result of :-

    a. Contact with contaminated water systems, associated fixtures, fittings and equipment,

b. Splash contamination as a poorly designed patient and non-patient areas i

c. Lack of safe storage facilities to minimize the risk of splash and aerosol contamination in bathrooms

d. Poor practices and processes of those involved in installing, commissioning and operating water systems and equipment, which could pose a risk

e. Poor cleaning and maintenance practices, including in non-patient areas

f. Poor practices and processes involved in food and drink preparation and delivery

g. Poor adherence to hand hygiene from all who may enter augmented care, including staff-only areas

58. Contamination from splashing from sinks and drains, both directly and indirectly, including in non-patient areas. For example, the potential for a contaminated plastic apron to cross-contaminate patients directly and indirectly.

Note, this is not an all-inclusive list

59. *PA* risk assessments are therefore much more complex than those required for *Legionella* as *PA*is not just limited to growth in water, it can grow in very low nutrient environments including sterile water, scavenging nutrients from the air, and can also grow on damp items such as face cloth's, tooth and shaving brushes etc., within sanitizing solutions made up incorrectly or with contaminated water, and also on damp cleaning cloths and mops etc. It can be spread by person to person and person to outlet contact so all potential uses of water must be taken into account not just water in distribution but equipment that at risk patients may be exposed to both off and on the wards with a multidisciplinary team to provide input together with environmental and physical factors such as splash contamination, the presence of damp personal articles and cleaning equipment for example.

60. The RA should therefore be carried out to BS 8580-2 by a competent multidisciplinary team, who have the local expereince to identify assets which pose a risk from exposure to *PA* or other waterborne pathogens in addition to those listed for *Legionella* taking account of all potential means of exposure and transmsission and consider all risks from water system design and engineeringThe *Legionella* asset register should be updated for all water systems and equipment used by patients in

augmented care, in addition to the required Legionella asset register (see HSE L8 (19)), to ensure all relevant assets are risk-assessed, controlled, and maintained as appropriate.

Recommendation 30.	**Whilst there is a gap in the risk assessment process and a lack of schematics for this area, this should be addressed as a priority, as both *PA*risk assessments and plans for effective real-time actions depend on the veracity of these assessments.**
Recommendation 31.	**The asset register should be updated to include items that require *PA*risk assessments and/or maintenance.**
Recommendation 32.	**There have been outbreaks associated with the use of wipes, etc., and these should be included in the risk assessment process to ensure due diligence in procurement and quality assurance processes that ensure they are safe for high-risk patient use.**
Recommendation 33.	**Assessors should have the competencies and experience needed to identify and assess all applicable systems and/or equipment which might pose a risk of infection in augmented care and be familiar with: the ecology of the target pathogen, the susceptible groups, All relevant modes of exposure, virulence factors, the means of transmission, how to achieve effective control taking into account all relevant factors which can contribute to the risk and consider the consequences of *PA*infections and the likelihood of those consequences arising, to derive a measure of harm and to set priorities for action.**
Recommendation 34.	**Where there is doubt about risk and /or the appropriateness of control measures, manufacturers, installers, and suppliers should be consulted, as necessary. Instructions from manufacturers on safe water uses should constantly be reviewed by the WSG before being implemented, as these have previously been found to be seriously deficient in some cases, leading to patient harm.**
Recommendation 35.	**It is essential that, for a meaningful risk assessment, the WSG identify relevant, competent, and trained staff to assist with the PA risk assessment who understand the ward/unit's activities and the patient-staff interactions that may pose risk. The team should include ward managers and IPC teams in each area to assess hand hygiene among staff, visitors, and patients, as well as cleaning regimes, training, and the understanding of all staff in augmented care areas, in particular.**
Recommendation 36.	**Consideration should also be given to areas outside of augmented care where high-risk patients may undergo diagnostic tests or treatment, as well as any outpatient areas.**
Recommendation 37.	**I would further recommend that a WSG subgroup be set up to share information and lead the risk assessment process. Following a suitable training session.**
Recommendation 38.	**Where there is a risk of infection from waterborne pathogens other than *Legionella*e and *PA* are implicated, those carrying out the risk assessment should have the competencies needed to assess the impact of the relevant hazardson pateitn safety, their ecological niches, modes of transmission and possible sources and assess all applicable systems and/or equipment which might pose a risk of infection and the measures needed to control the risk.**

11.1.1 Bottled drinking water.

61. It cannot be assumed that bottled water provided without due diligence checks, is safe for high-risk patients. The consumption of bottled water has been associated with causing outbreaks in several ICUs, so due diligence must be taken with high-risk patients and their families and visitors to ensure that they understand the risks from consuming water bought or brought from home.(1)

12 Training and competence

12.1 Training and Support Services Training

62. It is vital that all staff who influence water safety, including cleaning and kitchen support staff, understand the importance of using the correct practices and techniques and their role in protecting patients from infection. It has been found that where staff understand the risks, they take ownership and pride in trying to prevent patient infections. For example maintenance, cleaning and flsuhing staff can successfully act as the eyes and ears for nursing staff; identifying poor practices which may put patients at risk for example, outlets not being used, patients' chairs, beds, curtains, bins, and personal items etc. left within the splash zone (2m) etc. items brought in by relatives etc. which could put the patients at risk.

Recommendation 39. **All staff, including estates, contractors, nursing, clinical, medical, ancillary, patient support, and volunteers, should be aware of the risks to patients from waterborne pathogens and the best practices to prevent patient infection. All the above should undergo awareness training during induction and with more detail in augmented care.**

12.2 Plumbers / installers' competence and awareness

63. The practices of plumbers/ maintenance staff/ installers can have a detrimental effect on the whole system, not just in the localised areas where they are working (HTM 04 01). Components pressure tested with water may already be contaminated. Microbial sampling of the has shown both high TVCs and *P. aeruginosa*. Plumbers/installers must understand the risks to patients from poor adherence to personal hygiene and to tool/equipment hygiene, and from the prevention of cross-contamination in their practices.

Recommendation 40. **All plumbers/ maintenance staff / installers should receive training in water hygiene awareness, how waterborne infections can be transmitted, as well as hand hygiene, aseptic technique, and an understanding of the consequences to patients from poor adherence to Trust-approved practices.**

Recommendation 41. **Audits are periodically carried out to ensure that no untrained plumbers are used and that Trust protocols are adhered to. Ideally, a lead plumber would be appointed to act as a mentor to create a supported learning environment.**

Recommendation 42. **In addition, plumbers / installers working on water systems should have a Watersafe, or equivalent, blue card which shows they have received water hygiene training (see HTM 04-01(21) .**

Recommendation 43. **Ideally, there should be a separation of those who carry out work on the clean and contaminated areas of the water system. Tools, overalls etc. used for clean and dirty work should be kept separate and disinfected before use.**

13 Overall comments

64. The design and layout of the NICU are not conducive to effective infection prevention and control for such high-risk patients. The WSG are recommended to consider and ensure a plan is put in place to address the gaps and recommendations in this report and this is actioned as soon as possible.

Appendix 1: - Retrofitting Digital Temperature & Flow Monitoring

A2.2. Considerations for a Retrofit Approach

65. Automated temperature and flow monitoring should follow the guidance of HTM 04-01 Part A para.11 and HTM 08-05, ensuring systems are compliant with BS EN 61010-1 and BS EN 61326-1 for electrical and EMC safety. Manual verification remains a requirement (HTM 04-01 Part B para 6.63–6.66).

66. Data must be managed within the NHS Digital Data Security and Protection Toolkit framework and reported to the Water Safety Group as defined in BS 8680:2020.

67. I would start with critical circuits (e.g augmented care areas such as ICU, NICU, theatres) before whole-site deployment. Use systems compliant with BS EN 61010 & BS EN 61326 (electrical safety / EMC).Maintain the manual sentinel check schedule per HTM Part B to ensure verification.Ensure data outputs feed into the Trust's CAFM and WSG dashboard for Board-level assurance.

1) **System Survey – Map all sentinel and representative outlets, calorifiers, returns, and storage points.**
2) **Sensor Selection – Fit clip-on or inline digital temperature sensors (±0.5 °C accuracy) and ultrasonic flow meters where feasible. Bluetooth/LoRaWAN models minimise cabling.**
3) **Gateway Integration – Data transmitted to secure cloud/BMS dashboards for threshold alerts (e.g., HWS < 55 °C for >30 min).**
4) **Data Validation & Security – Cross-verify 5–10 % of sensor readings with manual thermometry monthly; store data per GDPR and NHS Digital Security Model.**
5) **WSG Reporting – Auto-generate trend graphs for sentinel circuits, exception logs, and corrective actions.**
6) **Return on Investment –reduces labour, improving energy efficiency (optimised recirc pumps and reduced over-heating).**

13.1 Relevant Standards:

1) **HTM 04-01 Part A §11 (BMS Integration) — supports use of automated systems to record temperature and flow data to supplement manual monitoring.**
2) **NHS Digital Estates and Facilities Strategy (2024) — encourages "smart building technologies" to reduce manual PPM burden and improve compliance visibility.**
3) **BS EN 12828 and BS EN 806 – system sensors and valve fitting for retrofits.**

14 Appendix 2 Standards and Guidance Reference List

1) **Department of Health and Social Care. Health Technical Memorandum 04-01: Safe Water in Healthcare Premises – Part A: Design, Installation and Commissioning. London: DHSC; 2023.**
2) **Department of Health and Social Care. Health Technical Memorandum 04-01: Safe Water in Healthcare Premises – Part B: Operational Management. London: DHSC; 2023.**
3) **Health and Safety Executive. Legionnaires' Disease: The Control of Legionella Bacteria in Water Systems (Approved Code of Practice L8). 5th ed. London: HSE; 2024.**
4) **Health and Safety Executive. HSG 274 Part 2: The Control of Legionella Bacteria in Hot and Cold Water Systems. London: HSE; 2024.**
5) **British Standards Institution. BS 8680: 2020 – Water Safety Plans – Code of Practice. London: BSI; 2020.**
6) **British Standards Institution. BS 8580-1: 2019 – Water Quality – Risk Assessments for Legionella Control – Code of Practice. London: BSI; 2019.**
7) **British Standards Institution. BS 8580-2: 2022 – Water Quality – Risk Assessments for Pseudomonas aeruginosa and Other Opportunistic Waterborne Pathogens – Code of Practice. London: BSI; 2022.**
8) **NHS Estates. National Estates Technical Bulletin 2024/3: Safe Water Systems. London: Department of Health and Social Care; 2024.**
9) **Energy & Utility Skills Ltd. EUSR Water Hygiene Scheme (Blue Card) – Competence Standard. Birmingham: EUSR; 2024.**
10) **World Health Organization. Guidelines for Drinking-water Quality. 4th ed. Incorporating 1st & 2nd Addenda. Geneva: WHO; 2022.**
11) **Health and Safety at Work etc. Act 1974 (UK Public General Act 1974 c. 37).**
12) **Control of Substances Hazardous to Health Regulations 2002 (SI 2002/2677).**
13) **The Private Water Supplies (England) Regulations 2016 (SI 2016/618).**
14) **Department for Environment, Food and Rural Affairs (DEFRA). Private Water Supplies (England) Guidance Notes. London: DEFRA; 2016.**
15) **NHS England. Infection Prevention and Control Manual – Waterborne Pathogens Section. London: NHSE; 2024.**
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17) **Health and Safety Executive. Legionnaires' Disease Technical Guidance – Part 3: Cooling Water Systems.London: HSE; 2024.**
18) **Department of Health. Health Building Note 00-09: Infection Control in the Built Environment. London: DH; 2013.**
19) **Institution of Mechanical Engineers. Water Systems Design for Healthcare Facilities – Good Practice Guide.London: IMechE; 2021.**
20) **NHS Estates. Water Safety Group and Water Safety Plan Implementation Guidance. London: DHSC; 2024.**

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Group Board

Meeting in Public on Thursday, 09 July 2026

Agenda Item	3.1	
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 significant developments across the Group since the previous public meeting of the Board in May 2026.

The period has seen continued progress in delivering the Group's strategic ambitions, while also requiring the organisation to respond to a number of significant quality, operational and financial challenges. This report highlights some of the key developments that have shaped the organisation over recent months and provides my perspective on the opportunities and challenges ahead.

The report reflects on a number of important quality and safety matters, including the publication of the independent Royal College of Physicians review into Interstitial Lung Disease services, our response to water safety issues within E Block at St Helier Hospital, confirmation of £57 million national investment to redevelop the St Helier Emergency Department, publication of the recent CQC service inspection reports, and the recent CQC Well-Led inspection of Epsom and St Helier.

It also highlights the Group's continued focus on innovation, leadership and organisational culture, including the Secretary of State's visit to St George's Hospital, the launch of our first Big Thank You Week, the Living Our Values Challenge, the inaugural gesh Leadership Forum, and recent Executive appointments.

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				
Highlights key strategic and operational risks currently facing the Group.				
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				
Summarised within the report; detailed financial position is reported separately.				
Legal and / or Regulatory implications				
Includes updates on regulatory matters, including CQC inspections and the Independent Review of ILD services.				
Equality, diversity and inclusion implications				
The report highlights initiatives to strengthen inclusion, staff experience and organisational culture.				
Environmental sustainability implications				
The report includes updates on sustainability initiatives and climate resilience.				

Group Chief Executive Officer's Report

Group Board, 09 July 2026

1.0 Purpose of paper

1.1 This report provides an overview of significant developments across the Group since the previous public meeting of the Board in May 2026. It highlights key achievements, reflects on some of the most important issues facing the organisation, and provides my perspective on the opportunities and challenges ahead.

1.2 Three months into my time as Group Chief Executive, I have continued to be inspired by the professionalism, compassion and ambition I see across our Group. The period since our last public Board meeting has reflected many of the opportunities and challenges facing the NHS today. We have celebrated significant achievements, secured major investment in our estate, welcomed national recognition for our services and colleagues, and continued to embrace innovation and transformation. At the same time, we have also had to confront difficult issues openly and honestly, learning from where care has fallen short and supporting our staff through periods of significant operational pressure.

1.3 Throughout all of this, I have been struck by one constant: the extraordinary commitment of our people. This report highlights just some of the developments that demonstrate both the resilience of our organisation and our determination to continue improving the care we provide.

2.0 Quality, Safety and Learning

Independent Review of Interstitial Lung Disease

2.1 One of the most significant issues before the Board at this meeting is the publication of the independent Royal College of Physicians invited review into the care provided to patients within the Interstitial Lung Disease service at Epsom and St Helier.

2.2 The circumstances that led to this review have been deeply distressing for the patients and families affected and for our staff. I would like to thank every patient and family member who has shared their experiences throughout this process, and the review team for undertaking such a thorough and independent assessment.

2.3 From the outset, our commitment has been to approach this work with openness, transparency and humility. Where care has fallen below the standards that patients rightly expect, we have acknowledged that, apologised and have taken steps to ensure that we learn. Equally importantly, we must ensure that those lessons result in tangible improvements to the way we deliver care in the future.

2.4 The accompanying Board paper later in the agenda sets out the findings of the review, the work already undertaken to strengthen respiratory services, and the comprehensive programme of actions that is now being implemented. I am committed to ensuring that this programme receives sustained Executive and Board oversight until we are satisfied that every recommendation has been fully addressed.

Water Safety in E Block at St Helier Hospital

2.5 In recent months, the Board and Executive team have also been required to consider one of the most significant estates and patient safety issues currently facing the Group.

2.6 Following extensive technical assessment and independent expert advice, we have concluded that while the wide range of mitigations currently in place mean services within E Block at St Helier Hospital remain safe, they do not represent a sustainable long-term solution. As a result, we have begun planning for the refurbishment of the building's water infrastructure, recognising that this will require a temporary decant of services.

2.7 I fully recognise the concern this has caused amongst staff, patients and the local community. We have undertaken an extensive programme of engagement with colleagues, patients, local authorities, Members of Parliament, neighbouring NHS organisations and the media. I have personally undertaken a number of media interviews because I believe it is important that we are open about the challenges we face, explain the evidence underpinning our decisions and reassure local communities that patient safety remains our overriding priority.

2.8 In particular, I want to acknowledge the uncertainty this creates for colleagues working within Women's and Children's Health services. I have been enormously impressed by the professionalism with which staff have continued to care for patients whilst also engaging constructively with difficult discussions about the future. We will continue to involve staff closely as options are developed and decisions are taken over the coming months.

Investing in the Future of Emergency Care at St Helier

2.9 One of the most significant developments since my last report has been confirmation that the Group has secured £57 million of national capital funding over the next four years to support the redevelopment of the Emergency Department at St Helier Hospital. This represents one of the largest recent investments in our estate and is a major vote of confidence in both the future of the site and the services we provide for our local communities.



2.10 The investment comes at a critical time. St Helier's Emergency Department was designed for a very different model of care and a much lower volume of patients than it now sees. As demand has continued to grow, our clinical teams have worked tirelessly within an estate that places increasing constraints on patient flow, privacy, dignity and the overall experience of both patients and staff. The redevelopment will enable us to create a modern, fit-for-purpose emergency department that is better equipped to meet the needs of today's patients while providing a safer and more supportive environment for our colleagues.

2.11 The importance of this investment was also reflected in the recent CQC service inspection, which identified the limitations of the current Emergency Department estate as a significant factor contributing to operational pressures at St Helier, whilst recognising the professionalism, compassion and resilience of our staff working within those constraints. The redevelopment provides an important opportunity to address those longstanding challenges and support improvements in patient flow, operational resilience and the overall quality of care.

2.12 Securing the funding is an important milestone, but it is only the beginning of what will be a complex programme of work. Over the coming months we will work closely with NHS England, our clinical teams, staff, patients and local partners to develop the detailed design and delivery programme, ensuring that services remain safe and accessible throughout the construction period. I know colleagues across the organisation are excited by the opportunities this investment presents, and I would like to thank everyone who has contributed to reaching this significant milestone.

CQC Service Inspection Reports at Epsom and St Helier

2.13 Since my last report, we have received the Care Quality Commission's reports following its inspections of services at Epsom and St Helier Hospitals. I would like to thank colleagues across both sites for the professionalism, openness and commitment they demonstrated throughout the inspection process and, more importantly, for the care they continue to provide every day.

2.14 The reports recognise a number of important strengths across our services. Inspectors consistently found compassionate, respectful care, with many patients describing staff as kind, supportive and attentive. They also recognised the commitment of teams to learning from incidents, using quality improvement to drive change and maintaining strong multidisciplinary working, even in the face of significant operational pressures. Across a number of services, inspectors highlighted visible and approachable leadership, positive team cultures and governance arrangements that support learning and improvement.

2.15 I am particularly pleased by the progress recognised within our maternity services. Following the previous inspections in 2023, significant work has been undertaken by colleagues to strengthen governance, improve staffing, enhance record keeping, modernise clinical pathways and invest in the maternity environment. The CQC recognised that both maternity services have improved to an overall rating of Good, with the previous breaches of regulations relating to governance lifted at both sites and the previous breach relating to safe care and treatment also lifted at St Helier. The reports recognise improvements in areas including triage processes, medicines management, mandatory training, governance, transitional care, bereavement facilities and the overall experience of women and families.

2.16 The reports also acknowledge the significant operational challenges facing the NHS. In particular, inspectors recognised the impact that sustained demand, patient flow and discharge pressures continue to have on services, especially urgent and emergency care and medical pathways. While these pressures remain, it was encouraging that the CQC also recognised the commitment of our teams to managing risk, learning from experience and continually improving services for patients.

2.17 Between 12 and 14 May 2026, the Care Quality Commission (CQC) undertook its Well-Led inspection of Epsom and St Helier. The inspection considered the effectiveness of leadership, governance, culture and organisational arrangements across the Trust. We have not yet received the inspection report and expect this in the coming months. Once the report has been received, we will consider its findings carefully alongside those from the St George's Well-Led inspection completed last year. This will enable us to develop a single Group-wide Well-Led

improvement plan, bringing together the common themes and priorities across both organisations, whilst recognising the need for site-specific actions where appropriate. Our ambition is to build a consistent, high-performing and well-led culture across the Group, drawing on learning from both inspections to support continuous improvement.

3.0 Delivering our Strategy

Visit from the Secretary of State and Digital Innovation

3.1 I was delighted to welcome the Secretary of State for Health and Social Care to St George's on 2 July. The visit provided an opportunity to demonstrate both the extraordinary pressures facing urgent and emergency care services and the innovative approaches we are taking to improve patient care. During his visit to our Emergency Department, the Secretary of State saw Ambient Voice Technology (AVT) being used in clinical practice, allowing clinicians to spend less time documenting consultations and more time caring directly for patients.



3.2 This technology represents only one example of our wider ambition to embrace digital innovation responsibly in order to improve quality, productivity and staff experience. Today's Board is considering our new Digital and Data Strategy, which sets out a comprehensive vision for creating a safer, more connected and more digitally enabled organisation over the next five years. The strategy reflects our belief that digital transformation is not simply about technology; it is about giving patients better access to services, reducing administrative burden for staff and enabling better clinical decision-making through high-quality information.

3.3 Innovation continues to extend beyond digital technology. I was particularly pleased to see national recognition for our cardiovascular research teams and the continued development of pioneering clinical technologies that reinforce our position as one of the country's leading academic healthcare organisations.

4.0 Our People

The Big Thank You

4.1 One of the highlights of this month is our first Group-wide Big Thank You Week, which we are holding this week.

4.2 Since joining the Group, one of the greatest privileges has been spending time with colleagues across our hospitals and community services. Every visit has reinforced the extraordinary commitment, compassion and professionalism that exists throughout gesh. Whether talking to clinical teams caring for some of our sickest patients, support staff keeping our hospitals running, or colleagues working behind the scenes to improve services, I have been struck by the pride people take in their work and the genuine care they show for patients and one another. Those conversations have also reminded me that, in the pressures of everyday NHS life, we do not always take enough time to recognise and thank one another for the difference we make.

4.3 The idea behind the week was simple. Throughout my conversations with colleagues since joining the organisation, and reflected clearly in the findings of the NHS Staff Survey, one message has come through consistently: while colleagues are deeply committed to caring for patients and proud of the work they do, they do not always feel sufficiently recognised for the extraordinary contribution they make every day. We cannot expect colleagues to continue giving their very best without ensuring that they feel valued, appreciated and supported in return.



4.4 The Big Thank You was therefore designed not simply as a week of celebration, but as an opportunity to begin strengthening a culture of recognition across the Group. Throughout the week, colleagues across our hospitals and community services took part in a wide range of activities, from wellbeing events and team celebrations to opportunities to thank colleagues personally, recognise outstanding contributions and spend time together away from the pressures of everyday work. With the generous support of our hospital charities, more than 10,000 meals and ice creams were made available to colleagues, alongside wellbeing activities designed to ensure that staff working across different sites and shift patterns could also take part.

4.5 What impressed me most, however, was not the programme itself but the response from colleagues. Across the Group I saw teams taking time to recognise one another, thank colleagues for their support and celebrate the countless acts of kindness, professionalism and teamwork that often go unnoticed. Those conversations reinforced my belief that creating a culture of appreciation is not about one annual event—it is about changing the way we work together every day.

4.6 The Big Thank You is therefore intended to be the beginning rather than the end of this journey. Alongside our response to the NHS Staff Survey, the Living Our Values Challenge and other initiatives to strengthen organisational culture, it forms part of our wider ambition to make gesh a place where every colleague feels recognised, respected and proud to work.



4.7 Recognition, however, is only one part of creating the culture we want to build across gesh. It must be accompanied by the behaviours, values and everyday interactions that shape how colleagues experience working here and, ultimately, the care our patients receive.

Living Our Values

4.8 Alongside the Big Thank You campaign, we have launched the Living Our Values Challenge, encouraging colleagues across the Group to reflect on what our CARE values mean in practice and how they can be demonstrated through everyday behaviours.



4.9 Culture is shaped far more by what people experience every day than by what is written in organisational strategies or policies. The challenge therefore seeks to encourage practical examples of collaboration, compassion, inclusion and continuous improvement, helping to embed our values throughout the organisation.

4.10 Together with the work underway in response to the NHS Staff Survey, these initiatives represent an important part of our ambition to make the Group a place where colleagues feel supported, listened to and able to do their very best work.

4.11 Living our values is not only about the way we work together; it is also about creating an organisation where everyone feels respected, included and able to be themselves. During June, colleagues across the Group came together to celebrate Pride Month, recognising the contribution of our LGBTQ+ colleagues and reaffirming our commitment to creating an inclusive workplace where diversity is valued and celebrated. Events such as Pride provide an opportunity not only to celebrate our colleagues, but also to reflect on the importance of inclusion, belonging and ensuring every member of staff feels able to bring their whole self to work.



Celebrating Long Service – gesh25 Hall of Fame

4.12 Our values are brought to life every day by colleagues across the organisation. Nowhere is that more evident than in those who have devoted decades of service to caring for patients and supporting one another. Recognising the commitment and dedication of colleagues who have devoted many years to caring for our patients is an important part of building a culture where people feel valued and appreciated.

4.13 In May, we held our gesh Long Service Awards, recognising colleagues who have each completed 25 years or more of NHS service. Across the Group, more than 120 colleagues were recognised, representing over 3,200 years of collective NHS service.



4.14 The event provided an opportunity to celebrate not only remarkable lengths of service, but also the lasting contribution these colleagues have made to the lives of patients, their fellow staff and the communities we serve. Collectively they have witnessed extraordinary change across the NHS, helping shape our organisations while continuing to demonstrate the compassion, professionalism and commitment that define our values today.

4.15 One of the things that has struck me most during my first few months at gesh has been the pride that colleagues take in working here and the depth of experience that exists across our workforce. The Hall of Fame was a fitting opportunity to recognise those who have dedicated so much of their professional lives to public service, and I was delighted to have the opportunity to thank them personally on behalf of the Group.

4.16 Celebrating the contribution of our experienced colleagues is important, but so too is investing in the next generation of leaders who will shape the future of our organisation.

Launch of the gesh Leadership Forum

4.17 The quality of leadership is one of the single biggest determinants of organisational culture, staff experience and ultimately the quality of care we provide. Alongside investing in our people and strengthening our organisational culture, we also need to ensure that our senior leaders have regular opportunities to learn together, share experience and develop a common understanding of the challenges and opportunities facing the Group.

4.18 On 26 June, we held the first gesh Leadership Forum, bringing together the Group Executive Team, Site Leadership Teams and senior operational and divisional leaders from across both Trusts for a half-day leadership event at St George's Hospital. The Forum focused on the changing NHS landscape, the opportunities presented by artificial intelligence and digital innovation, our emerging organisational priorities, and the leadership behaviours needed to deliver change across a complex organisation. Colleagues also took part in interactive sessions to help shape both our priorities for the coming years and our Group Accountability Framework, exploring how we create a culture in which decision-making is taken at the lowest appropriate level, supported by clear accountability, collaboration and empowerment.

4.19 The Leadership Forum represents an important evolution in how we develop leadership across gesh. Unlike some of our wider engagement events, it is designed as a focused quarterly forum for those leading services and delivering change across the organisation. By rotating the event across our hospital sites and varying attendance according to the topics being discussed, we aim to strengthen relationships across organisational boundaries, develop leadership capability and create a more connected leadership community across the Group.

4.20 The feedback from colleagues was extremely positive and reinforced the importance of creating dedicated time for leaders to step away from day-to-day operational pressures to focus on learning, collaboration and the longer-term development of the organisation. I look forward to seeing the Leadership Forum become an important part of how we continue to develop leaders at every level across gesh.

Recognising excellence across the Group

4.21 One of the greatest privileges of this role is seeing the extraordinary achievements of colleagues across every part of our organisation. During the past few months there have been many opportunities to celebrate the expertise, innovation, compassion and commitment that exist across gesh, and I would like to recognise just a few of those achievements.

4.22 I was delighted that our cardiovascular research team at St George's received national recognition at the National Institute for Health and Care Research Cardiovascular Research Awards. These awards recognise not only outstanding academic achievement, but also our continued commitment to ensuring patients benefit from world-leading research and access to the latest treatments and clinical trials.

4.23 Our Serious Violence Team has also been shortlisted for a national HSJ Patient Safety Award. This reflects the innovative work being undertaken to support patients affected by serious violence and demonstrates how our teams continue to work in partnership with local organisations to improve outcomes for some of the most vulnerable people within our communities.

4.24 Innovation continues to flourish across the Group. At St George's, colleagues have introduced CardioMEMS, an innovative remote monitoring system for patients living with heart failure, enabling earlier intervention and helping patients remain well at home. It is an excellent example of how technology can improve both patient experience and clinical outcomes.

4.25 These examples represent only a small proportion of the extraordinary work taking place across our hospitals and community services every day. Whether through pioneering research, innovation, outstanding clinical care or acts of kindness that rarely attract public attention, our colleagues continue to demonstrate why this organisation enjoys such an outstanding reputation nationally.

5.0 Operational Resilience

5.1 The prolonged period of exceptionally hot weather during June and early July presented significant operational challenges across the NHS, increasing demand for urgent care while also creating additional risks for vulnerable patients, staff and our estate.

5.2 Throughout this period, the Group maintained close operational support to our clinical teams to monitor pressures, coordinate responses and ensure that appropriate mitigations were implemented as conditions changed. Particular attention was given to the care of vulnerable patients, hydration, ward temperatures, staff welfare and the resilience of our estate and infrastructure.

5.3 Our clinical and operational teams worked proactively to minimise the impact of the heat on patient care, adapting services where necessary, providing additional support to frontline teams and maintaining close oversight of operational performance. Colleagues across estates and facilities also worked tirelessly to respond to the additional pressures placed on our buildings and infrastructure during periods of sustained high temperatures.

5.5 The recent heatwave also served as a timely reminder that climate resilience is becoming an increasingly important consideration for the NHS. During Green Day in May, colleagues from across the Group came together to celebrate the many ways in which we are reducing our environmental impact and embedding sustainability into the way we deliver healthcare. The events highlighted that environmental sustainability is not only about reducing our carbon footprint, but also about ensuring our services, buildings and infrastructure are resilient to the growing impact of extreme weather and other environmental challenges. The experience of recent weeks has reinforced the importance of continuing this work as part of our long-term planning for the future.

6.0 Financial Sustainability

6.1 Like NHS organisations across the country, the Group continues to operate in an exceptionally challenging financial environment.

6.2 Although both Trusts remain on plan at Month 2, this position continues to rely on careful management of underlying financial pressures and significant delivery of productivity and efficiency improvements over the remainder of the year. As the accompanying finance report makes clear, achieving our financial plan will require continued focus on cost improvement delivery, transformation and financial discipline.

6.3 The decision by NHS England to place the Group into enhanced oversight for finance underlines the seriousness of the challenge facing both our organisation and the wider NHS. While this inevitably increases the level of external scrutiny, it also provides additional focus on the pace and scale of change required. We remain fully committed to working constructively with NHS England and system partners to deliver our agreed financial plans.

6.4 The financial challenge cannot be addressed through traditional cost reduction alone. Sustainable improvement will depend upon successfully delivering our transformation programme, embracing digital innovation, improving productivity and continuing to redesign services around the needs of patients.

7.0 Leadership

7.1 The coming months will see a number of important changes to the Group's Executive Team, reflecting both the continued development of the organisation and the opportunities for talented colleagues to progress into new leadership roles.

7.2 I am delighted that **Azara Mukhtar** will join the Group in August as our new Group Chief Finance Officer. Azara brings more than 30 years of NHS finance experience, having held senior leadership roles at Guy's and St Thomas', Barts Health, NHS London, Croydon Health Services and, most recently, Oxleas NHS Foundation Trust. Alongside her extensive financial leadership experience, Azara has played an important role in organisational growth and system working across South West London. Her experience will be invaluable as we continue to strengthen the Group's financial sustainability, support delivery of our Medium Term Plan and transformation programme, and invest in improving care for our patients and communities.

7.4 I am also pleased that **Chinyama Okunuga** will join the Group on 1 October as Managing Director for Epsom and St Helier. Chin joins us from Whittington Health NHS Trust, where she is Chief Operating Officer, bringing an impressive track record in operational improvement, urgent and emergency care, elective recovery and system partnership working. She also brings extensive Board-level experience in quality, safety, governance and organisational resilience, and will play a pivotal role in leading services at Epsom and St Helier through the next phase of their development within the Group.

7.5 In November, **Tracy Luckett** will join the Group as Group Chief Nursing Officer. Tracy is currently Chief Nurse at Great Ormond Street Hospital, where she has Executive responsibility for infection prevention and control, patient experience, safeguarding and the professional leadership of nursing and allied health professions. Tracy's extensive experience of clinical leadership, patient safety, workforce development and quality improvement will make an important contribution as we continue to strengthen nursing, midwifery and allied health professional leadership across the Group and deliver our ambitions for consistently safe, high-quality and compassionate care.

7.6 Together, these appointments represent a strengthening of the Group Executive Team and bring a wealth of experience that will support delivery of our strategic ambitions over the coming years. Collectively they bring significant expertise across finance, operational delivery and clinical leadership, strengthening the breadth of experience within the Executive Team.

7.7 Following Alex Shaw's departure in mid-August, Rebecca Suckling, currently Site Chief Medical Officer at Epsom and St Helier, will undertake the role of Interim Managing Director until Chin joins the organisation in October. Rebecca will be supported in this interim period by Michael Pantlin, Group Deputy Chief Executive Officer, who will spend additional time at Epsom and St Helier to ensure continuity of executive leadership and support delivery of our operational and strategic priorities.

7.8 I would also like to take this opportunity to thank **Alex Shaw** for his outstanding contribution to the Group over the past four years and to congratulate him on his appointment as Chief Delivery Officer at University Hospitals Sussex NHS Foundation Trust. Alex joined the organisation as Site Chief Operating Officer in 2022 and, in September 2025, stepped up to undertake the role of Interim Managing Director for Epsom and St Helier. During his time with the Group, Alex has provided visible and compassionate leadership through a period of significant organisational change, helping to lead improvements in urgent and emergency care, elective recovery, diagnostics, cancer performance and patient flow, while also overseeing major transformation programmes including implementation of the electronic patient record system. Alex leaves with our sincere thanks for his commitment, professionalism and leadership over the past four years. On behalf of the Board and colleagues across the Group, I wish him every success in his new role and look forward to continuing to work with him through our wider NHS partnerships.

7.9 I would also like to thank **Lizzie Alabaster** for her exceptional financial leadership both in her role as Interim Group Chief Finance Officer, since stepping up to cover the role in December 2025, and in her substantive role as Site Chief Finance Officer at Epsom and St Helier. Lizzie has provided strong financial leadership during one of the most challenging periods the NHS has faced, supporting the Group through significant financial pressures while helping to shape our Medium Term Plan, transformation programme and wider financial strategy. Throughout this period she has brought calm judgement, integrity and a clear focus on supporting high-quality patient care through strong financial stewardship. On behalf of the Board and colleagues across the Group, I would like to thank Lizzie for the enormous contribution she has made to the organisation.

8.0 Closing Reflections

8.1 Three months into my time as Group Chief Executive, I remain enormously optimistic about the future of this organisation. There is no doubt that the challenges we face are significant. Financial pressures, rising demand, ageing estates and the pace of change required across the NHS mean that we cannot simply continue doing things as we always have. What gives me confidence is the quality of our people. Across every service I have visited I have met colleagues who care deeply about their patients, support one another through difficult circumstances and are determined to improve.

8.2 The Board agenda today reflects both the challenges we must confront and the opportunities before us. Whether learning openly from where care has fallen short, investing in digital innovation, celebrating our people, modernising our services or strengthening our strategic direction, we are building an organisation that is better equipped to meet the needs of the communities we serve for many years to come.

8.3 I would like to thank every colleague across the Group for their continued commitment, professionalism and compassion. It is a privilege to serve alongside them.

9.0 Recommendations

9.1 The Group Board is asked to note the report.

Group Board

Meeting in Public on Thursday, 09 July 2026

Agenda Item	3.2	
Report Title	**Month 2 Finance Report**	
Executive Lead(s)	Lizzie Alabaster, Group Chief Finance Officer	
Report Author(s)	Lizzie Alabaster, Group Chief Finance Officer Robert Chidlow, Site Chief Finance Officer – ESTH George Harford, Site Chief Finance Officer – SGUH	
Previously considered by	Finance & Performance Committee	26 June 2026
Purpose	**For Review**	

Executive Summary

- Both organisations remain on plan at M2
- While the Trusts remain on plan at month 2 there is material pressure on the year end forecast. The Group executive remains committed to work to deliver the financial plan as agreed but recognises there are material challenges in achieving that. The Finance and Performance Committee reinforced the need to work towards that and asked for assurance on plans at its next meeting.

Action required by Group Board

The Board is asked to:

a) note the two Trusts' financial position at Month 2 2026/27
b) note the pressure on the year end forecast

Committee Assurance	
Committee	Finance Committees-in-Common
Level of Assurance	Limited Assurance: The report and discussions did not provide sufficient assurance that the system of internal control is adequate and operating effectively and significant improvements are required and identified and understood the gaps in assurance

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

Implications				
Group Strategic Objectives				
☐ Collaboration & Partnerships			☐ Right care, right place, right time	
☒ Affordable Services, fit for the future			☐ Empowered, engaged staff	
Risks				
As set out in report.				
CQC Theme				
☐ Safe	☒ Effective	☐ Caring	☐ Responsive	☒ Well Led
NHS system oversight framework				
☐ Quality of care, access and outcomes			☐ People	
☐ Preventing ill health and reducing inequalities			☐ Leadership and capability	
☒ Finance and use of resources			☐ Local strategic priorities	
Financial implications				
As set out in report.				
Legal and / or Regulatory implications				
As set out in report.				
Equality, diversity and inclusion implications				
No EDI implications.				
Environmental sustainability implications				
No environmental sustainability implications.				

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

Finance Report M2
Public Board

Date: 9th July 2026

M2 ESTH

Reported position to NHSE

Performance £'m	YTD Plan	Actual	Variance	Annual Plan	Forecast	Variance
Income	124.24	127.76	-3.53 F	748.57	750.54	-1.97 F
Total Pay	**-85.66**	**-88.06**	**2.40 A**	**-502.12**	**-503.32**	**1.20 A**
Non-Pay	-41.96	-43.14	1.18 A	-239.13	-239.82	0.68 A
Non Operating Items	-1.22	-1.16	-0.06 F	-7.32	-7.40	0.08 A
Performance Target	**-4.60**	**-4.60**	**0.00**	**0.00**	**0.00**	**0.00**
DSF	-5.72	-5.72	0.00	-34.33	-34.33	0.00
Excluding DSF	**-10.32**	**-10.32**	**0.00**	**-34.33**	**-34.33**	**0.00**

CIP	YTD Plan £'m	Actual £'m	Variance £'m	Annual Plan £'m	Forecast £'m	Variance £'m
Pay - Recurrent	1.56	1.20	0.35 A	25.02	24.82	0.20 A
Non-pay - Recurrent	2.45	1.72	0.73 A	19.52	18.18	1.35 A
Income - Recurrent	0.30	0.12	0.18 A	4.45	4.18	0.27 A
Recurrent Efficiencies	**4.30**	**3.04**	**1.26 A**	**49.00**	**47.18**	**1.82 A**
Pay - Non-recurrent	0.31	0.53	-0.22 F	6.71	7.92	-1.21 F
Non-pay - Non-recurrent	0.61	1.66	-1.05 F	6.04	6.66	-0.62 F
Income - Non-recurrent	0.06	0.04	0.02 A	1.41	1.40	0.01 A
Non-Recurrent Efficiencies	**0.98**	**2.23**	**-1.25 F**	**14.16**	**15.98**	**-1.82 F**
Total Efficiencies	**5.28**	**5.27**	**0.01 A**	**63.15**	**63.15**	**0.00 A**

Efficiency Progress	Pay £'m	Non Pay £'m	Income £'m	Total £'m
Fully Developed	11.66	13.98	1.62	27.26
Plans in Progress	14.35	10.14	2.42	26.90
Opportunity	6.73	0.72	1.55	8.99
Unidentified	0.00	0.00	0.00	0.00
Total	**32.73**	**24.83**	**5.58**	**63.15**

Workforce	YTD Plan WTE	Actual WTE	Variance WTE	Move from M01 WTE
Substantive	6,422	6,440	-18 A	-5 A
Bank	816	941	-125 A	-1 A
Agency	59	49	9 F	4 F
Total	**7,297**	**7,431**	**-134 A**	**-3 A**

Key Metrics		Plan	Actual	Variance	M01 actual	Movement
Bed Number	**No**	**571**	**565**	**6 F**	**578**	**-13**

Summary financial position

- Whilst the trust remains on plan at month 2, underlying pressures have been mitigated in month by phasing or non recurrent action. There is material pressure on the year end forecast. The Group Executive remains committed to work to deliver the financial plan as agreed but recognises there are material challenges in achieving that. The Finance and Performance Committee reinforced the need to work through mitigations and CIP development and delivery across BAU and transformation CIP as planned.
- The Trust was £0.7m favourable in May offsetting the adverse variance reported in April for costs associated with Resident Doctor Industrial Actions, the Trust needs to work up cost out actions to mitigate.
- The Trust is forecasting being on plan for the year end in line with NHSE expectations.

Income

- Income is £3.5m favourable YTD largely driven by Patient Care income favourable position.
- Patient Care income favourable variance is driven by £2.0m SWL NR income phasing and other phasing adjustments.

Non pay & Non-Operating Items

- Non-Pay & Non-Operating items are £1.1m adverse YTD of this Theatres are £0.3m adverse.

Pay and workforce

- Pay is £2.4m adverse to plan YTD, £0.7m is last months industrial action. The remaining pressure is on CIP delivery slippage and pressures across clinical divisions to deliver services.
- Agency is on plan, but substantive is £0.5m adverse and bank is £1.8m adverse and in breach of the bank cap. Specific pressure relate to the ongoing requirements to deliver the enhanced care requirements of individual patients.
- The Trust is 134 WTE adverse to plan in M2, of this 100 WTE is due to slippage in the TUPE to St Georges for corporate consolidation. However, bank staff are 125 WTE more than plan as staffing has not reduced in line with the cap as a result of underlying pressures and CIP slippage.

M2 SGH

Reported position to NHSE

May-26

Performance	Plan £m	Actual £m	Variance £m	Annual Plan £m	Forecast £m	Variance £m
Income	215.18	215.26	0.08	1,299.65	1,299.65	0.00
Total Pay	-140.34	-141.18	-0.84	-815.08	-815.08	0.00
Non-Pay	-78.06	-77.30	0.76	-464.17	-464.17	0.00
Non Operating Items	-5.60	-5.59	0.00	-20.40	-20.40	0.00
Performance Target	**-8.80**	**-8.80**	**0.00**	**-0.00**	**-0.00**	**0.00**
DSF	-3.60	-3.60	0.00	-21.63	-21.63	0.00
Excluding DSF	**-12.41**	**-12.41**	**0.00**	**-21.63**	**-21.63**	**0.00**

CIP	Plan £m	Actual £m	Variance £m	Plan £m	Forecast £m	Variance £m
Pay - Recurrent	2.27	0.88	-1.39	34.03	34.03	0.00
Non-pay - Recurrent	1.81	1.19	-0.62	27.22	27.22	0.00
Income - Recurrent	0.45	0.50	0.05	6.81	6.81	0.00
Recurrent Efficiencies	4.54	2.58	-1.96	68.06	68.06	0.00
Pay - Non-recurrent	0.76	1.92	1.17	11.35	11.35	0.00
Non-pay - Non-recurrent	0.60	1.40	0.79	9.08	9.08	0.00
Income - Non-recurrent	0.15	0.15	-0.00	2.27	2.27	0.00
Non-Recurrent Efficiencies	1.51	3.46	1.96	22.70	22.70	0.00
26-27 CIP	**6.04**	**6.04**	**0.00**	**90.75**	**90.75**	**0.00**
FYE 25-26 (Recurrent)	2.30	2.30	0.00	13.80	13.80	0.00
NHSE CIP metric	**8.34**	**8.34**	**0.00**	**104.55**	**104.55**	**0.00**

Efficiency Progress	Pay £m	Non Pay £m	Income £m	Total £m
Fully Developed	10.15	8.10	4.95	23.20
Plans in Progress	19.71	16.43	5.04	41.18
Opportunity	9.80	9.08	7.49	26.38
Unidentified				0.00
Total	**39.66**	**33.61**	**17.49**	**90.75**

Workforce YTD	Plan £m	Actual £m	Variance £m	Plan £m	Forecast £m	Variance £m
Substantive	-130.44	-129.56	0.89	-763.40	-763.40	0.00
Bank	-7.99	-9.58	-1.59	-42.39	-42.39	0.00
Agency	-1.36	-0.52	0.84	-6.04	-6.04	0.00
Other Pay	-0.54	-1.52	-0.98	-3.25	-3.25	0.00
Total	**-140.34**	**-141.18**	**-0.84**	**-815.08**	**-815.08**	**0.00**

Workforce	Plan WTE	Actual WTE	Variance WTE	Move from M1 WTE
Substantive	10,292	10,119	173	-4
Bank	783	734	50	289
Agency	40	54	-15	9
Total	**11,115**	**10,907**	**208**	**294**

Summary financial position

- Whilst the trust remains on plan at month 2, underlying pressures have been mitigated in months by phasing or non recurrent action. There is material pressure on the year end forecast. The Group Executive remains committed to work to deliver the financial plan as agreed but recognises there are material challenges in achieving that. The Finance and Performance Committee reinforced the need to work through mitigations and CIP development and delivery across BAU and transformation CIP as planned.
- The Trust was £0.8m favourable in May offsetting the adverse variance reported in April for costs associated with Resident Doctor Industrial Actions, the Trust needs to work up cost out actions to mitigate.
- The Trust is forecasting being on plan for the year end in line with NHSE expectations.

Income

- Income is £0.1m favourable YTD, with patient care income £2.1m favourable and other operating income £2.0m adverse.
- Patient Care income is driven by £1.1m SWL NR income phasing and other phasing adjustments.
- Other Operating Income is driven by £1.2m TUPE slippage for Group corporate consolidation from ESTH, and £0.6m of R&I/SWLP offset by cost.

Non pay & Non-Operating Items

- Non-Pay & Non-Operating items are £0.8m favourable YTD. This is driven by a £0.6m inflation reverse release and R&I/SWLP offsets.

Pay and workforce

- Pay is £0.8m adverse to plan YTD where Bank pressure from M1 industrial action is the major cause of the variance.
- Substantive and Agency are below plan, with £0.1m payroll saving from industrial action included.
- Trust is 208 WTE favourable to plan in M2. The variance is explained by TUPE of 100 WTE, as well as cost pressures not recruited to. Seasonality and exit rate movements have also offset a shortfall in CIP of c70. The triangulation of the WTE and finance assumptions are being reviewed.
- The movement from M1 of 294 is partially owing to industrial action (33 WTE) and primarily from the restatement of bank and agency that had been queried in M1 (270 bank and 9 agency).

Group Board

Meeting in Public on Thursday, 09 July 2026

Agenda Item	3.3	
Report Title	**Group Integrated Quality & Performance Report (IQPR)**	
Executive Lead(s)	Michael Pantlin, Group Deputy Chief Executive Officer	
Report Author(s)	Ed Nkrumah, Group Director of Performance & PMO	
Previously considered by	Finance and Performance Committee	27 June 2025
Purpose	**For Review**	

Executive Summary

Oversight and Assurance

The NHS Oversight Framework (NOF) assessments and rankings for Quarter 4 of 2025/26 confirmed improvements in rankings at both Trusts with Segment 2 ratings which were subsequently adjusted to Segment 3 following the application of the financial override. Improvements were mainly in the operational performance domains.

The Framework for 2026/27 was published on 11 June 2026. This latest version reiterates NHS England's role as responsible for performance management, and decisions relating to the level of intervention associated with each segment. It offers greater freedoms to higher performing organisations and retains the financial override which limiting the highest overall segment achievable by organisations in financial deficit to Segment 3. The number of metrics has increased, from 20 to 32, to enable a more balanced judgement of performance across the seven domains. Segmentation updates will be published quarterly, in the subsequent period.

The IQPR will be updated to incorporate the new metrics for routine monitoring once finalised by NHSE.

ESTH remains under Tier 2 (regional oversight) for Urgent and Emergency Care performance. The most recent monthly oversight meeting with NHSE focused on

- Review of the newly developed UEC Recovery Action Plan
- Drivers of differential site-level performance against the 4-hour standard
- Review of progress against the five Exit Criteria metrics agreed with NHSE namely – waits of >12hrs in ED, corridor care, timely initial assessments, utilisation on UTC, and protection of SDEC as a non-bedded area.

Operational Performance

ESTH achieved the three key cancer standards in April 2026. SGUH missed the 28-day faster diagnosis (marginally), and 62-day cancer standard mainly due to demand and capacity imbalance. Discussions with system partners (RMP and the ICB) are ongoing to identify sustainable solutions for thoracic cancer

pathways. For non-urgent elective care (RTT), both Trusts have delivered on their plans for April 2026 relating to 18 weeks performance and 52-week waits. The reduction in 52-week waits has been particularly significant, with numbers more than halving at both Trusts since late summer 2025, resulting in fewer than 1% of patients waiting over 52 weeks by April 2026.

Elective access for children's services at Sutton Health and Care remains a challenge, with 49.7% of children waiting 18 weeks or less to start treatment against a target of 70%. Rising demand and increasing complexity continue to drive the long waits in Speech and Language Therapy. Harm reviews are ongoing, and an improvement plan is in place alongside a system health pathway review (gesh-Sutton Alliance Board-SHC). A committee deep dive is scheduled for September 2026.

For Urgent and Emergency Care (UEC), SGUH delivered 80% performance against the ED 4-hour standard in May 2026, marginally below the monthly plan. This improvement was enabled by strengthened front-door pathways and paediatric access, expanded triage capacity, enhanced data quality, and robust daily senior oversight. Performance at ESTH remains challenged delivering a performance of 61%, this was attributable to the Trust-wide launch of UTC First and ED–Medical Ambulatory Pathways on 22 April 2026. This included the review and revision of ED streaming and triage processes and associated reporting, with performance expected to be negatively impacted during the transition period.

The 2-hour urgent community response target of 70% continues to be met by Surrey Downs (90.7%), with Sutton Health and Care reporting compliance in May 2026. Improvement work within the *Home from Hospital* model is underway to enhance productivity, efficiency, and performance.

In relation to quality, the Group Executive Committee is monitoring progress on VTE risk assessment and delirium screening and assessment rates monthly, as priority areas requiring significant intervention to deliver the necessary step change.

Sickness absence levels remain high across gesh, adversely impacting performance, quality and efficiency. A pilot programme focusing on one division per site is being developed to sustainably reduce absence rates.

Action required by Group Board
The Board is asked to note this paper.

Committee Assurance	
Committee	Finance and Performance Committees
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				



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

Integrated Quality & Performance Report (IQPR)

May 2026

Email: gesh.performance@stgeorges.nhs.uk

Our Strategy | Medium-Term Plans | Board to Ward Priorities

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

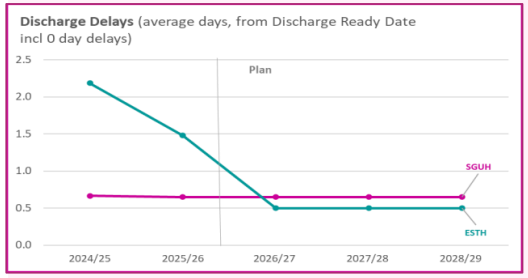
Board to Ward Priorities for 2026/27: Board Objectives

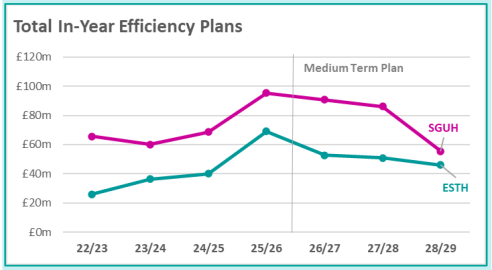
Work with other teams to reduce delays in patient journeys through our services: optimise admission avoidance services and reduce delayed discharges to top-quartile performance

Live within our means, reducing our costs: Deliver the Efficiency Programme

Minimise risk of harm from delays in care: Work towards eliminating Corridor Care & RTT Long Waits

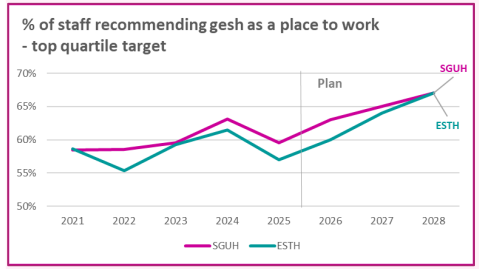
Make this a place we'd recommend to work and receive care: Position gesh in London's top five for staff experience and as a recommended place for care.

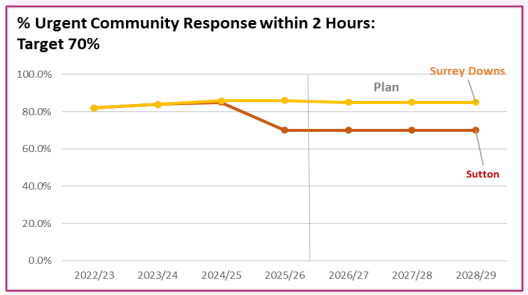




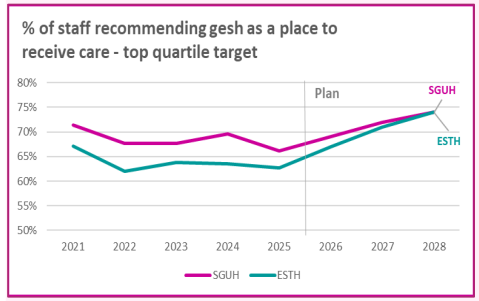
Emergency Department Corridor Care (Average daily count)

	May 2026 Actual	2026/27 Plan	Medium Term Plan
SGUH	18	tbc	Corridor care elimination timeline under review
ESTH	46	30	Corridor care elimination timeline under review









National Oversight Framework

Quarterly assessments, rankings and metric scores

Assessment Period: Q4 2025/26				SGUH Q1	SGUH Q2	SGUH Q3	SGUH Q4	ESTH Q1	ESTH Q2	ESTH Q3	ESTH Q4
			Trust Segment (adjusted)	3	3	3	3	3	3	3	3
			Ranking (Acute Trusts)	37/134	61/134	56/134	47/134	61/134	101/134	93/134	66/134
			Unadjusted Segment (pre finance override	1	2	2	2	3	3	3	2
			Overall Metric Score (breakdown below)	2.05	2.31	2.29	2.05	2.41	2.64	2.64	2.30
Domain	**No.**	**Metric**	**Data Period**	**Metric Scores**	**Metric Scores**	**Metric Scores**	**Metric Scores**	**Metric Scores**	**Metric Scores**	**Metric Scores**	**Metric Scores**
Access	1	RTT 18 weeks Performance	Mar-26	2.34	2.62	2.64	2.86	1.81	2.11	2.66	2.09
	2	RTT 18 weeks Performance vs Plan	Mar-26	1.00	1.00	2.07	1.00	1.12	3.17	3.65	1.00
	3	RTT 52 Weeks Performance	Mar-26	2.73	2.94	2.48	1.00	2.32	2.76	2.51	1.00
	4	Community Services - % waits over 52 Weeks	Mar-26	1.00	1.00	1.00	1.00	2.35	2.06	2.59	2.79
	5	Cancer - 28-Day Faster Diagnosis Standard	Q4-25/26	2.20	3.65	2.88	1.00	2.04	3.67	3.51	1.00
	6	Cancer - 62-Day Treatment Standard	Q4-25/26	1.00	2.15	2.62	2.17	1.00	1.00	1.00	1.00
	7	A&E 4-Hour Wait Standard	Q4-25/26	1.00	1.00	1.00	2.23	3.37	2.62	2.91	2.61
	8	A&E 12-Hour Waits (from arrival)	Q4-25/26	2.82	3.11	1.84	2.04	3.78	3.67	3.68	3.57
		Access to services domain score	**Q4-25/26**	1.76	2.18	2.07	1.66	2.22	2.75	2.81	1.88
Effectiveness & experience of care	9	Summary Hospital Level Mortality Indicator	R12 - Dec-25	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00
	10	Average number of days between planned and actual discharge date	Mar-26	1.74	2.38	2.86	2.02	Not Reported (DQ)	3.64	3.52	3.57
	11	CQC inpatient survey satisfaction rate	2024	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00
	12	Urgent community response 2-hour performance	Q4-25/26	N/A	N/A	N/A	N/A	2.24	2.76	2.42	2.52
		Effectiveness and experience of care domain score	**Q3-25/26**	1.91	2.13	2.29	2.01	2.08	2.60	2.49	2.52
Patient Safety	13	NHS Staff Survey -raising concerns sub-score	2025	3.12	3.12	3.12	3.05	2.78	2.78	2.78	2.67
	14	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	N/A	N/A
	15(a)	Rates of MRSA infections	R12 -Mar-26	2.37	2.33	2.28	2.27	2.63	2.60	3.01	2.81
	15(b)	Rates of C-Difficile infections	Mar-26	3.62	3.30	3.25	2.85	2.62	1.00	1.00	1.00
	15(c)	Rates of E-Coli infections	Mar-26	3.39	3.37	2.69	2.30	2.05	2.15	2.07	2.71
		Patient Safety to services domain score	**Q4-25/26**	3.12	3.06	2.93	2.76	2.62	2.35	2.40	2.42
People and workforce	16	Sickness absence rate	Q3 2025/26	1.72	1.60	1.79	1.82	2.44	2.68	2.54	3.01
	17	NHS Staff Survey engagement theme score	2025	2.38	2.38	2.38	2.42	2.20	2.20	2.20	2.47
		People and Workforce domain score	**Q4-25/26**	2.05	1.99	2.00	2.12	2.32	2.44	2.37	2.74
Finance and productivity	18	Planned surplus/deficit	2025/2026	4.00	4.00	4.00	4.00	4.00	4.00	4.00	4.00
	19	Variance year-to-date to financial plan	M12 2025/26	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00
	20	Implied Productivity Level	M9 YTD 25/26	1.74	3.28	3.46	3.71	3.26	3.44	3.53	3.86
		Finance and productivity domain score	**Q4-25/26**	1.87	2.64	2.73	2.85	2.63	2.72	2.76	2.93

Executive Summary

Safe, High-Quality Care

St George's Hospital

- **Never Events:** No never events were declared in May 2026
- **Patient Safety Incident Investigations (PSII)** - There were no Patient Safety Incident Investigations (PSIIs) declared in May 2026
- **VTE Risk Assessments:** Assessment rates remain below the national 95% target at 85.4%. NHSE has updated its guidance on measuring compliance against the requirement to assess patients within 14 hours, changing the start point from ward admission time to decision to admit which will adversely impact reported performance. The Hospital Thrombosis Groups across gesh are in active discussions to improve the digital workflows to drive improvement.
- **Pressure Ulcers:** In May 2026, there were 10 category 3 pressure ulcers reported, this is down slightly from March and April 2026. Five of the 10 were related to medical devices. There were zero category 4 pressure ulcers. The Trust action plan has been updated, and the rollout of new hybrid mattresses has commenced.
- **Delirium Assessments:** In May 2026, delirium assessment within 24 hours for patients >65 remained low; with a 1% increase seen across each of the last 3 months. Several key actions competed in May including reviewing the metrics reported, audit of assessment completion in patient notes as well as on the iClip proforma taking place in June 2026 (dashboard can only pull proforma).
- **Infection Control**: Neonatal Unit (NNU) MRSA Outbreak: 12 cases to date since December 2025. Last positive case 6th May. Action plan implemented, awaiting decant options/allow duct work cleaning. No clinical infections to date.
- **Complaints:** 98% of complaints were acknowledged within 3 working days in May 2026 – an improvement on the previous month (90%). An action plan remains in place to address staffing shortfalls and restore targets. The recent increase in formal complaints is driven by multiple factors. The main issues relate to appointments (delays in being seen and repeated cancellations) and communication (difficulty contacting services, staff–patient interactions, and slow responses), alongside concerns about clinical treatment.

Epsom & St Helier

- **Never Events**: A Never Event relating to a wrong site local anaesthetic block injection was declared in May 2026. As an immediate safety action to reduce risk, the team are implementing a local Stop Before Injection for local anaesthetic digit procedures.
- **Patient Safety Incident Investigations (PSII)** - There were two PSIIs initiated in May 2026. One maternity incident that meets the Maternity and Newborn Safety Investigation (MNSI) criteria. The second incident resulted in a patient death, the patient was admitted via the emergency department with gastric obstruction complicated by aspiration post nasogastric tube insertion.
- **VTE Risk Assessments:** Assessments rates remain below the national 95% target, at 79% in May 2026. The VTE clinical lead and Prevention Clinical Nurse Specialists meet monthly with the BI team to review discrepancies in the low-risk cohort and maternity compliance data. Progress remains limited however, a trust-wide prevention audit has now been completed, with results pending.
- **Pressure Ulcers:** There were zero category 3 and zero category 4 pressure ulcers reported in May 2026. There has been a slight increase in the number of category 2 pressure ulcers (10) and deep tissue injuries (6); no themes are evident currently; the tissue viability team continue to monitor.
- **Infection Control:** Weekly high level water safety discussions regarding E-block are ongoing. Mitigations remain in place and monitored via the Water Safety Group. No clinical infections to date.
- **Delirium Assessments:** In May 2026, delirium assessment within 24 hours for patients >65 remained low but improved slightly compared to March and April 2026. Improvement and Educational work is ongoing with collaboration between the Dementia and Delirium Clinical Nurse Specialist and a Frailty Consultant. Delirium metrics reviewed with the performance lead and audit of assessment completion in patient notes as well as on the iClip proforma taking place in June 2026 (dashboard can only pull proforma).
- **Complaints:** Complaints responded to within 35 working days has dropped below target in May 2026 to 79%. An action plan remains in place to recover performance.

Executive Summary

Operational Performance & Productivity

St George's Hospital

Successes

- Elective Recovery: Delivery is ahead of Medium Term Plan (MTP) trajectories for Referral to Treatment (RTT) and 52-week waits. The focus has shifted to sustaining gains through productivity-led transformation, supported by specialty-level RTT trajectories, clear accountability, and robust weekly Tier 1 oversight to proactively manage risk
- Theatre utilisation has improved.
- 4-hour performance remains strong at 80.04%, marginally below MTP.
- SGUH is developing a programme in line with GIRFT/NHSE policies to eliminate corridor care. This is supported by NEL system initiatives, including the Frailty Model, virtual wards, Home First, Urgent Community Response, and integrated neighbourhood teams

Challenges

- Faster Diagnosis Standard (FDS) performance was below plan in April 2026 delivering 78.4%, however improvements have been made and are on track to be compliant in May 2026. Delivery is constrained by key capacity issues in Urology (Bladder) and Lung/Respiratory pathways, while Lower GI shows recovery
- Cancer 62-day: Performance is impacted by lung cancer pathways (22.9%), with thoracic capacity constraints and high tertiary referrals, alongside limited diagnostics (including navigational bronchoscopy) restricting pathway flow; actions focus on capacity, pathway optimisation, and system collaboration
- Diagnostics performance is under pressure from capacity and workforce gaps across key services particularly Ultrasound over the coming months, with a risk to MTP delivery; mitigating actions include bank and agency utilisation, targeted recruitment, expanded flexible working, and service improvements to triage, booking, and overall capacity.
- Length of stay remains above ambition, recent interventions—including W-OPEL, expanded bridging services, and embedding acute medicine, are expected to support improvement, aligned to the gesh-wide Non-Elective Transformation Programme.
- Plans are in place to increase Patient-Initiated Follow-Up uptake through pathway expansion, validation, and pilot programmes beyond outpatients, supported by a standardised gesh-wide approach.

Epsom & St Helier

Successes

- All cancer performance standards were achieved in April 2026: 86.5% for 62day and 89.8% for 28day FDS.
- Capped theatre utilisation reached 81% in May 2026, sustaining performance above 80%, supported by focused morning huddles attended by Matrons and the Head of Nursing.
- RTT performance improved again in April 2026 (66.6%), exceeding the 65.5% target. The Trust also overachieved the end-of-April 2026 52-week wait target, with 475 patients waiting over 52 weeks for treatment, against a target of 563.
- Diagnostic performance remained stable in April compared to March 2026, while patients waiting over 6 weeks fell from 1,025 to 958, supported by a comprehensive recovery approach with increased activity, weekly validation, and workforce management to drive sustained performance improvement.
- PIFU returned above the national target of 5% in May 2026, achieving 5.1%, with 18 productivity schemes identified to further reduce avoidable follow-up activity.
- DNA rates have begun to recover following resolution of text reminder service issues, with assurance controls now in place.

Challenges

- Delays in cancer diagnostics within 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.
- ESTH 4-hour ED performance declined to 61.1% in May 2026 compared to 71.1% in April 2026. 12-hour waits also deteriorated to 20.2% in May 2026 compared to 15.3% the previous month. The deterioration has been driven by the GIRFT UEC recommendation and implementation of UTC First and the decommissioning of ED SDEC on 22nd April 2026. A robust UEC recovery plan is in place to address key drivers of current performance.
- Action plans are in place to reduce corridor care continues across both sites.
- Non-elective length of stay increased to 11.9 days in May 2026 compared to 11.5 days in April 2026. This was largely driven by the discharge of 32 complex patients from the STH site with lengths of stay exceeding 75 days, accounting for 3,381 bed days.
- The gesh-wide Non-Elective transformation programme is in development in addition to local ESTH and PLACE-based programmes to support 2026/27 UEC Transformation, aligning to national, regional and local priorities.

Executive Summary
Integrated Care Services

Quality & Safety

An increase in Category 3 pressure ulcers at both Sutton Health and Care (SHC) and Surrey Downs Health and Care (SDHC) reflects improved and more consistent reporting practices. The patient cohort has become more complex, with Primary Care Networks (community nursing teams) managing a growing number of complex assessments, and with patients experiencing deterioration either at home or following escalation from care agencies. A robust assurance process is in place to review all incidents.

Sutton Health & Care (SHC) Specific

- Safety and control indicators - MRSA, *C. difficile and* E. coli are stable, with no significant issues reported in May 2026.
- IPCC note improvements with Reablement Unit
- Patient Experience Review demonstrated strong overall performance, with an average of 97.8% of patients rating services as good or very good. However, engagement is low overall
- The number of formal complaints decreased but one was reopened due to continued dissatisfaction, primary themes around staff attitude, access to services, and the management of patient outcomes and communication . Targeted action plans have been developed and are being implemented to address the key themes identified through patient feedback and complaints analysis.
- Children's pathway and waiting list work continues across Dysphagia and Therapy referrals

Surrey Downs Health & Care(SDHC) Specific

- Safety and control indicators - MRSA, *C. difficile and* E. coli are stable, with no significant issues reported in May 2026.
- The annual Patient Experience Review demonstrated strong overall performance, with an average of 96% of patients rating services as good or very good.
- The number of formal complaints increased by 62.5%, primary themes around communication, staff attitude, access to services, and the management of patient expectations.
- The Patient Advice and Liaison Service (PALS) continues to provide an effective mechanism for resolving concerns at an early stage.
- Targeted action plans have been developed and are being implemented to address the key themes identified through patient feedback and complaints analysis.

Operational Performance

Sutton Health & Care (SHC)

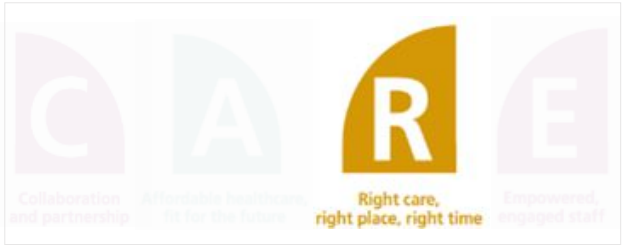
- In May 2026, 2-hour Urgent Community Response (UCR) performance remained above target at 73.5%. Referral levels were broadly stable, though some variation was seen out of hours, with early evening peaks. This trend reflects the introduction of the SWL Integrated Care Coordination Hub, which has shifted more referrals later in the day. As this does not fully align with current staffing patterns, adjustments are in progress alongside ongoing improvement work.
- Virtual Ward Occupancy has reduced in April 2026 to 60% against the 80% target. This is due to ongoing transformational work to determine the most appropriate cohort to ensure it functions as a viable alternative to hospital admission.
- Children's services waiting lists remain elevated, with an improvement plan in place alongside a system pathway review (gesh–Sutton Alliance Board–SHC). Demand continues to present challenges, largely driven by rising complexity of need. At the end of April 2026, 102 children were waiting over 52 weeks, while 49.7% were seen within 18 weeks. Harm reviews are ongoing to ensure patient safety despite the longer waiting times.
- Friends & Family Test response rates remain low due to an issue with interoperability between the Gather and iPlato systems. Following a meeting with gesh I.T. a plan is in place to resolve this issue.

Surrey Downs Health & Care (SDHC)

- Service continues to exceed the 2 –hour Urgent Community Response (UCR) target, achieving 89% in May 2026.
- Virtual ward occupancy rates exceeded target at 94.3% in May 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



Acute Services Quality Dashboard

Patient Safety, Outcomes, Effectiveness and Experience

gesh

St George's

KPI	Latest month	Previous Month Measure	Latest Month Measure	Target	Variation	Assurance	Target
Never Events	May 26	0	0	0			N/A
Patient Safety Incident Investigations	May 26	0	0	0			N/A
Moderate and Severe Harm from Falls	May 26	2	2	2			N/A
Pressure Ulcers - Acquired Category 3	May 26	12	10	7			N/A
Pressure Ulcers - Acquired Category 4	May 26	0	0	0			N/A
Infection Control - Number of MRSA	May 26	0	1	0			2nd Quartile
Infection Control - Number of Cdiff - Hospital & Community	May 26	5	2	5			3rd Quartile
Infection Control - Number of E-Coli	May 26	6	7	9			2nd Quartile
Delirium Assessment Compliance 65+ within 24 hours of admission	May 26	31.1%	33.1%	-		-	N/A
30-Day Emergency Readmission Rate	Apr 26	9.2%	8.6%	-		-	N/A
VTE Risk Assessment	May 26	85.0%	85.4%	95.0%			Lowest Quartile
Mortality - SHMI	Jan 26	0.91	0.92	-			As Expected
Complaints - Responded to within 35 working days	May 26	89.1%	76.0%	85.0%			N/A
Complaints - Acknowledgement within 3 working days	May 26	89.8%	98.0%	100.0%			N/A
Number of complaints not completed within 6 months from date of receip	May 26	4	5	0			N/A
Friends and Family Test - Inpatients Score	May 26	98.4%	97.7%	-		-	N/A
Friends and Family Test - Emergency Department Score	May 26	76.5%	74.6%	-		-	N/A
Friends and Family Test - Outpatients Score	May 26	94.5%	94.5%	-		-	N/A
Friends and Family -Inpatient Response Rate	May 26	31.1%	28.6%	-		-	N/A
Friends and Family -Emergency Department Response Rate	May 26	10.7%	7.9%	-		-	N/A
Friends and Family - Outpatient Response Rate	May 26	9.6%	9.4%	-		-	N/A

Epsom & St Helier

Latest month	Previous month measure	Lastest month measure	Target	Variatio	Assuran	Benchmark
May 26	1	1	0			N/A
May 26	0	2	0			N/A
May 26	3	1	1			N/A
May 26	3	0	6			N/A
May 26	0	0	0			N/A
May 26	0	0	0			3rd Quartile
May 26	5	4	6			2nd Quartile
May 26	1	5	5			2nd Quartile
May 26	47.1%	51.8%	-		-	N/A
Apr 26	10.1%	12.3%	-		-	N/A
May 26	86.0%	83.9%	95.0%			Lowest Quartile
Jan 26	1.14	1.14	-		-	As Expected
May 26	88.0%	79.0%	85.0%			N/A
May 26	100.0%	100.0%	100.0%			N/A
May 26	6	4	0			N/A
May 26	94.0%	93.9%	-		-	N/A
May 26	77.0%	68.6%	-		-	N/A
May 26	92.0%	92.4%	-		-	N/A
May 26	11.0%	14.3%	-		-	N/A
May 26	4.0%	0.3%	-		-	N/A
May 26	4.8%	6.0%	-		-	N/A

Maternity Services Dashboard

Quality, Safety, Effectives, Experience and Workforce

	St George's					Epsom & St Helier				
KPI	Latest month	Previous month measure	Lastest month measure	Variation	Benchmark	Latest month	Previous month measure	Lastest month measure	Variation	Benchmark
% Births with 3rd or 4th degree tear	May 26	2.2%	2.1%	L	3.3%	May 26	3.3%	5.5%		3.1%
% Births Post Partum Haemorrhage >1.5 L	May 26	2.2%	4.3%		3.0%	May 26	3.6%	1.7%		3.0%
Stillbirths per 1,000 births rolling 12 months	May 26	3.1	2.6		3.5	May 26	1.33	1.07	H	2.85
Neonatal deaths per 1,000 births rolling 12 months	May 26	4.5	4.8	H	2.4	May 26	0.27	0.54		1.12
Maternal Deaths	May 26	-	0		N/A	May 26	-	0		N/A
ITU Admissions	May 26	0	0	L	N/A	May 26	-	1		N/A
HIE (Hypoxic ischaemic encephalopathy) per 1,000 births	May 26	0.0	0.0		N/A	May 26	0.0	0.0		N/A
PSII- National Reporting (MNSI referrals)	May 26	-	0		N/A	May 26	-	1		N/A
PSII – Local PSIIs	May 26	-	0		N/A	May 26	-	0		N/A
Friends and Family Test - Maternity Births Score	May 26	100.0%	100.0%		N/A	May 26	94.7%	93.0%		N/A
Friends and Family - Maternity Births Response Rate	May 26	0.9%	3.2%	L	N/A	May 26	8.0%	6.0%	H	N/A
Maternity Appraisal Rate	May 26	-	73.0%		N/A	Mar 26	-	78.0%		N/A
Maternity Vacancy Rate	May 26	-	7.9%		N/A	Mar 26	-	9.7%		N/A
Maternity Turnover Rate	May 26	-	8.0%		N/A	Mar 26	-	2.0%		N/A

Maternity PSIIs are a subset of all PSIIs

Integrated Care Quality Dashboard

Patient Safety and Experience

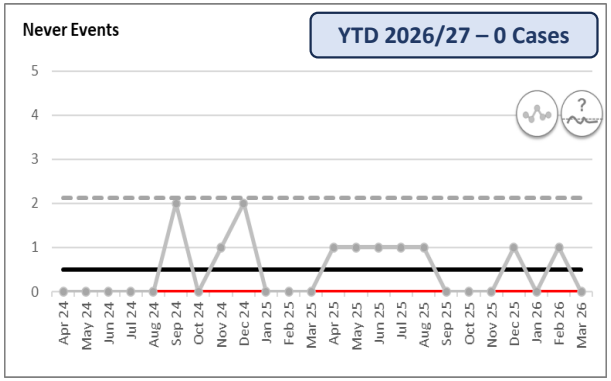
KPI	Sutton Healthcare						Surrey Downs					
	Latest month	Previous Month Measure	Latest Month Measure	Target	Variation	Assurance	Latest month	Previous Month Measure	Latest Month Measure	Target	Variation	Assurance
Patient Safety Incidents Investigated	May 26	0	0	0		?	May 26	0	0	0		?
Number of Falls with Harm (Moderate and Above)	May 26	0	0	-	L	-	May 26	0	1	-	H	-
Pressure Ulcers Category 3	May 26	12	15	-	H	-	May 26	4	5	-		-
Pressure Ulcers Category 4	May 26	2	2	0	H	?	May 26	2	2	0		?
Infection Control - Number of MRSA	May 26	0	0	-	L	-	May 26	0	0	0	L	?
Infection Control - Number of Cdiff	May 26	0	0	-		-	May 26	0	0	-		-
Infection Control - Number of Ecoli	May 26	0	0	-	L	-	May 26	0	0	-		-
Community Friends and Family - Community Score	May 26	93.0%	97.8%	90.0%	H	?	May 26	94.3%	96.6%	90.0%	H	?
Community Friends and Family - Response Rate	May 26	5.8%	2.6%	-		-	May 26	31.6%	42.6%	-		-

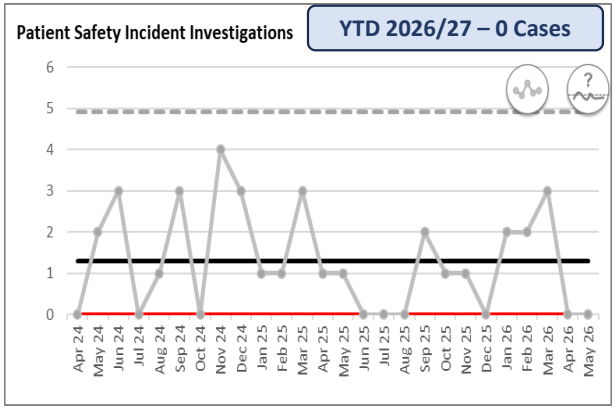
- Community FFT is a subset of Epsom and St Heliers FFT data.
- IC (Dorking and Molesey Hospitals – community do not have set national trajectories for HCAIs although all cases are reviewed and investigated)

Safe, High-Quality Care

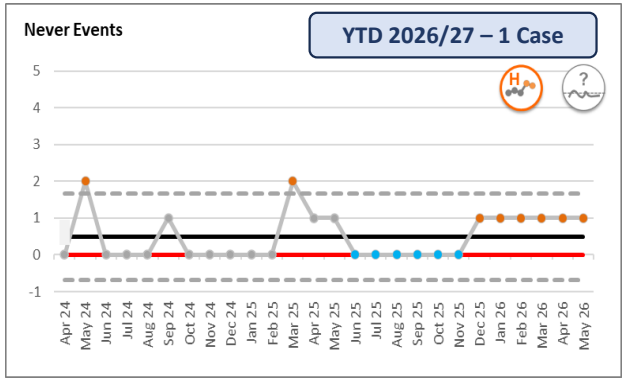
Overview of Incidents | SGUH and ESTH

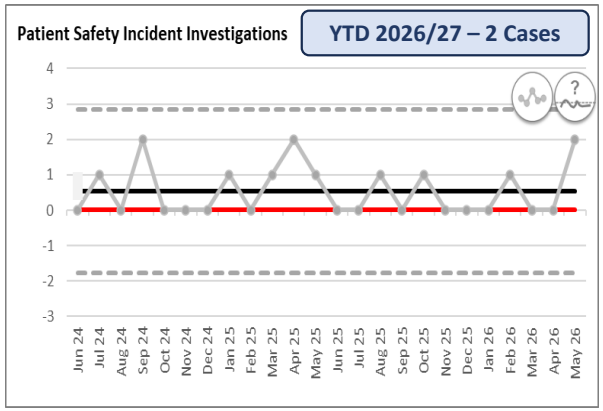
St George's





Epsom & St Helier





Summary and Actions:

SGUH

There were 0 Never Events declared in May 2026.

There were 0 Patient Safety Incident Investigations (PSIIs) declared in May 2026.

ESTH

A **Never Event** was declared in May 2026 relating to a wrong site local anaesthetic block injection before a toe surgery. As an immediate safety action to reduce risk, the team are implementing a local Stop Before Injection for local anaesthetic digit procedures. Further learning is being reviewed and incorporated into the Divisional Safety Improvement Plan.

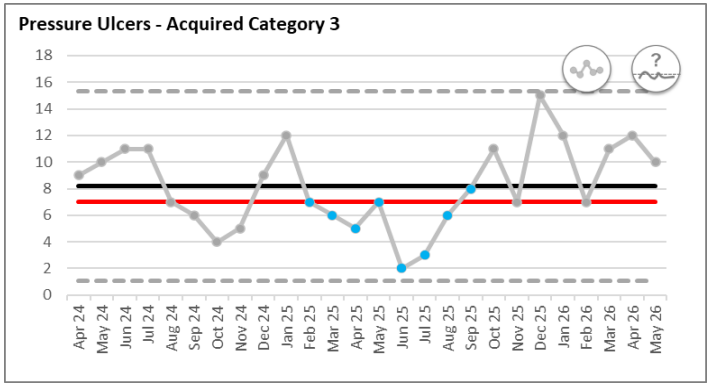
There were 2 **Patient Safety Incident Investigations** commenced in May 2026 one relating to a maternity incident that meets the Maternity and Newborn Safety Investigation (MNSI) criteria (the maternity PSII is also reported by maternity.)

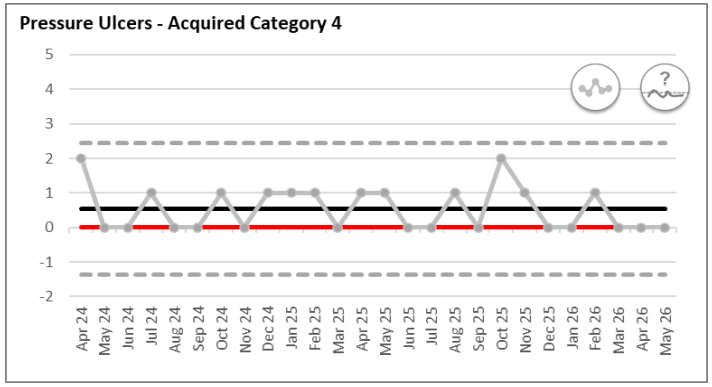
The second incident resulted in a patient death, the patient was admitted via the emergency department with gastric obstruction complicated by aspiration post nasogastric tube insertion.

11

Safe, High-Quality Care

Exception Report | SGUH - Category 3 & 4 Pressure Ulcers

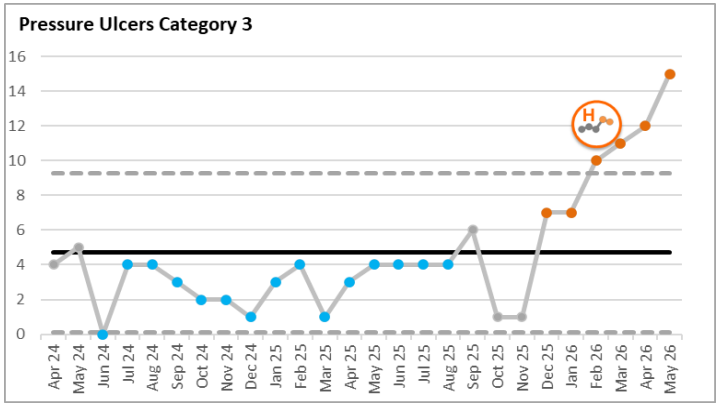


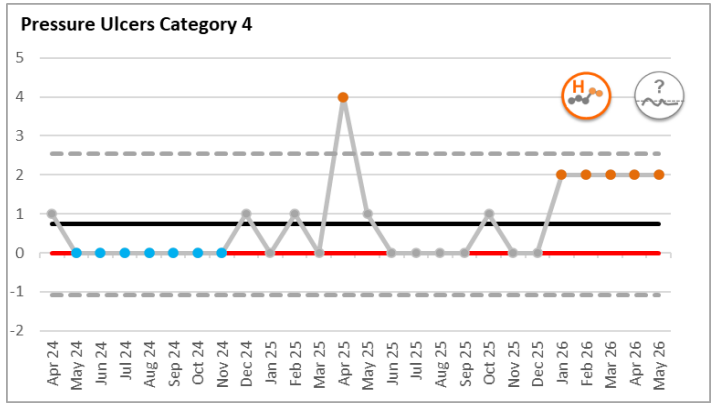


Site & Metric	Cause of variance/ non-compliance	Actions: Completed since last update, New, and Ongoing	Recovery Date
SGUH Pressure Ulcers Category 3: 10 cases in May 2026 Pressure Ulcers Category 4: No incidents occurred in May 2026 **Data Quality:** Sufficient for assurance	There were 10 category 3 pressure ulcers and zero category 4 pressure ulcers in May 2026, showing normal variation 8 pressure ulcers were reported in the Medicine and Cardiovascular Division, zero in Surgery, Neuro, Cancer and Theatre Division and 2 in Children's, Women's, Diagnostics and Therapies Division. 5 were medical device related with 2 related to naso-gastric tube bridles inserted in adult critical care areas. Most non-medical device related pressure ulcers continue to be acquired on the patients' sacrum, spine and heals; a theme across the last 5 months associated with an increase in patient acuity and likely related to increased flow pressures 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 have reached out to adult critical care areas regarding naso-gastric tube bridles • New brand of hybrid pressure relieving mattresses being rolled out to replace all existing mattresses in general inpatient areas across June, July and August 2026. Staff training almost at 50% • Tissue Viability Team continue to use 20 dynamic high spec mattresses (usually used in ICU) commenced for high-risk patients in general inpatient wards; on-going monitoring of impact. • Relevant wards across the Medicine and Cardiovascular Division have been rolling out the 'get-up, get dressed, get moving' initiative. • The pressure ulcer governance working group continues. Draft final process proposals are due in July 2026. • Pressure Ulcer Steering group increased to monthly from May 2026.	September 2026. Being reviewed at Site level

Safe, High-Quality Care

Exception Report| Sutton Health & Care | Category 3 & 4 Pressure Ulcers



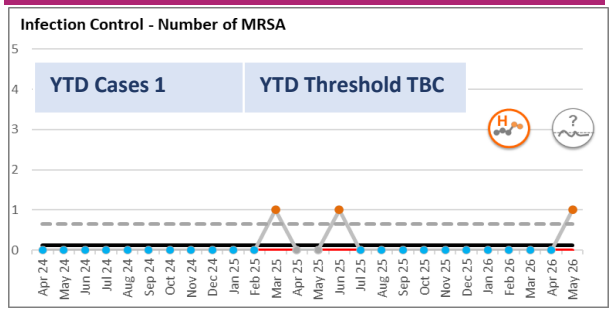


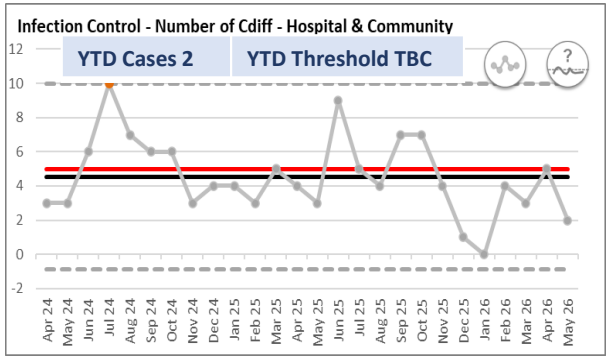
Site & Metric	Cause of variance/ non-compliance	Actions: Completed since last update, New, and Ongoing	Recovery Date
Sutton Health Pressure Ulcers Category 3 & 4 Special cause variation of a CONCERNING nature.	Whilst tracking upwards, Tissue Viability Nursing activity has increased with demand for complex reviews increasing. Patient deterioration occurring once home or escalated from care agency. One Primary Care Network's (PCN) community nursing team has been identified as being a particular area of concern in relation to leadership, poor documentation practice and communication. Increases also reflects more consistent reporting	• Changes in PCN leadership to offer dedicated resource and embedding of processes and practice • Review of staff sickness to improve consistency across the team • Focussed action plan to address areas of concern • Improving documentation – so it is clear where complexity is a contributing factor and that we have maximised care plans • Micro-sessions for teaching • Monthly Pressure Ulcer Assurance meeting	Aug 2026

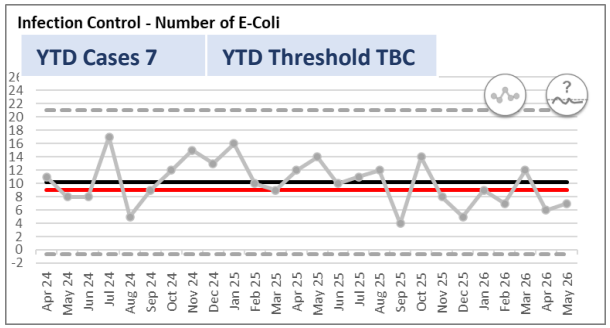
Safe, High-Quality Care

Overview Infection Prevention and Control |SGUH and ESTH

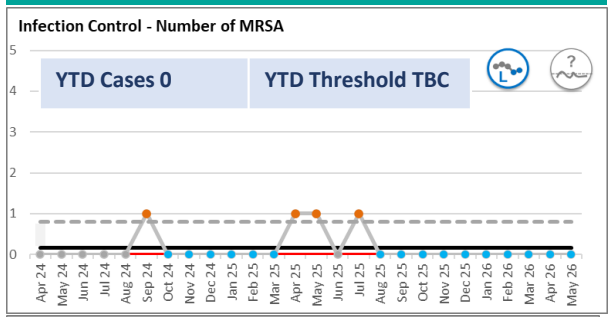
St George's

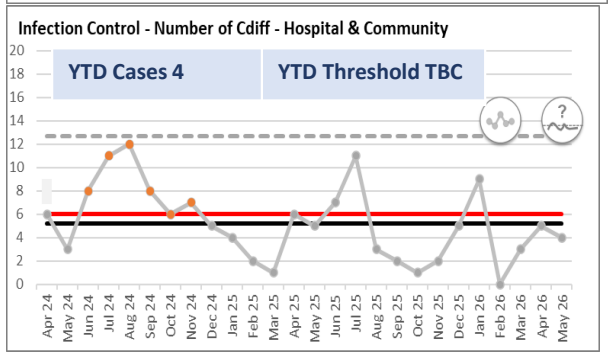


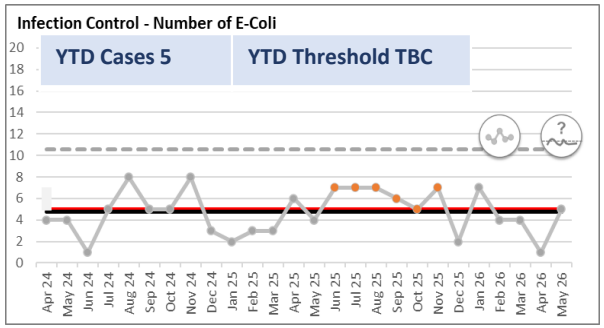




Epsom & St Helier







Summary with cause of variance / non-compliance

SGUH

Infection thresholds have not yet been set for 2026/27.

- 1 MRSA BSI cases in May 2026. The total year-to-date (YTD):1
- 2 C. difficile cases in May 2026 : YTD 7.
- Multidisciplinary C. difficile ward rounds and learning reviews continue. An enhanced environmental decontamination, post-discharge/transfer (HPV available) is in place
- NNU MRSA Outbreak: 12 cases to date since December 2025. Last positive case 6 May. Action plan implemented, awaiting decant options/allow duct work cleaning. No clinical infections to date, 3 positive babies on the Unit.

ESTH

- 0 MRSA BSI in May. YTD: 0
- 4 C. diff cases in May 2026. YTD 9. Multidisciplinary C. difficile ward rounds and learning reviews continue
- Ongoing surveillance, early identification, and adherence to infection prevention and control (IPC) measures are in place to reduce risk of cross infections.
- Water safety issues continue to be monitored via the Water Safety Group and SLT. Weekly touch point meeting with SLT to discuss proposed plans for E Block. No clinical infections reported.

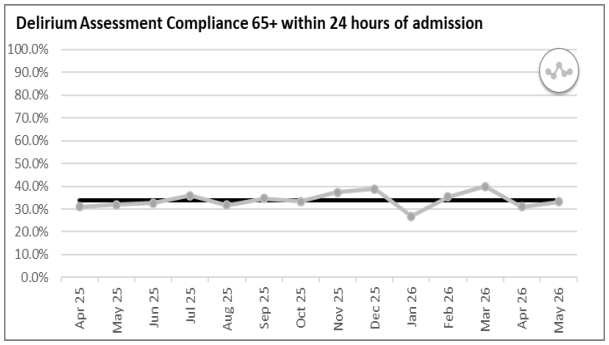
Group-wide:

- Comms shared following a UKHSA CAS alert with information regarding the current Ebola outbreak outbreak in DRC and Uganda
- Candida Auris screening new policy has been launched across the group.

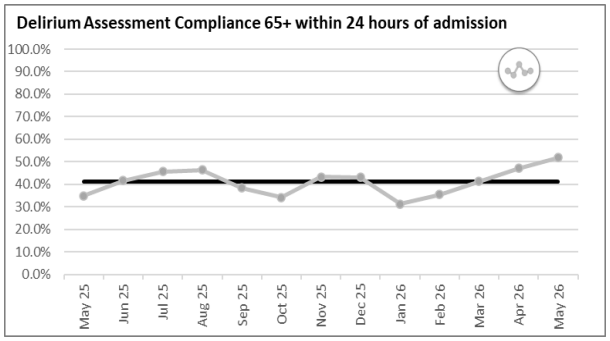
Safe, High-Quality Care

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

St George's



Epsom & St Helier



Data Quality Notice: This metric measures the percentage of admitted patients aged over 65 who received a delirium assessment using at least one approved assessment tool within 24 hours of admission.

A gesh-wide review is currently underway to ensure reporting is fully aligned with NICE guidance, including the definition of eligible cohorts and associated target setting. As a result, the target has been temporarily removed from the report pending completion of the data quality review.

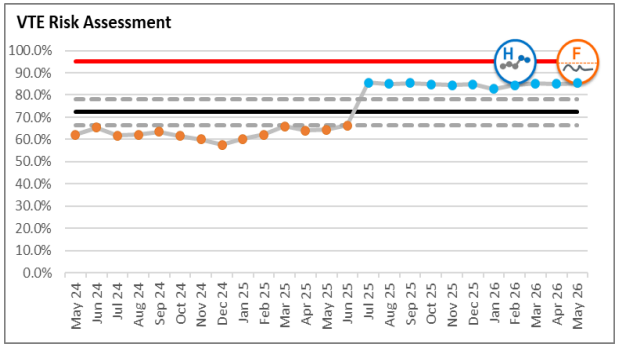
Please note this metric differs from the dementia assessment metric previously mandated by NHSE, which has now been discontinued.

Site & Metric	Cause of variance/ non-compliance	Actions: Completed since last update, New, and Ongoing	Recovery Date
SGUH: Delirium Assessment Medical within 24 hrs – 7.50% Delirium Assessment Nursing within 24 hrs – 27.58% RADAR Compliance (Daily Ax) – 10.13 % **Data Quality** – under review	• In May 2026, 59% of eligible admitted patients were assessed for delirium using at least one of the assessment methods available on iCLIP. Of which 33.17% were completed within 24 hours of admission. • Use of the delirium assessment proforma is not currently part of the 'business as usual' process of most admitting doctors and advanced practitioners. It is only possible to measure completion of the proforma and not when this is documented as free-text in the electronic patient record	• Delirium Lead attended Divisional Governance Groups • Dementia and Delirium nursing team to attended Friday Focus and present at Grand Round during Dementia Week • Audit taking place in June looking at completion of 4AT outside of the delirium assessment proforma (freetext in clerking) alongside National Audit of Dementia Census • Dementia and Delirium Steering group increased to monthly from June 2026 • Metrics reviewed with Performance Lead	Under review
ESTH: Delirium Assessment Medical within 24 hrs – 6.47% Delirium Assessment Nursing within 24 hrs – 47.06% RADAR Compliance (Daily Ax) – 19.09% **Data Quality** – under review	• In May 2026, 76% of eligible admitted patients were assessed for delirium using at least one of the assessment methods available on iCLIP. Of which 51.83% were completed within 24 hours of admission. • Use of the delirium assessment proforma is not currently part of the 'business as usual' process of most admitting doctors and advanced practitioners. It is only possible to measure completion of the proforma and not when this is documented as free-text in the electronic patient record	• Improvement and educational work between Dementia and Delirium Clinical Nurse Specialist (CNS) and Frailty consultant on-going with focus on Delirium Assessment completion. • B6 Developmental Dementia and Delirium CNS recruited • Medical led audit planned in ED and acute medical areas for May/ June to engage staff and explore barriers to completion; audit will also look at completion of 4AT outside of the delirium assessment proforma (freetext in clerking) • Metrics reviewed with Performance Lead	15

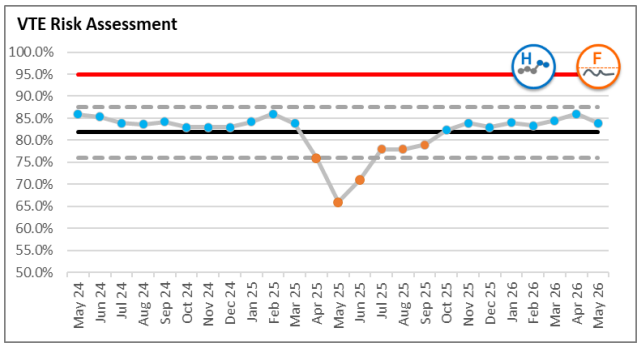
Safe, High-Quality Care

Exception Report| SGUH & ESTH - VTE Risk Assessment Rates

St George's



Epsom & St Helier

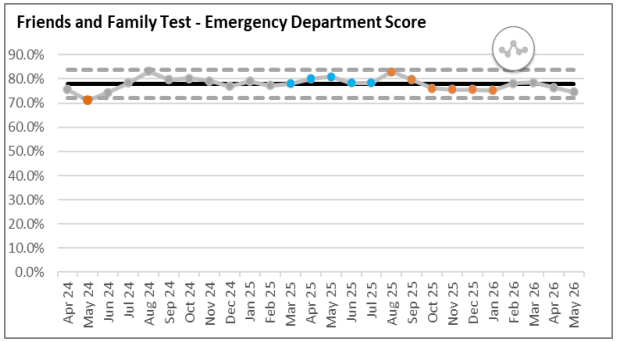


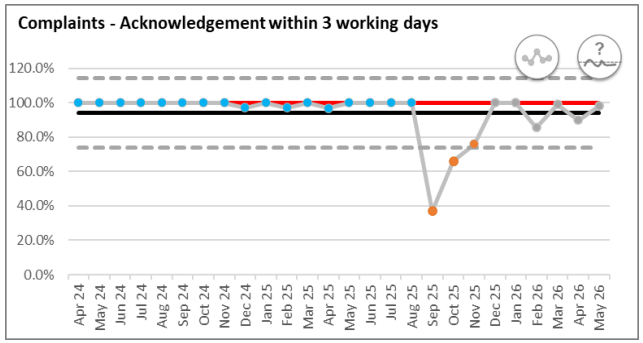
- **National guidance update**: NHSE has revised its guidance on measuring compliance against the requirement to assess patients within 14 hours, changing the start point from ward admission to the decision to admit to align with NICE guidance.
- **Data collection change:** The national VTE Risk Assessment Data Collection guidance has been amended to align with this change.
- **Implementation timing:** The revised requirement will take effect from July 2026 data (Q2 2026/27) to be submitted to NHSE in October 2026.
- **Key implication:** Changes to reporting logic with be required and *reported performance* is likely to be adversely impacted.

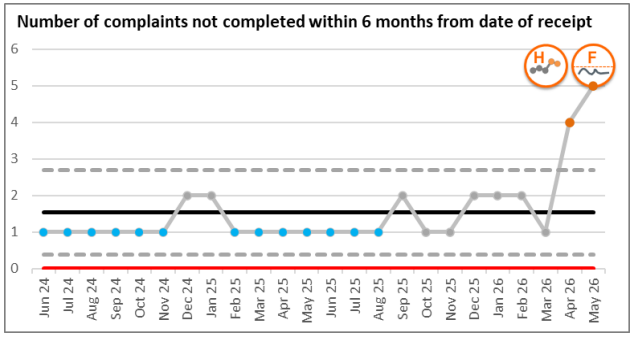
Site & Metric	Cause of variance/ non-compliance	Group Actions: Completed since last update, New, and Ongoing	Recovery Date
SGUH: VTE 85.4%. Not meeting target of 95% **Data Quality:** Sufficient for assurance	Rates remain below the 95% national target at 85.4% in May 2026. Work is underway to reinstate the VTE champion network and drive local improvements directly on wards within the MDT and at board rounds, and the gesh-wide review of the VTE risk assessment digital workflow is critical in addressing this performance gap.	• Shared digital VTE risk assessment tool, rules and controls to be developed to improve compliance- change freeze has now stopped and is a current priority. • Improve MAT (Medication Administration Tool) compliance and targeted support for underperforming areas	under review
ESTH: VTE 79% Not meeting target of 95% **Data Quality:** Sufficient for assurance	Rates remain below the 95% national target. Reporting at ESTH has also 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). • Further issues identified with compliance linked to the Maternity system Badgernet; Maternity risk assessments completed here rather than iClip	• Subject matter experts to resume updating the VTE risk assessment based on user feedback in collaboration with SGUH • Monthly meetings with BI team continue to work through on-going data issues and move to 12-hour definition for low-risk cohorts • Thromboprophylaxis audit complete for inpatients aged 16+, assessing prescribing against NICE guidelines NG89 and Royal College of Obstetricians and Gynaecologists RCOG 37a/37b standards, due end May 2026, results awaited • New VTE lead clinician appointed. Working with ESTH colleagues to jointly understand some of the challenges in getting further improvement.	under review

Safe, High-Quality Care

Exception Report| SGUH Patient Experience (Satisfaction & Complaints)



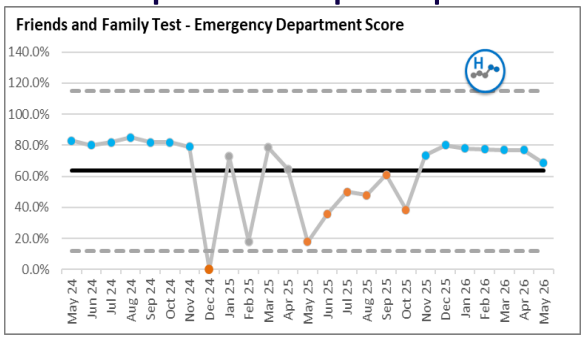


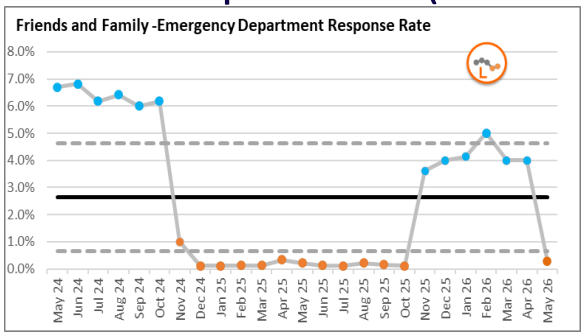


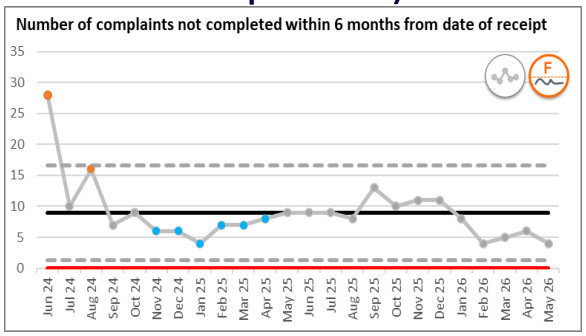
Site & Metric	Cause of variance/ non-compliance	Actions: Completed since last update, New, and Ongoing	Recovery Date
SGUH: FFT ED Score 74.6% normal variation **Data Quality** – sufficient for assurance	• In May 2026, 74.6% of patients said they would recommend the department. Scores reflect ongoing challenges such as long waits and corridor care. There has been a decrease in response rates in May 2026. Scores are in line with peers. However, response rates vary widely between settings, providers, and populations, making comparisons unfeasible.	• 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.	Internal targets under review
SGUH: Complaints Acknowledged within 3 working days shows normal variation but not meeting target	• There was a 98% acknowledgement rate in May 2026 equating to 2 acknowledgements falling outside of the 3 working day window. Staffing challenges with sickness have caused some delays in response times which has decreased to 76%. The team is working hard to remedy this.	• An action plan remains in place to address staffing shortfalls • Permanent recruitment successful to administrative role • Recruitment approved for an additional Band 5 complaints officer and maternity cover for Band 5 officer. • The recruitment process is underway for the new positions. • Bank backfill has also been requested to support during the gap.	September 2026
SGUH: Complaint's not completed within 6 months of receipt, Special cause variation of a CONCERNING nature	• There has been instability in the number of complaints being completed within 6 months. The team are now prioritising the 'closing off' of these complaints and ensuring they are accurately captured on Datix	• Complaints reviewed weekly with the Divisions to track progress and provide support / advice if necessary • Escalation to support delays and backlogs • Divisional action plans for severe delays • Group gesh complaints policy and SOP in development	September 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 (recommended and Response) Special cause variation of a CONCERNING nature for Responses. **Data Quality** – sufficient for assurance	The FFT contract at ESTH has ended and moved to Gather, where poster-based surveys reach a limited audience. Text messaging resumed in October 2025, improving response rates. There is some variation, especially in text-based survey services, while the A&E rate remains near zero. Fewer surveys were issued in May 2026 and early June 2026 due to new, unmapped ED locations. Although "Recommended" and "Response Rate" appear worse, this reflects the very small May sample size rather than a real trend.	• 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. • New ED locations now being mapped to Gather and surveys being sent.	Targets under review
ESTH: Number of complaints not completed within 6 months of referral – not meeting target. **Data Quality** – sufficient for assurance	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.	• The accountability for responding to complaints is being reviewed with divisional teams to transition this to the divisions. This work will inform training designed to improve the quality of complaint responses by divisional teams. • A gesh Complaints policy and Standard Operating Procedure is in development. • Changed to divisional complaints officers to have more support for divisional oversight • Plan to improve response rates with focus on current backlog from 2025. • Change to the way administrators work to speed up the logging and sending of complaints to divisions. This should give the divisions more time to respond to the complaint.	June 2026



Section 2.1:
Operational Performance

Operational Performance

Overview Dashboard – Acute Trusts

	St George's							Epsom & St Helier						
KPI	Latest month	Previous month measure	Lastest month measure	Target	Variation	Assurance	Benchmark	Latest month	Previous month measure	Lastest month measure	Target	Variation	Assurance	Benchmark
RTT - % of waits over 52 weeks	Apr 26	0.6%	0.7%	0.7%			2nd Quartile	Apr 26	0.8%	0.8%	0.5%			2nd Quartile
RTT - Percentage of waits within 18 weeks	Apr 26	63.4%	63.0%	67.8%			2nd Quartile	Apr 26	66.5%	66.6%	72.5%			3rd Quartile
Waiting List Community - Percentage of waits within 18 weeks	Apr 26	72.9%	79.6%	78.0%			TBC							
Cancer - 28 Day Faster Diagnosis Standard	Apr 26	81.5%	78.4%	80.0%			2nd Quartile	Apr 26	83.2%	89.8%	80.0%			Top Quartile
Cancer - 31 Day Decision To Treat to Treatment Standard	Apr 26	96.7%	97.1%	96.1%			Top Quartile	Apr 26	100.0%	100.0%	98.6%			Top Quartile
Cancer - 62 Day Referral to Treatment Standard	Apr 26	77.3%	73.8%	80.0%			3rd Quartile	Apr 26	86.8%	86.5%	81.1%			Top Quartile
Diagnostics - 6 Week Waits	Apr 26	6.0%	5.7%	2.0%			2nd Quartile	Apr 26	6.6%	7.0%	8.6%			2nd Quartile
4 Hour Operating Standard	May 26	81.0%	80.0%	82.2%			2nd Quartile	May 26	71.1%	61.1%	82.0%			3rd Quartile
4 Hour Operating Standard - Paediatrics <16 years	May 26	93.3%	89.5%	95.5%	-	-	TBC	May 26	80.2%	79.6%	95.0%	-	-	TBC
Over 12 Hours in ED from arrival (%) Type 1	May 26	8.6%	8.8%	8.5%			2nd Quartile	May 26	15.3%	20.2%	11.3%			Lowest Quartile
Emergency Department Corridor Care (Average Daily Count)	May 26	21	18	-		-	TBC	May 26	48	46	-	-	-	TBC
Ambulance handovers over 45 minutes	May 26	8.4%	9.2%	0.0%			TBC	May 26	5.3%	4.2%	0.0%			TBC
Ambulance average Handover Time (min)	May 26	00:24:28	00:24:42	00:15:00			TBC	May 26	00:23:51	00:22:37	00:22:00			TBC

Targets based on Operating Plan end of year 2026/2027 Medium Term Plan submissions
Benchmark Position in arrears in line with model hospital publication dates

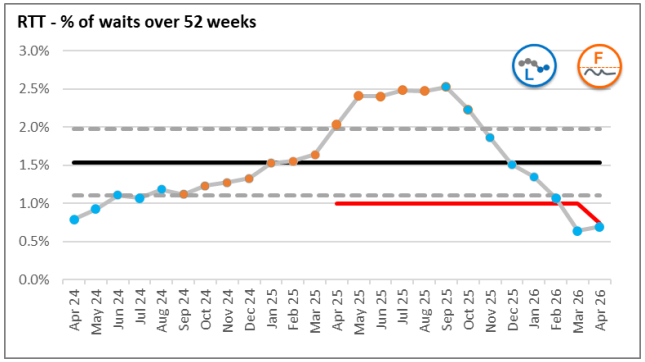
Operational Performance

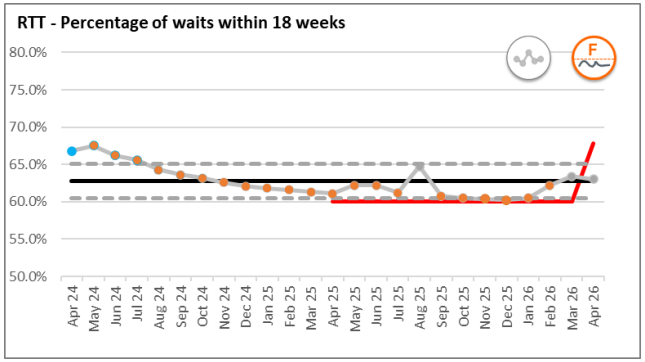
Overview Dashboard – Integrated Care

KPI	Sutton Healthcare						Surrey Downs					
	Latest month	Previous Month Measure	Latest Month Measure	Target	Variation	Assurance	Latest month	Previous month measure	Lastest month measure	Target	Variation	Assurance
Two hour UCR performance	May 26	71.8%	73.5%	70.0%			May 26	90.5%	89.0%	70.0%		
Virtual ward - Bed Occupancy	May 26	57.6%	60.0%	85.0%			May 26	93.5%	94.3%	80.0%		
Virtual ward - Average Length of Stay	May 26	4.9	4.5	-		-	May 26	6.1	7.7	-		
% of Intermediate care beds occupied by patients without criteria to reside	-	-	-	-	-	-	May 26	8.2%	10.5%	-		-
Waiting List Community - Waits over 52 weeks	May 26	103	107	0			May 26	0	0	0		
Waiting List Community - Percentage of waits within 18 weeks	May 26	83.8%	84.7%	78.0%			May 26	96.7%	97.8%	78.0%		
Waiting List Community Children - Waits over 52 weeks	May 26	100	102	0								
Waiting List Community Children - Percentage of waits within 18 weeks	May 26	49.6%	49.7%	78.0%								

% of Intermediate care beds occupied by patients without criteria to reside
Relates to Surrey Downs - Molesey and Dorking wards only

Operational Performance
Key Metrics | SGUH Referral to Treatment RTT



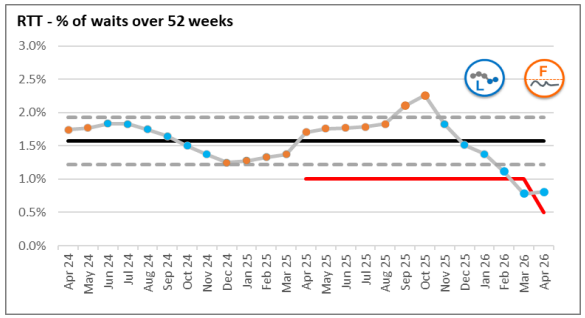


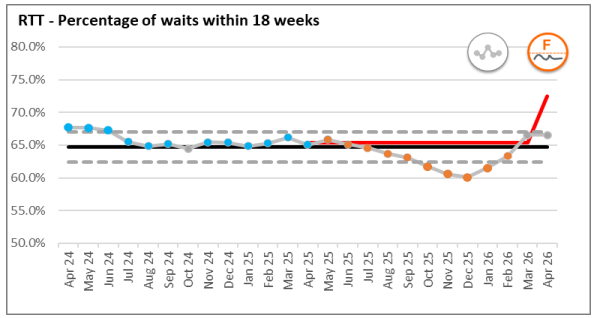
Site & Metric	Cause of variance/ non-compliance	Actions: Completed since last update, New, and Ongoing	Recovery Date

SGUH
 	
% 52 week waits, positively exceeding monthly plan
Apr-26 1.02%.
Mar-27 0.74%
 	
% waits within 18 weeks Positively exceeding monthly plan
Apr-26 60.6%.
Mar-27 67.8%
 	
Data Quality: sufficient for assurance
	At the end of April 2026, 472 patients were waiting for more than 52 weeks, 0.69% of the total PTL. This is below our 2026/27 MTP trajectory. The largest proportion of patients currently in this cohort are within; Cardiology (87), General Surgery (83) and Gynae (63).
	
	18 Week Performance for April 2026 delivered 63% ahead of the April 2026 MTP plan of 60.6%.
		Completed:
		The Trust has set specialty level RTT performance and long wait trajectories to support the delivery of the 7% RTT improvement requirement as part of the medium-term plan. This is monitored weekly through Tier One committee meetings.
		
		Ongoing/new:
		• Weekly Tier One committee meetings continue to be held. These focus on eliminating 65 week waits, reducing 52 week waits to <1% of the overall PTL and improving RTT performance.
		• Outpatient Transformation Programme workstreams have now commenced. These focus on:
		  • Outpatient clinic productivity - to include the standardisation of templates and appt slot times, reduction in follow up demand and "patient not present" activity.
		  • Digital – a number of digital solutions to support outpatient efficiency. Improved use and functionality within the patient portal, AI and RPA innovation to support DNA reduction and *smart* booking and ambient voice technology.
		  • Integrated Neighbourhood teams – to support the medium-term plan and "left shift" activity to community settings where clinically appropriate. Moving care closer to patients.
		  • In July, Source Group commence the validation of 23,000 patient pathways in the 18-40 week catchment.
			Delivering against MTP Plan 2026/27

Operational Performance

Key Metrics| ESTH Referral to Treatment RTT

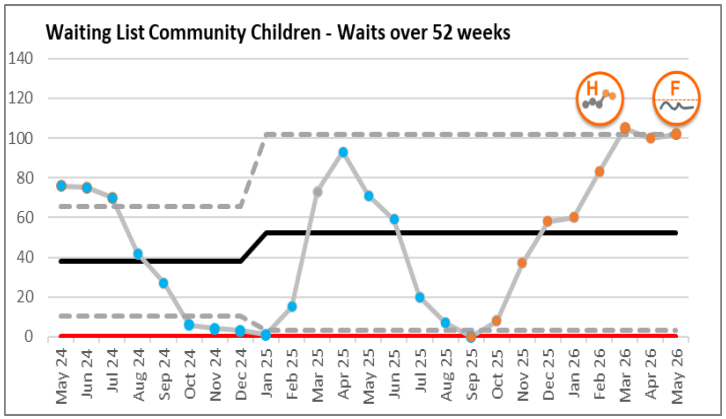


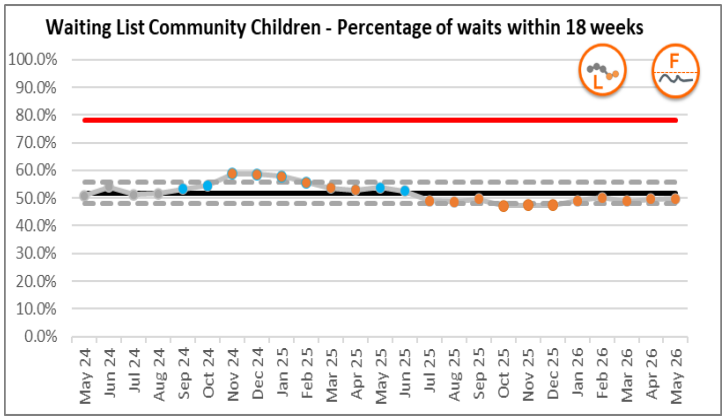


Site & Metric	Cause of variance/ non-compliance	Actions: Completed since last update, New, and Ongoing	Recovery Date
ESTH Total waits over 52 weeks – overachieved monthly trajectory of 563 Percentage within 18 weeks – overachieved monthly trajectory of 65.50%	• 52WW overachieved the April trajectory of 563, with a total of 475. The highest volumes were in Cardiology (105), Gynaecology (69) and Gastroenterology (62). • 65WW remained stable in April 2026 with a total of 20, compared to 18 in March 2026. • RTT performance also overachieved the April trajectory of 65.5% with a performance of 66.56%. • Percentage waits for first appointment under 18 weeks improved again from 77.6% in March 2026 to 78.0% in April.	**Total PTL** -ESTH's PTL remained above trajectory in April 2026 following the iCLIP innovation release issue earlier in the year. Alongside resolving this issue, the Trust implemented a recovery programme including additional RTT validation resource, external support, increased clinic and theatre capacity, targeted validation of affected pathways and strengthened operational oversight. **Long Waiters -52WW** - Recovery plans remain in place and ongoing for the most challenged specialties. • Cardiology: Cardiology continues to face pressure on first outpatient waits due to demand and capacity challenges. A business case for additional substantive consultant investment has been submitted to the Executive Team. Cardiac MRI waiting list remains challenged, with longest waiters dating back to July 2025. However, the Epsom cardiac MRI service and continued outsourcing are expected to support recovery. Reduced tracking resource, increasing PTL size and data quality pressures, continue to impact pathway oversight. • Gynaecology: Gynaecology continues to face sustained pressure from increasing demand and workforce capacity constraints, alongside the requirement to support Cancer performance. Recovery actions remain focused on managing 65 and 52-week long waiters, optimising capacity (including outsourcing), continuing validation activity and aligning Cancer and RTT priorities to proactively manage risk. • Gastroenterology: Service continues to face capacity constraints due workforce issues. A business case is being submitted to bolster the service which is currently pending review with the Executive Team. Inflated FIT results, which caused a 30% increase in two-week referrals over the winter, are still having an effect, as the department balance planned and urgent patients with long waiters.	52WW + RTT performance trajectories achieved in March 2026

Operational Performance

Exception Report| Sutton Health – Community Services Children's Waiting Times



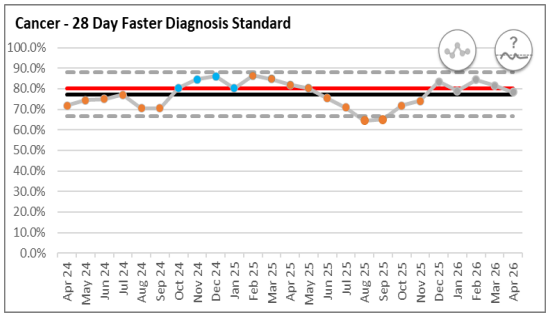


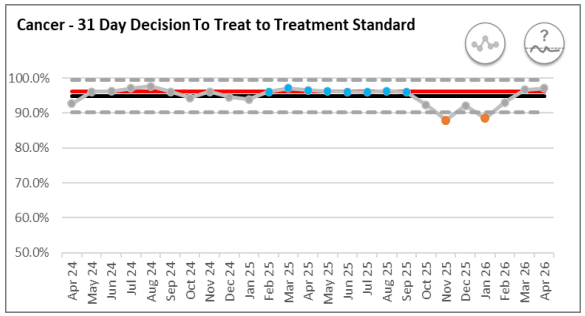
Site & Metric	Cause of variance/ non-compliance	Actions: Completed since last update, New, and Ongoing	Recovery Date

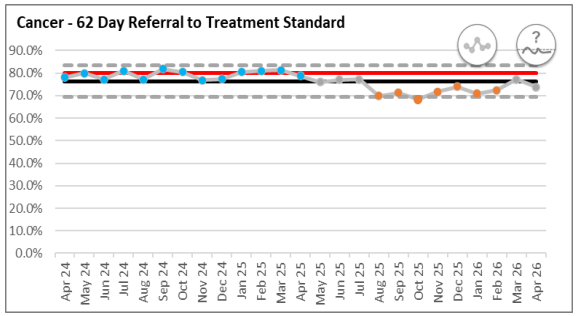
Sutton Health & Care waits over 52 weeks -
 	
Variation of a CONCERNING nature.
 	
Data Quality: Sufficient for assurance
	Of the children's community waiting list, 102 patients are waiting for more than 52 weeks. This reflects the national trend of increasing waits over the last 18 months.
	
	The overall children's services waiting list continues to increase, mainly in Speech and Language Therapy services and due to increasing complexity of need. This has been highlighted on the risk register.
	
	Children's 18-week performance remains low at 49.7%, with no observable improvement and a stable but underperforming position.
	
	To note – the overall community waiting list performance for Sutton exceeds the 2026/27 target of 78%.
		• There is a consolidated action plan in development across South- West London.
		• Harm reviews continue to take place to ensure there is no harm to children with longer waiting times. No concerns have been raised to date.
		• Education, Health and Care Plans (EHCP) targets remain on track.
		• Sutton Place partners are working together to review and mitigate any concerns related to the health pathway.
		  ○ This review is being taken forward with the SEND partnership forum (Sutton), and the CQC-OFSTED review (LBS).
		  ○ With a particular focus on dysphagia, it will include a review of delays in development/ treatment, workforce capacity, vacancies, hard to fill specialist posts and modelling improvement.
		• This is ongoing work in partnership with ICB and DCO for Sutton.
			TBC

Operational Performance

Key Metrics | SGUH - Cancer Performance Standards



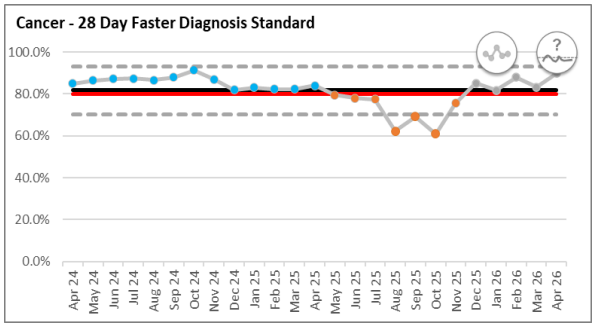


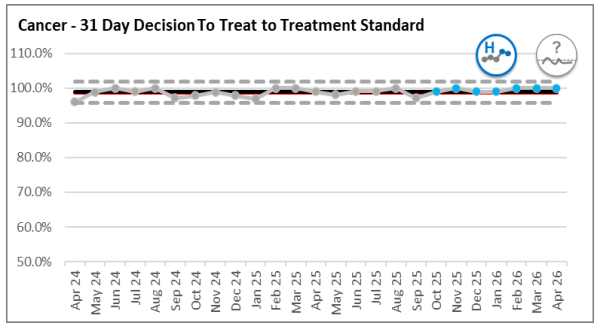


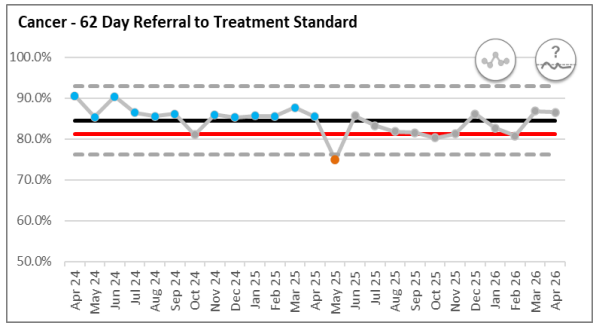
Site & Metric	Cause of variance/ non-compliance	Actions: Completed since last update, New, and Ongoing	Recovery Date
SGUH 28-Day FDS April 2026 78.4% normal variation, below MTP 62-Day standard April 2026 73.8% normal variation, below MTP 75% **Data Quality:** Sufficient for assurance	**FDS - Key drivers include:** • Urology pathways (Bladder) (49.4%) impacted by limited flexible cystoscopy capacity. • Lung Respiratory (62.1%) due to Navigational bronchoscopy access. • Lower GI performance improved to 71.3%. • Gynae, Skin and Breast were complaint. **62 Day- Key drivers include:** • Performance continues to be challenged by lung cancer pathways (22.9%), particularly within thoracic services. • Sustained theatre capacity constraints for thoracic surgery, alongside high tertiary referral volumes across SWL, Surrey and Sussex. • Diagnostic capacity, including navigational bronchoscopy, remains a further limiting factor.	**Breast -** An RM Partners (RMP)-led Breast Pathway Community of Practice took place on 12 May 2026, focusing on standardising diagnostic pathways, reducing treatment variation, and optimising treatment intensity. **Urology -** Work is underway to better align demand and capacity for flexible cystoscopy services, with stronger oversight and active management. The RMP urinary biomarker programme remains in early development **Head and Neck (H&N) -** Additional RMP-funded WLI activity is planned for May–June 2026 to reduce the backlog. A SWL Head and Neck Targeted Access Clinic (TAC) nurse sub-group meeting at St George's Hospital focused on aligning TAC principles to improve consistency across the sector **Dermatology -** RMP resilience funding (up to £18k) will support three additional weekly MOP lists over three months. A CNS will deliver four weekly MOP lists, with further capacity added via summer consultant-led Tuesday super clinics. A pathway navigator will improve monitoring and clinic utilisation. The RMP-led SWL operational delivery group will also develop dermatology workstreams (2026/27), including USC pathways and digital solutions **Lung / Thoracic -** An RMP-led SWL Lung Cancer Forum at St George's (22 May 2026) reviewed pathways, diagnostics, and performance, focusing on rapid diagnostics, tissue access, and shared care to improve services **Access Meeting -** Weekly Divisional Cancer Access Meetings provide oversight of performance and delivery, while the cancer performance framework supports proactive management of breaches and prompt booking for patients awaiting treatment. **Resilience Funding Summary -** A total of £50k of RMP resilience funding has been allocated to support performance delivery.	FDS on track to deliver MTP May 2026 62 Day TBC

Operational Performance

Key Metrics | ESTH - Cancer Performance Standards



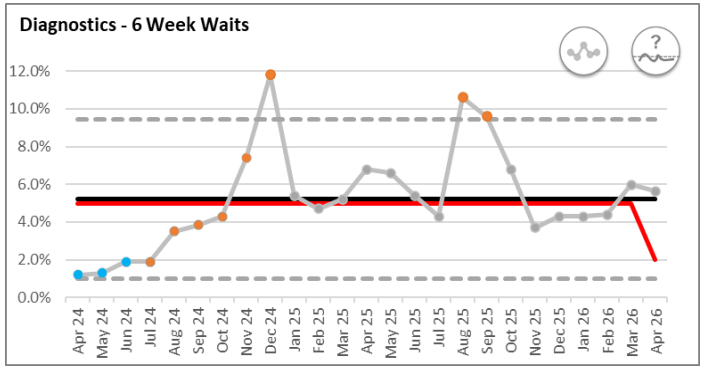




Site & Metric	Cause of variance/ non-compliance	Actions: Completed since last update, New, and Ongoing	Recovery Date
28 Day FDS 89.8 % meeting MTP 62 Day Standard 86.5% meeting MTP	**Lower GI** (80.0%): FDS has increased significantly comparted to March (68.5%). Lung (66.7%): Delays to diagnostics	**Lower 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. **Lung:** FDS breaches were driven by diagnostic delays, capacity pressures, and the complexity of individual patient pathways.	As per MTP
Data Quality: Sufficient for assurance	**Lung** (54.5%): Delays to external diagnostic. **Lower GI** (75.6%): Complex pathways requiring multiple investigations and support. **Gynaecology** (63.6%): Limited capacity for G&A and outpatient hysteroscopy services has contributed to delays in the diagnostic pathway.	**Lung:** Imperial has commenced navigational bronchoscopy, provided additional capacity, reducing pressure on Brompton. Radiology staffing is now fully established, enabling increased CT-guided biopsy capacity. SWL-wide benchmarking of the lung pathway is underway to improve patient flow and reduce pathway delays. **Lower GI**: Complex pathways requiring multiple diagnostic tests and limited endoscopy capacity have contributed to delays. Endoscopy has implemented measures to improve turnaround times, resulting in significant improvements in FDS performance, which are expected to support a reduction in 62-day breaches. **Gynaecology:** Improved collaboration with gynaecology service team has strengthened FDS performance. Capacity reviews and increased/protected dedicated cancer slots are expected to further reduce breaches.	

Operational Performance

Exception Report| SGUH Diagnostic Performance



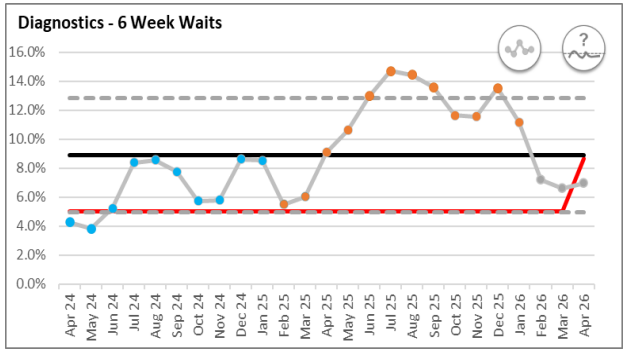
Modality	6 Week Breaches	>6 Week Performance
Cardiology - echocardiography	205	12.4%
Respiratory physiology - sleep studies	176	36.0%
Gastroscopy	158	26.4%
Magnetic Resonance Imaging	126	4.4%
Colonoscopy	95	28.7%
Non-obstetric ultrasound	45	0.6%
Flexi Sigmoidoscopy	34	23.0%
Neurophysiology - peripheral neurophysiology	31	9.8%
Urodynamics - pressures & flows	18	21.4%
Cystoscopy	4	2.7%
Audiology - Audiology Assessments	0	0.0%
Computed Tomography	0	0.0%
DEXA Scan	0	0.0%

Target line based on Operating Plan end of year 2026/2027 Medium Term Plan submissions

Site & Metric	Cause of variance/ non-compliance	Actions: Completed since last update, New, and Ongoing -	Recovery Date
SGUH Normal variation – Not meeting monthly MTP plan Apr-26 5% Mar -27 2% **Data Quality**: Sufficient for assurance	April 2026 diagnostics missed the 5% MTP target (5.64%); backlog reduced but ongoing capacity and workforce issues risk delivering future MTP performance. **Echocardiography** – Staffing gaps leading to capacity constraints through March 2026 creating a backlog of approx. 200 patients. Demand has exceeded capacity despite adding additional lists. **Endoscopy** requires long-term planning to reduce waits and meet MTP targets, as it accounts for 40% of breaches. Capacity was significantly impacted in March–April by annual leave, bank holidays, and short-term workforce gaps from two consultant departures and an Endoscopy Fellow on maternity leave. **Non-Obstetric Ultrasound** – Rising ultrasound demand amid acute sonographer shortage is impacting DM01 with ~1,400 breaches expected at the end of May 2026. Recruitment unsuccessful despite multiple campaigns and declined offers due to lack of recruitment and retention premium (RRP)	**Echocardiography** Short-term plan: Use of bank staff and short-term recruitment provided capacity through May 2026 which has reduced backlog, alongside ongoing recruitment to Band 7 and Band 6 vacancies. **Endoscopy** Short Term- interim cover is arranged, with a substantive consultant starting in July 2026 . Long term plan - capacity is being increased through the redistribution of cancelled sessions and training of nurse endoscopists. Operational improvements include a more streamlined booking process, improved visibility of appointments, measures to reduce DNAs, emphasis on triaging referrals and more flexible use of locations (sites) **Non-Obstetric Ultrasound** Currently using Agency Sonographers (The agency spend is off-set by CDC funding) Substantive staff providing additional bank shifts on top of their substantive hours.	TBC

Operational Performance

Exception Report| ESTH Diagnostic Performance



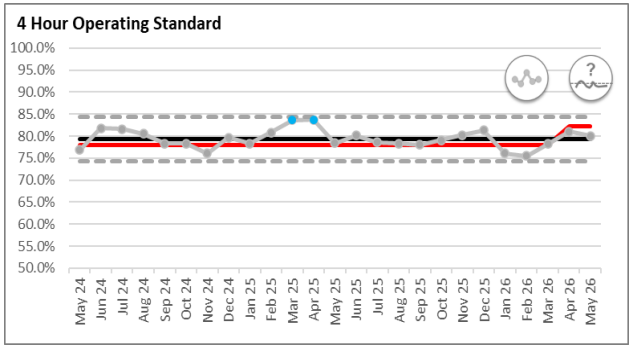
Modality	6 Week Breaches	>6 Week Performance
Colonoscopy	260	32.70%
Gastroscopy	224	30.19%
Urodynamics - pressures & flows	136	49.45%
Non-obstetric ultrasound	95	1.36%
Flexi sigmoidoscopy	68	37.16%
Cardiology - echocardiography	50	14.58%
Audiology - Audiology Assessments	37	4.60%
Computed Tomography	24	1.58%
Cystoscopy	24	14.20%
Neurophysiology - peripheral neurophysiology	21	44.68%
DEXA Scan	13	2.32%
Magnetic Resonance Imaging	6	0.42%

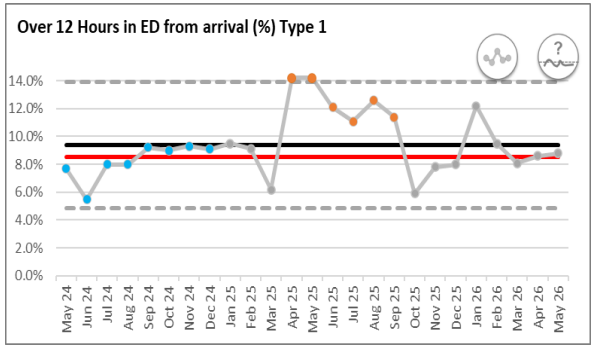
Site & Metric	Cause of variance/ non-compliance	Actions: Completed since last update, New, and Ongoing	Recovery Date

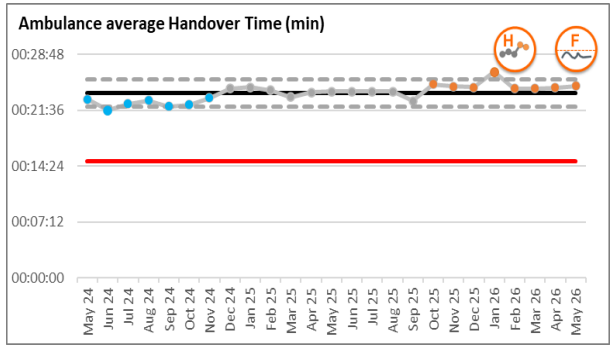
ESTH: April 2026 6Wk waits 6.9% ahead of MTP 2026/27 Plan
 	
Data Quality: April 2026 data still includes some issues following EPR implementation. These are being addressed, mainly within OP modalities Urodynamics, Cystoscopy, ECHO and Neuro-Physiology. These are likely to have a minimal impact on performance.
	• At the end of April 2026, there were **958** patients waiting more than six weeks for their diagnostic (DM01), a further reduction from 1,025 at the end of March 2026. However, due to a reduced waiting list size, performance remained fairly static with a performance of **93.1% in April**, compared to 93.4% in March.
	
	• The modalities with the highest volumes waiting >6 weeks at the end of April 2026 were:
	  • **Endoscopy (552)**
	  • **Urodynamics (136)**
	  • **NOUS (95)**
	
	Imaging modalities all remain above 95%.
		• **Endoscopy:** An Endoscopy recovery plan remains in place, with 15 additional Saturday Waiting List Initiative sessions approved for six months from April 2026 to support delivery against performance targets. Approval has also been granted to extend the dedicated DM01 validation post through to the end of 2026. There is now a concerted focus on coding and outcoming processes to address ongoing DM01 performance issues linked to data quality. Targeted training will be delivered by RTT trainers to ensure patients are coded correctly throughout their pathway, reducing duplicate and unnecessary waiting list entries, particularly within the inpatient pathway.
		
		• **Urodynamics:** Performance continues to improve; however, capacity remains constrained while newly recruited staff complete competency training. Nurse training is progressing, and additional capacity is expected once independent practice is achieved.
		
		• **NOUS:** DM01 performance demonstrated a significant improvement in April, with breaches reducing from 216 in March to 95 in April (98.6%). The improvement has been driven primarily by the implementation of both insourcing and outsourcing solutions, which have increased overall diagnostic capacity and supported the clearance of backlogs.
			As per MTP

Operational Performance

Key Metrics| SGUH A&E Waits and Ambulance Handovers



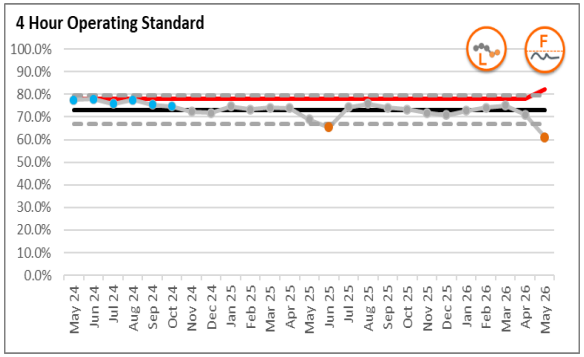


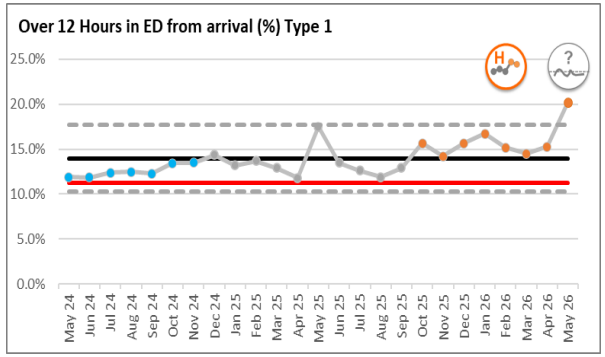


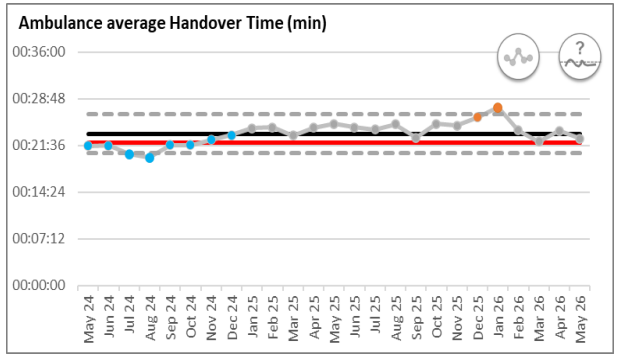
Site & Metric	Cause of variance/ non-compliance	Actions: Completed since last update, New, and Ongoing -	Recovery Date
SGUH 4 Hour Target normal variation 12 Hour Waits – normal variation Ambulance delays **Data Quality:** Sufficient for assurance. Ambulance data supplied by NHSE not validated	• May 2026 4-hour performance, achieving 80.04%, slightly below MTP plan of 80.8% • On average 37 patients per day waited >12 hours before discharge in ED, a decline of 2 patients on average from previous month • May 2026 saw 2,750 ambulance conveyances, with 76% offloaded within 15 minutes. • Patients awaiting admission from ED waited on average: 14 hours 51 minutes. A deterioration of 105 minutes from the previous month. This is linked to flow out of the hospital and mental health demand. • 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. • The Emergency care delivery board ensures assurance and accountability on ED performance. • Improvements to data processes have aligned the local data and national Emergency Care Data set, reducing discrepancies from 20% to 1-2% through enhanced documentation practices. • NEL workstream lead by STG MD looking at a series of strategic actions to improve flow and performance. • Plan to visit Walsaw NHS Trust to learn lessons from their eradicating corridor care programme.	MTP Trajectory

Operational Performance

Key Metrics| ESTH A&E Waits and Ambulance Handovers



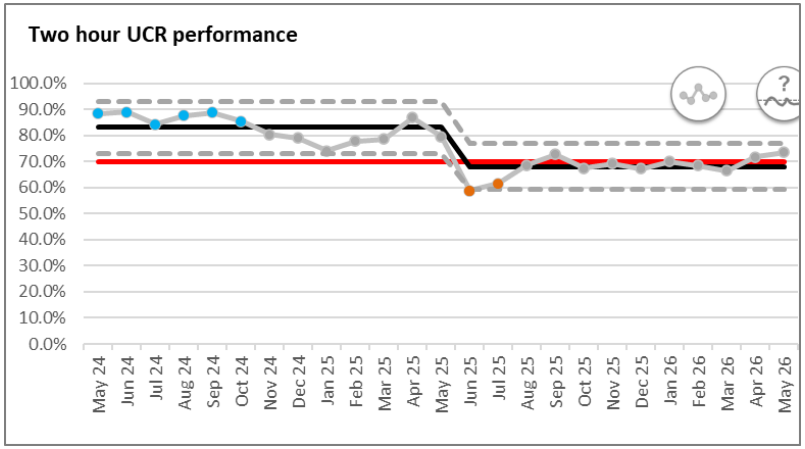




Site & Metric	Cause of variance/ non-compliance	Actions: Completed since last update, New, and Ongoing	Recovery Date
ESTH 4 Hr performance - normal variation below MTP ED Type 1 LOS>12 Hours - Increasing trend **Data Quality:** Sufficient for assurance	• ESTH 4-hour emergency department (ED) performance deteriorated in May 2026, delivering 61.1% versus 71.1% last month. • 12-hour waits for type 1 attendances deteriorated to 20.2% in May 2026 from 15.3% in the previous month. • Average Ambulance handover times remain stable in May 2026, with 23 minutes. • The deterioration has been driven by the GIRFT UEC recommendation and implementation of UTC First and the decommissioning of ED SDEC on 22nd April 2026. A robust UEC recovery plan is in place to address key drivers of current performance	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 pathway. Key actions implemented during the last month include: • The ESTH UTC First and ED Medical Ambulatory pathways were launched trust-wide on 22 April 2026. The redirection and supporting pathways are functioning effectively, with increased numbers of appropriate patients being streamed and triaged to both UTC and ED Medical Ambulatory services. This includes ring-fenced SDEC capacity for patient assessment. A dedicated working group has been established to support post operational delivery and data resolution following implementation of the UTC First model. • 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 Consultant-to-Consultant discussions. • Ring-fencing 1 bed in the frailty hub to accommodate x3 chairs for ambulatory patients. • Decision to Admit (DTA) huddles continue to form business as usual in Emergency Departments at 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.	As per MTP

Operational Performance

Key Metrics| 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 **Data Quality:** Sufficient for assurance	• May 2026 2-hour Urgent Community Response performance improved to 73.5%, exceeding the 70% target for a second consecutive month following a period of underperformance. • Referral volumes remain within the normal range; however, variation has been observed, particularly out of hours, following the implementation of the SWL Integrated Care Coordination Hub. This has resulted in a mismatch between staffing and demand profiles.	• As part of the Sutton Home from Hospital model, improvement work is underway to ensure increases in productivity and efficiency, and to resolve issues on mitigating actions to ensure the service is performing above target. • Staffing profile changes are underway to align with demand	N/A



Section 2.2:
Operational Productivity

Operational Productivity

Overview Dashboard

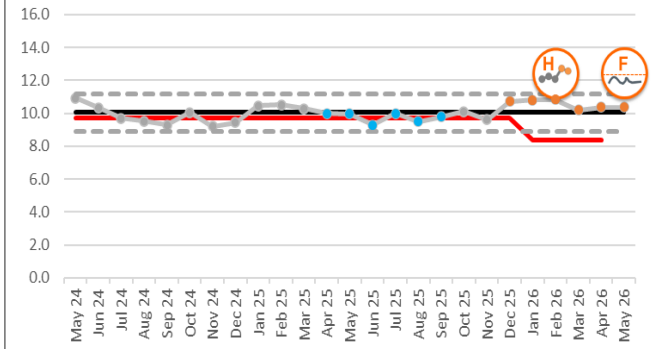
	St George's							Epsom & St Helier						
KPI Operational Productivity	Latest month	Previous month measure	Lastest month measure	Target	Variation	Assurance	Benchmark	Latest month	Previous month measure	Lastest month measure	Target	Variation	Assurance	Benchmark
Implied Productivity Growth YTD	Dec 25	-1.6%	-1.6%	-	N/A	N/A	Lowest Quartile	Dec 25	-0.4%	-3.8%	-	N/A	N/A	Lowest Quartile
Cost Weighted Activity Growth YTD	Dec 25	-1.2%	-1.5%	-	N/A	N/A	Lowest Quartile	Dec 25	-2.1%	-5.1%	-	N/A	N/A	Lowest Quartile
Real Terms Resource Use Growth YTD	Dec 25	0.4%	0.2%	-	N/A	N/A	2nd Quartile	Dec 25	-1.6%	-1.4%	-	N/A	N/A	3rd Quartile
Non Elective Length of Stay (SWL Methodology exc 0 days, exc <18 years)	May 26	10.4	10.4	8.4			N/A	May 26	11.5	11.9	10.9			N/A
Average days from Discharge Ready Date to date of discharge (inc 0 day delays)	Apr 26	0.6	0.7	-			3rd Quartile	Apr 26	1.4	1.4	-		-	Lowest Quartile
Theatre Utilisation (Capped)	May 26	81.6%	85.4%	85.0%			Top Quartile	May 26	79.9%	80.5%	85.0%			2nd Quartile
BADS All Daycase & Outpatient Procedures % of total procedures	Feb 26	81.5%	78.8%	87.0%			3rd Quartile	Feb 26	68.1%	68.0%	87.0%			Lowest Quartile
Outpatients Patient Initiatied Follow Up Rate (PIFU)	May 26	2.4%	2.2%	5.2%			Lowest Quartile	May 26	4.9%	5.1%	5.0%			2nd Quartile
Outpatients Missed Appointments (DNA Rate)	May 26	9.1%	10.0%	8.0%			Lowest Quartile	May 26	8.5%	7.5%	6.0%			3rd Quartile
First and Procedure Attendances as a proportion of Total Outpatients	May 26	53.6%	52.1%	49.0%			Lowest Quartile	Mar 26	42.0%	41.6%	49.0%			Lowest Quartile

Operational Productivity

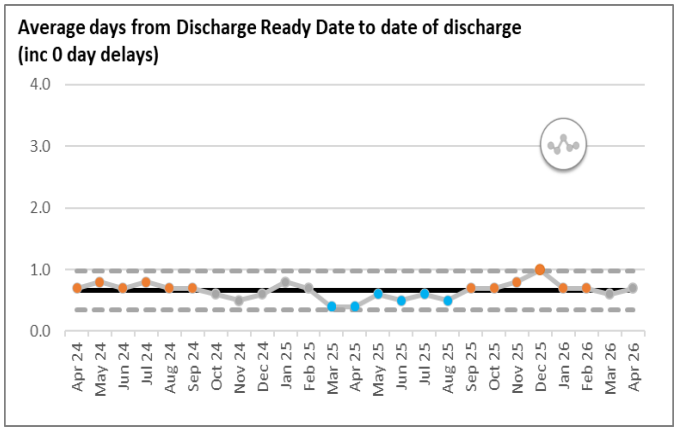
Bed utilisation

St George's

Non Elective Length of Stay (SWL Methodology exc 0 days, exc <18 years)

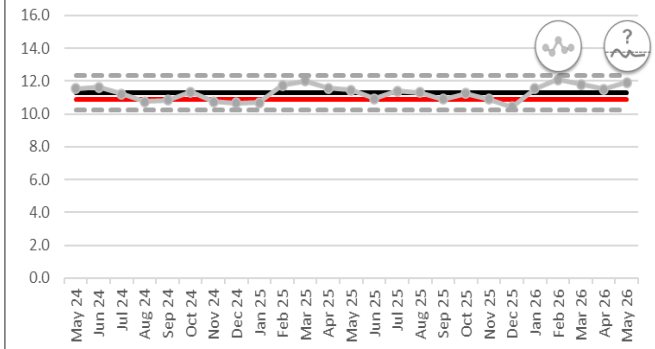


Average days from Discharge Ready Date to date of discharge (inc 0 day delays)

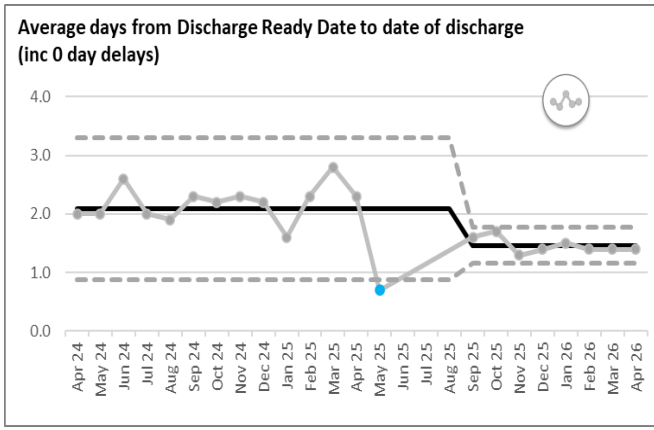


Epsom & St Helier

Non Elective Length of Stay (SWL Methodology exc 0 days, exc <18 years)



Average days from Discharge Ready Date to date of discharge (inc 0 day delays)



Analyses & Key actions

Group-wide

- Aligned to gesh-wide Non-Elective Transformation Programme

SGUH

- Non-elective length of stay (excluding 0 days) for May is 10.4 days.
- SGUH is developing a programme to reduce/ eradicate corridor care based on NHSE guidance.
- Further development is being driven through the NEL strategy programme, including Virtual ward, Home first, Urgent Community Response and integrated Neighbourhood teams.
- Published data indicates an average of 3.8 patients per day are displaced on a ward (Corridor care – 8am snapshot).

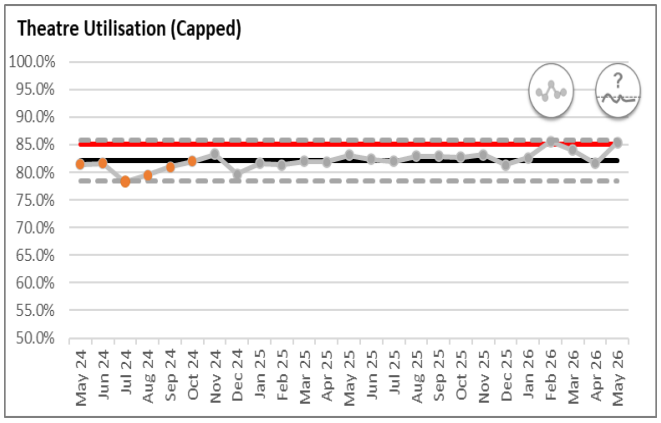
ESTH

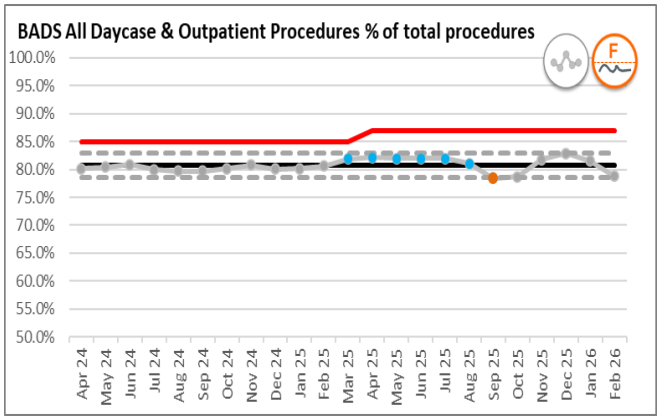
- Non-elective length of stay increased to 11.9 days in May 2026 compared to 11.5 days in April 2026, remaining above target. This was largely driven by the discharge of 32 complex patients from the StH site with lengths of stay exceeding 75 days, accounting for 3,381 bed days.
- Therapies and capacity-release models are live, supported by a ring-fenced reablement bed, with decision to admit (D2A) modelling progressing in line with the gesh NEL programme.
- Optimising Bed Base: Phase one of the SWIFT and AMU relocations has been implemented, with the SWIFT ward decanted to its interim location. This enables ward refurbishment to progress, supporting both non-elective flow and expanded elective and private patient capacity, alongside associated revenue opportunities.
- Additionally, this phased programme of work supports the ongoing development of a single-site CCU, including scoping and revised models of care.

Operational Productivity

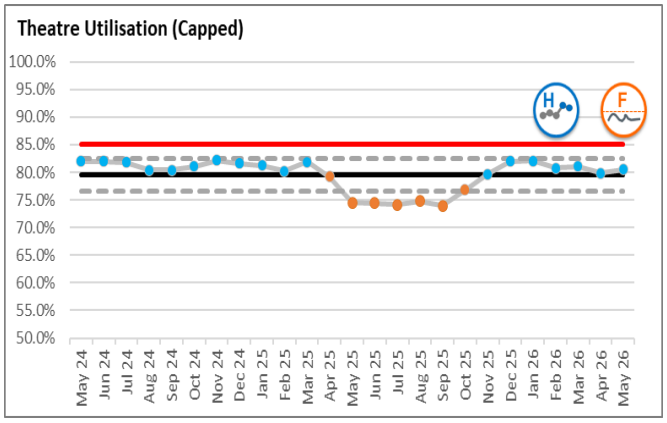
Theatre Utilisation

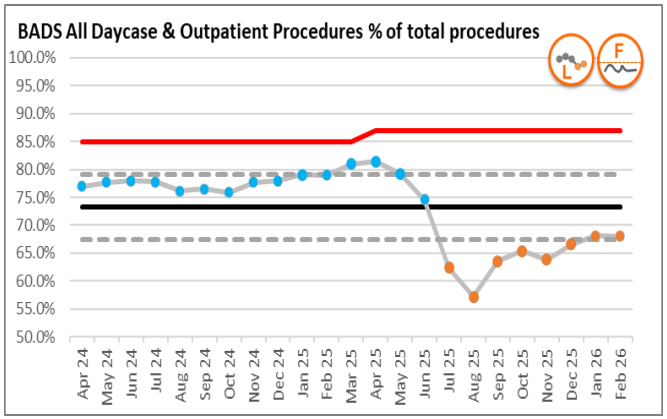
St George's





Epsom & St Helier





Analyses & Key actions

Group-wide - A gesh-wide group has been set up to deliver electronic Pre-Operative Assessment by the end of July 2026. The team currently working to finalise the write-back functionality from the patient portal into iClip and the landing page.

SGUH

- Theatre utilisation is above target, reflecting improved stability in scheduling processes and supporting effective use of available operating capacity across specialties.
- Work continues to optimise case selection and list structures, ensuring appropriate procedures are delivered through day case pathways wherever clinically suitable and supporting efficient patient flow.
- Focus has shifted to reducing variation in theatre performance through specialty reviews, strengthening resilience, and maximising productivity from existing resources.

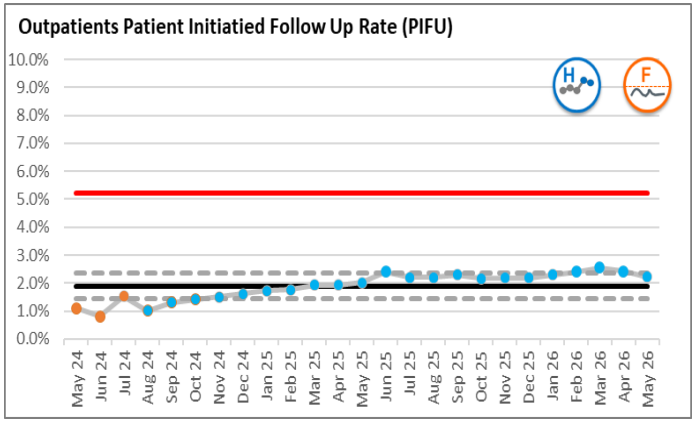
ESTH

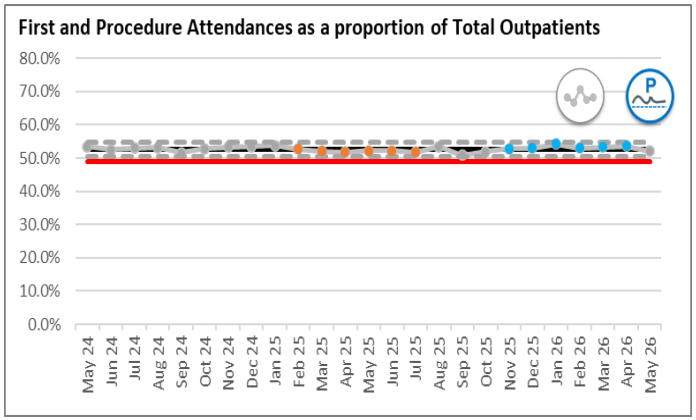
- Embed the Golden Patient model as a standardised, sustainable approach to optimise theatre start-time performance.
- Establish clear, system-wide definitions for theatre list timings to drive consistency, benchmarking, and long-term performance management.
- Reinforce standard operating practices through ongoing visual prompts and theatre-level accountability mechanisms.
- Align scheduling and data standards (Cerner/EOC) to enable accurate classification, reporting, and strategic capacity planning.
- Define and implement 'perfect morning' operating model to underpin reliable, timely list starts and continuous improvement across theatres.

Operational Productivity

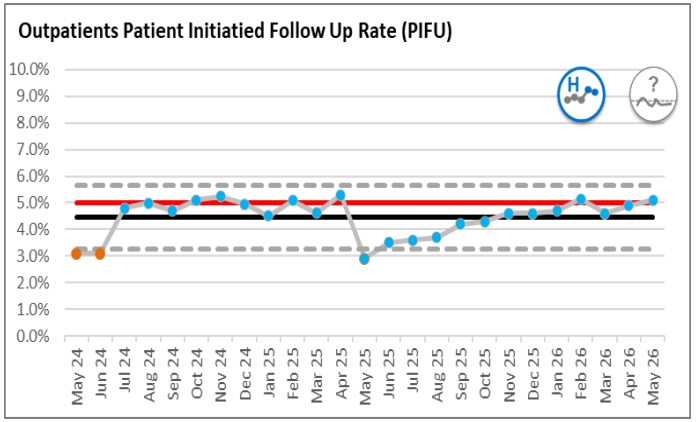
Outpatient Follow-ups

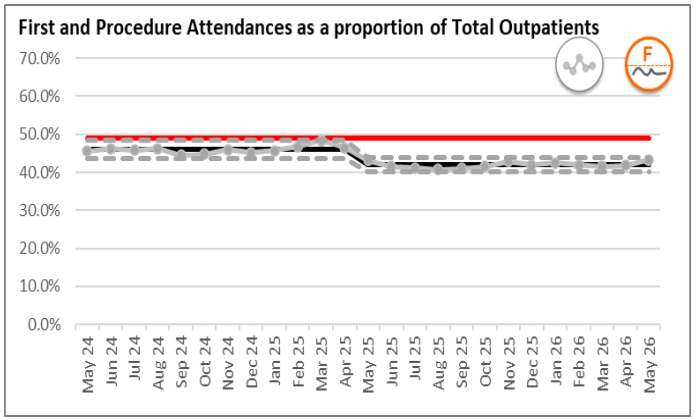
St George's





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 SGUH Productivity workstream in gesh OP Transformation programme
- ~26k annual non-attended appointments identified as inflating reported performance, with plans to remove them from future SUS submissions
- Work to commence expansion of PIFU types used by Trust planned.
- Plan to embed PIFU into standard clinical pathways
- Wait list validation to expand and be automated.
- Work underway to develop workflow to support PIFU for non outpatient pathways (Daycase/Surgical). Interventional Radiology to pilot.

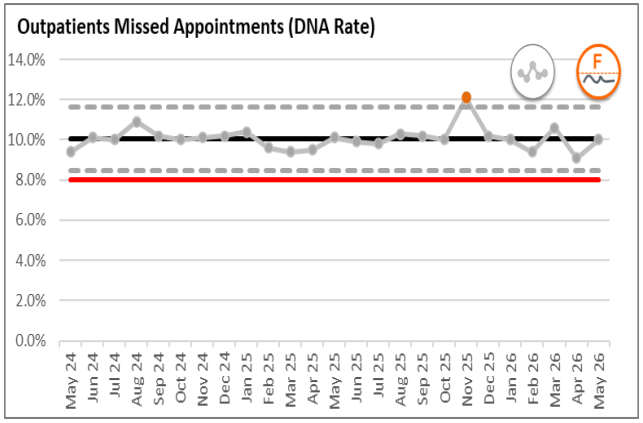
ESTH

- The proportion of first and procedure attendances remained stable in May 2026, whilst the PIFU rate increased to 5.1%, returning to the Trust target.
- PIFU use is increasing across specialties, focusing on areas below pre-iClip levels to reduce avoidable follow-ups and move towards top-quartile performance
- All six focus specialty workshops have now taken place and identified 18 improvement schemes aimed at reducing unnecessary follow-ups and improving outpatient productivity. Detailed scoping is underway to quantify benefits and establish delivery plans.

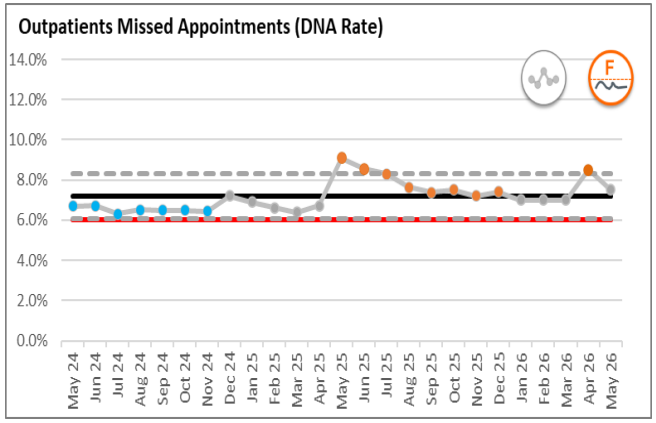
Operational Productivity

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. Improved visibility of patients' appointments will be in place July 2026.
- A trial to change the timing of SMS reminders to 14 and 5 days prior to appointment has commenced.
- Bid in place to fund expansion of automated 2-way telephone reminders following a successful pilot.
- SMS-based digital letters (via Netcall) are being implemented alongside existing digital letters
- Following a successful T&O pilot, vacant slots from short-notice cancellations are now used trust-wide for long-waiting patients.
- Plan to expand portal to encompass paediatrics is underway.
- Partial booking light rolled out to Urology, Plastics and T&O
- DNA rebooking process developed to reduce multiple DNAs
- DNA survey sent to >4K patients. The results will inform DNA programme improvement actions.

ESTH

- DNA rates are recovering after April–May 2026 technical issues with text reminders, now resolved with enhanced assurance checks in place
- By the end of May 2026, all outpatient services had active and up-to-date text reminders in place.
- Reporting requirements have been reviewed and a new reporting solution developed and tested, with further refinements underway.
- An updated process for onboarding new clinics to the text reminder service is being finalised, with a supporting communications pack to follow.



Section 3:
Our People



Section 3 - Our People

Overview Dashboard | People Metrics

St George's

KPI	Latest month	Previous month measure	Lastest month measure	Target	Variation	Assurance
Staff Sickness Absence rate	May 26	4.7%	4.9%	4.0%		
MAST	May 26	91.3%	91.2%	85.0%		
Vacancy Rate	May 26	5.6%	5.9%	10.0%		
Appraisal Rate Medical	May 26	88.2%	87.9%	90.0%		
Appraisal Rate Non Medical	May 26	76.7%	75.8%	90.0%		
Turnover (12-month)	May 26	8.7%	9.0%	13.0%		
Percentage BAME staff band 8a and above	May 26	32.2%	32.1%	-		-
Workforce WTE All Staff Total	May 26	10841	10907	11115		
Substantive Total	May 26	9943	10119	10292		
Bank Total	May 26	852	734	783		
Agency Total	May 26	46	54	40		

Epsom & St Helier

Latest month	Previous month measure	Lastest month measure	Target	Variation	Assurance
May 26	5.3%	5.5%	4.0%		
May 26	89.1%	88.9%	85.0%		
May 26	11.0%	10.9%	10.0%		
May 26	91.2%	91.2%	90.0%		
May 26	79.3%	81.2%	90.0%		
May 26	8.2%	8.4%	12.0%		
Apr 26	30.5%	32.2%	-		-
May 26	7471	7428	7297		
May 26	6435	6452	6422		
May 26	940	941	816		
May 26	53	49	59		

Sutton Healthcare

KPI	Latest month	Previous Month Measure	Latest Month Measure	Target	Variation	Assurance
Sickness Absence Rate	May 26	5.9%	6.2%	4.0%		
MAST	May 26	92.8%	92.7%	85.0%		
Vacancy Rate	May 26	13.5%	13.0%	10.0%		
Appraisal Rate Medical	May 26	100.0%	100.0%	90.0%		
Appraisal Rate Non Medical	May 26	83.3%	83.3%	90.0%		
Turnover (12-Month)	May 26	10.0%	10.1%	12.0%		
Percentage BAME staff band 8a and above	Apr 26	27.1%	28.3%	-		-

Surrey Downs

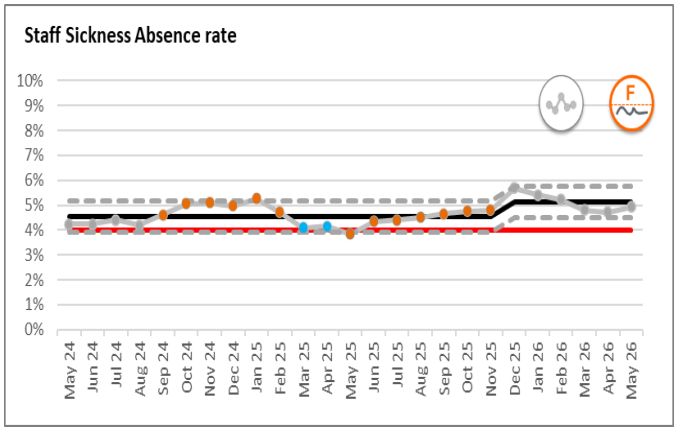
Latest month	Previous Month Measure	Measure	Target	Variation	Assurance
May 26	4.4%	5.3%	4.0%		
May 26	93.5%	92.7%	85.0%		
May 26	7.0%	7.4%	10.0%		
May 26	100.0%	100.0%	90.0%		
May 26	81.5%	80.4%	90.0%		
May 26	9.5%	9.6%	12.0%		
Apr 26	10.9%	10.9%	-		-

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

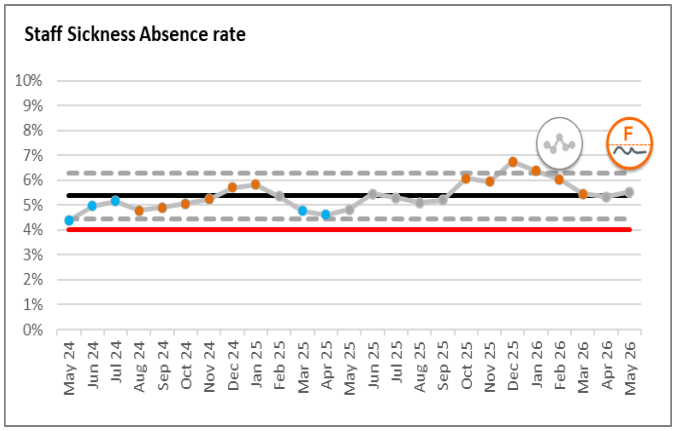
Our People

Exception Report| Sickness Absence Rate

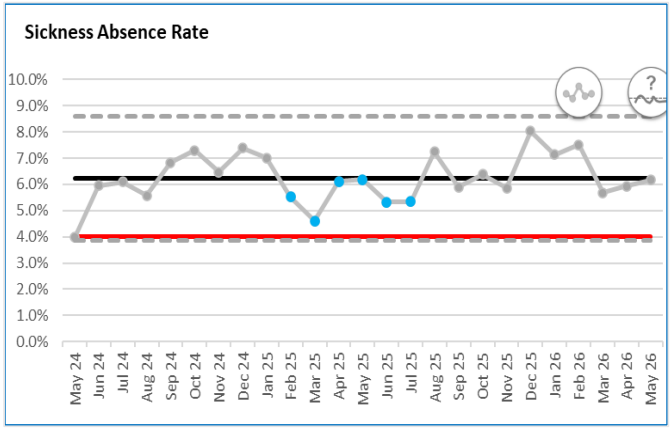
St George's



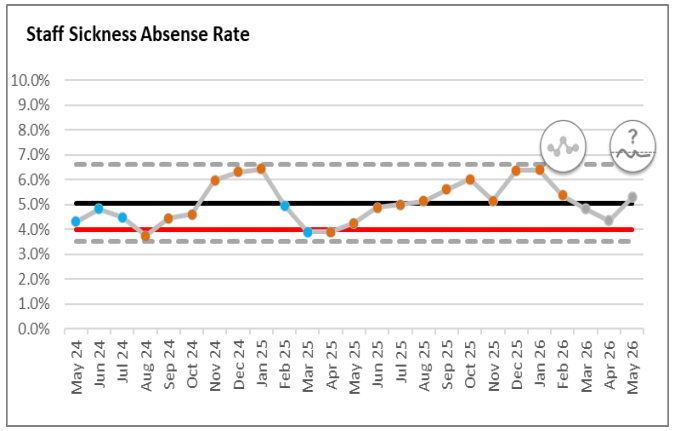
Epsom & St Helier



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.
- A pilot programme to improve absence management in one division per site has been confirmed – Medicine (ESTH) and MedCard (SGUH). This is part of phased

gesh

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

Appendices

Appendix 1 - Statistical Process Control (SPC)

Interpreting Charts and Icons

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

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

Appendix 2 - Watch List Metrics

Overview Dashboard

St George's

KPI	Latest month	Previous month measure	Lastest month measure	Target	Variation	Assuranc	Benchmark
Mixed Sex Accommodation Breaches	May 26	115	107	0			Lowest Quartile
Number of Complaints Received	May 26	131	103	-		-	N/A
Number of re-opened complaints in month	May 26	3	4	-		-	N/A
Parliamentary and Health Service Ombudsman (PHSO) Received	May 26	3	0	-		-	N/A
Parliamentary and Health Service Ombudsman (PHSO) Closed	May 26	2	0	-		-	N/A
RTT - Total Size Incomplete Waiting List	Apr 26	66997	68138	-		-	N/A
On the Day Cancellations not re-booked within 28 days	May 26	2	2	0			2nd Quartile
Outpatient Advice & Guidance Rate per 100 First OPA	Feb 26	21.3	22.8	16.0			3rd Quartile
Emergency Department Attendances per day	May 26	439	438	-		-	N/A
Mental health delays 4 Hour Breaches	May 26	165	139	-		-	N/A
Length of stay > 21 days (super stranded)	May 26	156	157	-		-	3rd Quartile
Overnight G&A beds occupancy - Adults	May 26	95.9%	95.5%	96.0%			N/A
Number of patients not meeting criteria to reside (Daily Avg)	May 26	112	113	-		-	2nd Quartile

Epsom & St Helier

Latest month	Previous month measure	Lastest month measure	Target	Variation	Assuranc	Benchmark
May 26	41	32	0			Lowest Quartile
May 26	47	58	-		-	N/A
May 26	3	0	-		-	N/A
May 26	0	2	-		-	N/A
May 26	1	2	-		-	N/A
Apr 26	58229	58847	-		-	N/A
Mar 26	1	1	0			2nd Quartile
Feb 26	62.8	72.6	16.0			Top Quartile
May 26	443	443	-		-	N/A
May 26	227	239	-		-	N/A
May 26	184	163	-		-	Lowest Quartile
May 26	95.5%	93.7%	88.0%			N/A
May 26	204	177	-		-	TBC

Sutton Healthcare

KPI	Latest month	Previous Month Measure	Latest Month Measure	Target	Variation	Assurance
Urgent Community Response (UCR) Referrals	May 26	429	438	-		-
Virtual ward - Admissions	May 26	312	307	-		-
Virtual ward Length of Stay (Average)	May 26	4.9	4.5	-		-
Discharge to Assess- Pathway 0-3 Delays (Median Days)	May 26	6	1	-		-
Total number of adult patients on the waiting list	May 26	2782	3074	-		-
Total number of children patients on the waiting list	May 26	1193	1191	-		-
Total Number of Compliants Received	May 26	0	1	-		-

Surrey Downs

Latest month	Previous month measure	Latest month measure	Target	Variation
May 26	582	601	-	
May 26	307	257	-	
May 26	6.1	7.7	-	
May 26	1	1	-	
May 26	5579	5526		
May 26	0	4		

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
Suspected brain/central nervous system tumours	Apr 26	N/A	N/A	100.0%	-	Apr 26	94.1%	100.0%	100.0%	
Suspected head & neck cancer	Apr 26	85.3%	78.9%	80.5%		Apr 26	94.2%	92.2%	80.5%	
Suspected breast cancer	Apr 26	89.8%	91.1%	91.4%		Apr 26	N/A	N/A	91.4%	
Exhibited (non-cancer) breast symptoms - cancer not initially suspected	Apr 26	90.3%	89.4%	92.1%		Apr 26	N/A	N/A	92.1%	
Suspected lung cancer	Apr 26	79.3%	61.4%	87.9%		Apr 26	90.9%	67.7%	87.9%	
Suspected upper gastrointestinal cancer	Apr 26	72.1%	62.5%	79.6%		Apr 26	80.3%	86.2%	79.6%	
Suspected lower gastrointestinal cancer	Apr 26	71.3%	66.0%	72.7%		Apr 26	67.8%	79.3%	72.7%	
Suspected gynaecological cancer	Apr 26	62.8%	85.9%	74.8%		Apr 26	70.9%	83.7%	74.8%	
Suspected testicular cancer	Apr 26	N/A	N/A	88.8%	-	Apr 26	N/A	N/A	88.8%	-
Suspected haematological malignancies (excluding acute leukaemia)	Apr 26	92.3%	66.7%	75.0%		Apr 26	97.2%	90.0%	75.4%	
Suspected skin cancer	Apr 26	89.8%	87.5%	92.5%		Apr 26	100.0%	83.3%	75.0%	
Suspected sarcoma	Apr 26	N/A	N/A	58.3%	-	Apr 26	94.3%	98.7%	92.5%	
Suspected children's cancer	Apr 26	70.0%	75.0%	98.1%		Apr 26	N/A	N/A	58.3%	-
Suspected cancer - non-specific symptoms	Apr 26	67.3%	29.8%	74.4%		Apr 26	100.0%	100.0%	98.1%	
						Apr 26	89.2%	87.0%	74.4%	

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	Apr 26	68.8%	57.1%	76.4%		Apr 26	85.7%	63.6%	76.4%	
Skin	Apr 26	74.4%	76.2%	94.4%		Apr 26	98.7%	95.7%	94.4%	
Lung	Apr 26	55.1%	33.3%	69.5%		Apr 26	69.2%	54.5%	69.5%	
Other (a)	Apr 26	93.3%	100.0%	90.0%		Apr 26	0.0%	75.0%	90.0%	
Lower Gastrointestinal	Apr 26	81.8%	64.5%	76.4%		Apr 26	100.0%	75.6%	76.4%	
Head & Neck	Apr 26	76.7%	72.2%	76.7%		Apr 26	75.0%	100.0%	76.7%	
Breast	Apr 26	89.0%	89.2%	73.2%		Apr 26	N/A	66.7%	73.2%	
Upper Gastrointestinal - Oesophagus & Stomach	Apr 26	100.0%	40.0%	79.2%		Apr 26	55.6%	66.7%	79.2%	
Haematological - Lymphoma	Apr 26	37.5%	50.0%	77.8%		Apr 26	100.0%	100.0%	77.8%	
Upper Gastrointestinal - Hepatobiliary	Apr 26	80.0%	69.2%	92.4%		Apr 26	90.9%	93.8%	92.4%	
Urological - Prostate	Apr 26	79.4%	100.0%	75.8%		Apr 26	90.0%	100.0%	75.8%	
Urological - Other (a)	Apr 26	66.7%	50.0%	67.5%		Apr 26	61.1%	100.0%	67.5%	
Haematological - Other (a)	Apr 26	100.0%	100.0%	100.0%		Apr 26	100.0%	100.0%	100.0%	

Appendix 4 – Metric definitions

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
SHMI	Risk-adjusted measure that compares the actual number of patient deaths occurring in hospital or within 30 days of discharge with the number expected, based on the characteristics and case mix of patients treated.	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 MTP	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 MTP	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 MTP	NHS England
Diagnostic Waits > 6 Weeks	Percentage of patients waiting for more than 6 weeks for one of the 15 diagnostic tests from referral or request date.	NHS Oversight Framework, Constitution, and MTP	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 MTP	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.	National and local Priority. NOF contextual metric	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 MTP	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.	MTP	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 National Oversight Framework, Local Priority, and MTP	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 MTP	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 Priority – National and Local	NHSI
PIFU Rate	Numerator: The number of episodes moved or discharged to a Patient Initiated Follow Up (PIFU) pathway. Denominator: Total outpatient activity	MTP	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 Priority – National and Local	Model Hospital
BADS	Day case and outpatient % of total procedures (inpatient, day case and outpatient)	NHS Priority – National and Local	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	NHSE National Oversight Framework (contextual metric from 26/27)	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
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
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

Terms	Description
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
SALT	Speech and Language Therapy
SDEC	Same Day Emergency Care
SDHC	Surrey Downs Health and Care
SGUH	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

Terms	Description
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
WID	Widschwendter Initiative Diagnostics
W-OPEL	Ward based Operational Pressures Escalation Levels

Group Board

Meeting in Public on Thursday, 09 July 2026

Agenda Item	3.4	
Report Title	Epsom and St Helier UEC Recovery Plan	
Executive Lead(s)	Alex Shaw, Interim Managing Director – ESTH	
Report Author(s)	Debbie Frodsham, Deputy Site Chief Operating Officer – ESTH	
Previously considered by	Finance & Performance Committees	26 June 2026
Purpose	For Review	

Executive Summary

This paper outlines the current position, challenges, and recovery actions in relation to adult Urgent and Emergency Care (UEC) performance against the 4-hour standard. Over the past six months, overall adult UEC performance has remained below the national standard, ranging between 70% and 75% from January to mid-April 2026. While non-admitted pathway performance has remained comparatively stable at 78–80%, performance for admitted patients has been significantly lower, highlighting sustained operational pressures within this pathway.

Performance has been further impacted by recent service changes, including the implementation of the UTC-first model and the decommissioning of ED SDEC. These changes have been associated with an increase in breaches, particularly within the non-admitted pathway.

In response, a comprehensive recovery plan has been developed with immediate actions focused on improving non-admitted pathway performance, alongside system-wide initiatives to address patient flow, data quality, and admitted pathway delays. The plan sets out a clear trajectory to restore UEC performance to 70 by the end of June 2026, with a further ambition to achieve 78% by the end of Q2 2026/27.

The identified recovery actions are expected to deliver a reduction of at least 500 breaches per week. Based on current activity levels (approximately 2,450 weekly attendances and 1,000 breaches), this reduction would support a return to approximately 80% performance. In addition, a range of behavioural and cultural initiatives are being progressed to support sustained improvement, although their impact is not directly quantifiable.

A robust governance and accountability framework has been established to oversee delivery, including an Executive Sponsor, Senior Responsible Officer (SRO), and Operational Leads. Progress will be monitored through weekly recovery meetings, supported by a suite of KPI dashboards enabling daily,

weekly, and monthly performance tracking. Performance oversight will also be embedded within Site Leadership forums.

Key risks to delivery have been identified and are being actively managed, with mitigations in place to support successful implementation. Alongside immediate recovery actions, a broader programme of transformation is being progressed through the 2026/27 UEC Improvement Plan to deliver sustainable improvement.

Delivery of the plan requires targeted investment, with a significant proportion of the £2m identified through business planning expected to support priority interventions. All proposed investment is being reviewed to minimise expenditure, ensure value for money, and prioritise actions that can deliver improvement without additional cost wherever possible.

Approval of proposed investments will be managed through SLT and GEC governance routes, with oversight and updates provided to Finance Committee.

Collectively, these measures provide a structured and deliverable approach to restoring performance and supporting sustained improvement in UEC delivery

Action required by Group Executive

The Committee is asked to:

a. To review and approve the ESTH UEC Recovery Plan

Committee Assurance	
Committee	Finance & Performance Committees
Level of Assurance	Not Applicable

Appendices	
Appendix No.	**Appendix Name**
Appendix 1	Epsom and St Helier University Hospitals NHS Trust Urgent and Emergency Care Recovery Plan

Implications

Group Strategic Objectives

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

Risks

As set out in report.

CQC Theme

☒ Safe	☒ Effective	☒ Caring	☒ Responsive	☒ Well Led

NHS system oversight framework

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

Financial implications

As set out in report, with further analysis to be undertaken.

Legal and / or Regulatory implications

The UEC Plan must be submitted to NHS England.

Equality, diversity and inclusion implications

As set out in paper.

Environmental sustainability implications

Non identified.

Appendix 1

EPSOM AND ST HELIER UNIVERSITY HOSPITALS NHS TRUST
UEC RECOVERY PLAN – JUNE 2026

EXECUTIVE SUMMARY

This paper outlines the current position, challenges, and recovery actions in relation to adult Urgent and Emergency Care (UEC) performance against the 4-hour standard. Over the past six months, overall adult UEC performance has remained below the national standard, ranging between 70% and 75% from January to mid-April 2026. While non-admitted pathway performance has remained comparatively stable at 78–80%, performance for admitted patients has been significantly lower, highlighting sustained operational pressures within this pathway.

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The identified recovery actions are expected to deliver a reduction of at least 500 breaches per week. Based on current activity levels (approximately 2,450 weekly attendances and 1,000 breaches), this reduction would support a return to approximately 80% performance. In addition, a range of behavioural and cultural initiatives are being progressed to support sustained improvement, although their impact is not directly quantifiable.

A robust governance and accountability framework has been established to oversee delivery, including an Executive Sponsor, Senior Responsible Officer (SRO), and Operational Leads. Progress will be monitored through weekly recovery meetings, supported by a suite of KPI dashboards enabling daily, weekly, and monthly performance tracking. Performance oversight will also be embedded within Site Leadership forums.

Key risks to delivery have been identified and are being actively managed, with mitigations in place to support successful implementation. Alongside immediate recovery actions, a broader programme of transformation work is being progressed as part of the 2026/27 UEC improvement plan.

Collectively, these measures provide a structured and deliverable approach to restoring performance and supporting sustained improvement in UEC delivery

CURRENT PERFORMANCE

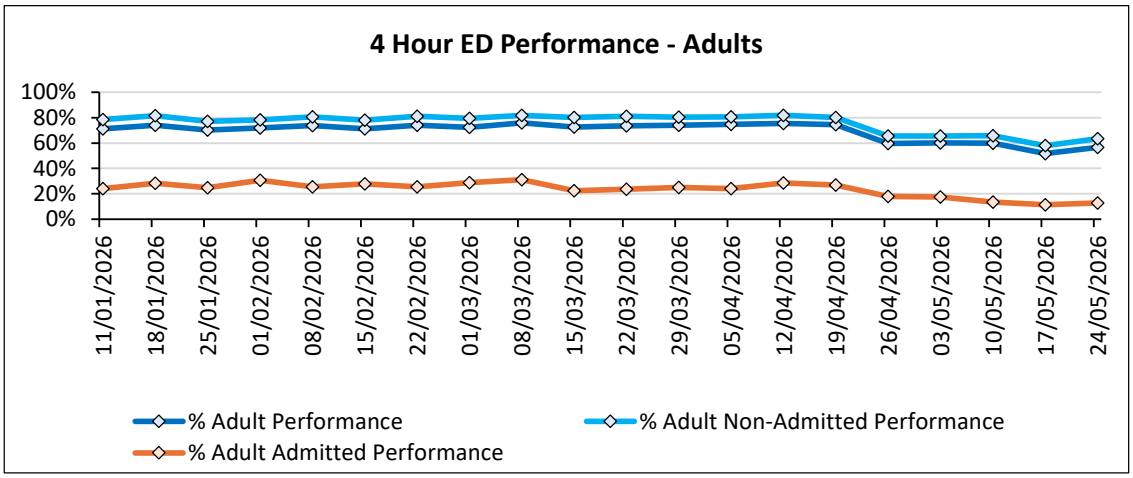
During 2025/26, the Trust achieved 72.5% compliance against the 4-hour Urgent and Emergency Care (UEC) standard, representing a decline from 75.1% in 2024/25. This reduction in performance was largely attributable to a marked dip in May–June 2025, when compliance fell below 70%, coinciding with the implementation of a new electronic patient record system.

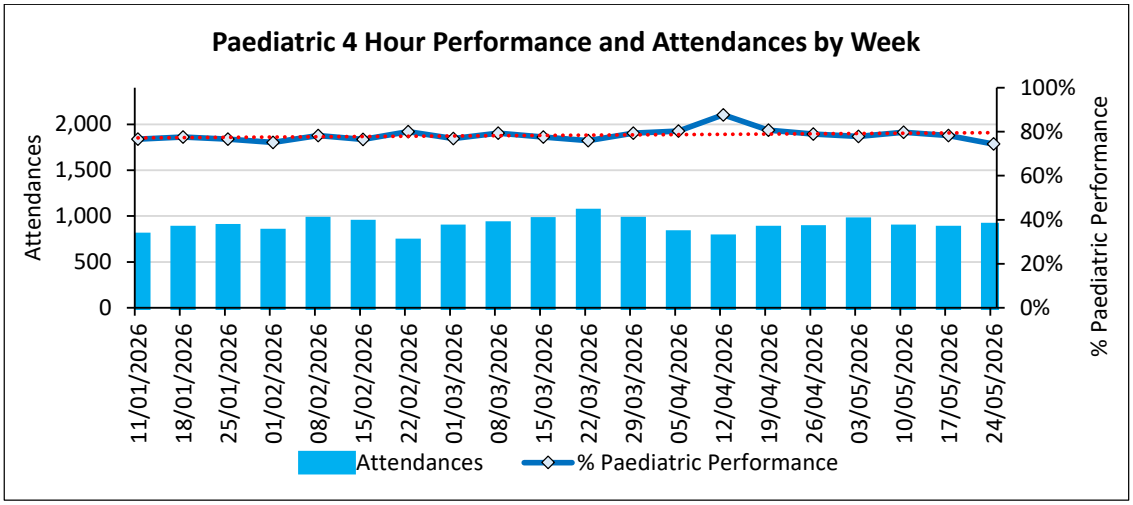
In response, the Trust prioritised recovery of UEC performance across the remainder of the year, resulting in a steady improvement trajectory. By March 2026, performance had risen to 75.09%. Although this fell short of the planned 78% target, it reflects a year-on-year improvement compared to March 2025 (74.1%) and demonstrates the positive impact of sustained recovery efforts.

The 2026/27 operating plan sets a trajectory for improvement, requiring delivery of 78% performance against the 4-hour UEC standard from April 2026, rising to 82% by March 2027. However, the Trust reported performance of 71.1% in April 2026, with a further deterioration observed in subsequent weeks.

The chart below illustrates adult weekly performance against the 4-hour UEC standard over the past six months, including a breakdown of admitted and non-admitted pathways. Between January and mid-April 2026, overall adult UEC performance ranged between 70% and 75%. Non-admitted performance remained relatively stable at 78–80%, while performance for patients on the admitted pathway was notably lower, ranging between 20% and 30%, highlighting ongoing challenges in this area.

The additional chart illustrates paediatric weekly UEC performance over the past 6 months with performance ranging from 75-80% with average performance across the time period of just over 78%.





ROUTE CAUSE ANALYSIS

There are several issues that have contributed to a decline in UEC performance from April onwards and these are outlined below:

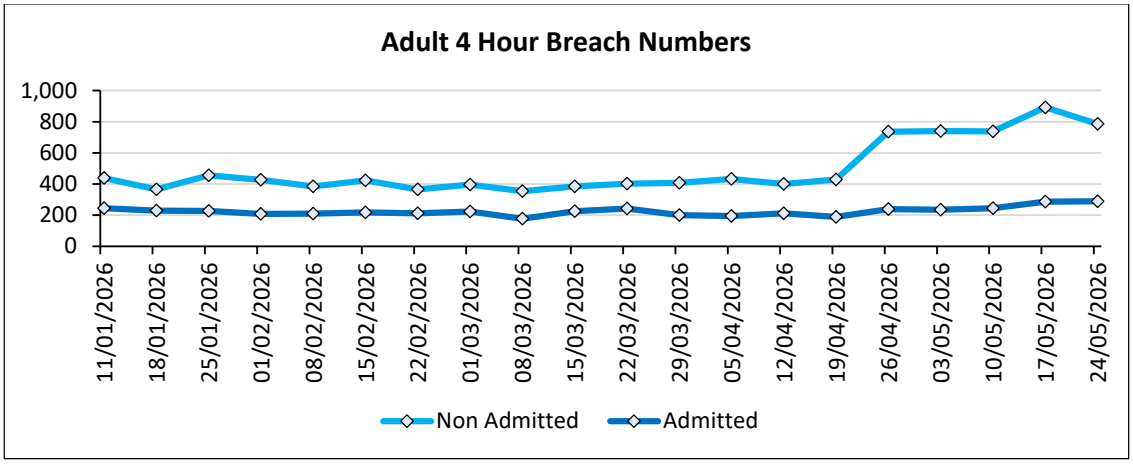
- *UTC First Model Implementation*
  The implementation of the UTC First model on 22nd April 2026 has introduced a number of operational challenges. These are primarily driven by increased demand within the Urgent Treatment Centre (UTC), resulting in longer waits for initial assessment and a consequent impact on overall Emergency Department performance. Addressing these pressures will require sustained focus on behavioural and cultural change across the system, alongside a review of workforce capacity and resource allocation to ensure services are configured to support improved and sustainable performance.

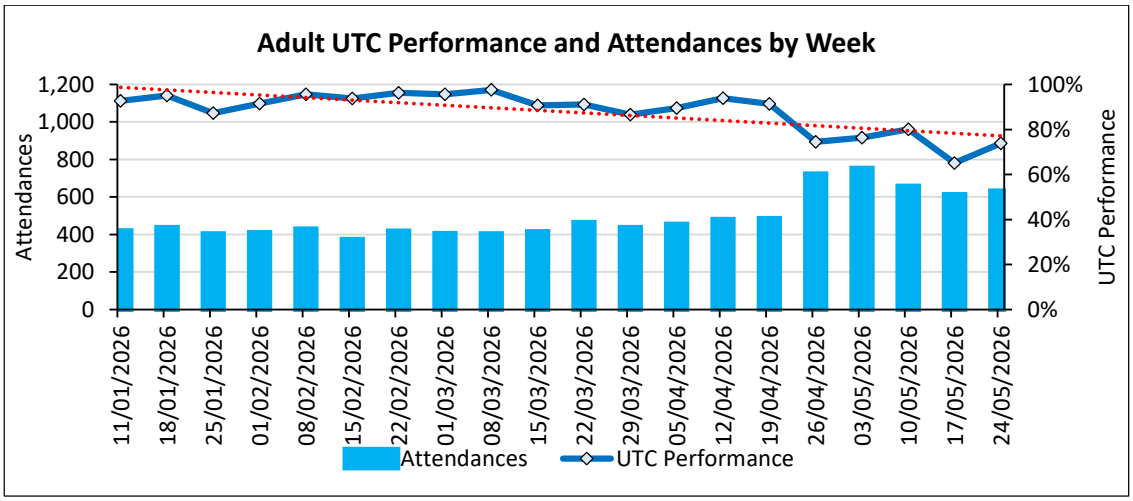
- *Elimination of Emergency Department Same Day Emergency Care (SDEC)*
  Alongside the implementation of the UTC First model, the Trust decommissioned Emergency Department Same Day Emergency Care (ED SDEC) and introduced an Extended Emergency Medicine Ambulatory Care Unit (EEMAC). Access criteria for EEMAC are aligned to national guidance and are therefore more restrictive, resulting in fewer patients being transferred compared to the previous ED SDEC model. As a consequence, a higher proportion of patients remain within the Emergency Department and Urgent Treatment Centre footprint, with the 4-hour clock continuing to run. This has increased system pressure within front-door pathways and contributed to the challenge of maintaining performance against the 4-hour standard.

- *Data Quality/Breach Validation*
  Data quality remains a significant concern, with ongoing challenges around real-time data entry and the timely discharge of patients from the ED system. These issues continue to affect key performance metrics.

The charts below demonstrate the impact of the issues outlined above, showing a clear correlation between the implementation of the UTC-first model and the decommissioning of ED SDEC, alongside

an increase in the number of adult breaches. This rise is particularly evident among patients on the non-admitted pathway with 300-400 more breaches per week.

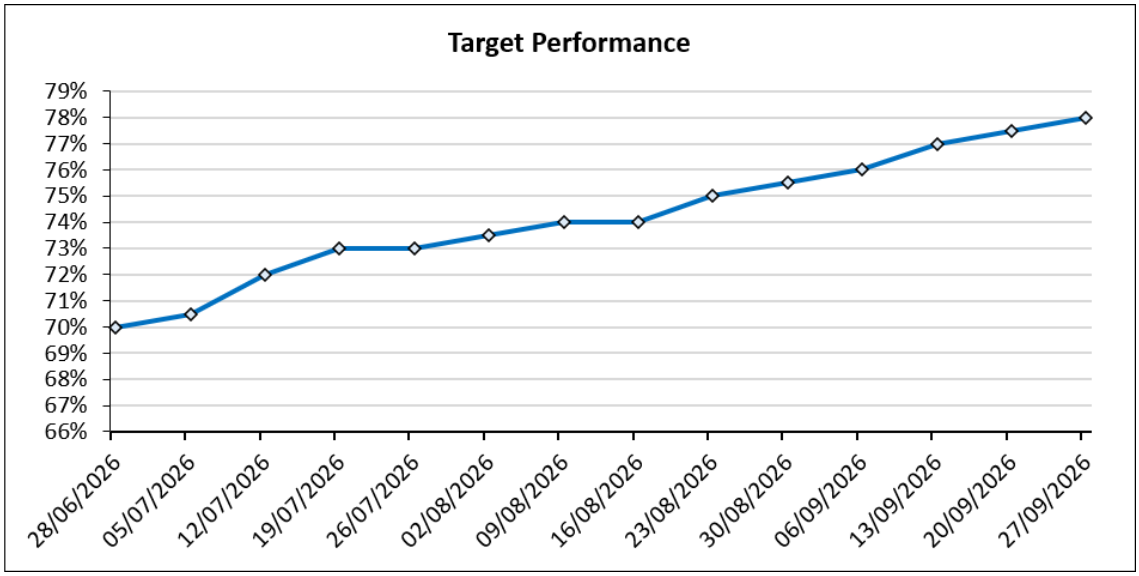




RECOVERY OBJECTIVES

Our immediate recovery objectives will focus on improving performance within the adult non-admitted pathway, alongside a commitment to increase overall UEC performance to 70% by the end of June. We will then continue to work towards achieving 78% UEC performance by the end of Q2 2026/27.

The chart below illustrates our projected weekly performance improvement trajectory, covering the period from the week ending 28th June 2026 through to the week ending 27th September 2026.



RECOVERY PLAN

A suite of recovery actions have been identified and are being implemented with immediate effect. The table below outlines each action and, where applicable, the associated weekly benefit in terms of cross-site breach reduction.

The combined impact of these actions is expected to deliver a reduction of at least 500 breaches per week, thereby restoring overall weekly UEC performance to a minimum of 75%. Current weekly adult ED attendances average approximately 2,450, with around 1,000 breaches across both admitted and non-admitted pathways. A reduction of 500 breaches per week would improve adult UEC performance to approximately 80%.

In addition, a number of actions are focused on behavioural and cultural change. While the impact of these initiatives is not directly quantifiable, they are expected to make a meaningful contribution to sustained breach reduction and avoidance over time.

KPI	Action	Expected Outcome	Breach Reduction (weekly cross-site)	Cost	Date
4-hour wait (target 80%)	ED resident doctor to move to medical SDEC at 1600 hours	To ensure continuation of medical SDEC until at least 2000 hours	100	To be confirmed	June 2026 AMU rota review to establish if cost neutral
4-hour wait (target 80%)	Dedicated operational management support for ED 1600-0000	To ensure increased oversight for non-admitted pathway and 4-hour breach monitoring/avoidance	100	Cost neutral	22nd June 2026
4-hour wait (target 80%)	Expansion of EEMAC internally within ED	To ensure increased capacity for appropriate patients	100	Cost neutral	22nd June 2026
4-hour wait (target 80%)	Development of a streaming process to the acute gynae unit	To help streamline process for appropriate Gynae patients	5	Cost neutral	June/July 2026 Cross-divisional engagement

4-hour wait (target 80%)	Speciality Delay – 2 hourly huddles of speciality registrars on call in hours with ED NIC/CIC to update plans. OOH this should be every hour	Regular updates and support specialities to process patients to admission or discharge	10	Cost neutral	In place
4-hour wait (target 80%)	Undertake a review of resources across the non-admitted/UTC pathway and reallocate staff to better support periods of increased demand	To ensure staff are aligned to periods of increased demand to better support more timely assessment and treatment	Non-quantifiable	To be confirmed	In place
4-hour wait (target 80%)	Undertake a demand and capacity exercise of the current ED estate footprint	An ability to demonstrate performance that is possible within the current ED estate footprint	Non-quantifiable	Cost neutral	Complete
120-minute referral to Specialty (Target 60%)	Specialty Delay breach circulation to specialty leads	Will not affect referral times, but will increase awareness on importance for timely response by specialty teams	Non-quantifiable (culture/behaviour)	Cost neutral	15th June 2026
4-hour wait (target 80%)	Allocation of matron to Streaming as capacity allows	To provide additional support/leadership in streaming	Non-quantifiable (culture/behaviour)	Cost neutral	In place
4-hour wait (target 80%)	Senior operational support for ED (redeployment)	To ensure consistency of data accuracy and validation	Non-quantifiable (culture/behaviour)	Cost-neutral	In place
4-hour wait (target 80%)	Mandatory medical SDEC activity review as part of the 2 hourly board rounds	To ensure consistent oversight of medical SDEC activity	Non-quantifiable (culture/behaviour)	Cost-neutral	In place
4-hour wait (target 80%)	Mandatory discharge paperwork status review as part of the 2 hourly Board rounds	To ensure timely outcomes and reduce volume of validation	Non-quantifiable (culture/behaviour)	Cost-neutral	In place
4-hour wait (target 80%)	Mandatory 2100 huddle for review of patients suitable for discharge and next day review	A reduction in the number of patients waiting in ED during the overnight period	Non-quantifiable (culture/behaviour)	Cost-neutral	In place
60-minute ED doctor assessment (target 60%)	Dedicated RAT doctor for both sites	To support streaming, initiating plans, and quick turnaround of simple cases	50	£15K per month (Epsom only)	June/July 2026 Funding approval
60-minute ED doctor assessment (target 60%)	Additional experienced MG late/twilight (Monday to Friday)	To provide senior leadership and increase overnight productivity	100	£30K per month (Both sites)	June/July 2026 Funding approval

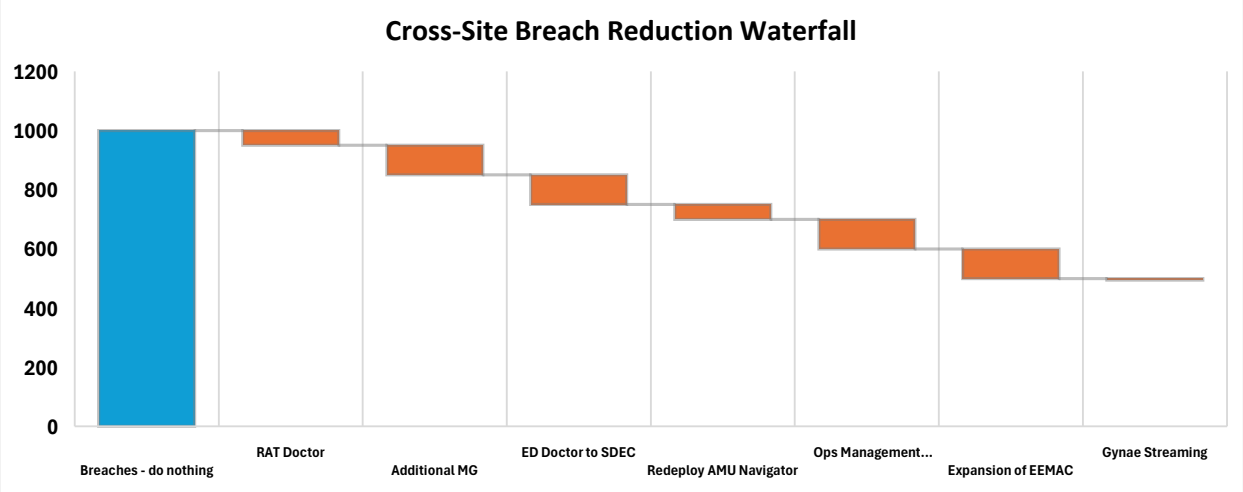
RECOVERY PLAN – DATA QUALITY

In addition to the actions outlined above, a dedicated workstream has been established to improve Emergency Department data quality as part of the 2026/27 Urgent and Emergency Care transformation programme.

This workstream is focused on three key areas:

- **Real-time data entry:** Ensuring that patient information and activity are captured accurately at the point of care to support operational decision-making and performance reporting.
- **Breach validation processes:** Strengthening the processes for identifying, reviewing, and validating breaches to ensure consistency, transparency, and data integrity.
- **EPR workflow optimisation:** Reviewing and refining electronic patient record (EPR) workflows to streamline data capture, reduce duplication, and support clinical and operational teams in maintaining high-quality data standards.

Collectively, these actions will enhance the reliability and timeliness of ED data, enabling better performance management, improved patient flow, and more informed decision-making across the UEC pathway. Updates on progress will be discussed/monitored at the weekly UEC recovery meeting.



Alongside the immediate actions outlined above, we will continue to progress a broader programme of hospital-wide initiatives to further improve UEC performance. This will include a targeted focus on data quality, patient flow, and improvements to the admitted patient pathway which are monitored via our fortnightly UEC transformation group. These additional workstreams form a core component of the 2026/27 UEC transformation programme.

RISKS AND MITIGATIONS

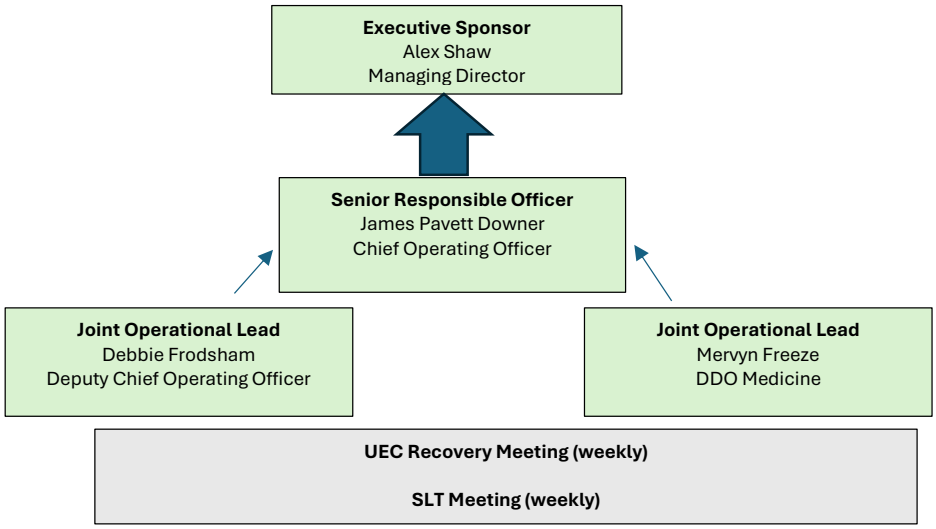
A number of risks have been identified in relation to the delivery of the UEC recovery plan. These are outlined in the table below, alongside the associated mitigation actions.

Risk	Mitigation Actions
There is a risk that the identified recovery actions will not have the intended impact in relation to breach reduction	Weekly recovery meetings chaired by the SRO to review the impact of actions on breach reduction. Timely review and implementation of additional actions required to stabilise position.
There is a risk that additional staffing resource (where required) will not be available to support delivery	Timely approval for additional staff requirements to ensure that additional staff can be sourced via staff bank. Early engagement with existing workforce to explore availability for additional shifts.
There is a risk of lack of engagement from existing staff to support changes required	Management team led meetings with staff to ensure that they are fully engaged Increased senior operational management support to clinical teams on the shop floor On-going increased site leadership visibility and engagement with clinical teams
There is a risk that the existing ED footprint does not provide sufficient capacity to manage an increase in UTC activity	Dynamic use of existing ED estate footprint to better manage patient flow through the department Demand and capacity exercise to fully understand capacity limitations to manage activity volume
There is a risk of not achieving financial approval for the areas of targeted spend required to improve performance. £2m was put forwards into the financial plan to support UEC performance	SLT and GEC review of essential requirements Ensure all actions which don't require funding are fully progressed Review of options for other sources of funding

GOVERNANCE AND ACCOUNTABILITY

A clear governance and accountability framework has been established to oversee progress against key actions and the associated recovery programme. This includes an Executive Sponsor, a Senior Responsible Officer (SRO), and designated operational leads (as set out below).

Weekly recovery meetings, chaired by the SRO, are in place and bring together joint operational leads alongside wider UEC medical, nursing, and operational colleagues. In addition, weekly performance reviews will be incorporated into Site Leadership meetings to ensure continued oversight, accountability, and timely escalation of risks and issues.



PERFORMANCE MONITORING

A suite of KPI dashboards has been developed to support the monitoring of UEC performance, enabling tracking at daily, weekly, and monthly intervals. These dashboards will continue to be used to oversee performance compliance within the established governance and accountability framework.

CONCLUSION

In summary, UEC performance remains below the required standard, driven by sustained pressures across both admitted and non-admitted pathways and exacerbated by recent service changes. However, a clear and structured recovery plan is now in place, with a combination of immediate operational actions and longer-term transformation initiatives designed to address the underlying causes of underperformance.

The delivery of identified actions, supported by robust governance, clear accountability, and enhanced performance monitoring, is expected to deliver a significant reduction in breaches and a return to improved performance levels in the short term. This will be further strengthened by a continued focus on patient flow, data quality, and admitted pathway improvements as part of the wider 2026/27 UEC transformation programme.

While risks to delivery have been recognised, mitigations are in place and will be actively managed through established governance routes. With sustained organisational focus, collective ownership, and disciplined execution, there is confidence that these measures will stabilise performance and support a trajectory towards achieving and sustaining the national UEC standard.

Group Board Meeting (Public)

Meeting in Public on Thursday, 09 July 2026

Agenda Item	3.5.1	
Report Title	**Perinatal Quality Oversight Model March Exception Report**	
Executive Lead(s)	Elaine Clancy, Interim Group Chief Nursing Officer	
Report Author(s)	Michelle Cudjoe group CMO Annabelle Keegan, Director of Midwifery and Gynaecology Nursing Adaline Smith, Director of Midwifery and Gynaecology Nursing	
Previously considered by	Quality Committees	04 June 2026
Purpose	**For Assurance**	

Executive Summary

1.0 Purpose

This report is submitted to provide oversight of maternity service across GESH and escalate for review as required.

Key highlights and successes

1. Maternity Oversight: Positive MatNeoIST (formerly Maternity Safety Support Programme) meeting at SGUH on 13th May the service will remain on the programme for another 3 months with specific areas of focus. Positive ESOG (Enhanced Safety Oversight Group) meeting at ESTH on 3rd June -no allocated actions from the regional team
2. ESTH: Rated as Good across both sites with Outstanding in the responsiveness domain
3. The reporting cadence for maternity services will now be aligned to quarterly cycles across the group and will be streamlined to include utilisation of NHSR standard templates for Q1 of 26/27. In order to standardise site reporting the newly published national template will be used by each site. The first Maternity Board Sub-Committee will meet on the 27th July 2026.

Alert: Key risks and issues for escalation

Although there is good evidence presented within this report of progress and improvement across the services (see appendices) there remains some key areas of risk that need to be highlighted to the Board.

ESTH

1. **STAN monitoring and storage of CTG issues: Background**: 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: Decision taken by SLT to cease utilisation of STAN and continue with NICE guidance. The team are procuring the new central monitoring storage system- interim mitigations will continue until the roll out of the new storage system.

2. Water Safety Issue- E Block St Helier (within Corporate Risk Register). Most recent testing demonstrated that mitigations are currently working and continued to be monitored through the E block working and water safety groups. Fortnightly meetings with staff and agreement obtained for resourcing a helpline for women

SGUH

There are two extreme risks on the risk register –

1. Compliance of regulatory standards, with the majority of actions completed and the outstanding actions (Documentation, Appraisals, Medication Management, Daily Safety Checks) . This is under close governance oversight.

    - Appraisals: The trajectory is to attain 90% compliance by end of July 2026.

    - Focus on Medicines Management is taking place on Gwillim Ward with joint working with the Maternity Lead Pharmacist.

2. Maternity information System iClip issues

    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.

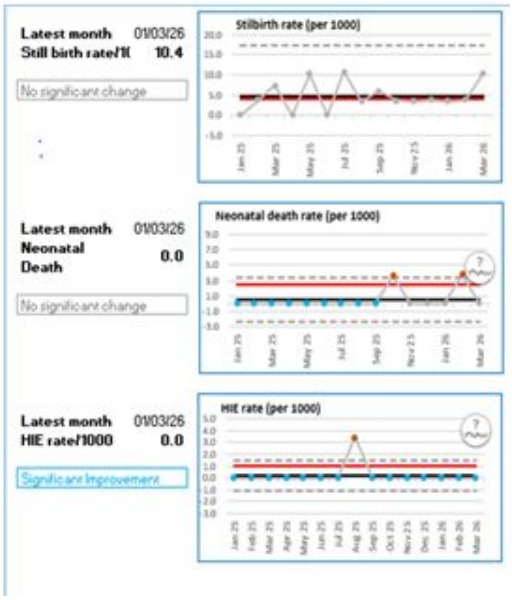
- **Data Migration** did not take place at time of Go-Live in February 2025.There are currently there 1400 records that still require migration.
  Action: Mitigation has now been put in place to add a red flag on to each case file. Resources to be allocated to clear backlog by Aug 2026
- **Lack of mandatory 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: A fix of MEWS scoring error has been confirmed and was tested on the Live system on 21 April. Issues were identified and following an update this was relaunched on 5 May 2026 and now appears to be working well. 125 staff have completed MEWS update training.

Additional risks of concern:

Sonographer Shortage
There is currently a shortage of Sonographers within the Maternity Fetal Medicine Unit. This results in an increased risk of ultrasound scans not meeting set timescales within the Fetal Abnormality Screening Programme (FASP).
Action:

- Demand and capacity modelling being undertaken
- Reopened on the Maternity Risk Register
- Daily monitoring of activity, scan booking, and any concerns of potential breaches are escalated to ensure slots are made available within appropriate screening timescale.
- Clinical Fellows are supporting, and Bank cover is being provided by sonographers.
- X2 Sonographer posts out to advert and Lead Sonographer Post interview date 15 May 2026.

ESTH Outcomes



As can be seen above the HIE (Hypoxic Ischaemic Encephalopathy -brain injury at or around the time of birth) rates at ESTH has shown a sustained reduction in the last 6 months. This is often a cumulative impact of a series of safety interventions that are in place. There were 3 stillbirths in the month of March- 2 of which were at Term and resulted in the MOSS alert reported on last month. 2 of 3 women who had a stillbirth were from the global majority. The local findings mirror national evidence in relation to a disproportionate involvement of women from a global majority in adverse outcomes. Work is underway in relation to health equity across the group.

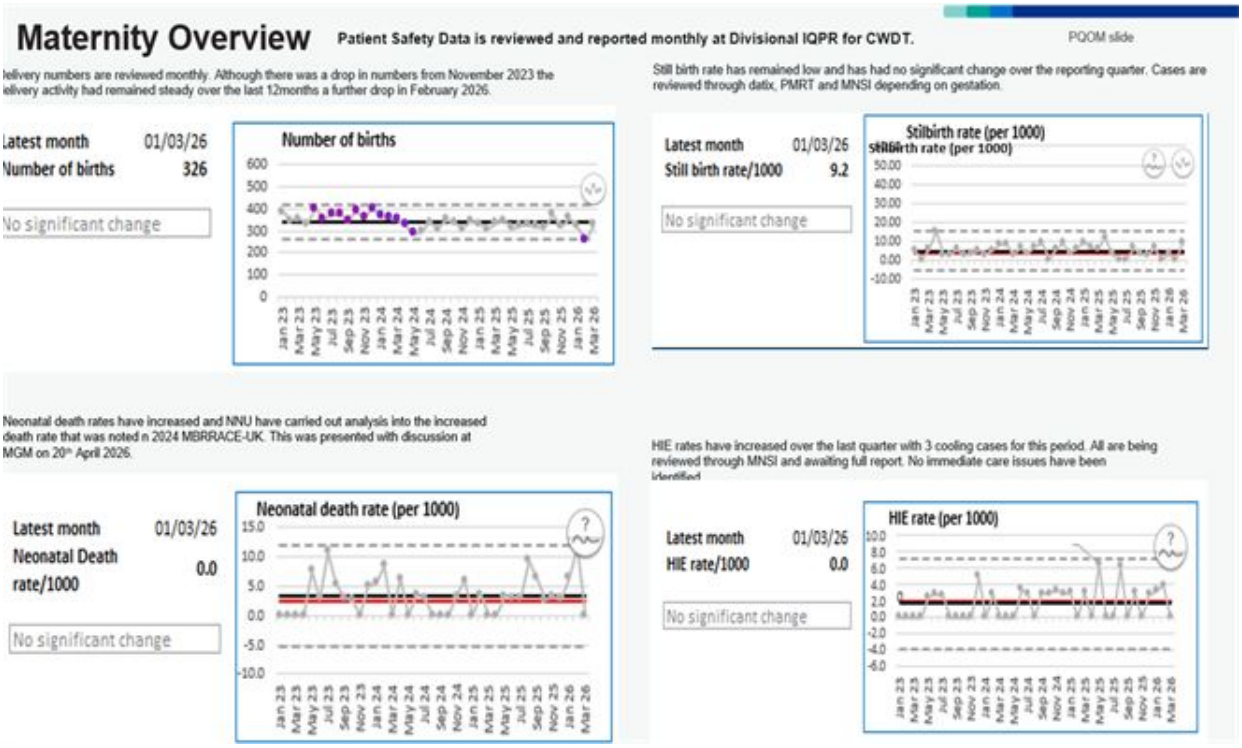
1. **PPH and 3/4th degree tears:** In the month of March disparity in terms of ethnicity for 3rd/4th degree tears was also identified, it is important to review this over a period of time rather than reviewing this in monthly isolation. An increase in 3/4th degree tears is a known risk factor for groups of women (RCOG states this to be Asian ethnicity) oversight of all outcomes is maintained through the local dashboard, local Perinatal meeting and Governance meetings. The service is not an outlier in either of these outcomes. ESTH **EDI working group**: This

group meets every 6 weeks with quoracy including the MNVP and Trust EDI lead to review the maternity dashboard along with the national data set to highlight any gaps with an aim to reduce health inequalities. One area of focus is stillbirth rates which will be reported on in the next quarter, along with the work being undertaken in this area of focus. ESTH was in attendance at the group-wide Maternity Health Equity Task and Finish meeting on the 14th May where key initiatives in relation to health equity were agreed.

3. **BBA** – the monthly data shows 5 cases with an average of 1 per month in the preceding 12 months. In March there were: 1 concealed pregnancy, 4 SROM and quick birth, none booked for home birth. These cases will be individually reviewed to explore any shared learning.

SGUH Outcomes

As seen in the graph below, whilst HIE and Stillbirths are within national ranges there has been an increase in the Neonatal death rate partly linked to a cluster of deaths in Jan and Feb 2026. These cases have all been individually reviewed and a thematic review of learning has been requested.



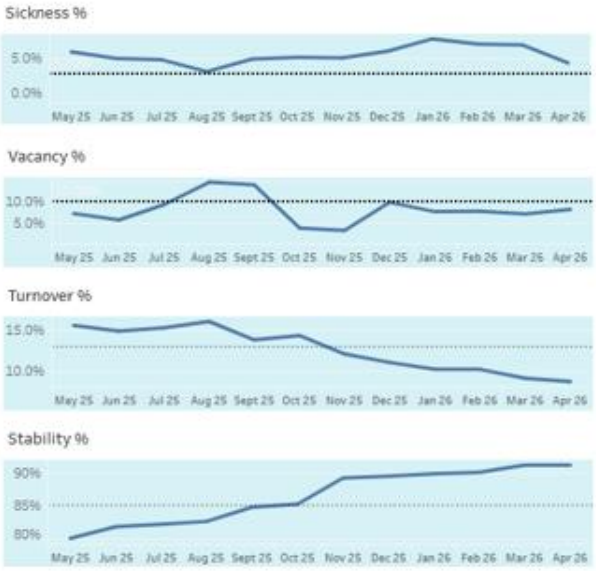
Workforce and Staffing

ESTH

Midwifery staffing consistently meets fill rate targets of 98% with Obstetric fill rates at 100% across March. NNU and SCBU meet BAP standards for neonatal and medical staffing. There has been some RM agency usage during March to maintain safe staffing and these are approved only once cross-site assessment has taken place via the huddle. This is tracked via the SitRep on each site and amalgamated into the joint huddle to maintain oversight of workforce safety. Recruitment is on-going with 2 WTE RM out to advert for the homebirth team and 1 WTE B7 Birth centre lead moving to advert.

SGUH

Midwifery staffing pressures have shown a positive improvement with daily escalation processes in place to maintain safety. There has been zero use of agency staff throughout March. Recruitment of 14 additional Band 5 midwives has made notable improvements and vacant Band 6 posts have been recruited into. Neonatal staffing remains stable in NICU, with mitigation in place for SCBU pressures. Consultant obstetric staffing remains fully compliant with RCOG standards.



There is a positive reduction in long-term (3.81%) and short-term sickness (2.84%) in March which continues to drop going into April.

Vacancies have improved from last year, with the highest vacancies now in support staff.

There is a marked positive reduction in staff turnover, and this is reflected with the positive stability within the service.

Aware

- MIS Year 8 challenge across group linked to the introduction of Pulse Oximetry new standard within MIS 8 not been implemented at either site. Training and equipment requirements being explored.
- Fetal Medicine review undertaken at SGUH interim report received. Discussion with Regional Obstetric MIA in relation to supporting the implementation of actions that may arise from the review.
- MatNeoist Review at SGUH on 13th July. Considering the publication of the Amos and Ockenden national reviews a recommendation was made to continue targeted support until September 2026 in a way that meets service needs. SGUH team have identified areas of focus including a community midwifery review, Fetal Medicine (as above) and maternal medicine.
- Work is being undertaken at SGUH to develop a Maternity dashboard which can then be stratified by ethnicity and deprivation.
- Briefing paper on the Ockenden and Amos reports shared with Board
- Escalation of a thematic concern from MNSI investigations in relation to CTG interpretation at SGUH. Immediate review of preceding cases and actins coproduced with local, regional and MatNeoIST teams within the 5 day timescale given by MNSI. The detailed action plan will be shared at the Maternity Sub Committee in July 2026.

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

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	SGUH March PQOM Report
Appendix 2	ESTH March PQOM Report

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
May 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 (2026)

Slide No.	Metric	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	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

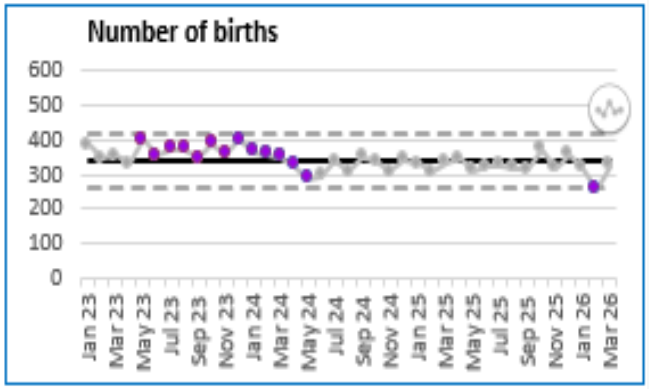
Patient Safety Data is reviewed and reported monthly at Divisional IQPR for CWDT.

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	01/03/26
Number of births	326

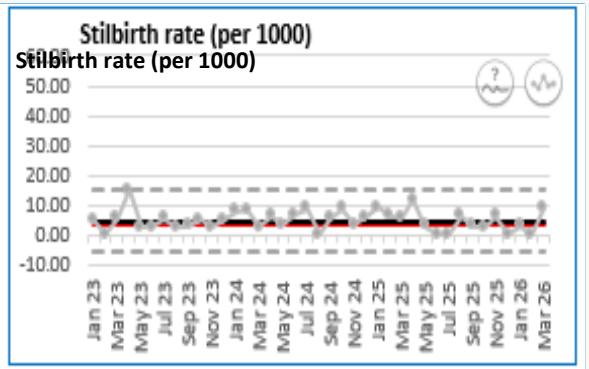
No significant change



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	01/03/26
Still birth rate/1000	9.2

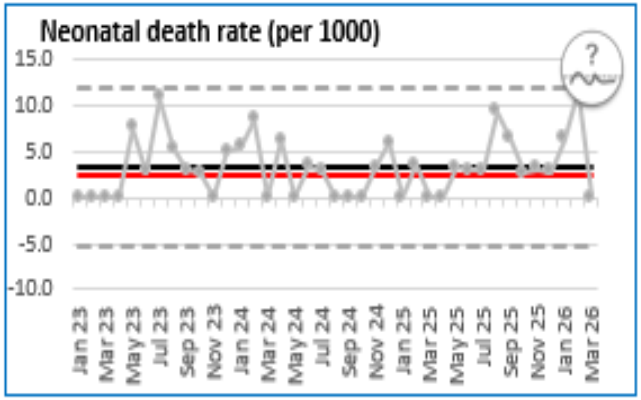
No significant change



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	01/03/26
Neonatal Death rate/1000	0.0

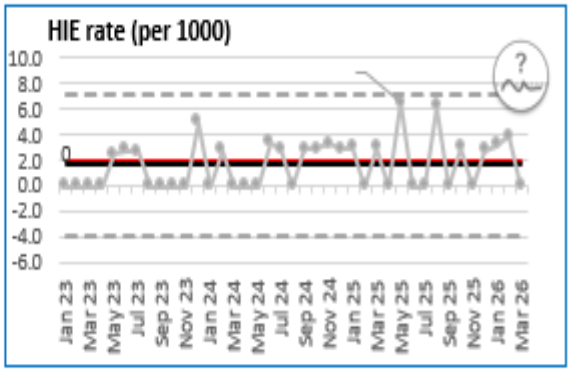
No significant change



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	01/03/26
HIE rate/1000	0.0

No significant change



1. Perinatal Mortality rate

The graphs above demonstrate how the Trust is performing against the national safety ambition.

Ref. No.	Incident Category	Outcome/Learning/Actions	Responsible (role)	By when
101310	NND at 24/40	Discusssed at PMRT meeting on 25/03/26 Grading of care: AAA	No care issues identified	NA
100790	NND at 23/40	Discussed at PMRT meeting on 25/03/26 Grading of care: CAA Care issues identified during the antenatal period.-Seen next page for actions	Pre-term consultants and Risk consultant	30/06/26

Cases reported in March 2026

Ref. No.	Incident Category	Reported as soon as possible via SPEN	PMRT meeting scheduled	
102712	Stillbirth- twin pregnancy at 26/40	SB on 03/03/26; reported on 04/03/26	10/06/26	
103023	Stillbirth at 27/40	SB on 24/03/26; reported on 26/03/26	24/06/26	

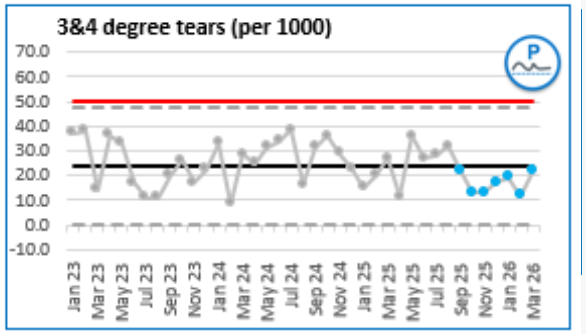
Maternity Overview

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.

Latest month	01/03/26
3&4 degree tears (per 1000)	21.5

Significant Improvement

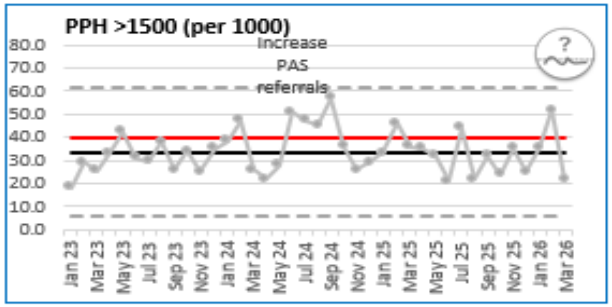


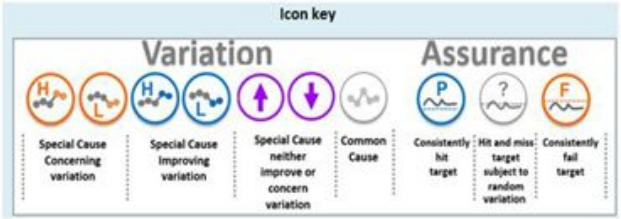
There are a number of actions in place (described in previous quality report) to reduce overall PPH rates after SGUH was highlighted as an outlier with higher than expected PPH rates. The unit is a PAS centre but recognised the PPH rate was still higher than expected and has delivered a number of successful 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	01/03/26
PPH >1500 (per 1000)	21.5

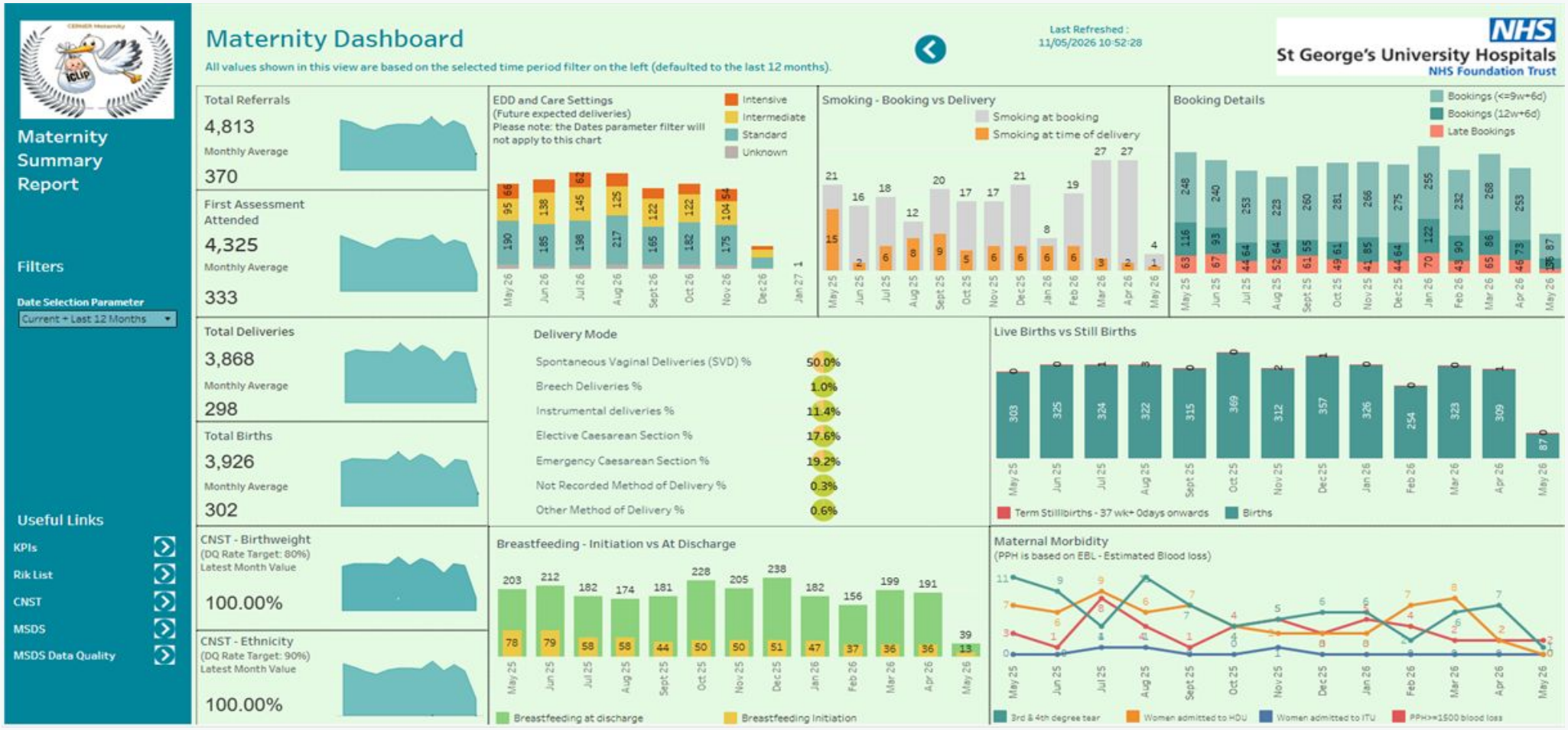
No significant change





6

Introduction to New Maternity Dashboard



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.

Perinatal Mortality Reporting Compliance

SGH Data from the PMRT data tool

	Feb 2025 – Jan 2026	Mar 2025 – Feb 2026	Apr 2025 – Mar 2026
Antepartum stillbirths	16	14	14
Intrapartum stillbirths	1	1	0
Stillbirth (unknown timing	2	2	3
Early neonatal death	17	17	16
Late neonatal death	7	9	9
	(43)	(43)	(42)
<24 weeks	16	15	13
24 – 27 weeks	12	14	15
28 – 31 weeks	4	2	2
32 – 36 weeks	5	5	5
37 – 41 weeks	6	7	7
≥ 42 weeks	0	0	0

The latest ***MBRRACE-UK*** Perinatal Mortality Report for 2024 birth has shown that SGH are up to 5% higher when compared with similar Trusts for stillbirth, and up to 5% higher or up to 5% lower for neonatal death (excluding deaths due to congenital abnormalities).

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.

1. Perinatal Mortality rate

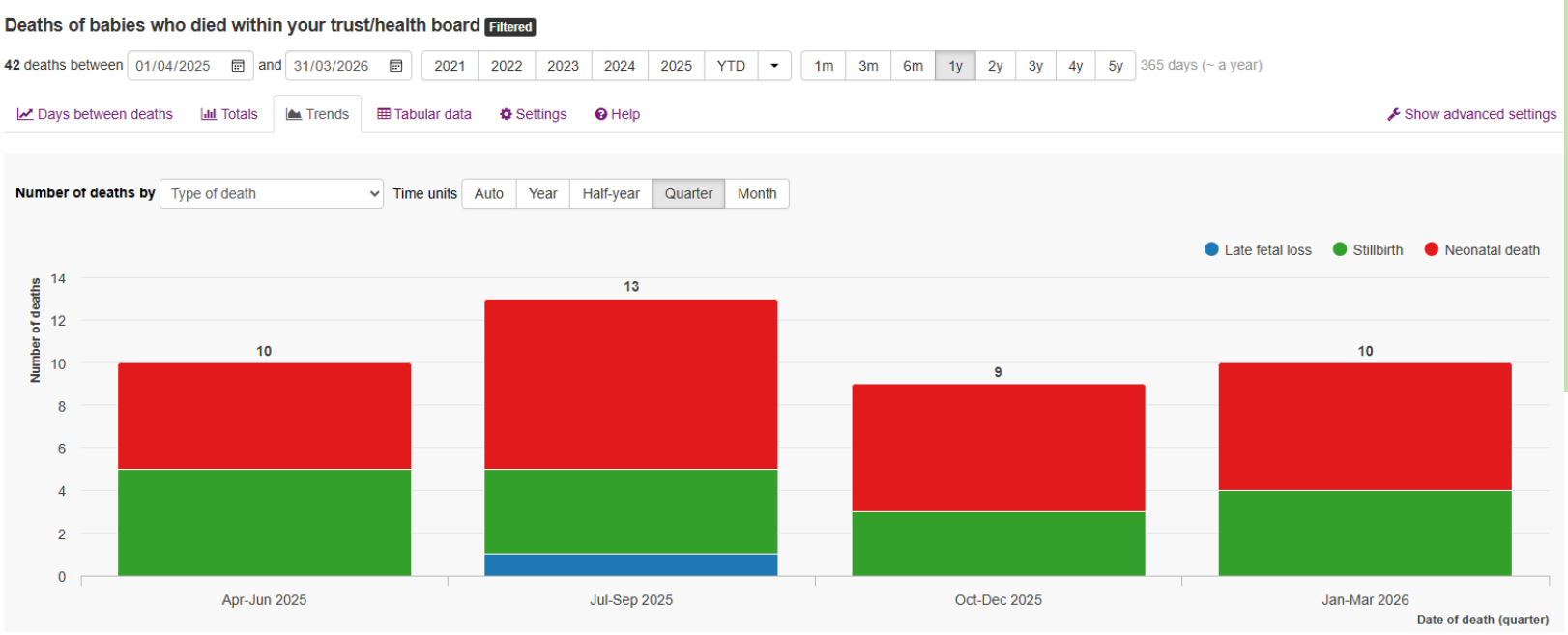
1.1 .Learning from PMRT reviews

Theme	Issue	Actions	Responsible (role)	By when
	Patient delivered at home, Pt was seen previous day in Delivery Suite triage by a Junior Obstetrician. Patient declined any examinations and self-discharged home.	1. Pre-term Birth clinic consultants to provide teaching session to junior doctors on assessment for Threatened Pre-term Labour. 2. Obstetric Risk Consultant Lead to provide individual feedbacks from the PMRT review to the Doctors and staff involved in the care.	Preterm consultants and Obstetric Risk consultant lead	30/06/26

gesh

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

Overview of cases reported to MBBRACE-UK

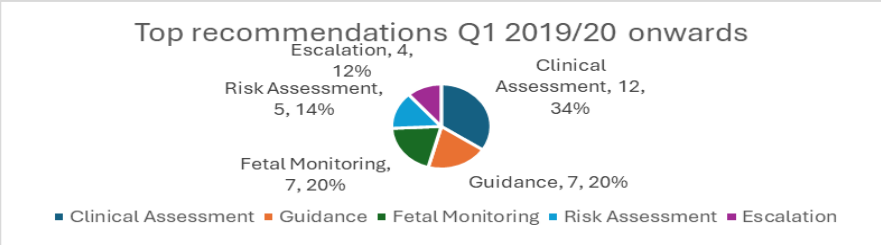


There were 4 cases reported in March 2026; these were all reported within 7 working days in accordance with MIS Year 8 (CNST)

Maternity and Newborn Safety Investigation Programme

Investigation progress update

PQOM slide



6 open cases with MNSI

MNSI Ref	Reason for referral	Date of confirmed investigation	Local Investigation	Duty of candour complete Y/N	Case Status
DW223760/ MI- 040236	Maternal Death	04/03/2025	AAR Draft	Yes	Final report received, action plan awaiting sign off
DW234674/ MI-047572	Admission to NNU/Cooled	07/10/2026	AAR completed	Yes	Final report received, action plan to be agreed 18/05/26
DW238587/ MI-051101	Admission to NNU/cooled	22/12/2026	MDT review completed	Yes	Draft report received returned to MNSI with comments
DW240139/ MI-052127	Admission to NNU/Cooled	22/02/2026	MDT review completed	Yes	Investigation ongoing
DW240139/ MI-052127	Maternal Death	17/02/2026	AAR completed	Yes	Investigation ongoing
DW241577/ MI-053269	Admission to NNU/Cooled	17/02/2026	MDT review completed	Yes	Investigation ongoing

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2.0 Maternity and Newborn Safety Investigation Programme (MNSI)

2.2 .Learning from MNSI Investigations

Theme	Issue	Actions	Responsible (role)	By when
Patient voice	Patient consent and care outside of guidelines	QI project into informed patient consent and implementation of the BRAIN acronym.	Intrapartum Consultant Midwife	31/07/2026
Clinical Standards	Consistency of guidelines between ED and maternity	Joint ED and maternity working group: quarterly meeting	Obstetric guideline lead and ED Governance Lead	Ongoing
Health Inequalities	Poor outcomes	Thematic review of maternity cases with poor outcomes focusing on health inequalities	Governance Lead	Paused while no Governance lead in place
Communication	MEWS not calculating correctly	Digital team to correct manual calculation mitigation in place until complete	Digital Lead and DOM	May 26
Clinical Standards	Test results follow up	Pilot system for reviewed test results within maternal medicine team	Maternal Medicine Lead	July 26
Clinical Standards	Holistic case review in labour	Introduction of abnormal CTG review tool audit effectiveness	Audit and Guidelines Midwife	June 26

2.3 Maternity Patient Safety Incidents (PSI)

Maternity Patient Safety Incidents completed during the period Jan to April 26:

Ref No.	Incident Category	Outcome/Learning/Actions	Responsible (role)	By when
DW21 4997	PSII	Biannual Antenatal CTG training and review guidelines for Antenatal CTG and preterm labour	Fetal monitoring lead	Completed
DW21 4997	PSII	Antenatal ward handover incorporated into DS midwifery and medical safety huddle	DS obstetric lead and matron	Completed
DW21 4997	PSII	Planned antenatal ward admissions to be clerked DS if arrive out of hours	DS obstetric lead and matron	Completed
DW21 9352	PSII	MSW trained to assist with swab count	DS matron	Ongoing
DW21 9352	PSII	Obstetric Resident's induction to include swab count	DS Obstetric Lead	Ongoing
DW21 9352	PSII	PROMPT to include PPH simulation station	Maternity Education Team	Ongoing

Maternity and Newborn Safety Investigation Programme (MNSI)

PQOM slide

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

Patient Safety Incidents

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)

Summary of incidents reported:	
Date Range	01.03.2026 – 31.03.2026
Total no of Incidents (Maternity and Obstetrics)	96
No harm	67
Low harm	12
Moderate Harm	13
High Harm	4
Extreme Harm	0
Cases reported to MBRRACE for PMRT	4
Cases reported to MNSI	0
PSII reported on StEIS	2
Incident type (Top 3)	Patient labour and Delivery (22) Patient – Treatment and Procedures (13) Staff – Staffing Levels (12)

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

Moderate and above Harm Outcomes

In ***March 2026*** there were 17 cases reported which resulted in moderate or above harm;

- Twin stillbirth at 26+3 weeks, presented with pain and was fully dilated on admission.
- IUD, attended with reduced fetal movements.
- X6 PPH ≥ 1000mls
- EM LSCS readmitted with postnatal psychosis, vulnerable teenager with SG concerns
- Cat 1 GA LSCS for cord prolapse of DCDA twins. Good outcome
- Baby born with accidental scalp laceration down to periosteum
- Sub total hysterectomy at delivery due to large fibroids (7.2kgs)
- 2nd degree tear sutured with non dissolvable suture in error, identified by GP
- 3rd degree tears x2

None of the stillbirth cases were eligible for reporting to MNSI. All cases will undergo review by the PMRT panel, and the parents have been informed of the review process and offered the opportunity to share their concerns, questions or perspectives. We have received question from the family who experienced the stillbirth at 37/40, and these will be answered as part of the review.

There is still no clear guidance on the grading of harm for maternity incidents; NHSE state that units should not be grading harm based on outcomes but based on if a PSI occurred which contributed to, or caused, the outcome. The NHSE policy guidance on recording levels of harm states:

The supplementary question "how much did the [an] incident contribute to the outcome for the patient?" allows the reporter to indicate their best assessment of the extent of association between incident and outcome.

Although this reflects the CQC guidance on Duty of Candour, the CQC has been critical of units who have graded outcomes such as stillbirth as no or low harm. We therefore grade all stillbirths and neonatal deaths as 'death'. PPH and 3rd degree tears are reviewed and grades at weekly Moderate Case Review.

PQOM slide

Maternity and Neonatal Patient Safety Incidents (PSII)

Maternity Patient Safety Incidents during the period Jan – March 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

Incident themes (PSIRF)

The majority of incidents reported in Maternity Services fall under the Category Patient Labour and Maternity.

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)

Further information is included on the Outcomes Dashboard (slide 3). Detailed information is provided monthly to the Trust PSIR Panel via the maternity DIRG Report.

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)

Top 5 Incidents March 2025

- Staffing levels – inadequate (9)
- PPH ≥1000mls (6)
- Perineal tear 3rd degree (4)

- Unexpected admission to NNU(3)
- Unintended injury in the course of surgery (3)
- Failure to act on adverse test results (3)

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 January- March 2026 (20 complaints)

Care during labour and birth (no clear themes)
Safeguarding/referral to Mental health Services
Communication
Transgender patient care
Management of jaundice in Black and Brown babies

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

5 top Categories
- PPH (19)
- Still birth/Neonatal death (all cases including late miscarriages (10)
- Delayed clinical assessment (9)
- 3rd degree tears (8)
- Baby admission to NNU/readmission (4)

Themes September October and November 2025

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

Learning January, February, March 2026

- 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 June 2026	
Thematic review of 14 cases including stillbirth, neonatal deaths and maternal deaths commencing.	End June 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)

Signal summary table

Signals over last 6 months		Signals over last 12 months	
Level 1	Level 2	Level 1	Level 2
0	0	0	0

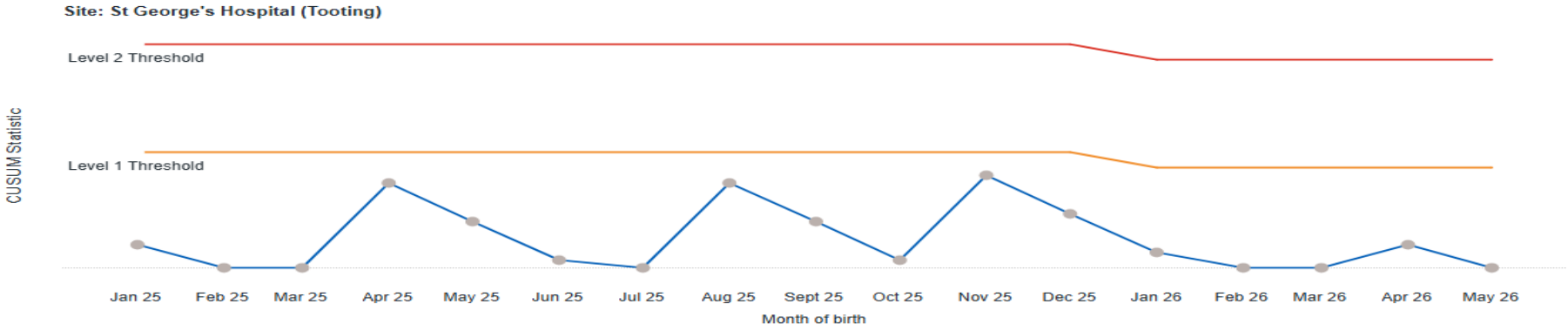


Table of Events - Trust: St George's University Hospitals NHS Foundation Trust

Date of term birth	Events (term only)	Site name
19 Apr 26	1 Term Stillbirth(s)	St George's Hospital (Tooting)
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)

PQOM slide

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

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 January 2026	SGUH February 2026	SGUH March 2026
PROMPT 90%	Midwifery Staff	97%	92%	92%
	Maternity Support Workers	97%	100%	100%
	Consultant Obstetricians	100%	100%	100%
	Trainee and Staff Grade Obstetricians	94%	94%	91%
	Anaesthetics	100%	100%	100%
	Junior Anaesthetists	100%	100%	100%
CTG Training 90%	Midwifery Staff	86%	91%	93%
	Consultant Obstetricians	100%	100%	100%
	Trainee and Staff Grade Obstetricians	100%	100%	100%
Essentials (CCF)	Midwifery Staff		86%	86%
NLS (Newborn Life Support) 90%	Midwifery Staff	96%	91%	90%
NLS (Newborn Life Support) 90%	Neonatal Nursing Staff	90%	94%	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.

Mast Training

PQOM slide

- **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

	Dec 25	Jan 26	Feb 26	Mar 26
Children and Women's Diagnostic and Therap..	90.94%	90.43%	90.15%	90.75%
Ante Natal Clinic 712678	88.07%	89.50%	86.47%	87.18%
Birthing Centre 712679	100.00%	100.00%	97.30%	96.72%
Carmen Suite 712680	92.98%	93.39%	94.35%	92.72%
Community Midwifery 712681	89.85%	90.86%	91.75%	91.58%
Delivery Suite 712682	91.48%	89.74%	89.37%	90.67%
Fetal Medicine Unit 712683	84.87%	87.84%	85.81%	87.20%
Gwillim Ward 712684	94.77%	89.42%	89.37%	91.30%
Maternal Medicine 712685	91.53%	90.60%	88.46%	83.85%

	Dec 25	Jan 26	Feb 26	Mar 26
Conflict Resolution	94.12%	95.09%	94.72%	93.88%
Dementia Awareness	98.62%	98.01%	98.33%	98.65%
Equality, Diversity and Human Rights	91.35%	92.36%	90.97%	92.57%
Fire Safety	93.08%	92.69%	91.97%	92.57%
Health, Safety and Welfare	92.73%	92.36%	91.64%	92.91%
Infection Prevention and Control Clinical	85.28%	85.97%	87.73%	87.64%
Infection Prevention and Control Non Clinical	87.50%	82.61%	86.36%	90.48%
Information Governance	88.58%	87.38%	85.95%	88.51%
Moving and Handling	89.97%	88.37%	87.29%	87.50%
Moving and Handling Patient	84.19%	84.72%	85.78%	83.56%
Prevent - Basic Awareness Levels 1 - 2	90.24%	88.89%	88.00%	88.73%
Prevent - Level 3	98.07%	95.91%	94.20%	94.67%
Resuscitation ALS		83.33%	84.21%	83.33%
Resuscitation BLS	78.33%	77.94%	79.12%	83.39%
Resuscitation ILS	75.00%	0.00%	0.00%	0.00%
Resuscitation Non Clinical	88.46%	87.50%	86.36%	85.71%
Safeguarding Adults Level 1	91.67%	86.96%	86.36%	90.48%
Safeguarding Adults Level 2	90.28%	84.87%	87.42%	88.03%
Safeguarding Children Level 1	87.50%	86.96%	86.36%	85.71%
Safeguarding Children Level 2	91.38%	91.38%	90.57%	90.00%
Safeguarding Children Level 3	93.72%	90.00%	87.05%	86.22%
Grand Total	90.54%	89.67%	89.35%	90.04%

Medical Staff
MAST Compliance

	Dec 25	Jan 26	Feb 26	Mar 26
Children and Women's Diagnostic and Therap..	81.79%	82.07%	82.74%	84.41%
O & G Junior Medical Staff 712688	82.87%	80.73%	83.72%	86.34%
Obstetrics Medical Staff 712689	82.38%	86.07%	83.20%	83.61%

	Dec 25	Jan 26	Feb 26	Mar 26
Dementia Awareness	95.24%	93.44%	94.92%	96.61%
Equality, Diversity and Human Rights	90.48%	90.16%	89.83%	91.53%
Fire Safety	92.06%	90.16%	91.53%	89.83%
Health, Safety and Welfare	85.71%	88.52%	89.83%	91.53%
Infection Prevention and Control Clinical	79.37%	77.05%	74.58%	72.88%
Information Governance	87.30%	88.52%	83.05%	83.05%
Moving and Handling	85.71%	86.89%	88.14%	89.83%
Moving and Handling Patient	100.00%	100.00%	100.00%	100.00%
Prevent - Basic Awareness Levels 1 - 2	74.29%	69.70%	76.67%	78.57%
Prevent - Level 3	82.76%	82.76%	82.76%	90.32%
Resuscitation BLS	45.45%	50.00%	54.55%	54.55%
Resuscitation ILS	51.22%	58.97%	59.46%	67.57%
Safeguarding Adults Level 2	81.58%	80.56%	85.71%	88.57%
Safeguarding Children Level 2	87.50%	83.33%	88.89%	92.86%
Safeguarding Children Level 3	77.42%	77.42%	77.42%	80.65%
Grand Total	82.69%	82.72%	83.52%	85.28%

Safe Maternity staffing

Fill rates – planned versus actual

	January 2026						February 2026						March 2026					
Site /Area	Day			Night			Day			Night			Day			Night		
	Planned	Actual	%	Planned	Actual	%	Planned	Actual	%	Planned	Actual	%	Planned	Actual	%	Planned	Actual	%
Carmen Suite	741	677	90%	713	689	97%	705	348	49%	610	253	41%	755	476	63%	667	346	52%
Delivery Suite	5314	4523	85%	4991	4410	88%	4846	4010	83%	4492	3826	85%	5266	4573	87%	4922	4321	88%
Gwillim Ward	2,322	1,990	86%	1426	1385	97%	2135	1679	79%	943	842	89%	2275	2021	89 %	1426	1347	94%

Midwifery Support Workers

	January 2026						February 2026						March 2026					
Site/ Area	Day			Night			Day			Night			Day			Night		
	Planned	Actual	%	Planned	Actual	%	Planned	Actual	%	Planned	Actual	%	Planned	Actual	%	Planned	Actual	%
Carmen Suite	0	0	0	0	0	0	361	240	66%	322	322	100 %	399	299	75%	356.5	356	100 %
Delivery Suite	1,075	924	86%	1,069	1,057	99%	953	865	90%	943	896	95%	1062	877	82%	1047	1015	97%
Gwillim Ward	1,205.5	828	69%	1,081	955	88%	1020	803	78%	943	842	89%	1164	922	79 %	1070	999	93 %

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

Action: Staff moved to highest acuity areas where needed. 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

	January 2026						February 2026						March 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%	5169	5189	100 %	5152	5152	100 %	5914	5935	100 %	5888	5889	100 %
SCBU	1981	1643	83%	1886	1543	78%	2437	1679	69%	2254	1577	70%	1958	1477	75%	1880	1305	69%

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)

Service User Feedback

Complaints
We received 20 formal complaints over the period January - March 2026. 4 are 'stop the clock' as there are MNSI investigations taking place. 1 relate to a maternal death in 2025. 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
- Transgender care
- Racial discrepancies in care provision

January – March 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

PQOM slide

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 with care of wife and management of pain and potential SSI. Unhappy with information relating to recognition of jaundice in black and brown babies.	Reassured that information relating to jaundice was correct, explained care given and apologised for poor perceived experience.
Transgender patient unhappy with staff misgendering him, referral to safeguarding and care provided by staff.	Feedback to SG team and ward staff – important learning from transgender patient's experience of using maternity services.

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

PQOM slide

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.

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 Working Group on Gwillim ward in May 2026 to review 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

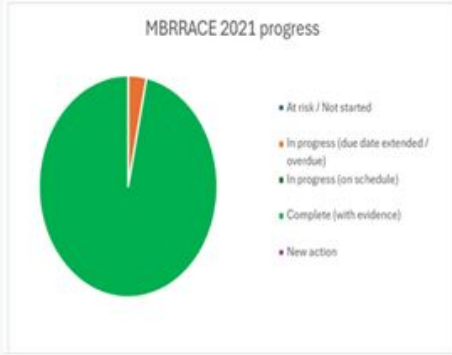
- **Data Migration** did not take place at time of Go-Live in February 2025, meaning staff must view the old system alongside iClip during patient care. New members of staff do not have access to E3 and cannot access previous records. There are currently there 1400 records that still require migration.
  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 was tested on the Live system on 21 April. Issues were identified and following an update this was relaunched on 5 May 2026 and now appears to be working well. 125 staff have completed MEWS update training.
- **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.

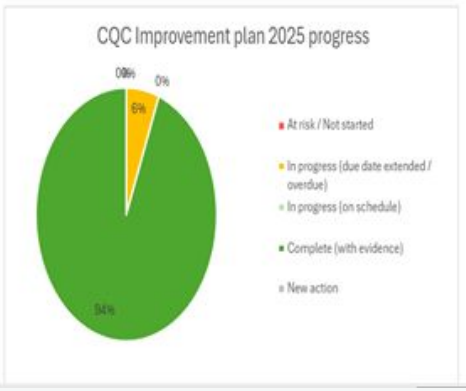
Integrated Unified Action Plan

PQOM slide

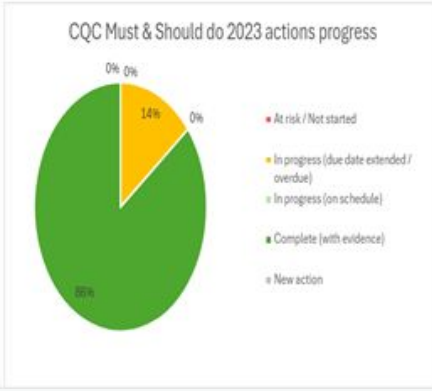
	Number closed	% Closed	Number open	% Open
Baby Falls	20	100%	0	0%
Transitional Care	14	100%	0	0%
SA3 Avoidable term admissions	9	100%	0	0%
MBRRACE 2020	9	100%	0	0%
MBRRACE 2021	29	97%	1	3%
Early notification scheme	7	100%	0	0%
MIS Year 6 actions	4	100%	0	0%
MIS Year 7 Actions	10	100%	0	0%
CQC Must dos 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 – **13** approved and **2** remain partially approved. Evidence Assurance panel on 30th April - **Appraisals** evidence was presented. Compliance is currently at 72% and requires further work to bring this up to 90%. **Standard of documentation** e.g. perineal repair, use of SBAR and MEWS, sepsis risk assessment for babies, (not limited to these areas). Good evidence of work to embed audits but there are still areas that are not compliant and concerns continue regarding MEWS compliance. Discussed that MEWS fix was set to Go Live 5 May 2026. This is now in place and appears to be working with calculated MEWS scores 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

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National Maternity Survey Action Plan 2024
Co-production with MNVP's

Theme	Progress	Support requirements
Antenatal history and continuity of care	Explore maternity passport for patients with complex needs. Enable all staff to access and read electronic records in all care settings	Working to provide printers in clinic and improve IT Dongles n community
Postnatal Ward – call bell response	MNVP are planning ward-based audit on call bell response times	None
Discharge processes	Ward review of PN discharge process including management of TTO's	Working with ward pharmacist
Early labour and being sent home	Look at options for women to stay in hospital. Strengthen communication and informed decision making. Adding BRAIN acronym to Maternity Booklet	None
Postnatal care at home	Review initial contact process to ensure it is consistent across teams. Promote Maternity Triage if required in early postnatal period.	None

Considered making a complaint

	All trusts in England		
Your trust score	National average	Lowest score	Highest score
6.1	6.5	4.3	7.9

39

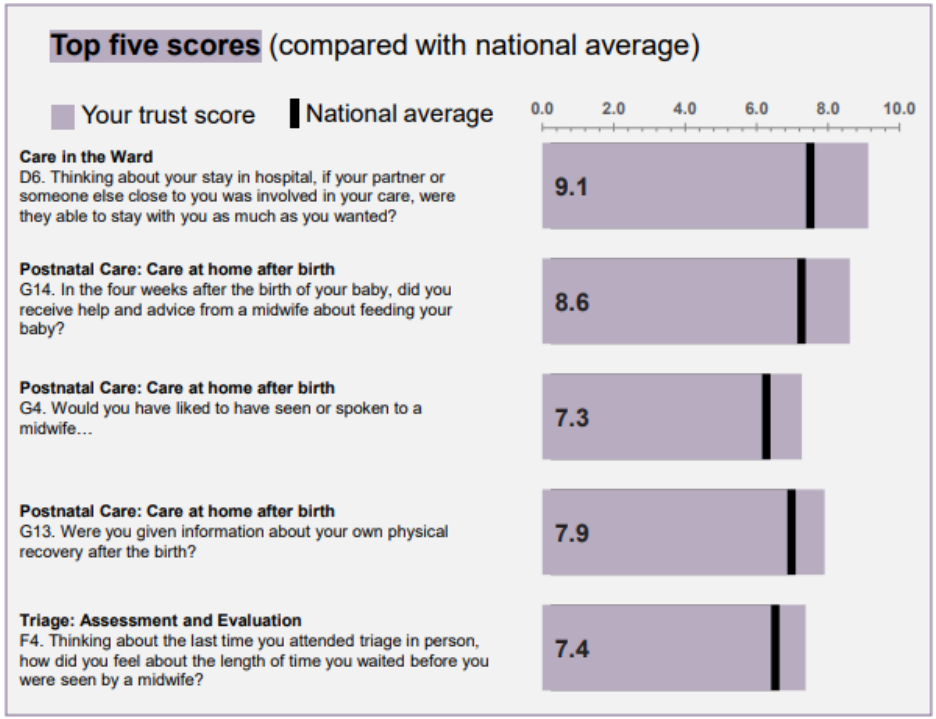
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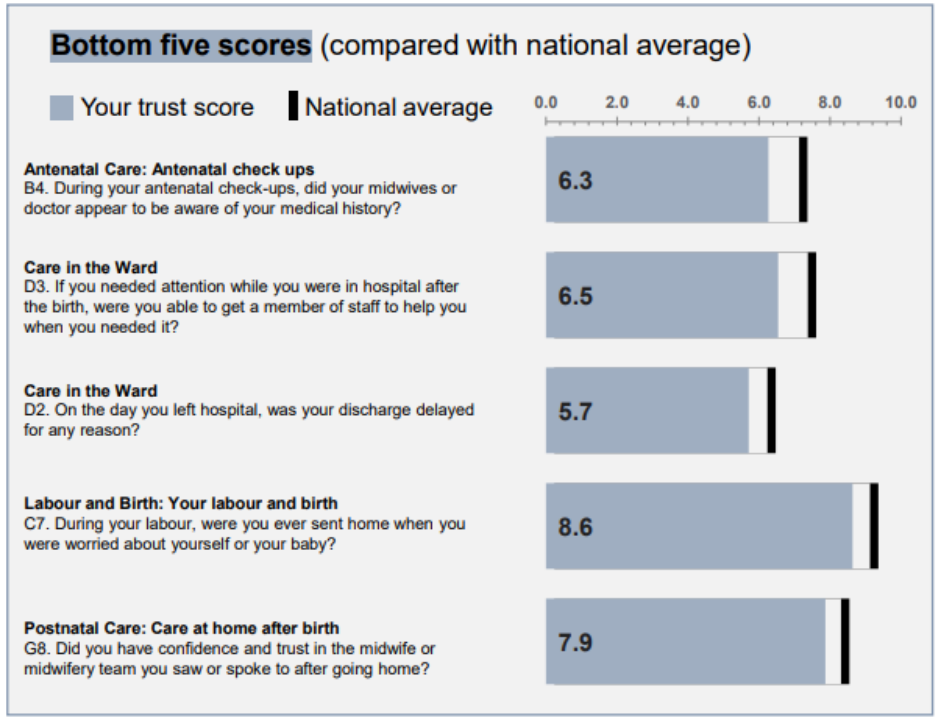
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Best and worst performance relative to the national average

These five questions are calculated by comparing your trust's results to the average trust score across England.

- **Top five scores**: These are the five results for your trust that are highest compared with the national average. If none of the results for your trust are above the national average, then the results that are closest to the national average have been chosen, meaning a trust's best performance may be worse than the national average.
- **Bottom five scores:** These are the five results for your trust that are lowest compared with the national average. If none of the results for your trust are below the national average, then the results that are closest to the national average have been chosen, meaning a trust's worst performance may be better than the national average.





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].

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National Maternity Survey 2025 – Comparison to other Trusts nationally

Much better than expected

- No questions for your trust fall within this banding.

Better than expected

- G14. In the four weeks after the birth of your baby, did you receive help and advice from a midwife about feeding your baby?

Somewhat better than expected

- C10. Did the staff treating and examining you introduce themselves?
- G13. Were you given information about your own physical recovery after the birth?

Somewhat worse than expected

- B4. During your antenatal check-ups, did your midwives or doctor appear to be aware of your medical history?

Worse than expected

- No questions for your trust fall within this banding.

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*

Operational team's challenges update

Vacancy - Maternity Specialists
Head of Governance 1 WTE
Lead Sonographer 1 WTE
Sonographer posts 2 WTE

Actions:
- Divisional Governance team assisting with complaints and incident management.
- Interview date set for lead Sonographer post

FMU Sonographer Vacancies
Concerns regarding lack of uptake for FMU sonographer posts. Maternity speciality (FASP) training is required. Local hospitals appear to be offering enhanced payment due to challenges with recruitment.
Risk due to shortage of staff – currently struggling to meet set timescale for women to receive screening 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

PQOM slide

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

Saving Babies Lives v3.2- Q3 (Oct 2025 – Jan 2026) reviewed by SWL LMNS on 27 Jan 2026 - (86%)

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	70%
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	92%
Element 6	Diabetes	Partially implemented	83%	Partially implemented	83%
All Elements	TOTAL	Partially implemented	87%	Partially implemented	86%

See next slide for update of actions

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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 (70%)
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 (92%)
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%)

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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.

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Thank you.

For any other information, please see:

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Maternity & Neonatal Board Safety Report (PQOM)- ESTH

March 2026

Presented by:
Annabelle Keegan
Director of Midwifery and Gynaecology Nursing

June 2026

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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, 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.

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Data measures – perinatal quality oversight tool (2026)

Slide No.	Metric	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Notes
6	1. Findings of review of all perinatal deaths using the real time data monitoring tool	✓	✓											
7	2. Findings of review of all cases eligible for referral to MNSI	✓	✓											
8 - 12	2a. The number of patient safety incidents logged and what actions are being taken	✓	✓											
14	2b. Training compliance for all staff groups in maternity, related to the core competency framework and wider job essential training	✓	✓											
15	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	✓	✓											
19 - 20	3. Service user voice feedback - themes	✓	✓											
21	4. Staff feedback from frontline champion and walk-abouts - themes	✓	✓											
11	5. MNSI/NHSR/CQC or other organisation with a concern or request for action made directly with Trust	✓	✓											
8	6. Coroner Reg 28 made directly to Trust	✓	✓											
11	7. Progress in achievement of CNST 10 safety actions	N/A	N/A											
	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												***63% / 64.3%***
	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												***87%***

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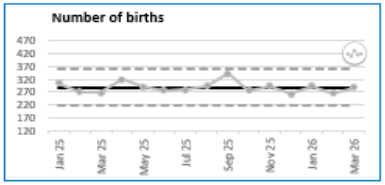


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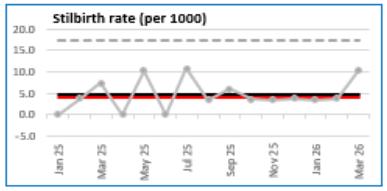
Maternity Overview

Maternity overview ESTH

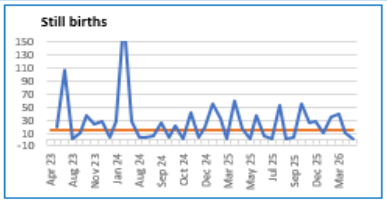
Latest month 01/03/26
Number of birth: 288
No significant change



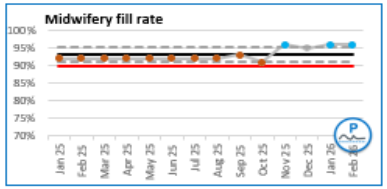
Latest month 01/03/26
Still birth rate/1(10.4
No significant change



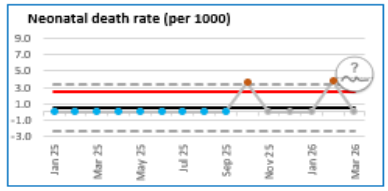
Date of last stillbirth ######
Average days between 14.9
No significant change



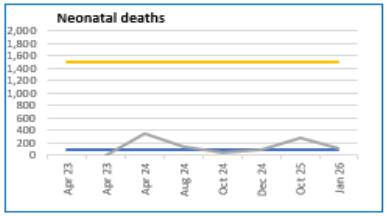
Latest month 01/02/26
Midwifery fill rate 90%
Significant Improvement



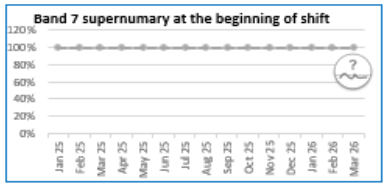
Latest month 01/03/26
Neonatal Death 0.0
No significant change



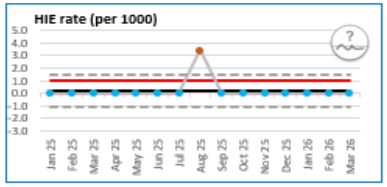
Date of last neonatal death 26/01/26
Average days between 93.9
No significant change



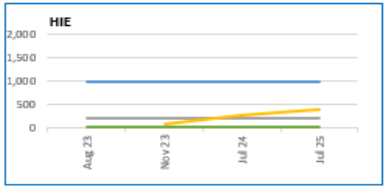
Latest month 01/03/26
Supernumary status 100%
No significant change



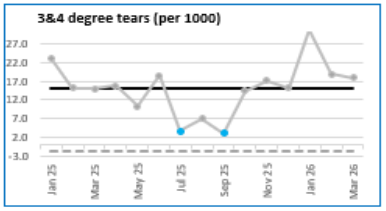
Latest month 01/03/26
HIE rate/1000 0.0
Significant Improvement



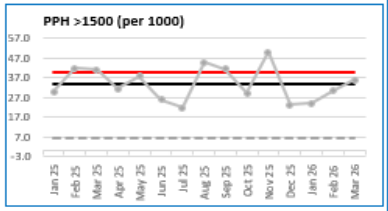
Date of last HIE ######
Average days between HIE 207.4
No significant change



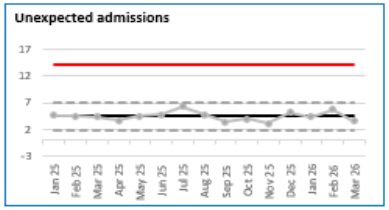
Latest month 01/03/26
3&4 degree tears (per 1000) 17.9
No significant change



Latest month 01/03/26
PPH >1500 (per 1000) 35.7
No significant change



Latest month 01/03/26
Unexpected admissions to NNU ATAIN 3.5
No significant change

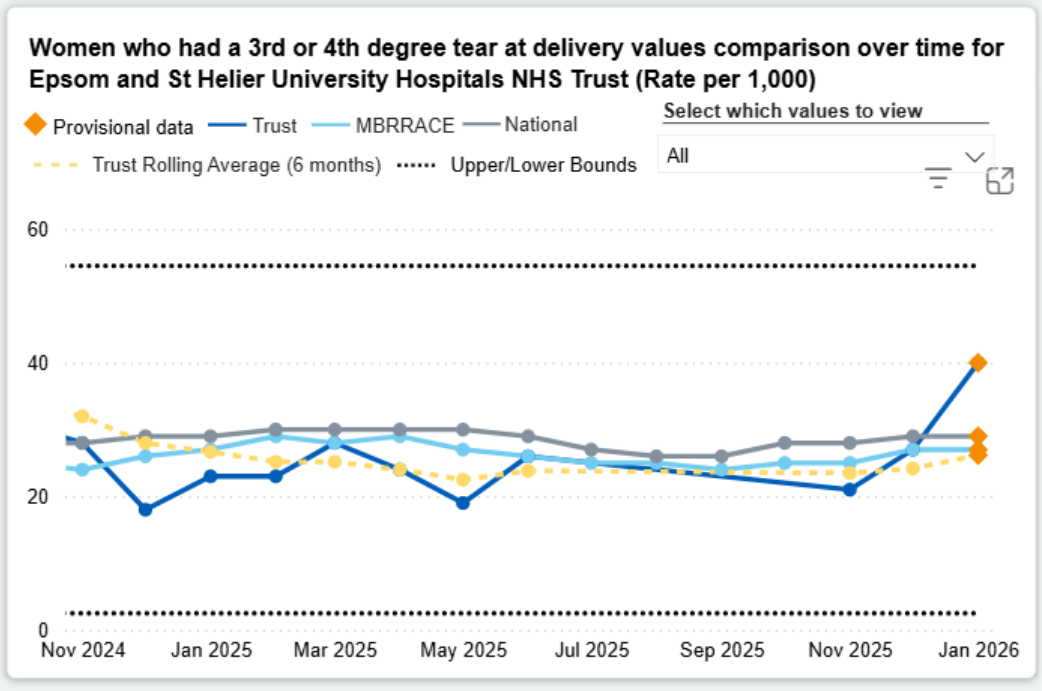


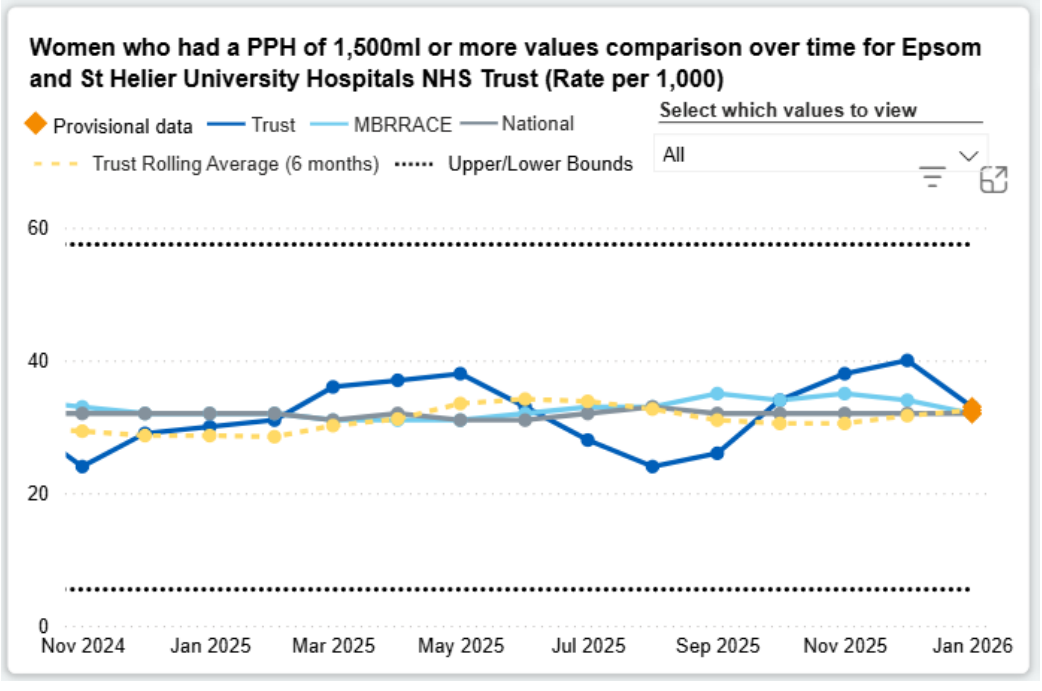
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How we compare nationally





This shows that currently our rolling averages have not identified that we are an outlier for either of these outcomes (information from the National Maternity Dashboard)

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Maternity Overview – Outcomes by ethnicity March 2026

- In March 2026, 33% of women who booked with ESTH for maternity care where from the global majority.
- Of the 5 women who experienced 3rd/4th degree tears 4 were from the global majority (80%).
- Of the 10 women who experienced a PPH >1500mls 5 (50%) were from the global majority.
- Of the 9 term babies who were admitted to the NNU, 5 (55%) were from the global majority.
- There were 3 woman who had a stillbirth in March 2026, 2 of which were from the global majority.

Each element of the data is assessed and reviewed at the EDI working group. This group maintains oversight of transformation work and action plans associated with key areas including here. The work will be reported back through PQOM

It is clear that focused work, already underway, to understand the disparity in outcomes for Global Majority women is required. This will be reported in the next PQOM

Risks – High and Extreme (10 and above)

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Description of Risk	Review Date	Mitigations/Update	Current Risk Level	Risk Owner
General environmental issues were highlighted during the 2023 CQC inspection	30/04/2026	Building work to increase the unit footprint to accommodate triage is currently underway for completion in summer 2026	Extreme	Kathryn Hughes
We have discovered that some cardiotocograph records have not be auto-stored; this has been raised with the manufacturer and has also been reported to the MHRA via the Yellow Card Scheme. Other local units have also been affected.	31/05/2026	IT has provided a secure USB and currently all data from the machine is being manually downloaded and uploaded to the storage area on a weekly basis. A software update is underway on 1 machine at STH, to be site rolled out during week 27/4/26 and if safe to do so, roll out at EGH will immediately follow. Further meeting with Neoventa requested.	Extreme	Annabelle Keegan
Inappropriate clinical area for the Early Pregnancy unit. The unit frequently sees women who have had a pregnancy loss and co-location with the antenatal clinic is causing distress to women.	30/04/2026	A space has been identified in Langley Wing and building work to ensure this is fit for purpose is almost completed. This is an enclosed space which will allow for scanning, a private waiting area and consultation rooms. Meeting planned for 27/4/26 to plan moving in and be fully functioning	Extreme	Kathryn Hughes
Maternity lift breakdowns restricting access to labour and maternity wards and risk of entrapment for staff and patients	30/09/2026	An external lift was installed at STH but this does not give access to the main building (main theatres) as does not go down to basement level. At EGH contingency measures are in place through SWLEOC to mitigate the risk. STH have continued to experience frequent lift breakdowns.	High	Annabelle Keegan
Our current staffing establishment only allows backfill for 23 hours of mandatory training and this is not sufficient to cover essential and nationally mandated training. SGUL by contrast have 34 hours per year.	30/09/2026	This is currently unresolved and unmitigated due to financial constraints. The next Birthrate+ study has been completed and establishment work well underway; uplift is based on 21% with 24% included to support correct number of study days per year and we must achieve the former in order to be compliant with MIS Year 8 (CNST).	High	Natilla Henry
The maternal assessment unit (MAU) at EGH is located in a separate building to Labour Ward	30/04/2026	There is a SOP and process in place to mitigate the risk. Work to increase the unit footprint to accommodate MAU is underway for completion in summer 2026.	High	Annabelle Keegan

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Perinatal Mortality

ESTH Data from the PMRT data tool

	Feb 2025 – Jan 2026	Mar 2025 – Feb 2026	Apr 2025 – Mar 2026
Antepartum stillbirths	17	17	18
Intrapartum stillbirths	0	0	0
Stillbirth (unknown timing	0	0	0
Early neonatal death	4	5	4
Late neonatal death	0	0	1
	(21)	(22)	(23)
<24 weeks	3	3	3
24 – 27 weeks	3	3	3
28 – 31 weeks	4	5	5
32 – 36 weeks	7	6	5
37 – 41 weeks	4	5	7
≥ 42 weeks	0	0	0

The latest ***MBRRACE-UK*** Perinatal Mortality Report for 2024 birth has shown that ESTH are overall average when compared with similar Trusts for neonatal death (up to 5% higher or up to 5% lower) and high than average for stillbirth (more than 5% higher).

- **Cases discussed, themes and open actions**

PMRT Panel	Cases reviewed	Emerging Themes/Learning	Open Actions from previous reviews, year to date
ESTH: One panel meeting was held on 13/03/2026. There was an external panel at one meeting.	INC-187173	No new clear emerging themes identified to date that contributed to the deaths, but the panel has noted that there is a trend of not completing partograms/observations in labour for cases of intrauterine death and 2 incidents highlighted issues with following up result (unrelated to the outcomes).	There are 8 open actions: • Placental histology to be added to i-Clip Pro (outside of our gift but the request is being progressed) • Missed CMW referral to Maternal Medicine – findings of the report to be shared with the CMW • Audit of Partogram completion • Review of how missed appointments are followed-up • Documentation of discussions around domestic abuse

Ethnicity
Between 01/04/2025 and 31/03/2026 the breakdown of the mother's ethnicity is as follows:

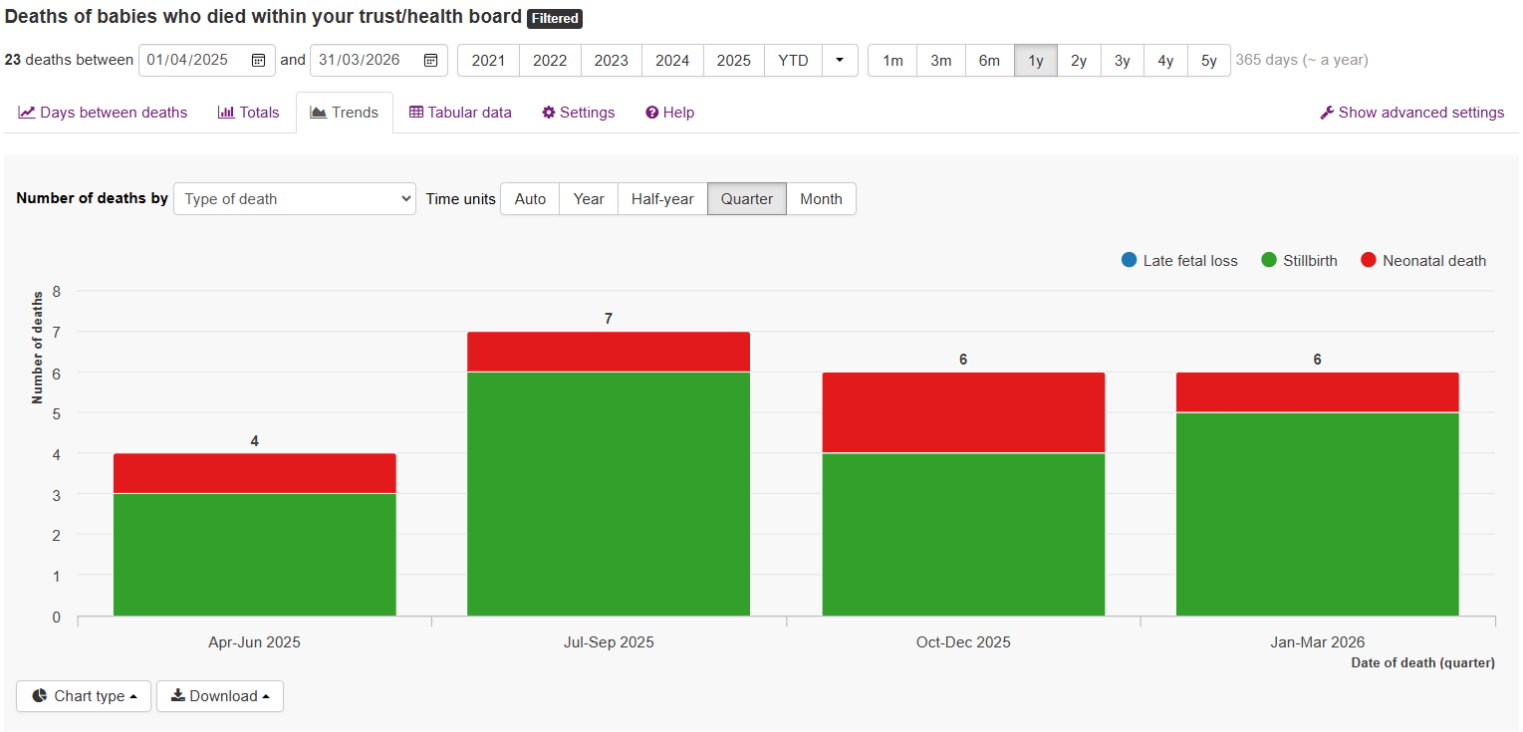
White – 6 women
Asian or Asian British - 10 women
Black or Black British – 6 women
Mixed - 1

Around 62% of women delivering in the same period were from white backgrounds; however, only 26% of women experiencing stillbirth or neonatal death were from a White British Background. An EDI workstream, including MNVP and Trust EDI lead, is in place to address health inequalities and reported back through PQOM.

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Overview of cases reported to MBBRACE-UK



There were 3 cases reported in March 2026; these were all reported within 7 working days in accordance with MIS Year 8 (CNST)

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MNSI Cases

There is currently one case open with MNSI. The mother's ethnicity is ***Indian*** for the open case which related to a neonatal death ***(MI-047467).***

The family were informed of the role of MNSI and of the PMRT review process.

There is currently one open action; a review of the Birth Centre guidance is currently underway, with a view to clarify and simplify the admission criteria.

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Patient Safety Incidents

Summary of incidents reported:	
Date Range	01.03.2026-28.03.2026
Total no of Incidents (Maternity and Obstetrics)	103
Neonatal (assigned to maternity team)	5
No harm	49
Low harm	50
Moderate Harm	1
Severe Harm	0
Death	3
Cases reported to MBRRACE for PMRT	3
Cases reported to MNSI	0
PSII reported on StEIS	0
Incident type (Top 3)	Readmission of baby Term admission to NNU/SCBU Guidelines not followed

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Moderate and above Harm Outcomes

In ***March 2026*** there were 4 cases reported which resulted in moderate or above harm;

- PPH 1600mls; this is currently under review and will be downgraded to low harm if it is found that care went as expected.
- Stillbirth at 38+1/40; this was an expected stillbirth as the baby had diagnosed congenital abnormalities which were not compatible with life.
- Stillbirth at 37/40; this baby appeared to have congenital abnormalities at delivery, and the result of the postmortem is awaited.
- Stillbirth at 35/40

None of the stillbirth cases were eligible for reporting to MNSI. All cases will undergo review by the PMRT panel, and the parents have been informed of the review process and offered the opportunity to share their concerns, questions or perspectives. We have received question from the family who experienced the stillbirth at 37/40, and these will be answered as part of the review.

There is still no clear guidance on the grading of harm for maternity incidents; NHSE state that units should not be grading harm based on outcomes but based on if a PSI occurred which contributed to, or caused, the outcome. The NHSE policy guidance on recording levels of harm states:

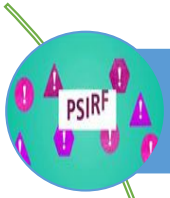
The supplementary question "how much did the [an] incident contribute to the outcome for the patient?" allows the reporter to indicate their best assessment of the extent of association between incident and outcome.

Although this reflects the CQC guidance on Duty of Candour, the CQC has been critical of units who have graded outcomes such as stillbirth as no or low harm. We therefore grade all stillbirths and neonatal deaths as 'death'. PPH and 3rd degree tears are reviewed and downgraded in care went as expected and have asked for some guidance from the regional team, which is awaited.

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PSIIs/Learning/Themes



The actions from the most recently completed PSII (which concerned an out-of-area discharge that was not completed correctly and resulted in missed postnatal community midwife visits and an emergency readmission for severe jaundice) has been finalised with a number of actions around discharge processes. There are no other open actions from PSIIs. There are 8 open actions from AARs.



During March 2026, 2 investigations were closed; both were After Action Reviews (AAR). Actions include a learning session on the use of Partosure, Message of the Weeks around escalation, review of the fetal monitoring guideline as well as presentation of the cases for shared learning.



There are currently 7 open investigations/learning responses; all the cases relate to stillbirth and are being reviewed by the PMRT panel.



We have found that the SWARM and rapid AAR approach does not always fit well with the Maternity Specialty as, in order to undertake a meaningful review for learning, we need to look back over the whole of the antenatal care. Whilst this means our AARs may take longer, this is the right thing to do to gain a meaningful outcome and learning.

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Incident themes (PSIRF)

Top 5 Incidents March 2026

The majority of incidents reported in Maternity Services fall under the maternity and neonatal category. The top 5 reported within this category in December 2025 were:

- Readmission of baby (21)
- Term baby admitted to the neonatal unit (10)
- Guidelines not followed (7)
- Maternal readmission (6)
- Blood loss >1500mls (5)
- 3rd/4th degree tear (5)
- Born Before Arrival (BBA) (5)
- Intrauterine Death (5)

This indicates a relatively stable position over time and further information is included on the Outcomes Dashboard (slide 3). Detailed information is provided monthly to the Trust PSIR Panel via the specialty's DIRG Report.

Top 5 Incidents January 2026

- Readmission of baby (16)
- 3rd/4th degree tears (9)
- Blood loss >1500mls (7)
- Guidelines not followed (7)
- Maternal readmission (6)

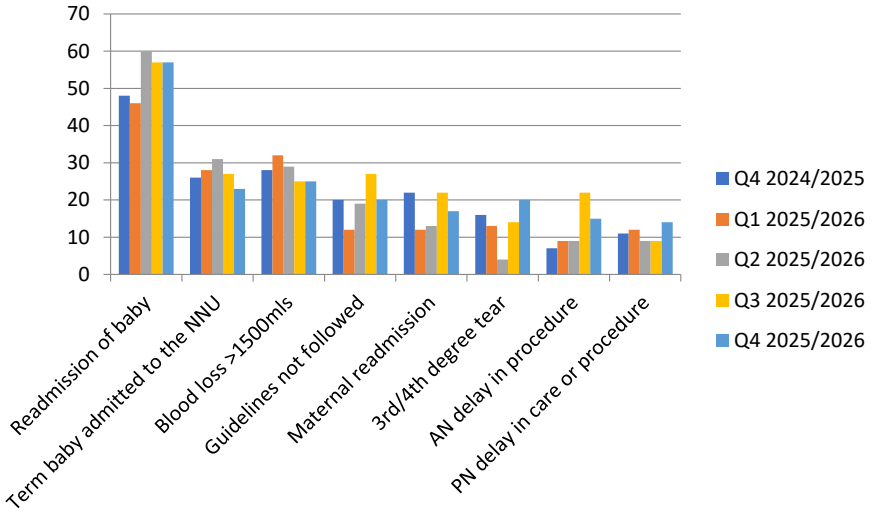
Top 5 incident February 2026

- Readmission of baby (20)
- Blood loss >1500mls (10)
- Term baby admitted to the NNU (8)
- Guidelines not followed (8)
- Antenatal delay in procedure (6)

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Incident themes Quarterly analysis/QI (PSIRF)



As readmission of babies has consistently been our most frequently reported incident and has a significant impact on both families and the service, we have commenced a deep dive audit and will present the findings and recommendations when the audit has been completed.

We have a maternity-specific PSIRP; an-depth analysis of incidents has been undertaken to inform this, and this includes readmission of babies as one of the areas for local focus.

Our current PSIRP (areas for local focus) are:

1. Readmission of babies
2. PPH >1500mls has shown consistency over the last 15 months; we have only showed as above the national average on 2 of the last 15 months (National Maternity Dashboard) but have decided to keep this as an area for local focus.
3. Medication errors.

ESTH Claims Scorecard

April 2015 – March 2025

Top injuries by volume: • Unnecessary pain (9) • Fatality (8) • Adtnl/unnecessary operation (8) • Stillbirth (6) • Psychological damage (5)	**Top injuries by value:** • Brain damage (4) • Cerebral Palsy (3) • Wrongful birth (2) • Erb's palsy (2) • Deafness (1)
Top causes by volume: • Fail – antenatal screening (8) • Failure/delay treatment (7) • Fail to monitor 1st stage labour (5) • Fail to act on abnrl test result (5) • Fail to warn – informed consent (4)	**Top causes by value:** • Fail antenatal screening (8) • Fail to monitor 1st stage labour (5) • Fail to recognise complication (2) • Fail to warn – informed (4) • Fail to act on abnrl test result (5)

Incidents Q3 and Q4 2025-2026 (moderate and above harm outcomes)

ITU admission (1)
Still birth/Neonatal death (all cases including late miscarriages (6)
PPH (2)

Complaints Q3 and Q4 2025-2026 (19 complaints)

Care during labour and birth (no clear themes) (8)
Antenatal care (2)
Postnatal care (2)
Use of fetal scalp electrode (1)
Consent (1)
Staff conduct (1)
Retained placenta (1)
Early pregnancy (2)

Themes Q3 and Q4 2025-2026

- There are no obvious themes emerging in response to incidents, complaint, user feedback and claims when correlated with the claims scorecard. All stillbirth and neonatal death cases are reviewed through PMRT where eligible and no themes that contributed to the outcomes are emerging.

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Maternity Outcomes Signals System (MOSS)

MOSS is a new national system that monitors term stillbirth and neonatal deaths in real time and generates a signal to individual Trusts where they are reporting higher than expected rates. Trusts are then required to undertake a rapid review for presentation to the Board and the ICB. We have not yet triggered a signal.





The St Helier Hospital site received a MOSS signal on 31st March 2026 and as per national guidance completed the Critical Safety Check, which was signed-off at Board level and shared with the ICB and regional teams within the required timeframe.

No concerns were identified from the check. The signal resulted from a doubling from our benchmark rate of 1 case to 2; all deaths were reviewed and it was noted that one death had congenital abnormalities diagnosed antenatally that were not compatible with life, but the family wished to continue the pregnancy. NHSE have confirmed that in the next release of the MOSS system babies with congenital abnormalities will not be included.

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Training Compliance

Type of Training and % compliance	Staff Group	ESTH Jan 26	ESTH Feb 26	ESTH Mar 26
PROMPT 90%	Midwifery Staff	94%	95%	91%
	Maternity Support Workers	99%	93%	91%
	Consultant Obstetricians	97%	89%	93%
	Trainee and Staff Grade Obstetricians	71%	78%	81%
	Anaesthetics	95%	93%	93%
CTG Training 90%	Midwifery Staff	96%	93%	97%
	Obstetricians	93% Cons/83% Other	86% Cons/89% Other	90% Cons/96% Other
Maternity Essentials (CCF)	Midwifery Staff	36% (new)	43% (new)	58% (new)
NLS (Newborn Life Support) 90%	Midwifery Staff	94%	95%	91%
NLS (Newborn Life Support) 90%	Neonatal Nursing Staff	100%	100%	94%
NLS (Newborn Life Support) 90%	Neonatal Medical Staff	100%	100%	100%

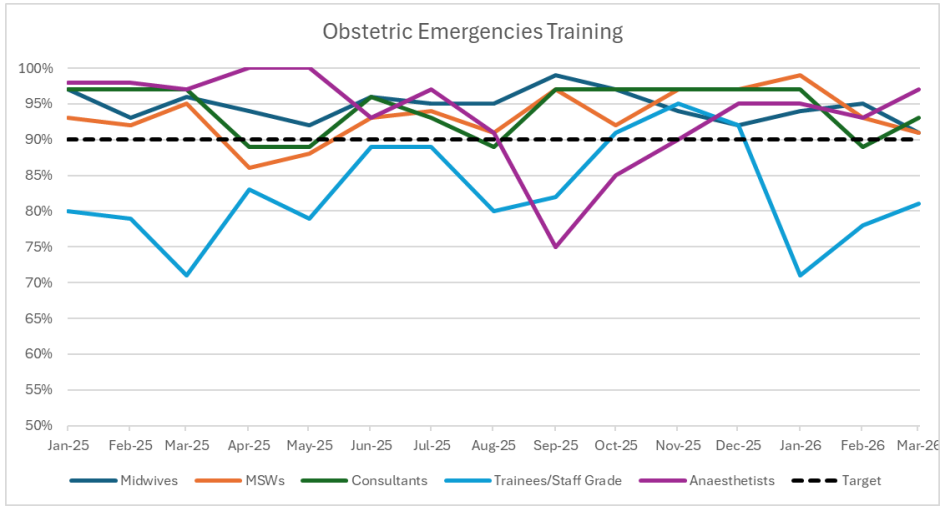
Obstetric medical staff attendance is now mapped and rostered with consistent updates to the leadership team to support their attendance. Improvement is being seen. Yr 8 CNST standards require a mid-point assessment, confirmed for ESTH as June 2026 to achieve compliance

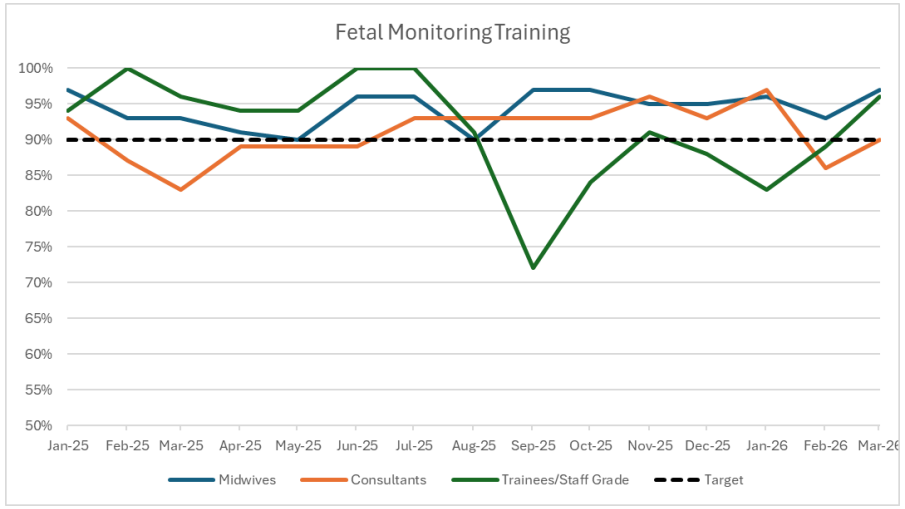
All new starters (obstetric medical staff) attend CTG and PROMPT training within 3 months of their start date. Neonatal medical staff attend NLS/BLS as part of their induction when they start.

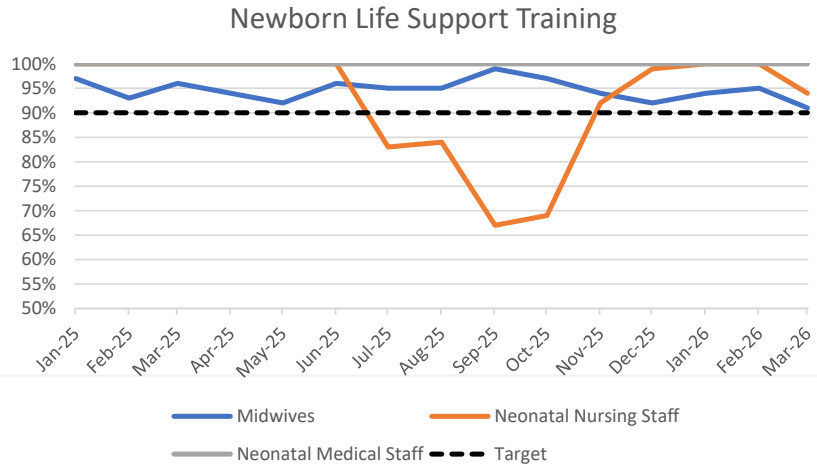
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Training Compliance







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Safe Staffing

Midwifery

37	January 2026						February 2026						March 2026					
Site /Area	Day			Night			Day			Night			Day			Night		
	Planned	Actual	%	Planned	Actual	%	Planned	Actual	%	Planned	Actual	%	Planned	Actual	%	Planned	Actual	%
Epsom	3962	3827	96 %	3182	3129	98 %	3698	3570	96 %	2875	2833	98 %	3909	3767	96 %	3209	3767	97 %
St H	4414	4105	93 %	3887	3731	93 %	3942	3724	94 %	3370	3265	96 %	4458	4150	95 %	3887	3680	97 %

Midwifery Support Workers

	January 2026						February 2026						March 2026					
Site/ Area	Day			Night			Day			Night			Day			Night		
	Planned	Actual	%	Planned	Actual	%	Planned	Actual	%	Planned	Actual	%	Planned	Actual	%	Planned	Actual	%
Epsom	1413	1209	85 %	1070	1001	93 %	1311	939	869	966	941	997	1397	1123	80 %	1070	1000	93%
St H	1601	1384	86 %	966	910	94 %	1355	1174	86 %	909	886	97 %	1592	1430	89 %	1024	897	98%

Daily huddles continue on both sites with senior midwives meeting following these to establish escalation/mitigations required. Staff moved to highest acuity areas where needed, elective procedures also moved between sites to ensure safety and minimise delay. Vacant shifts sent to bank as roster published, where not filled and the above actions do not mitigate risk of low fill rate, shifts sent to agency. **There are currently no midwifery or MSW vacancies.**

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Safe Staffing

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Neonatal

Staff Group	Jan 2026		Feb 2026		Mch 2026	
	ESTH STH	ESTH EGH	ESTH STH	ESTH EGH	ESTH STH	ESTH EGH
Neonatal Nursing	***Day – 96% Night – 100%***	***Day – 97% Night – 96%***	***Day – 100% Night – 100%***	***Day – 97% Night – 96%***	***Day – 96% Night - 97%***	***Day – 100% Night – 100%***
Neonatal Medical	***97%***	***97%***	***100%***	***98%***	***96%***	***100%***

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Service User Feedback (complaints, FFT, PALS and actions)

COMPLAINTS
We received 3 complaints in March 2026. There are no clear themes, but issues identified include;

- Consent for a Fetal Scalp Electrode (1)
- Consent to perform a VE (1)
- Postnatal Care (1)

A review of complaints over the last 6 months is included on slide 16.

FFT responses Dec 2025 – March 2026

1. The majority of the responses fell into the 'very good' and 'good' categories.
2. Positive comments about the kindness of staff and level of support.
3. Mainly positive feedback on the experience on the Birth Centre St Helier
4. Negative feedback regarding noise within the units due to refurbishment works

ACTIONS

- Strengthening the following up of blood results in Triage
- Induction of Labour Guideline review and information leaflet
- Refurbishment of Birth Centre, labour ward and PN ward bathrooms St Helier
- Move of MAU Epsom to site adjacent to DES
- Works commenced on new triage area EGH

PALS
In March 2026 there were 9 contacts; 4 of these were to express gratitude towards staff. The other contacts were around consent, information about caesarean section, complaints about individual staff and complaints about the homebirth service provision.

There were a further 9 contacts giving very positive feedback in relation to maternity care.

FFT - YOU SAID/WE DID:

There were some comments around delayed IOL and the Lead Midwife for transformation is leading a QI project to improve the IOL pathway along with auditing of IoL decision making and timing led by a resident doctor. This is fed back through the EDI working group and will be reported via PQOM

Bathrooms were reported as cold and non-functional, with showers broken. Most Bathrooms at STH have now been refurbished with new windows and sanitary fittings with the final 3 almost completed

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MNVP Feedback and co-production

MNVP feedback – Positive feedback themes included professional caring staff with excellent focus on the birthing person. Great experience on Birth Centre.

There were concerns raised around induction of labour information, mental health support in pregnancy, feeding support on the ward and options around place of birth.

Concerns were raised around issues with appointments following the move to i-Clip Pro which have now largely been resolved.

Co-production

- EDI review of services was commenced in January 2026.
- MNVP input into the QI project around induction of labour commenced in March 2026.
- Antenatal education, including content and delivery, to ensure this meets service user needs.
- CQC Patient Survey 2025 action plan is under development

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Safety Champions Meetings

Next planned walkabout – 15th June

Safety Champions Meeting:

Date	Role	Attendance
17/11/25	Board Safety Champion	Yes
17/11/25	Board Safety champion	Yes
17/11/25	Perinatal Obstetric Lead	No
17/11/25	Perinatal Midwifery lead	Yes
17/11/25	Perinatal neonatal lead	Yes
17/11/25	Perinatal management lead	Yes
17/11/25	MNVP lead	Yes

Feedback from staff engagement sessions and walkarounds:

Feedback raised by staff	Action and progress
Triage works needed at both sites	EGH – triage works well underway with expected completion date June 2026 STH – triage works planned in financial year 26/27
STH ward bathrooms require modernisation	March 26 – 5 bathrooms completed refit, 3 bathrooms expected to be completed this month
Positive feedback from staff at EGH re general working environment	No action required
Feedback raised by service users	**Action and progress**
Very positive feedback received regarding labour care, MAU and postnatal care	Widely fed back to teams with gratitude for the kindness and compassion of the teams
Additional safety champions intelligence	**Action and progress**
N/A	N/A

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Concerns (MNSI/NHSR/CQC/Regulation 28)

There are no current MNSI letters of concern

There are no current NSHR concerns

The CQC rating for the Maternity Service is 'Requires Improvement' and an action plan has now been completed, and reviewed through the Evidence Assurance Panel – ESTH alongside SGUL entered onto the Maternity Support Programme, but ESTH have now exited the programme. A further CQC inspection took place on 2nd and 3rd December 2025, and no significant concerns were raised at the time. We await the report.

There are no current Regulation 28 Reports (reports to prevent future deaths issued by a Coroner). There is currently one case (neonatal death – MNSI case in October 2025) which has been reported to the Coroner, and two cases (neonatal death in 2024 on the Birth Centre and neonatal death in 2023 following an elective caesarean section) which are proceeding to a Coroner's inquest, but these have not yet been listed.

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Cultural improvement plans/survey/SCORE survey

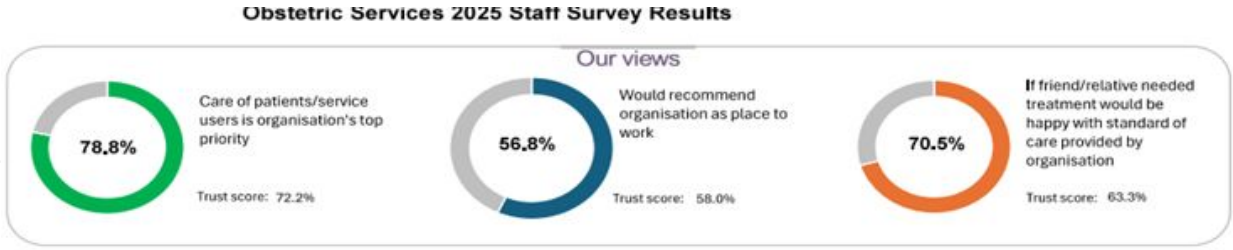
CQC patient survey identified a number of areas for improvement at ESTH, mostly focused on postnatal care. An action plan will be co-produced with the MNVP to ensure learning is embedded in the transformation work underway across maternity services, meeting date now in place

Band 7 bespoke training has now been delivered in conjunction with OD. This has been very well received and will be followed up with further bespoke sessions during the 26/27 financial year. The aim is to improve cohesive working across the B7 teams, increase understanding of leadership responsibilities and come together to improve morale, share learning and shape maternity services

An EDI working group has commenced to oversee all transformation and QI work in maternity. The ToR is in place and membership includes MNVP and review of National Maternity and Neonatal Health Inequalities dashboard. This will be reported via PQOM

Cultural improvement themes were identified through multiple surveys and ESTH are 1 year through a 2 year programme of improvement. The actions are wide ranging and are reported through our Unified Improvement Plan

Proportion of specialty trainees in Obstetrics & Gynaecology responding with 'excellent or good' on how would they would rate the quality of clinical supervision out of hours (Reported annually) – ***87% (2024)***



CQC Action Plan: Progress Since August 2023 CQC Inspection

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CQC inspection August 2023 - Must and Should do action log
Our approach to these was a fully MDT one, involving all staff at Unit Meetings, Perinatal meetings and Leads meetings

The Must Do 2 – Estates is the only remaining action for ESTH. This remains open due to two elements:
the triage works at both EGH and STH are planned and agreed within this financial year – EGH underway, STH planned

Unique Action Identifier	Status	Update / comments
Must Do actions		
CQCMD01 - Statuatory and mandatory training	Complete (with evidence)	Signed off at EAP Jan 2025
CQCMD02 - Estates	In progress (on schedule)	1. Triage estate works (EGH) commence Sept 25 2. Triage works (STH) planned for 25/26 financial year 3. No scope to adjust the delivery suite (STH) en- suite bathrooms
CQCMD03 - Mitigating risk	Complete (with evidence)	Signed off at EAP Nov 2024
CQCMd04 - Triage	Complete (with evidence)	Signed off at EAP Nov 2024
CQCMD05 - Early Warning Score Documentation	Complete (with evidence)	Signed off at EAP Nov 2024
CQCMD06 - Transitional Care	Complete (with evidence)	Signed off at EAP Jan 2025
CQCMD07 - Recovery Practitioner	Complete (with evidence)	Signed off at EAP Jan 2025
CQCMD08 - Care Records	Complete (with evidence)	Signed off at EAP Dec 2024
CQCMD09 - Oversight of Maternity	Complete (with evidence)	Signed off at EAP Jan 2025
Should Do actions		
CQCSD01 - CTG Fresh Eyes Check	Complete (with evidence)	Signed off at EAP Dec 2024
CQCSD02 - SBAR handover	Complete (with evidence)	Signed off at EAP Jan 2025
CQCSD03 - Appraisal	Complete (with evidence)	Signed off at EAP Mar 2025
CQCSD04 - Infection Prevention and Control	Complete (with evidence)	Signed off at EAP Feb 2025

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Single Improvement plan – progress report

Appreciative Enquiry

Progress against actions	Count	Status (%)
At risk / Not started	0	0%
In progress (due date extended / overdue	6	11%
In progress (on schedule)	17	31%
Complete (with evidence)	31	57%
New action	0	0%
Total	54	100%

BFI

Progress against actions	Count	Status (%)
At risk / Not started	0	0%
In progress (due date extended / overdue)	0	0%
In progress (on schedule)	4	29%
Complete (with evidence)	10	71%
New action	0	0%
Total	14	100%

Baby Re-Admissions

Progress against actions	Count	Status (%)
At risk / Not started	0	0%
In progress (due date extended / overdue	0	0%
In progress (on schedule)	7	44%
Complete (with evidence)	9	56%
New action	0	0%
Total	16	100%

CQC Patient Survey Plan 2024

Progress against actions	Count	Status (%)
At risk / Not started	0	0%
In progress (due date extended / overdue)	2	14%
In progress (on schedule)	8	57%
Complete (with evidence)	4	29%
New action	0	0%
Total	14	100%

CNST Year 7

Progress against actions	Count	Status (%)
At risk / Not started	0	0%
In progress (due date extended / overdue	0	0%
In progress (on schedule)	0	0%
Complete (with evidence)	10	100%
New action	0	0%
Total	10	100%

CQC Must & Should Do

Progress against actions	Count	Status (%)
At risk / Not started	0	0%
In progress (due date extended / overdue)	0	0%
In progress (on schedule)	0	0%
Complete (with evidence)	34	100%
New action	0	0%
Total	34	100%

Maternity and neonatal single improvement plan has been developed for oversight and assurance of national and local objectives with improvements being made overall.

Closed actions:

1. CNST Year 7 – achieved all 10 SA
2. CQC Must and Should do – completed all actions with assurance given at EAP meetings

Progress to report:

1. Appreciative Enquiry – 2 year programme commenced in April 2025

Risks and gaps:

None to report

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Single Improvement plan – progress report

Home Birth Action Plan

Progress against actions	Count	Status (%)
At risk / Not started	0	0%
In progress (due date extended / overdue	0	0%
In progress (on schedule)	4	12%
Complete (with evidence)	4	50%
New action	0	0%
Total	8	100%

Midwifery Student Feedback

Progress against actions	Count	Status (%)
At risk / Not started	0	0%
In progress (due date extended / overdue)	0	0%
In progress (on schedule)	20	31%
Complete (with evidence)	44	69%
New action	0	0%
Total	64	100%

NN Workforce & Training

Progress against actions	Count	Status (%)
At risk / Not started	1	9%
In progress (due date extended / overdue	0	0%
In progress (on schedule)	10	91%
Complete (with evidence)	0	0%
New action	0	0%
Total	11	100%

PSIRF Action Plan

Progress against actions	Count	Status (%)
At risk / Not started	0	0%
In progress (due date extended / overdue)	0	0%
In progress (on schedule)	4	100%
Complete (with evidence)	0	0%
New action	0	0%
Total	4	100%

Triage Action Plan

Progress against actions	Count	Status (%)
At risk / Not started	0	0%
In progress (due date extended / overdue	0	0%
In progress (on schedule)	2	13%
Complete (with evidence)	14	88%
New action	0	0%
Total	16	100%

MSSP

Progress against actions	Count	Status (%)
At risk / Not started	0	0%
In progress (due date extended / overdue)	0	0%
In progress (on schedule)	1	10%
Complete (with evidence)	9	90%
New action	0	0%
Total	10	100%

Progress report:

1. PSIRF – 2 year programme completing in April 2027
2. Midwifery student feedback – year long programme commenced in May 2025. Student forums continue
3. Homebirth Action plan – on pause until full review completed, action plan to be updated
4. Triage action plan – awaiting estates work completion (EGH) and estates work commencement (STH)
5. MSSP – final action is to review internal pathway for reviewing Unified Plan

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Single Improvement plan – cont.

Safety Champion Walkabout

Progress against actions	Count	Status (%)
At risk / Not started	0	0%
In progress (due date extended / overdue	0	0%
In progress (on schedule)	1	25%
Complete (with evidence)	3	75%
New action	0	0%
Total	4	100%

Progress report:

Safety Champion walkabout – final action relates to triage estates work which is underway at EGH and planned for coming year (STH)

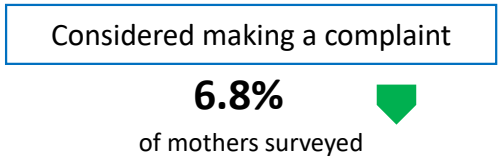
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National Maternity Survey Action Plan 2024

Theme	Progress	Support requirements
Service users given appropriate information and advice on the associated risks with induction	Awaiting translation of information leaflet – commenced Jan 2026	None
Service users given enough support for their mental health.	Community support increased – 2025 report showed satisfaction for this theme	None
Service users given information about any warning signs to look out for during pregnancy	Maternity website QI project underway	Trust support available to improve maternity element of website
Information from midwife or doctor to help service users decide where to have their baby	MNVP co-production of AN Education project commenced in Jan 2026	None
Service users offered choice about where to have their baby	Feedback sought from MNVP directly with service users – no concerns raised	None

- **CQC survey:** Percentage of mothers that considered making a complaint during their maternity care journey (2025 vs 2024)



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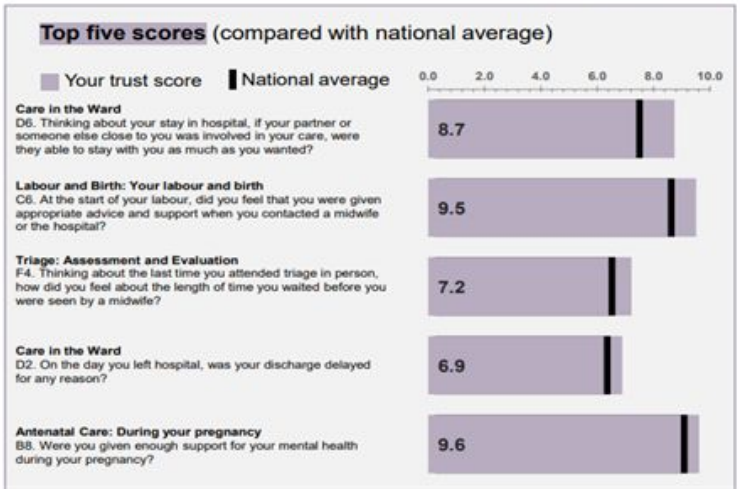
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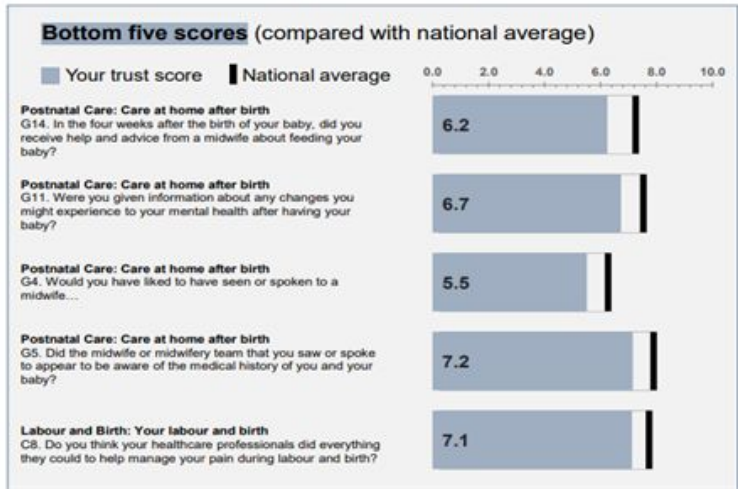
National Maternity Survey 2025 – coproduced action plan is underway

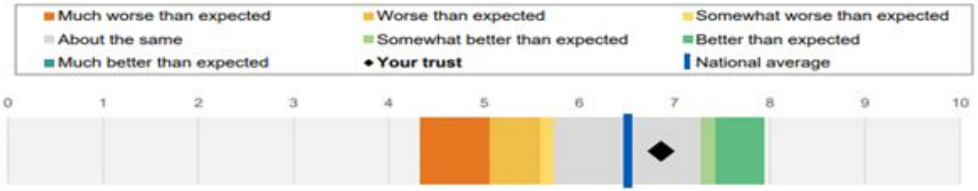
Best and worst performance relative to the national average

These five questions are calculated by comparing your trust's results to the average trust score across England.

- **Top five scores**: These are the five results for your trust that are highest compared with the national average. If none of the results for your trust are above the national average, then the results that are closest to the national average have been chosen, meaning a trust's best performance may be worse than the national average.
- **Bottom five scores:** These are the five results for your trust that are lowest compared with the national average. If none of the results for your trust are below the national average, then the results that are closest to the national average have been chosen, meaning a trust's worst performance may be better than the national average.







		All trusts in England		
Number of respondents	Your trust score	National average	Lowest score	Highest score
112	6.9	6.5	4.3	7.9

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National Maternity Survey 2025 – Comparison to other Trusts nationally

Much better than expected

- C6. At the start of your labour, did you feel that you were given appropriate advice and support when you contacted a midwife or the hospital?

Better than expected

- B8. Were you given enough support for your mental health during your pregnancy?
- C9. If your partner or someone else close to you was involved in your care during labour and birth, were they able to be involved as much as they wanted?

Somewhat better than expected

- D5. Thinking about the care you received in hospital after the birth of your baby, were you treated with kindness and understanding?

Somewhat worse than expected

- No questions for your trust fall within this banding.

Worse than expected

- No questions for your trust fall within this banding.

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MSSP Update

NHS England

MatNeoIST (previously known as MSSP) have confirmed that ESTH have exited the programme with 3 reporting points added in March, moving us to Regional Oversight. These will be outlined in next report

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Saving Babies Live Care Bundle Compliance

EI 1: Smoking in pregnancy
EI 2: Fetal growth
EI 3: Reduced fetal movement
EI 4: Fetal monitoring
EI 5: Pre-term births
EI 6: diabetes in pregnancy

Trust: Epsom and St Helier University Hospitals NHS Trust

ICB: London

	Baseline Assessment	Assessment 1	Assessment 2	Assessment 3
Review Quarter	Q4	Q1	Q2	Q3
Assurance Review Date	18/07/2025	24/07/2025	23/10/2025	22/01/2026
Element 1	90%	90%	90%	60%
Element 2	100%	95%	100%	100%
Element 3	100%	100%	100%	100%
Element 4	100%	100%	100%	100%
Element 5	100%	96%	96%	100%
Element 6	83%	83%	83%	83%
TOTAL	97%	94%	96%	93%

Actions: Element 1- action underway with teams, awaiting funding from SWL to support service needs (initial review shows increased position to 90% for Q4)

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Key Learning (triangulation)

Shared Learning from incidents Q3 and Q4 2025-2026

- Importance of accurate and timely documentation
- Management of pink/blood-stained liquor
- Smoking cessation referral process
- Use of interpreting services
- Labelling babies
- Management of small for gestation age babies
- Management of gestational diabetes
- Wrong blood in tube incidents

Shared Learning from service user feedback Q3 and Q4 2025-2026

- Importance of accurate and timely documentation
- Management of pink/blood-stained liquor
- Smoking cessation referral process
- Use of interpreting services
- Labelling babies
- Management of small for gestation age babies
- Management of gestational diabetes
- Wrong blood in tube incidents

PMRT parent's insight Q3 and Q4 2025-2026

- Feeling that concerns were not acknowledged or taken seriously
- The BadgerNet App was prompting bereaved parent to review content such as 'looking after your newborn' which was distressing
- The importance of continuity of carer

Key Actions – You Said/We did

Review of the homebirth service/2nd on-call	On-going	
Review of readmissions (neonatal), PPH and medication errors	Formalised in the PSIRP	
Quality Improvement plan and cultural improvement plan in progress	On-going	
BadgerNet option to tailor content for bereaved families to be added to the bereavement checklist and incorporated in mandatory documentation training	Completed	
We need to undertake a review the ease in which women can amend their automatically generated appointments as this has now been highlighted as an issue in 2 cases	To be commenced	

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Service Suspensions

	January 2026	February 2026	March 2026
Obsteric Units	NIL	NIL	NIL
Birth Centres	NIL	NIL	NIL
Neonatal Units	NIL	NIL	NIL

IOL Delays

	January 2026	February 2026	March 2026
Epsom	2	2	3
St Helier	0	0	0

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Thank you.

For any other information, please see:

Group Board

Meeting in Public on Thursday, 09 July 2026

Agenda Item	3.5.2	
Report Title	**Briefing on Ockenden Nottingham and Amos National Maternity and Neonatal Reports**	
Executive Lead(s)	Elaine Clancy, Interim Group Chief Nursing Officer	
Report Author(s)	Michelle Cudjoe group Chief Midwifery Officer	
Previously considered by	gesh Quality Group	25 June 2026
Purpose	**For Review**	

Executive Summary

Purpose

To provide the Board with an overview of the key national learning arising from the Nottingham Maternity Review and the Valerie Amos National Maternity & Neonatal Review, outline the immediate actions expected by NHS England, and seek Board endorsement of the Trust's approach to implementation and oversight.

Executive Summary

The publication of the Nottingham Maternity Review and the Valerie Amos National Maternity & Neonatal Review represents a significant opportunity to strengthen maternity and neonatal services through a sustained focus on safety, quality, equity, culture and leadership.

The Nottingham Review identified the consequences of long-standing failures within one Maternity service, while the Valerie Amos review concludes that many of the issues identified are systemic rather than isolated. The reports both highlight the importance of compassionate leadership, effective governance, multidisciplinary working, listening to women, families and staff, reducing inequalities, and maintaining strong Board oversight.

Strategic Themes for Oversight

1. Listening to Women and Families

- Women and families should be active partners in designing, delivering and improving services.
- Feedback, complaints, PALS, maternity surveys and engagement activities should be routinely reviewed.
- Learning is translated into measurable improvements in experience and outcomes.

2. Listening to Staff

- Staff should experience psychological safety and are supported to speak up.
- Freedom to Speak Up themes, staff survey findings, cultural indicators and workforce intelligence should be routinely reviewed.
- Staff feedback informs quality improvement, leadership development and organisational learning.

3. Equity

- Equity must be recognised as a patient safety and quality priority.
- Boards to receives routine reporting on maternity outcomes and experience by ethnicity, deprivation and other protected characteristics.
- Actions are in place to reduce inequalities and unwarranted variation, particularly for Black, Asian and other underserved women and babies.

4. Safe, High-Quality Care

- Safe staffing, education and competency frameworks are maintained.
- Clinical escalation, fetal surveillance, triage and multidisciplinary working are regularly reviewed.
- Learning from incidents is implemented and sustained.
- Safety metrics demonstrate continuous improvement.

5. Compassionate Leadership and Culture

- Leaders demonstrate compassionate, inclusive leadership.
- A just culture promotes openness, transparency and continuous learning.
- Staff wellbeing, engagement and retention are monitored.
- Duty of Candour is consistently embedded.

6. Governance, Accountability, Improvement and Board Oversight

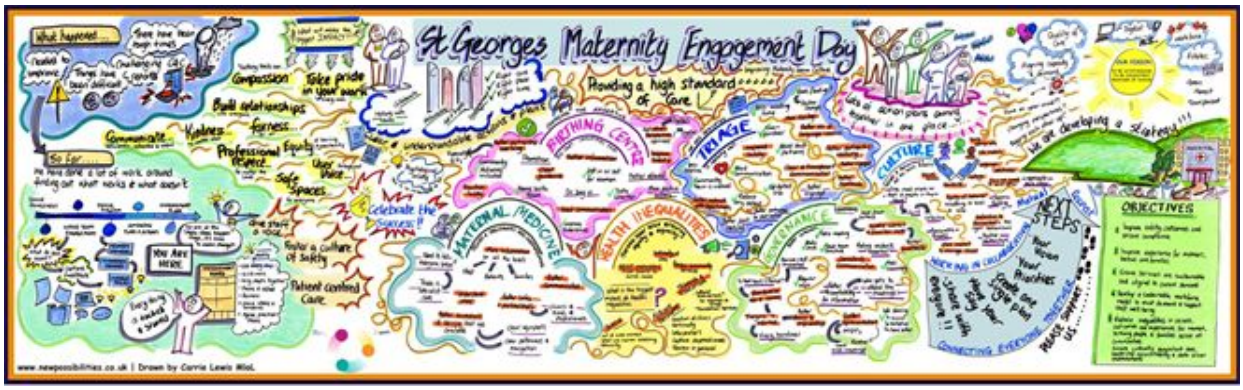
- Quality, safety, workforce, experience and equity intelligence should be triangulated.
- National recommendations are embedded within the Trust's maternity improvement programme.
- The Board receives comprehensive maternity assurance
- Risks are escalated promptly and improvement is evidenced through measurable outcomes.

An initial review of the findings of both reports demonstrate that existing improvement programmes across gesh are aligned closely with the key themes identified within the recent reports including:

- Board Oversight - Introduction of Maternity Sub Committee
- Culture Improvement Plans
- Health Equity

- Leadership development
- Governance and safety culture
- Listening to women and families
- Developing our workforce
- Clinical Pathways that underpin safe care – Triage, Homebirth Services, Fetal and Maternal Medicine

The digital synthesis below captured at the SGUH engagement day in May 2026 is a visual depiction of the maternity improvement plan and demonstrates alignment with recent recommendations. These priorities are also reflected in the ESTH Unified plan.



NHS England Immediate Priorities (First 100 Days)

NHS England has subsequently requested organisations to undertake immediate actions during the first 100 days following publication of the Amos Review to provide assurance that local maternity services are safe, equitable and continuously improving.

In line with NHS England Priorities the Trust will complete the following immediate actions:

1. Strengthen listening to women and families by rolling out Martha's rule across Maternity
2. Listening to women and their families via real-time and transparently reported outcomes. Experience and clinical audit data acted upon at Board Level
3. Dual Board level accountability between Medical Directors and CNOs
4. Amos into action staff listening exercises
5. Addressing inequalities in Maternity and Neonatal Outcomes
6. Ensuring 24/7 safety and responsiveness of maternity and neonatal services
7. Trusts to review their homebirth services
8. Responding to patient safety incidents, complaints and concerns with humanity, candour and through a trauma informed approach

9. Deliver safe and effective triage in maternity services
10. Post death care- including immediate audit of mortuary services

Board Assurance

- There is strong alignment between the Trust's current maternity improvement programmes and the recommendations of both reports.
- Some recommendations have only recently been implemented and are therefore in the early stages of local implementation.
- Newly published recommendations (including the roll out of Martha's rule and the audit of mortuary services) have been prioritised and will be progressed through site specific governance processes with reporting to the Quality Committee and Board.
- Each site will benchmark its service against the immediate actions within the reports and assess the effectiveness of existing actions.
- The introduction of the Maternity Sub Committee provides a robust process to monitor ongoing implementation and impact.

The Board will continue to receive assurance through:

- The introduction of the Maternity Sub Committee
- Quality Committee oversight.
- Maternity Incentive Scheme reporting.
- Perinatal Quality Surveillance reporting
- MNVP presence at Maternity Sub Committee - Listening to women and families.
- Maternity and Neonatal Safety Champions- Listening to staff.
- Freedom to Speak Up reporting.
- Staff Survey, Maternity Survey and Patient Experience reports.
- Equity dashboard (being developed) and quality metrics.
- Integrated Quality Performance Report with Maternity Scorecard.

Recommendations

The Board is asked to:

1. Note the findings of the Nottingham Maternity Review and the Valerie Amos National Maternity & Neonatal Review.
2. Note the NHS England 10 point plan for the first 100 days
3. Agree to receive assurance reports during the first 100 days and quarterly reports thereafter through the Quality Committee and Board.

Action required by Group Board
The Group Board is asked to: a) Note the findings of the Nottingham Maternity Review and the Valerie Amos National Maternity & Neonatal Review. b) Note the NHS England 10 point plan for the first 100 days c) Agree to receive assurance reports during the first 100 days and quarterly reports thereafter through the Quality Committee and Board.

Committee Assurance	
Committee	Group Board (Private)
Level of Assurance	Not Applicable

Appendices	
Appendix No.	**Appendix Name**
Appendix 1	**ESTH Maternity Services Summary report**
Appendix 2	**SGH Maternity Services Summary report**

Implications

Group Strategic Objectives

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

Risks

As set out in report.

CQC Theme

☒ Safe	☒ Effective	☐ Caring	☐ Responsive	☒ Well Led

NHS system oversight framework

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

Financial implications

To be explored further

Legal and / or Regulatory implications

SGUH: There is an ongoing requirement to achieve compliance in the MUST and SHOULD Do actions issued by the CQC 2023 inspection at SGH maternity services in line with the Health and Social Care Act 2008 (Regulations 2014) and CQC Registration Regulations. In January 2025, SGUH maternity received a section 29A following their CQC inspection in October 2024. Maternity have completed an action plan, which is being monitored via the maternity oversight group. CQC Inspection Report October 2024 was published in September 2025. Overall SGH maternity services were rated as Requires Improvement which demonstrates some improvement although concerningly CQC theme Safe remained at Inadequate. ESTH: Sign off required for reports as outlined. CQC inspected maternity services as part of the Trust inspection in December 2025, awaiting feedback.
Equality, diversity and inclusion implications
Maternity services across GESH remain committed to delivering equitable, person-centred care that recognises and responds to the diverse needs of women, birthing people, and families using the service. Data continue to show disparities in maternity outcomes across ethnic groups, levels of deprivation, and other protected characteristics; ongoing review of outcome data aims to identify and address any inequalities. Targeted community engagement strengthened use of interpretation services, and culturally sensitive care planning are being embedded to support informed choice and improve access to care. Staff continue to undertake mandatory equality, diversity and inclusion training, with a focus on cultural awareness and unconscious bias. The services also promotes inclusive workforce practices through staff networks and equitable access to professional development. These actions collectively support the maternity objective to reduce health inequalities and ensure all service users receive safe, respectful and responsive maternity care.
Environmental sustainability implications
SGH: none noted ESTH: none noted

Group Board Meeting (Public)

Meeting on Thursday, 09 July 2026

Agenda Item	4.1	
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 May and June 2026 and the matters the Committees wish to bring to the attention of the Group Board. These include:

1. Quality Accounts: Committees members approved the draft Quality Accounts for both ESTH and SGUH, recommending their approval to the Group Board.
2. Maternity Services: Committees members discussed the receipt of a maternity and newborn safety investigation letter of concern, noting that a response to this is required within five working days. The letter details repeated failures in CTG interpretation, escalation and adherence to trust guidance around CTG. SGUH has received 26 recommendations over the last few years, and the letter advises of limited evidence of sustained improvement. It was advised that an immediate review is underway, including review of the governance arrangements. This will be discussed at the newly established Maternity Board in July, with a report then presented to Quality Committees on the findings of the review.
3. 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 acted upon. The team are currently ensuring that duty of candour is fulfilled for all affected patients, with the full report planning to be published and discussed at the Group Board in public, on 9 July 2026.

Action required by Group Board

The Group Board is asked to note and discuss the issues escalated by the Quality Committees and the wider issues on which the Committees received assurance in May and June 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, 09 July 2026

1.0 Purpose of paper

1.1 This report sets out the key issues considered by the Quality Committees at its meetings in May and June 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 in the reporting period the Committees considered the following items of business:

4 June 2026 (deferred May Meeting)	**25 June 2026**
• gesh Safety and Compliance Report • Draft Quality Accounts • Maternity Services Report • Never Events Report • Dementia and Delirium Q4 Report • Interstitial Lund Disease Update • Quality Governance Improvement Plan • Learning from Patient Deaths Report Q4 • Integrated Quality Performance Report: Focus on Quality and Safety Metrics	• gesh Safety and Compliance Report • Integrated Quality and Performance Report: Quality Metrics Focus • Patient Safety Incident Report • Acute Medicine at St Helier Quality Turnaround Programme • Quality Impact Assessments of Cost Improvement Plans • Patient Experience Report • Board Assurance Framework • Forward Planner

2.2 The Committees was quorate at both meetings.

3.0 4 June 2026 – Key Issues for Escalation to Group Board

3.1 Draft Quality Accounts

3.1.1 The Committees received the draft Quality Accounts for both ESTH and SGUH. Upon review, it was noted that there is currently no sufficiently explicit reference to the EPR implementation at Epsom & St Helier, and it was agreed that this should be included as it is a point of difference between SGUH and ESTH with regards to EPR.

3.1.2 The Committees **approved** the draft Quality Accounts, recommending their approval to the Group Board. This approval was subject to:

- Inclusion of EPR implementation narrative.
- Revision of patient survey wording for accuracy and transparency.

3.2 Maternity Services Report

3.2.1 When reviewing the report, members discussed the recognition that health inequalities are impacting outcomes. Committees members requested that more detailed reporting on this is included in the next report.

3.2.2 Committees members agreed that, given recent strengthening of leadership, **reasonable** assurance could now be taken regarding the management of maternity services.

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

3.3.1

A report was presented on the Trust's response to the external review by the Royal College of Physicians into the care provided to patients with Interstitial Lung Disease at Epsom and St Helier.

The Trust is implementing a comprehensive programme of work to ensure that patients and bereaved families are communicated with appropriately, that Duty of Candour obligations are discharged, including engagement with the Coroner where required, and that the organisation is fully prepared before the Group Board discusses the RCP Report in public on 9 July.

3.3.2 Members noted the GCMO has been confirmed as the Senior Responsible Officer for the management of ILD, who is chairing a dedicated steering group meeting twice weekly to ensure there is sufficient oversight.

3.3.3 Committees members noted the report, advising that although there is an improved grip and structure, there is a need to maintain focus on organisation-wide learning and not just the patient response

3.4 Never Events (NEs)

3.4.1 GCMO presented the report, advising that in total, fourteen NEs have occurred between April 2025-April 2026, with seven at each site. Trend data identifies that across both Trusts, 'retained foreign object' is the most common type reported over the last two years, followed by 'wrong site surgery.' Key areas of improvement therefore focus on theatres safety and interventional procedures.

3.4.2 Members noted that whilst improvements have been achieved through focused interventions e.g. guide wires, dermatology pathways, the overall volume of events remains concerning. It was agreed that there is a need for clear based outcome-metrics, rather than purely focusing on the event count

3.4.3 Whilst Committees members acknowledged the progress in managing never-events, it was agreed that this progress was insufficient to demonstrate sustained improvement and therefore agreed that **limited** assurance could be taken in relation to the management of never events.

3.5 Quality Governance Improvement Plan

3.5.1 The Committees welcomed the report, which included the key performance indicators (KPIs) which will be used to measure the progress and highlight risks to achieving the targets. The KPIs will be reported on a quarterly basis to the programme Steering Group, which is co-chaired by the Group Chief Nursing Officer and Group Chief Medical Officer. The Programme will submit a six-month progress report to the Quality Committees.

3.5.2 Committees members discussed how the success of the improvement plan depends on not only a structured approach as outline in the report, but also on a positive cultural change.

Executives advised that there has been a restructure of the governance flow, meaning that quality concerns will be escalated more efficiently going forward, allowing executives the opportunity to problem solve at an earlier stage.

3.5.3 Committees members agreed that **reasonable** assurance could be taken regarding the quality governance improvement plan.

3.6 Delirium Assessment Performance

3.6.1 When discussing the report, members expressed concerns over the medical compliance with assessment being very low, at 3–5%, also noting that although nursing performance improved it is still below expectation. It was advised that one reason for the low uptake is a perception of additional workload burden, it was also noted that the delirium forms do not necessarily have to be completed by doctors as part of their workflow and the team are looking into whether the form can become part of the automatic workflow to increase completion.

3.6.2 Members asked that future reports include detail on both the number of patients who have been screened on admission, along with the percentage of those who have then gone on to have an assessment as a result of the screening.

3.6.3 Committees members noted that as this improvement work is ongoing; an update is suggested for October 2026, with the metrics continuing to be reported monthly as part of the IQPR.

4.0 25 June 2026 – Key Issues for Escalation to the Group Board

4.1 Patient Safety and Compliance Report

4.1.1 When discussing never events, committees members noted that whilst some incidents represent poor individual compliance, others also represent wider system failure. Certain clinicians have been identified as repeatedly non-compliant and members noted there is a potential cultural concern where staff may not feel able to challenge this non-compliant behaviour. Committees members agreed that the current level of never events is unacceptable, agreeing the following actions to mitigate this:

- Proceed with an external theatre review at EStH
- Develop an enhanced assurance framework for never events, the content of this to be agreed between GCMO, GCNO and the Committees Co-Chairs.
- Continue to report on never events to the Quality Committees on a monthly basis, including trend analysis.

4.1.2 Committees members discussed the receipt of a maternity and newborn safety investigation letter of concern, noting that a response to this is required within five working days. The letter details repeated failures in CTG interpretation, escalation and adherence to trust guidance around CTG. SGUH has received 26 recommendations over the last few years, and the letter advises of limited evidence of sustained improvement. It was advised that an immediate review is underway, including review of the governance arrangements. This will be discussed at the newly established Maternity Board in July, with a report then presented to Quality Committees on the findings of the review.

4.2 PSIRF Report

4.2.1 Committees members welcomed the report, which provided an overview of patient safety incidents, Patient Safety Incident Investigations (PSIIs), emerging safety themes and learning across St George's University Hospital (SGUH) and Epsom & St Helier University Hospitals (ESTH) for March and April 2026.

4.2.2 The Committees Co-Chair highlighted a case involving a woman of ethnic minority background who presented twice and was discharged following second attendance and unfortunately, she and her baby subsequently died. The Co-Chair advised his concern over the case, asking what the follow up response will be. It was advised that an external review is underway, with ethnicity and access being key themes examined in the review. The report on this is expected to be completed within one month.

4.2.3 Committees members noted the report, agreeing that there is **reasonable** assurance that systems are in place to learn from patient safety events, however the assurance is limited with relation to being assured that the right actions are in place to prevent the recurrence of never events

4.3 St Helier AMU Turnaround Update

4.3.1 Committees members noted that the Turnaround Programme has achieved some early success with improved compliance for supervisor training, improved feedback from Medical trainees and learning from a multidisciplinary visit from the St Helier AMM Team to St Georges Hospital and a timeline has been produced to implement numerous agreed changes as a result of the visit.

4.3.2 Key future actions include implementation of structured board rounds and safety huddles; completion of rota review; governance dashboards; consultant development; embedding trainee feedback; and expansion of SDEC pathways.

4.3.3 **Reasonable** assurance was agreed regarding the adequacy of the Turnaround Programme and implementation plan. The Committee recognised that assurance regarding service outcomes remains dependent upon successful delivery of the programme.

4.4 Patient Experience Report

4.4.1 Members discussed whether the patient experience programme generates meaningful insight into experiences of people with learning disabilities. It was advised that learning disability representation is embedded through safeguarding and carers groups. Also, a new GESH Accessibility Patient Group has been established whose membership includes individuals requiring reasonable adjustments, including people with learning disabilities, sensory loss and physical disabilities.

4.4.2 Committee members **supported** the endorsement request relating to the Carers Charter and recommended Board endorsement.

4.4.3 The Committees agreed that **reasonable** assurance could be taken regarding the direction of travel and effectiveness of the Patient Experience Programme. The Committee also recognised opportunities to further integrate patient experience intelligence, complaints and survey data.

4.5 Board Assurance Framework

4.5.1 GCCAO presented the report, which detailed the draft Board Assurance Framework (BAF) entries for Strategic Risk 6 (Research and Innovation) and Strategic Risk 8 (Patient Safety and Quality).

4.5.2 For SR6, the proposed current risk score is 12 (Consequence 4 x Likelihood 3). The proposed score reflects the potentially significant consequences should the risk materialise, including

reduced access to research opportunities, poorer patient outcomes and experience, missed opportunities to reduce inequalities, lower research income and funding, and reduced ability to attract and retain high-calibre staff The Committees **supported** the risk score of 12.

4.5.3 For SR8, the proposed current risk score is 15 (Consequence 5 x Likelihood 3). The proposed score reflects the potentially severe consequences should the risk materialise, including avoidable harm to patients, poorer clinical outcomes, widening inequalities, poor patient experience and regulatory scrutiny.

4.5.4 When discussing SR8, Committees members discussed the risk score remaining at 20, rather than reducing to 15, because the likelihood score should remain at 4 rather thn being reduced to 3. The reasons for this were due to ongoing maternity concerns, issues relating to never events and the current corridor care pressures. Members agreed that a reduction to 15 could be considered once:

- Quality governance improvements are embedded.
- Fundamentals of care improve.
- Cultural improvement programmes mature.

4.5.5 In conclusion, the Committees agreed that the risk score for SR6 is 12, and the risk score for SR8 is 20. Committees members would like the likelihood for SR8 to be able to be reduced to 3 by May 2027.

5.0 Recommendations

5.1 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.

Group Board

Meeting in Public on Thursday, 09 July 2026

Agenda Item	4.2	
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 May and June 2026 and sets out the matters the Committee wishes to bring to the attention of the Board.

The Assurance rating of Limited reflects the current financial risks at the Trusts.

Action required by Group Board

The Board is asked to:

a) Note the paper

Committee Assurance

Committee	Finance & Performance Committees
Level of Assurance	Limited Assurance: The report and discussions did not provide sufficient assurance that, whilst the system of internal control is adequate and operating effectively, the current financial deficit plan is deliverable without significant improvements.

Appendices	
Appendix No.	**Appendix Name**
Appendix 1	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, 09 July 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 May and June 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 29th May and 26th June 2026, the Committee considered the following items of business:

29th May 2026	26th June 2026
PUBLIC MEETING • IGCFO/DCEO report • IQPR • SGH Thoracic Cancer deep dive • Integrated Finance report M1 • Costing update • Medium Term Financial Plan • SWL Procurement Partnership update	**PUBLIC MEETING** • IGCFO/DCEO report • IQPR • ESTH UEC Recovery Plan • Data Quality deep dive • Integrated Finance report M2* • Medium Term Plan delivery • BAF Operational Risk* • BAF Finance Risk*

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

2.2 The Committee was quorate for both meetings.

4.0 Sources of Assurance

4.1

a) Integrated Finance Report M2

The Committee noted that both Trusts are on plan at M2. However, the pressure and adverse position in the underlying position at both Trusts was noted. The requirement to develop cost out mitigations to the April Resident Doctor Industrial Action was also noted. This had been mitigated by brought forward and non-recurrent benefits year to date. The Committee noted the trends in the underlying run rates across pay and non-pay expenditure at each Trust, the improvement over 2025/26 but the risk presented in the underlying increase in expenditure over the last few months. The Committee noted work being undertaken to improve the underlying run rate in pay, as well as further identification of CIPs.

b) Medium-Term Financial plan delivery

Colleagues noted the challenge of underlying pay run rates increasing in recent months. Coupled with the challenges of CIP identification and delivery, increase the

risk to delivery of the Medium-Term Financial plan. The Committee discussed some of the key changes that are being implemented to mitigate these risks, with an emphasis on driving down run rates from the executive team.

c) Operational Performance

The Committee noted the good work going on across operational performance, with particular focus on the work being done to improve performance in children's therapy services and ESTH UEC. Committee noted the progress being made and that regular updates will be made to the committee.

d) Costing update

The May committee noted the key updates in Costing, where work on the National Cost Collection exercise is now underway. This was then submitted in the first week in July, with next steps and an analysis of what this means for productivity to be a part of the next quarterly update in August.

e) SWL Procurement partnership update

The Committee noted the key priority of the new Chief Procurement Officer to make sure the pipeline of contracts is manageable and avoid late extension requests.

5.0 Risk Implications

5.1 Following formal review, the Committee did not consider any changes necessary to recommend to Group Board on the BAF operational-related risk SR 6 – Timely access to Care. The score remains ‘20’ and Partial assurance. The target for the March 2028 is ‘15’ and Reasonable assurance.

5.2 Following formal review, the Committee did not consider any changes necessary to recommend to Group Board on the BAF finance risk SR1 - Financial Sustainability and recommended no changes to the score of ‘25’ and Limited assurance. The target for the March 2028 is ‘15’ and Reasonable 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 May and June 2026.

Group Board Meeting (Public)

Meeting on Friday, 10 July 2026

Agenda Item	4.3	
Report Title	**People Committees Report to Group Board**	
Non-Executive Lead	Yin Jones, People Committees Chair, SGUH & ESTH NED	
Report Author(s)	Yin Jones, People Committees Chair, SGUH & ESTH NED	
Previously considered by	n/a	
Purpose	**For Assurance**	

Executive Summary

This report sets out the key issues considered by the People Committees at its meeting in June 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:

New Risks and Issues for Escalation

The Committees decided to escalate the following:

- Staff anxiety and anticipated sickness increases due to the E-block water issues at St Helier. The GCPO explained that both HR and employment legal consultations were underway.
- Good progress was reported on the transactional and administrative items of the NHS 10 Point Plan for Improving Resident Doctors' Working Lives, but Workplace Wellbeing required immediate action. The Estates department committed to providing timelines for remedial estates work to improve the resident doctor working environment, including both quick wins as well as long-term improvements ahead of the dedicated steering group meeting on 22 July 2026.
- Interpersonal difficulties requiring mediation that are currently affecting approximately one-third of teams at SGUH. The GCEO suggested that managing this ongoing problem should become a dedicated agenda topic for future committee meetings.

Group Chief People Officer (GCPO) Report

The Committees received a comprehensive GCPO update covering national, SW London, and gesh-specific contexts. She reported that the anticipated resident doctor strike had been called off and reassured the Committees that new national visa salary thresholds would not affect current staff or international doctor recruitment. She highlighted a tight two-month timeline for the Transforming People Services programme's outline business case and noted that the Trust was collecting data returns to build a strategic workforce plan.

Workforce KPI Performance Report and BAF (Board Assurance Framework)

The group is currently 346 WTE over establishment. Focus will be on reducing bank/agency use, leveraging natural attrition, and implementing a Mutually Agreed Resignation Scheme (MARS), for which principles are being drafted. The Committees also agreed to refresh the Board Assurance Framework (BAF), streamlining people risks to SR9 (Workforce Sustainability) at a score of 20, and SR10 (Inclusive Culture) at a score of 16.

Medical Revalidation and GoSW

The Committees approved the Medical Revalidation Annual Reports, noting ESTH appraisal rates are above target at 93%, and SGUH rates are improving at 85%. The Guardian of Safe Working (GoSW) reported that exception reporting at ESTH doubled to 219, which was viewed positively as a sign of an accessible, barrier-free system following the removal of clinical supervisor narrative requirements. Similarly, at St George's there was also a steep rise in the number of exception reports, mainly in AMU, dermatology, medical oncology, obstetrics and gynaecology and general surgery. Ongoing rota review was underway.

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 June 2026.

Committee Assurance

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

Appendices

Appendix No.	Appendix Name
Appendix 1	N/A

Implications

Group Strategic Objectives

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

Risks

Three people-related strategic risks (Recruitment/Retention, Culture/EDI, and Engagement) remained scored at 20 (Extreme).

CQC Theme

☐ Safe	☐ Effective	☐ Caring	☐ Responsive	☒ Well Led

NHS system oversight framework

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

Financial implications

As set out in the 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, 09 July 2026

1.0 Purpose of paper

1.1 This report sets out the key issues considered by the People Committees at its meeting in June 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 18 June 2026, the Committees considered the following items of business:

18 June 2026
• Group Chief People Officer Report • Temporary Staffing • Job Evaluation • People Policies • NHS 10 Point Plan for Improving Resident Doctors' Working Lives • Medical Revalidation Report Q3/Q4 and Annual Report 2025/26 • Guardian of Safe Working (GoSW) Q4 • Board Assurance Framework – Strategic People Risks & People Risks • Workforce KPI Performance Report

2.2 The Committees, chaired by Yin Jones, meet every two months as agreed by the Group Board. An informal meeting between the Chair and GCPO takes place in the month between two public Committee meetings. The meeting on 18 June 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:

<u>New Risks and Issues for Escalation</u>
Staff anxiety and anticipated sickness increases were expected due to the E-block water issues at St Helier. HR and employment legal consultations were underway.

Secondly, there is an urgent need for remedial estates work to improve the resident doctor working environment as a part of the 10-Point Plan. The Estates department committed to providing timelines for remedial estates work to improve the resident doctor working environment, including both quick wins as well as long-term improvements ahead of the dedicated steering group meeting on 22 July 2026.

The GCPO also reported that Interpersonal difficulties and mediation requirements were affecting approximately one-third of teams at SGUH. The GCEO added that the management team was being pulled into dealing with these issues and conducting mediations, which was distracting them from focusing on their core business. He suggested that managing this ongoing problem should become a dedicated agenda topic for future committee meetings.

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:

Temporary Staffing
The Committees received a reasonable level of assurance regarding temporary staffing, noting that while ESTH is a London outlier at 14%, this is skewed by in-house estates, facilities, and non-emergency transport services.

Job Evaluation
The Committees agreed on a substantial level of assurance for Job Evaluation, with efforts underway to manage business-as-usual and integration-driven evaluations, alongside improving records of previously matched roles to reduce from-scratch evaluations.

Medical Revalidation Report
A substantial level of assurance was received, and the annual reports for submission for both trusts were approved. ESTH appraisal rates were reported above target at 93%, while SGUH rates were at 85%. SGUH deferrals were primarily driven by locally employed doctors on short-term rotations who lack five years of continuous appraisal history.

Board Assurance Framework
The GCCAO explained that the refreshed BAF streamlined people risks from three to two: SR9 (Workforce Sustainability) with a current score of 20, and SR10 (Inclusive Culture) with a current score of 16. The Committees agreed with the proposed risk scores and target positions for the refreshed People risks and recommended them for incorporation into the overarching corporate Board Assurance Framework (BAF).

People Policies
The Committees received reasonable assurance, acknowledging the pace of policy rollouts with 18 core policies successfully approved. Future plans include implementing an AI Large Language Model to help staff quickly query policies.

NHS 10 Point Plan for Improving Resident Doctors' Working Lives
Good progress was reported on transactional and administrative items, but Workplace Wellbeing required immediate action. It was highlighted that poor working environments severely damage morale, with instances of doctors sitting on bins, using broken computers, and lacking secure lockers. The Estates department committed to providing timelines for quick wins as well as long-term improvements ahead of the dedicated steering group meeting on 22 July 2026. The Committees received a limited level of assurance for Workplace Wellbeing and reasonable assurance for the other items on the plan.

5.0 Other issues considered by the Committees

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

Workforce KPI Performance Report
The group is currently 346 WTE over establishment. To counter this, the focus will be on reducing bank/agency use, leveraging natural attrition, and implementing a Mutually Agreed Resignation Scheme (MARS). Sickness absence increased to 5.17%, and ongoing organisational changes alongside the ESTH water safety issues are expected to drive further anxiety and sickness. The Committee received reasonable assurance on the controls in place, but limited assurance on outcomes.

Guardian of Safe Working (GOSW) Q4 Report

Q4 Exception reporting at ESTH doubled to 219 this quarter, which is viewed positively as a sign of an accessible system following the removal of clinical supervisor narrative requirements. The high volume of exception reports in acute and general medicine directly triangulates with safety pressures discussed at the Quality Committee.

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 18 June 2026.

Group Board

Meeting in Public on Thursday, 09 July 2026

Agenda Item	4.4
Report Title	**Infrastructure Committees Report to Group Board**
Non-Executive Lead	Claire Sunderland Hay, Associate Non-Executive Director (SGUH), Chair of IT-focused meetings. Phil Wilbraham, Associate Non-Executive Director (ESTH), Chair of Estates-focused meetings.
Report Author(s)	Claire Sunderland Hay, Associate Non-Executive Director (SGUH) Phil Wilbraham, Associate Non-Executive Director (ESTH)
Previously considered by	n/a
Purpose	**For Assurance**

Executive Summary

This report sets out the key issues considered by the Infrastructure Committees at their meetings on 22 May 2026 (Estates & Facilities and IT focus) and 19 June 2026 (IT focus). The key issues the Committees wished to highlight to the Board are:

1. **Group Chief Officer - Facilities, Infrastructure & Environment (GCOFIE) Update**
   The Committees received an update regarding the SGUH ITU project, noting a claim from the contractor Vanguard regarding practical completion delay, for which a delay assessor had been appointed. The Epsom car park purchase is complete, and positive plans are progressing to install a large photovoltaic (PV) array over the car park to maximise external NHS England funding benefits.

2. **ESTH Estates and Facilities Update (Fire and Water Safety)**
   The Committees noted recent progress on Fire Safety, with Surrey Fire and Rescue standing down 4 of 5 articles at Epsom. In relation to water safety, the Committees noted the Board's decision that despite the extensive programme of mitigation implemented in response to identified water safety risks in E Block at St Helier Hospital, such temporary measures were not sustainable in the long term and that remedial refurbishment works were necessary. It would be necessary to vacate the building during these works. Options for decanting services were being developed and would be presented to the Board for consideration. Electrical safety compliance remains strong, though aging infrastructure presents ongoing challenges.

3. **Digital Priorities and Strategy**
   The Committees reviewed the Digital Priorities for 2026/27, noting a focus on safe and secure foundations using the £23m-£25m capital allocation strictly on risk remediation. The IT team is starting a step-by-step plan to improve the Electronic Patient Record (EPR) system so that it directly helps doctors and nurses provide better care, rather than just doing routine technical updates. The Committees challenged the financial deliverability of the broader Digital Strategy, requesting a "strategy on a page" and a detailed annual plan mapping the deliverables.

gesh

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

Action required by Group Board

The Group Board is asked to:

a) Note the issues escalated by the Infrastructure Committees to the Group Board and the wider issues on which assurance was received in May and June 2026.
b) Note the Infrastructure Committees Annual Report to the Board
c) Approve the updated Terms of Reference for the Infrastructure Committee, which has been endorsed by the Committee.

Committee Assurance

Committee	Infrastructure Committees
Level of Assurance	Not Applicable

Appendices

Appendix No.	Appendix Name
Appendix 1	N/A

Implications

Group Strategic Objectives

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

Risks

The Board Assurance Framework contains two risks overseen by the Infrastructure Committee in relation to Digital Transformation and Estates Modernisation and Infrastructure.

CQC Theme

☐ Safe	☐ Effective	☐ Caring	☐ Responsive	☒ Well Led

NHS system oversight framework

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

Financial implications

Set out in the paper.

Legal and / or Regulatory implications

Set out in the paper.

Equality, diversity and inclusion implications

N/A

Environmental sustainability implications

N/A

Infrastructure Committees Report
Group Board, 09 July 2026

1.0 Purpose of paper

1.1 The report sets out the key issues considered by the Infrastructure Committees' meetings on 22 May 2026 and 19 June 2026 and includes matters the Committees specifically wish to bring to the attention of the Group Board.

2.0 Items considered by the Committees

2.1 At its meetings on 22 May 2026 and 19 June 2026, the Committees considered the following items of business:

22 May 2026 (Both Estates & IT focus)	19 June 2026 (IT focus)
• Group Chief Officer - Facilities, Infrastructure & Environment Update • Epsom St Helier Estate and Facilities Update • PAM (Premises Assurance Model) Report • Digital Priorities for 2026/27 • Digital Risks • Infrastructure Committee digital items forward look • Infrastructure Committees Annual Review 2025/26	• Digital Strategy • Forward Plan Update (Digital and Estates) • Board Assurance Framework (BAF) Update.

2.2 The Committees were quorate on 22 May 2026 but not on 19 June 2026. Any decisions made during inquorate meetings are ratified by email or at the next quorate meeting.

3.0 Key issues for escalation to the Group Board

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

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

The Committees received and discussed a written update from the Group Chief Officer Facilities, Infrastructure and Environment (GCOFIE) on the key developments that took place between two meetings, including:

- SGUH ITU Project: The contractor Vanguard has submitted a claim regarding practical completion delay. The Trust has appointed a delay assessor to defend against potential litigation, but patient treatment in the new building remains scheduled for autumn 2026.
- Epsom Car Park: The purchase is now complete. Plans are advancing to install a large photovoltaic (PV) array over the car park to generate electricity, leveraging a new NHS England funding scheme.

3.2 ESTH Fire and Water Safety Updates

The Committees noted recent progress on fire safety. Surrey Fire and Rescue has stood down 4 of 5 articles at Epsom, with remaining articles expected to reduce to a notice of deficiency by September 2026.

In relation to water safety, the Committees noted the Board's decision that despite the extensive programme of mitigation implemented in response to identified water safety risks in E Block at St Helier Hospital, such temporary measures were not sustainable in the long term and that remedial refurbishment works were necessary. It would be necessary to vacate the building during these works. The Committees requested an action for the team to return in six weeks with a high-level feasibility update on the three decant options (full onsite, partial onsite and dispersal across SW London).

3.3 Digital Strategy and Priorities 2026/27

The Committees reviewed the Digital Priorities for the year, supporting the allocation of available capital (£23m-£25m) focused heavily on remediating foundational risks (e.g., network hardware, Wi-Fi coverage). The Committees challenged the financial deliverability of the broader Digital Strategy, seeking clarity on translating the high-level strategy into tangible deliverables without over-relying on speculative national funding. A "strategy on a page" summary and a detailed annual financial map were requested.

3.4 Board Assurance Framework (BAF) Update

During the 19 June 2026 meeting, the Committees reviewed the two new strategic risks on the refreshed Group Board Assurance Framework. The Committee endorsed the proposed risk scores and assurance ratings for Strategic Risk 4 (Digital Transformation) and Strategic Risk 5 (Estates Modernisation and Infrastructure). The Committees discussed how best to frame the target risk score for SR5 given the current condition of the estate particularly at St Helier Hospital. The Committee agreed that it would be unrealistic to expect the risk score to reduce from 20 (5c x 4l) by March 2028, but it was reasonable to expect the level of assurance to improve over this time period.

4.0 Key Issues on which the Committees received assurance

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

4.2 PAM (Premises Assurance Model) Report

The Committees received the PAM report and noted a positive shift in overall compliance, with steady progress significantly reducing 'red' areas. The Committees noted the shift in culture away from annual pushes toward continuous, regular quarterly compliance updates utilising the PAM tool, providing crucial evidence for CQC Well-Led inspections.

4.3 Digital Risks Update

The Committees noted the update on IT-related extreme risks on the Corporate Risk Registers of the two Trusts. The following three extreme Digital Infrastructure risks remained requiring executive oversight: Data centre failure, Core network infrastructure failure, and Cyber security attack. The members noted that, while progress was being made to reduce exposure where possible, the current ratings reflected the scale and complexity of the underlying issues, the interdependencies between infrastructure components, and the time required to deliver sustainable improvement. The Committees received assurance that these risks were directly

mitigated by the new Digital Priorities capital plan and aligned with the Audit and Risk Committee's annual assessment.

4.4 **ESTH Electrical Safety**

The Committees reviewed the electrical infrastructure condition at St Helier Hospital. Assurance was provided that the current group risk rating of 12 was justified, as recent generator test failures occurred safely during structured tests rather than actual power cuts. Substation replacement is planned over the next two years with identified funding.

5.0 Other issues considered by the Committees

5.1 **Combined Forward Plan**

The Committees noted the digital forward look and requested that an integrated forward plan be developed through engagement with Executive and Site colleagues to cover the full financial year through to March 2027. The updated plan will combine both estates and digital elements to ensure all terms of reference are met, including responsibilities related to cybersecurity and information governance recently transferred from the Audit and Risk Committees.

5.2 **Committee Governance**

The Committees approved the Annual Report 2025/26, with some minor amendments to attendance records. The Committee also reviewed and endorsed an updated Terms of Reference. The updated Terms of Reference strengthen the Committee's strategic role, provide greater balance between estates and digital oversight, and clarify the Committee's responsibilities in relation to infrastructure resilience, cybersecurity and major infrastructure projects.

6.0 Recommendations

6.1 The Group Board is asked to:

a) Note the issues escalated by the Infrastructure Committees to the Group Board and the wider issues on which assurance was received in May and June 2026.
b) Note the Infrastructure Committees Annual Report to the Board
c) Approve the updated Terms of Reference for the Infrastructure Committee, which has been endorsed by the Committee.

Infrastructure Committees-in-Common

Annual Report 2025/26

1 April 2025 – 31 March 2026

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Infrastructure Committees-in-Common 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.

This report sets out a high level overview of the work of the Infrastructure Committees-in-Common in 2025/26. 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 Infrastructure 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.

2.1 Purpose

The purpose of the Committee, as set out in the terms of reference in place during 2025/26, is to provide assurance to the Board on the safe and effective operation of the Trust's estates, facilities, information, digital and technology infrastructure, systems, processes and controls including:

- Overseeing and providing assurance to the Board on the implementation of the Group Strategy in relation to facilities, infrastructure and environment, specifically the Group strategic objectives of environmental sustainability and buildings that fit for 21st century healthcare.
- delivering on the commitments in the Group strategy in respect of estates, facilities and information technology.
- maintaining the safety of the Trust's estates and facilities for patients, visitors and staff.
- overseeing action to deliver against the Trust's commitments in relation to environmental sustainability.

2.2 Duties

The duties of the Committee are set out in the terms of reference at appendix 2. This also includes the proposed revisions for 2026/27.

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 Infrastructure Committees-in-Common:

St George's Infrastructure Committee			
Name	**Role**	**Designation**	**Period**
Ann Beasley	Member	Committee Chair, Non-Executive Director	1 April 2025 – 12 October 2026
Claire Sunderland Hay	Member	Committee Chair (from 13 Oct 2026), Associate Non-Executive Director	1 April 2025 – 31 March 2026
Andrew Murray	Member	Non-Executive Director	1 April 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
Andrew Grimshaw	Member	Group Chief Finance Officer	1 April 2025 – 30 November 2025
Lizzie Alabaster	Attendee	Interim Group Chief Finance Officer	1 December 2025 – 31 March 2026
Mark Bagnall	Member	Group Chief Infrastructure, Facilities and Environment Officer	1 April 2025 – 31 March 2026
Michael Pantlin	Member	Group Deputy Chief Executive Officer	10 December 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	15 September 2025 – 31 March 2026
Kate Slemeck	Member	Managing Director – St George's	1 April 2025 – 31 March 2026
Stephen Jones	Attendee	Group Chief Corporate Affairs Officer	1 April 2025 – 31 March 2026
Ralph Michell	Attendee	Group Chief Transformation Officer	1 April 2025 – 31 March 2026

Epsom & St Helier Infrastructure Committee			
Name	**Role**	**Designation**	**Period**
Ann Beasley	Member	Committee Chair, Non-Executive Director	1 April 2025 – 12 October 2026
Phil Wilbraham	Member	Committee Chair (from 13 Oct 2026), Associate Non-Executive Director	1 April 2025 – 31 March 2026
Andrew Murray	Member	Non-Executive Director	1 April 2025 – 31 March 2026
Peter Kane	Member	Non-Executive Director	1 April 2025 – 31 March 2026
Bidesh Sarkar	Member	Non-Executive Director	1 October 2025 – 31 March 2026
Leonie Penna	Member	Associate Non-Executive Director	1 October 2025 – 31 March 2026
James Blythe	Member	Managing Director – Epsom & St Helier	1 April 2025 – 20 September 2026
Alex Shaw	Member	Interim Managing Director – Epsom & St Helier	21 September 2025 – 31 March 2026
Mark Bagnall	Member	Group Chief Officer, Facilities, Infrastructure and Environment	1 April 2025 – 31 March 2026
Andrew Grimshaw	Member	Group Chief Finance Officer	1 April 2025 – 30 November 2025
Lizzie Alabaster	Attendee	Interim Group Chief Finance Officer	1 December 2025 – 31 March 2026
Michael Pantlin	Member	Group Deputy Chief Executive Officer	10 December 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
Stephen Jones	Attendee	Group Chief Corporate Affairs Officer	1 April 2025 – 31 March 2026
Ralph Michell	Attendee	Group Chief Transformation Officer	1 April 2025 – 31 March 2026

Members of the St George's University Hospitals NHS Foundation Trust Council of Governors also attended to observe meetings of the Infrastructure Committees-in-Common during the period.

3.2 Committee meeting attendance

Under the Committees-in-Common arrangements, the Infrastructure Committee of each Trust was required to be quorate. The quorum for each Infrastructure Committee was a minimum of four Committee members, including two Non-Executive Directors and two Executive Directors. The Committee recognised the importance of consistent Executive attendance and this has been reflected in the Committee effectiveness review and forward planning for 2026/27.

The Committee held a total of 12 meetings, of which 6 were estate focused and 6 were I.T focused. The attendance of members and regular attendees as defined in the Terms of Reference are set out below.

Attendance			
Name	Role	Trust	Attendance
Ann Beasley	Committee Chair	Both	6/6
Phil Wilbraham	Member	ESTH	12/12
Claire Sunderland Hay	Member	SGUH	10/12
Peter Kane	Member	Both	6/6
Andrew Murray	Member	Both	9/12
Leonie Penna	Member	Both	4/6
James Blythe	Member	Both	3/5
Alex Shaw	Member	Both	4/7
Andrew Grimshaw	Member	Both	5/8
Lizzie Alabaster	Member	Both	1/4
Michael Pantlin	Member	Both	3/4
Kate Slemeck	Member	SGUH	2/12
Arlene Wellman	Member	Both	2/5
Elaine Clancy	Member	Both	2/7
Mark Bagnall	Member	Both	8/12
Stephen Jones	Attendee	Both	11/12
Ralph Michell	Attendee	Both	6/12

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

SGUH Governors observing		
Name	Role	Attendance
Chelliah Lohendran	Public Governor, Merton	6
Luisa Brown	Public Governor, Merton	1
John Hallmark	Public Governor, Wandsworth	3
Alfredo Benedicto	Appointed Governor, Healthwatch Merton	3
Augustine Odiadi	Public Governor, Wandsworth	2
Jackie Parker	Public Governor, Wandsworth	1

4. Committee activity and focus

During 2025/26, the Infrastructure Committees supported the Group Board in its oversight of the Group's estates, facilities, digital infrastructure and wider infrastructure transformation agenda across both Trusts. The Committees operated through alternating meetings focused on Estates & Facilities and Information Technology, enabling more detailed scrutiny of the broad range of operational, strategic and regulatory issues within the Committee's remit.

The Committee's work during the year reflected the increasing importance of infrastructure as a critical enabler of safe, sustainable and effective healthcare delivery. This included oversight not only of the physical estate and digital environment, but also of the systems, governance arrangements and capital investment programmes required to support the Group's wider strategic objectives and operational resilience.

A major theme throughout the year was the balance between:

- managing immediate operational and safety risks associated with ageing infrastructure and legacy systems; and
- supporting longer-term transformation and modernisation across estates, facilities and digital services.

The Committee therefore maintained oversight of a wide range of issues including:

- estate safety and compliance
- fire and water safety risks
- backlog maintenance and capital planning
- major infrastructure and redevelopment schemes
- digital transformation and cyber resilience
- Electronic Patient Record (EPR) implementation and stabilisation
- development of a Group-wide digital operating model and digital strategy
- sustainability and delivery of the Green Plan

The Committee also played an important role in overseeing the integration of infrastructure, facilities and digital services across the Group, supporting the move towards more aligned planning and operational delivery arrangements between the two Trusts.

Throughout the year, the Committee sought assurance that appropriate controls, governance arrangements and mitigation plans were in place in relation to significant infrastructure risks. This included scrutiny of both strategic risks on the Board Assurance Framework and operational risks arising from the condition and resilience of the estate, delivery of major programmes, and increasing dependency on digital infrastructure.

A recurring feature of the Committee's discussions was recognition that many of the risks within its remit were long-term and systemic in nature, requiring sustained investment, organisational focus and robust programme governance. The Committee therefore placed particular emphasis on:

- the pace and sustainability of risk mitigation activity
- the realism and deliverability of capital and digital plans
- alignment between infrastructure priorities and wider organisational strategy
- the resilience of operational arrangements during periods of significant transformation and change

The Committee's work over the year reflected a position in which substantial progress was being made in strengthening infrastructure governance, integration and strategic planning, while also recognising the scale of the challenges associated with ageing estate infrastructure, cyber risk, financial constraints and delivery of major transformation programmes.

4.1 Estates, Facilities and Capital Programme

The Committee maintained regular oversight of estates and facilities risks across both Trusts, including backlog maintenance, fire safety, water safety, operational resilience and delivery of the capital programme. Regular updates were received from the Group Chief Officer – Facilities, Infrastructure and Environment (GCOFIE), including progress on major projects, infrastructure risks and integration of the facilities and estates functions across the Group .

Throughout the year, the Committee reviewed a number of major capital developments, including:

- the Epsom multi-storey car park project
- the SGUH ITU development
- the St Helier emergency department refurbishment programme
- estate safety funding bids and wider capital planning

The Committee sought assurance that appropriate governance arrangements, risk management processes and programme oversight were in place for these schemes. In later meetings, members highlighted the increasing scale and complexity of the capital programme and requested more consolidated reporting on major projects, including clearer oversight of interdependencies, operational impacts and strategic risks.

The Committee welcomed progress in strengthening infrastructure governance and integration across the Group, including development of more aligned facilities and infrastructure arrangements and increased focus on strategic estate planning. However, members also recognised that delivery remained heavily dependent on access to external capital funding and that the age and condition of parts of the estate continued to create significant operational risk. This included recognition of the direct impact that estate resilience and infrastructure reliability can have on patient safety, operational continuity and staff experience.

4.2 Fire Safety and Water Safety

A significant and recurring area of focus during the year was fire and water safety, particularly at ESTH. The Committee received regular updates on:

- London Fire Brigade and Surrey Fire and Rescue Service enforcement notices at Epsom and St Helier
- Fire safety compliance programmes
- Water safety concerns within clinical areas, particularly in relation to E-Block at St Helier Hospital
- Wider estate safety risks

The Committee expressed concern regarding the pace and scale of work required to address these issues, particularly where risks related to ageing infrastructure and longstanding maintenance challenges. Particular scrutiny was given to:

- the Frank Deas ward fire safety actions
- the Epsom Hospital enforcement notices
- Water safety concerns at St Helier maternity services

The Committee reviewed the findings of an external expert report relating to water safety, including concerns regarding pipework, control measures and broader infrastructure resilience within E-Block at St Helier Hospital. Members emphasised the importance of ensuring that medium- and long-term solutions were developed, rather than relying solely on interim mitigations and operational workarounds.

In relation to fire safety, the Committee was only able to take limited assurance in some areas, reflecting the presence of active enforcement notices and the scale of remedial work still required albeit noting that good progress was being made in addressing the issues identified.

4.3 Digital Transformation and Digital Strategy

The Committee maintained oversight of the Group's digital transformation agenda throughout the year, including the development of the Group Digital Strategy and the establishment of a more integrated Group-wide digital operating model.

The Committee reviewed:

- the development of the Group-wide Digital Strategy
- digital governance arrangements
- development of a single Group digital team
- digital operating model redesign
- alignment with the NHS 10-Year Plan and wider South West London digital developments

Members supported the move towards a more integrated Group-wide digital structure and recognised the importance of creating common processes, governance arrangements and digital infrastructure across both Trusts.

The Committee also considered how digital transformation should balance innovation with operational resilience. Discussions highlighted both opportunities relating to AI, automation and digital transformation and concerns regarding basic IT functionality, ageing infrastructure and operational reliability. The Committee therefore sought assurance not only on future strategy and innovation, but also on the robustness of core digital systems required to support safe operational delivery

4.4 Electronic Patient Record (EPR) Programme

The Shared Electronic Patient Record (EPR) Programme remained a major area of Committee focus throughout the year. The Committee closely monitored progress towards the EPR go-live in May 2025, including review of:

- readiness assessments
- programme governance
- stabilisation arrangements
- transition into business-as-usual support

The successful go-live was recognised as a significant organisational achievement, with positive feedback received from Oracle and high levels of data migration success reported.

Following implementation, the Committee maintained oversight of:

- stabilisation activity
- issue resolution
- transition of responsibilities into operational IT teams
- benefits realisation

Members consistently emphasised the importance of ensuring that the expected operational and clinical benefits of the EPR programme were fully realised over time and that sufficient support arrangements remained in place as the programme transitioned into routine operational management

4.5 Cybersecurity and Digital Resilience

Cybersecurity became an increasingly prominent area of Committee focus during 2025/26. The Committee reviewed a range of issues relating to cyber resilience, including:

- cybersecurity strategy development
- Windows 11 migration risks
- NHS.net migration
- supply chain vulnerabilities
- scenario-based resilience testing
- Data Security and Protection Toolkit (DSPT) compliance

The Committee consistently recognised cybersecurity as a critical organisational risk and emphasised that investment in digital resilience was essential to maintaining safe operational delivery and protecting patient services.

While members welcomed progress in developing a more strategic approach to cybersecurity, including plans for a single Group cyber function and wider infrastructure modernisation, they also noted ongoing risks associated with legacy infrastructure, delayed digital programmes and the scale of transformation required.

The Committee therefore continued to seek further assurance regarding:

- pace of delivery
- organisational resilience
- long-term sustainability of digital infrastructure improvements

4.6 Governance, Risk and Board Assurance

The Committee also maintained oversight of infrastructure-related risks within the Board Assurance Framework (BAF), particularly:

- SR5 – Modernising our Estates
- SR6 – Adopting Digital Technology

The Committee reviewed assurance ratings, risk scores and mitigating actions throughout the year and supported continued development of infrastructure risk reporting and governance arrangements.

In addition, the Committee approved and recommended a number of strategic governance documents during the year, including:

- the refreshed Green Plan
- updates to the Committee's Terms of Reference
- proposals relating to the transfer of primary cybersecurity and information governance oversight to the Infrastructure Committee

The Committee also reflected on its own effectiveness and sought to strengthen ongoing oversight through continuous improvement in reporting, discussion quality and strategic focus.

4.7 Overall position on assurance

Overall, the Committee was able to take assurance that significant programmes of improvement and transformation were underway, governance arrangements were becoming more mature and integrated, and there was increasing strategic alignment across estates, facilities and digital services. However, assurance remained mixed across the portfolio.

The Committee continued to seek further assurance in relation to:

- fire safety and water safety risks

- backlog maintenance and estate resilience
- delivery timescales for major capital projects
- cyber resilience and digital infrastructure sustainability
- the pace and consistency of implementation of improvement programmes

The Committee's work throughout 2025/26 reflected the scale and complexity of the infrastructure challenges facing the Group, while also recognising the significant progress being made towards a more integrated, strategic and resilient infrastructure model across both Trusts.

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, respondents assessed the Committee as operating reasonably effectively, with the majority of respondents rating the Committee as very effective, although a smaller number rated it as somewhat or partially effective.

The review highlighted the extent to which the establishment of a dedicated Infrastructure Committee had strengthened Board-level oversight of estates, facilities and digital issues, particularly given the scale and complexity of the infrastructure challenges facing the Group. Respondents also recognised the increasing maturity of the Committee's discussions and its role in improving organisational understanding of key infrastructure risks.

Areas of strength and good practice identified included:

- The creation of a dedicated Committee providing focused Board-level oversight of estates, facilities and digital infrastructure issues
- Improved Board visibility and understanding of key infrastructure risks, including estates safety and digital resilience
- High quality and constructive discussions, enabling detailed consideration of complex infrastructure issues
- Effective challenge and transparency within Committee discussions
- The Committee's role in supporting estates, facilities and digital teams in managing complex operational and strategic issues
- Oversight of a broad range of infrastructure functions and specialist areas
- The value of dedicated time for detailed review of specialist reports, deep dives and site-specific issues

The review also identified a number of opportunities to further strengthen the Committee's effectiveness, particularly in relation to the maturity and integration of infrastructure governance across estates and digital services.

Areas identified for further development included:

- Developing a more integrated approach to infrastructure assurance across estates, facilities and digital services
- Improving the quality, consistency and timeliness of papers presented to the Committee
- Strengthening the quality and strategic focus of digital reporting and discussion
- Refreshing agendas and the forward plan to ensure that the Committee's time is focused on the areas of greatest assurance value

- Reviewing whether the current alternating structure of estates-focused and digital-focused meetings remains the most effective model
- Ensuring that significant infrastructure risks are escalated more proactively for whole Board discussion where appropriate
- Supporting development of a longer-term estates strategy
- Increasing opportunities for Committee members to undertake site visits to strengthen understanding of infrastructure challenges directly
- Reviewing Executive attendance and engagement to ensure the Committee benefits from the most appropriate operational and strategic input

These findings will inform the Committee's work programme for 2026/27, including updates to the Terms of Reference, forward plan and reporting approach. In particular, the Committee intends to strengthen its focus on strategic infrastructure assurance, improve the quality and integration of reporting, and ensure that the Committee continues to evolve in line with the increasing importance of estates and digital infrastructure to the delivery of safe and sustainable healthcare services.

6. Committee Forward Plan and Terms of Reference

The Committee's Terms of Reference has been reviewed to draw on the themes from the Committee effectiveness review and to ensure they remain aligned with the Committee's evolving role and wider organisational developments in estates, infrastructure and digital transformation.

The revised Terms of Reference strengthen the Committee's strategic focus, particularly in relation to:

- oversight of major infrastructure and capital programmes
- development of the Group Estates Strategy and Group Digital Strategy
- cyber resilience and digital transformation
- infrastructure resilience and estate safety risks
- integration of estates, facilities and digital planning across the Group

The revisions also introduced greater flexibility regarding the structure and format of Committee meetings, enabling the forward plan to determine the most appropriate balance between integrated agendas, themed discussions and deep dives.

Overall, the changes are intended to ensure that the Terms of Reference reflect the Committee's work in practice and support its role in providing robust assurance to the Board on significant infrastructure, digital and estate-related risks and transformation programmes.

7. Conclusion

During 2025/26, the Infrastructure Committees continued to develop their role in providing Board-level oversight of estates, facilities, digital infrastructure and major infrastructure transformation programmes across the Group.

The Committees' work reflected the increasing strategic importance of infrastructure resilience, estate safety and digital capability to the delivery of safe, sustainable and effective healthcare services. Throughout the year, the Committees maintained oversight of a broad range of operational and strategic risks, including fire and water safety, backlog maintenance, capital programme delivery, digital transformation and cybersecurity.

The Committees were able to take assurance that significant programmes of improvement and transformation were underway and that governance arrangements across estates, facilities and digital services were continuing to mature. At the same time, the Committees recognised that a number of infrastructure risks remain significant and long term in nature, requiring sustained organisational focus, investment and robust programme governance.

The Committee effectiveness review demonstrated that the Committees are operating effectively and continuing to mature. The proposed updates to the Terms of Reference and development of the forward plan for 2026/27 are intended to support the continued evolution of the Committees, strengthen strategic oversight and ensure robust assurance to the Board on significant infrastructure, digital and estate-related risks and transformation programmes.

Infrastructure Committee

Terms of Reference

1. Name

The Committee shall be known as the “Infrastructure 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 safe and effective operation of the Trust’s estates, facilities, information, digital and technology infrastructure, systems, processes and controls by seeking assurance in relation to:

- ensuring that the Group’s infrastructure supports the delivery of safe, sustainable and resilient healthcare services for patients and local communities.
- delivering on the commitments in the Group strategy in respect of estates, facilities, digital transformation and information technology.
- supporting the development and delivery of a Group Estates Strategy and Group Digital Strategy.
- maintaining the safety of the Trust’s estates, facilities, digital systems and infrastructure for patients, visitors and staff.
- overseeing action to deliver against the Trust’s commitments in relation to environmental sustainability.
- maintaining the highest standards of health and safety and ensuring the Trust is compliant with all relevant statutory and regulatory requirements.
- ensuring the Trust has secure, resilient and effective digital infrastructure, cybersecurity, systems and information governance arrangements to support safe clinical and operational delivery.
- ensuring appropriate governance arrangements are in place in relation to infrastructure and that the Committee is able to provide the Trust Board with assurance on these matters as appropriate.

- providing assurance to the Board on the governance, delivery and risk management of major infrastructure and capital programmes.

4. Duties

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

4.1 Estates and Facilities

- Oversee and provide assurance to the Board on the implementation of the Group Strategy in relation to estates and facilities, specifically the Group strategic objective of 'affordable services fit for the future', and associated strategic initiatives and corporate enablers:
  - Buildings fit for twenty-first century healthcare
  - Environmental sustainability
- Oversee the development and implementation of a Group-wide estates strategy aligned to the Group Strategy, Medium-Term Plan, capital planning assumptions and system-wide priorities.
- Seek assurance in relation to the safe, resilient and effective operation and performance of the Trust's estates and facilities, including risks relating to fire safety, water safety, electrical safety, backlog maintenance, infrastructure resilience, operational continuity and security management.
- Review the Trust's Premises Assurance Model to ensure it provides an accurate and comprehensive assessment of the safety and effectiveness of the Trust's estates and facilities.
- Undertake a programme of proactive deep dives in agreed areas within the Premises Assurance Model to ensure the assurances provided are appropriately robust and undertake further deep dives on areas where the Committee feels the need for further assurance.
- Oversee and seek assurance in relation to land and property appraisal by reviewing the outcomes of six-facet surveys and any associated action plans.
- Review and seek assurance in relation to the prioritisation, governance and delivery of the estates and infrastructure capital programme, recognising the ongoing role of the Finance & Performance Committee in approving individual business cases and overall financial oversight.
- Oversee governance arrangements for major capital and infrastructure programmes and seek assurance that operational, financial and patient safety risks are appropriately identified and managed.
- Review and seek assurance in relation to the coordination of estates maintenance with emerging capital projects and the Epsom and St Helier Building Your Future Hospitals Programme.
- Review the Trust's Green Plan and actions to deliver against agreed actions and priorities in relation to environmental sustainability.
- Review and seek assurance in relation to the Trust's arrangements for the safe, effective and efficient provision of non-emergency patient transport.
- Review risks on the Corporate Risk Register and Group Board Assurance Framework in relation to estates and facilities and seek assurance that these are being appropriately managed.

4.2 Health and Safety

- Seek assurance that the Trust has robust arrangements for compliance with statutory and regulatory requirements relating to estates, facilities and infrastructure safety.
- Seek assurance that the Trust has in place the systems, processes and controls necessary to ensure compliance with the Health and Safety at Work Act 1974 and all other relevant health and safety legislation and regulations, including – but not limited to – fire safety, via regular reports from the lead for health and safety,
- Review the outcome of inspections by the Health and Safety Executive and scrutinise any associated action plans developed by the Trust.
- Oversee and seek assurance in relation to the Trust's performance in relation to the NHS Violence Prevention and Reduction Standard, coordinating oversight with the work of the People Committee where appropriate.
- Review risks in relation to health and safety and seek assurance that these are being appropriately managed.

4.3 Digital, information technology, and cybersecurity

- Oversee and provide assurance to the Board on the implementation of the Group Strategy in relation to information technology, specifically the Group strategic objective of 'affordable services fit for the future', and associated strategic initiatives and corporate enablers, specifically the development and delivery of a Group Digital Strategy, digital transformation priorities, cyber resilience and major digital programmes, including the embedding of the electronic patient record.
- Oversee the development of Group-wide relevant strategies in relation to information technology that support the new Group Strategy and monitor progress in the implementation of these, in the context of the local Integrated Care System(s) and financial and operational plans.
- Oversee and seek assurance in relation to cybersecurity, cyber resilience and digital business continuity arrangements.
- Seek assurance in relation to the safe, secure and effective operation and performance of the Trust's information technology infrastructure, systems and processes through review of internal processes and controls as well as mandated reviews such as the Digital Security and Protection Toolkit.
- Receive assurance on the effectiveness of the Trust's information management, digital reporting and data quality arrangements, ensuring systems are appropriate, resilient and fit for purpose.
- Seek assurance regarding the development of the Group digital operating model and the alignment of digital services across the Group and South West London where appropriate.
- Undertake a programme of risk-based, proactive deep dives in relation to information technology, and undertake further deep dives on areas where the Committee feels the need for further assurance.
- Review risks on the Corporate Risk Register and Group Board Assurance Framework in relation to information technology and seek assurance that these are being appropriately managed.

4.4 General

- Referring any matter to any other Board Committee and respond to items referred to the Committee from other Board Committees.

- Identify significant infrastructure risks or issues requiring escalation to the Board for wider strategic discussion or assurance.
- Seek assurance that estates, facilities and digital strategies are appropriately aligned and integrated.
- 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.
- 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, 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 Officer, Facilities, Infrastructure and Environment is the executive lead for the Committee.

Membership of the Committee comprises:

- Minimum three Non-Executive Directors (including the Chair)
- Group Chief Officer, Facilities, Infrastructure and Environment
- Group Deputy Chief Executive Officer
- Group Chief Nursing Officer and Director of Infection Prevention and Control
- Managing Director(s)

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

- Site Director of Estates and Facilities
- Group Head of Health and Safety and Non-Clinical Risk
- Group Chief Finance Officer
- Group Chief Transformation Officer
- Group Chief Digital Information Officer
- Group Chief Corporate Affairs 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 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 Infrastructure 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 Infrastructure Committee, acting as part of a Group-wide Infrastructure 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
- Areas where the Committee was assured, where further assurance was requested, and where assurance remained limited
- Progress in delivery of strategic infrastructure priorities and major infrastructure transformation programmes

8. Meeting Format and Frequency

The Committee will meet monthly, with the structure and focus of meetings determined through the Committee's forward plan. Meetings may include integrated agendas, themed discussions or deep dive sessions on estates, facilities, digital or infrastructure risk areas as appropriate. 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 Infrastructure 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	Infrastructure Committee Terms of Reference
Version	1.3
Executive Sponsor	Group Chief Officer Facilities, Infrastructure and Environment Officer; Group Deputy Chief Executive Officer
Author	Group Chief Corporate Affairs Officer
Approval	
Date of Committee approval	22 May 2026
Date of Board approval	9 July 2026
Date for next review	July 2027

Group Board

Meeting in Public on Thursday, 09 July 2026

Agenda Item	5.1	
Report Title	**Group Strategy Update**	
Executive Lead(s)	Michael Pantlin, Group Deputy Chief Executive Officer	
Report Author(s)	Zahra Abbas, Group Strategy & Planning Manager	
Previously considered by	Group Executive	30 June 2026
Purpose	**For Noting**	

Executive Summary

Our CARE strategy, agreed in 2023, sets out our vision for Outstanding Care, Together. It explains how we will deliver this vision through three key areas:

- **Local improvements**: delivered through an annual set of priorities aligned to our CARE objectives.
- **Corporate enablers**: corporate teams working with clinical services to develop and implement supporting strategies.
- **Transformation:** board-backed, change programmes

In May 2025, at the midpoint of the strategy, we carried out a stocktake to review progress. There was agreement that our vision and the CARE framework remain fit for purpose. However, like NHS organisations across the country, we are operating in an increasingly challenging financial environment, with rising demand for services and significant pressure on resources. With a financial challenge of approximately £160 million in 2026/27 for the Group, with an efficiency requirement of 7.5%, achieving our ambitions required change.

In response, we have developed a medium-term transformation portfolio that builds on work already underway and aligns with the ambitions of the NHS 10-Year Plan. The portfolio focuses on shifting care closer to home, improving workforce productivity through digital transformation, developing centres of excellence across key clinical services, and creating a high-performing integrated organisation capable of delivering the benefits of scale and collaboration. These programmes are designed to improve care, quality and patient outcomes, while making an important contribution to the wider actions required to address the Group's financial challenge and deliver our medium-term plan.

This report provides an update on progress so far and outlines the next steps across these delivery areas. Detailed reporting on financial performance and progress against the Medium-Term Plan is provided to the Board separately and is therefore not included within this six-monthly update.

Action required by Group Executive Committee

The Board is asked to:

- Note progress in the implementation of the Group Strategy

Committee Assurance	
Committee	Group Board (Public)
Level of Assurance	Not Applicable

Appendices	
Appendix No.	**Appendix Name**
Appendix 1	Group Strategy Update

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

As set out in the paper

Legal and / or Regulatory implications

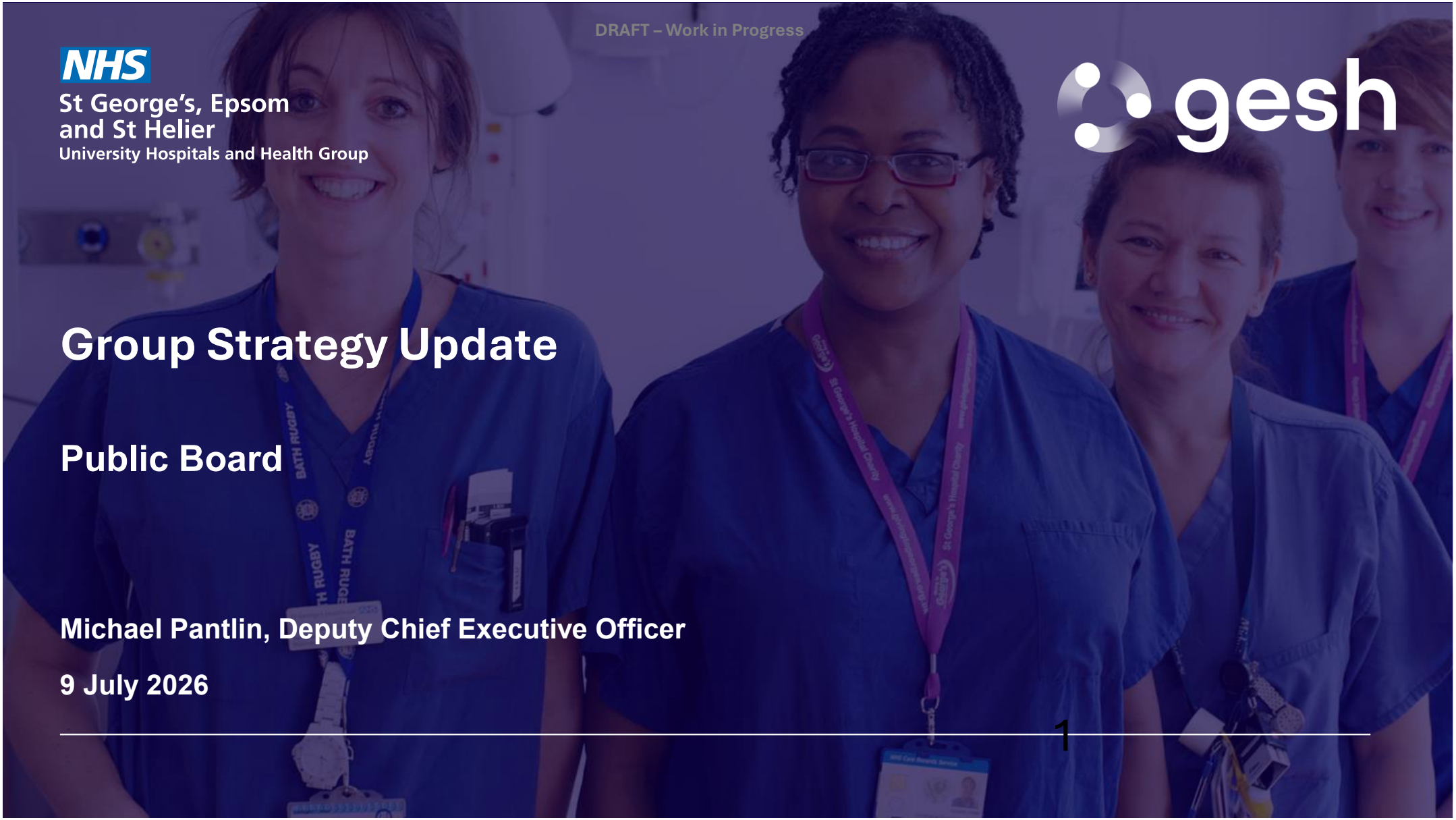
As set out in the paper

Equality, diversity and inclusion implications

As set out in the paper

Environmental sustainability implications

As set out in the paper


DRAFT – Work in Progress
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Group Strategy Update
Public Board
Michael Pantlin, Deputy Chief Executive Officer
9 July 2026
1

Executive Summary

This paper provides an update to the Board on the delivery of our Group CARE strategy.

Our CARE strategy, agreed in 2023, sets out our vision for **Outstanding Care, Together**.

It explains how we will deliver this vision through three key areas:

- **Local improvements**: delivered through an annual set of priorities aligned to our CARE objectives.
- **Corporate enablers**: corporate teams working with clinical services to develop and implement supporting strategies.
- **Transformation:** board-backed, change programmes

In May 2025, at the midpoint of the strategy, we carried out a stocktake to review progress. There was agreement that our vision and the CARE framework remain fit for purpose. However, like NHS organisations across the country, we are operating in an increasingly challenging financial environment, with rising demand for services and significant pressure on resources. With a financial challenge of approximately £160 million in 2026/27 for the Group, with an efficiency requirement of 7.5%, achieving our ambitions required change.

In response, we have developed a medium-term transformation portfolio that builds on work already underway and aligns with the ambitions of the NHS 10-Year Plan. The portfolio focuses on shifting care closer to home, improving workforce productivity through digital transformation, developing centres of excellence across key clinical services, and creating a high-performing integrated organisation capable of delivering the benefits of scale and collaboration. These programmes are designed to improve care, quality and patient outcomes, while making an important contribution to the wider actions required to address the Group's financial challenge and deliver our medium-term plan.

This report provides an update on progress so far and outlines the next steps across these delivery areas.

The Board is asked to:

- Note progress in the implementation of the Group Strategy.

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Our vision



How do we achieve our vision?

1. Local improvement

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

2. Corporate enablers

Action led by corporate teams against organisation-wide strategies.

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

3. Transformation

Board-backed, ambitious change programmes.

Hospital to community shift	Transforming our productivity	Centres of excellence	Our ways of working
Transforming Non-Elective Care	Clinical Workforce Transformation	Renal	Quality Management System
Transforming outpatients, and building new models of care	Corporate Services Transformation	Children's, Maternity and Neonates	Route to IHO / Merger
	Clinical Ops / Admin & Clerical Workforce	Surgery	
		Clinical Support Services	
		Medical Specialties Across ESTH	

Local improvement update

Local improvement is driven locally and part of our wider Quality Management Systems Programme (in the new Transformation portfolio's focus on *'Our Ways of Working'*).

In January, we agreed our *Board to Ward* priorities for 2026. These are designed as a balanced set of priorities that all teams can contribute to - whether on wards, in corporate functions, or within clinical support services. The priorities are:

- **C** – Work with other teams to reduce delays in patient journeys
- **A** – Live within our means by innovating, improving efficiency, and reducing costs
- **R** – Keep our patients safe, including those waiting for care
- **E** – Make our organisation a great and inclusive place to work

The QMS programme supports the consistent rollout of these priorities across the organisation.

As part of this, the *High Performing Wards* initiative continues to gain momentum. We are working closely with our initial launch wards at St George's, and the programme has now expanded into ESTH. St Helier Emergency Department (ED) is the first area there to go live with High Performing Wards improvement huddles.

We are reviewing the first phase of delivery to capture learning and continuously improve how we engage staff as the programme develops.

Building on the success of previous years, nominations for the CARE Awards 2026 are now open. The awards are an important way of embedding our CARE framework across the organisation, with all categories aligned to our strategic priorities. They continue to be a popular initiative that celebrates staff contributions and reinforces the behaviours and culture we want to see across our teams. The CARE Awards Ceremony is scheduled for 23 September 2026 at Kia Oval.

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Corporate enablers update

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The Board agreed that six corporate strategies should be developed.

#	Strategy	Update
1	People	Approved by Board in May 2024. The gesh People Strategy is due to run until the end of December 2026. There is a delivery plan that backs implementation. Updates have been made to the governance arrangements to strengthen both oversight and delivery, including the establishment of a Delivery Group to enable accountability and collaboration across the team. Progress has been made across the four pillars, including joint People policies, the South West London Occupational Health Service, the launch of the refreshed gesh Leadership and Management Programme and a series of ED&I initiatives. In addition to this, a performance dashboard has been developed to support the monitoring of progress.
2	Quality & Safety	Approved by Board in July 2024. Implementation is monitored through the Group's Quality governance arrangements. Over the past year, the Group has strengthened quality governance through a more consistent governance framework and enhanced reporting across both Trusts. Patient safety and organisational learning have been improved through the implementation of PSIRF and LFPSE, supporting a more proactive approach to risk and incident management. Quality intelligence has been brought together into a single reporting framework, enabling better oversight and decision-making. Building on progress made in 2025/26, the 2026/27 Group Quality Priorities have been refined to focus on areas where collective action will have the greatest impact, while increasing local accountability for improvement.
3	Green Plan	The delivery of our green plan has made good progress, including a full LED lighting rollout across gesh, delivering substantial cost savings and carbon reduction (over £1m and 500 tonnes of carbon pa). EV charging points have been introduced at St George's to enable the move to EV pool cars and solar panel installations are underway at three locations (enough to power 70 houses). Clinical leadership within the programme has been strengthened through a Clinical Steering Group chaired by the Chief Medical Officer, and staff engagement strengthened through regular Green Days and Grand Rounds. Quarterly updates are being provided to the infrastructure committee, and the annual update of the Green Plan is planned for Autumn 2026 alongside a new Green Plan Annual Report. Key actions for 26/27 is to deliver the Clinical Workshops supporting implementation at the local level and delivery of the Heat Decarbonisation Plans for Estates.
4	Estates	Work on the updated Estates Master Plan work is led by Group Chief Officer, Facilities, Infrastructure and Environment . Since the previous update we have secured up to £57 million in funding from NHS London to improve St Helier Emergency Department. Longer-term options (including estates strategy) for clinical services have been prioritised in the Group's transformation portfolio.
5	Digital and Data	The procurement process for the ambient voice recognition technology and is now being rolled out to early adopters in outpatients. The Digital and Data team have continued the integration of the workforce across the gesh group which has been supported by the recruitment of a CDIO and deputies. With the CDIOs support the Digital and Data strategy has been viewed at GEC and Infrastructure committee and is being presented at Board 9 July.
6	Research & Innovation	In development. The gesh Group & City St George's Executive partnership met in June to discuss collaboration opportunities in research, and there was a roundtable looking at collaboration in the digital innovation space in May. At the same time, the research team has conducted staff engagement which has fed into the draft vision, objectives and themes being discussed by the R&I Strategy development steering group.

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Delivering ambitious transformation

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

The aims of our medium-term transformation portfolio:

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

The following slides summarise the medium-term Transformation portfolio's progress.

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Our transformation portfolio

Ambitious change programmes underpin our approach

Hospital to community shift	Transforming our productivity	Centres of Excellence	Our ways of working
Transforming Non-Elective Care	Clinical Workforce Transformation	Renal	Quality Management System
Transforming outpatients, and building new models of care	Corporate Services Transformation	Clinical Support Services	Route to IHO / Merger
	Clinical Ops / Admin & Clerical Workforce	Surgery	
		Children's, Maternity and Neonates	
		Medical Specialties Across ESTH	

Transformation Portfolio Update

Overview

1. The transformation portfolio continues to progress into delivery, with governance arrangements and delivery workstreams established across the majority of programmes. Whilst implementation activity is now underway across most programmes, additional capacity and capability will be required in some areas, with Transformation Fund bids expected to support delivery pace and achievement of programme objectives.
2. Our transformation programmes are crucial to help us close the Group's financial gap while supporting improvements in patient care, outcomes and experience.
3. The portfolio snapshots include the key actions required to progress the Top 5 schemes towards Fully Developed (Blue) status and strengthen delivery confidence against 2026/27 requirements. The Top 5 schemes are Non elective, Transforming outpatients, Clinical workforce, Corporate services and Admin and clerical workforce transformation.
4. The gesh Group's Communications team is working on an updated communications to help improve staff understanding of our strategy and Medium Term Plan. This will explain our ambitions for transformation and change from now until 2030, and will include live examples of how we are engaging our people and external stakeholders across a range of initiatives.

The following programme updates are highlighted:

- Integration of the Children's, Maternity and Neonatal programmes is being progressed, with joint reporting established and a shared governance structure in development. Subject to formal ratification, this will reduce the number of programmes within the transformation portfolio from 13 to 12.
- The Surgery Strategy programme has been renamed the Surgery Optimisation Programme to better reflect its focus on service optimisation and delivery of future surgical models.

Portfolio Snapshot – (1/5)

Transformation Programme	SRO	Expected Benefits / Outcomes	Key Progress and Priorities
1. **Non-Elective Transformation**	Kate Slemeck	• New, digitally enabled model of community care, with our Place partners, for patients with frailty and long-term conditions. • Significantly reduce the amount of time patients with frailty and long-term conditions need to stay in hospital. • Halve the number of bed days occupied by patients not meeting the Criteria to Reside or admitted for ambulatory care-sensitive conditions. • Release capacity to enable investment in the new model of care.	• Progress on acute capacity reduction schemes remains critical, with SGH scheme planned for August and further work required to confirm feasibility of ESTH reduction schemes within 2026/27. • ICB Frailty Business Case specifications have now been released, creating an opportunity to reduce the programme's reliance on Transformation Fund investment in 2026/27, while supporting the delivery of the left shift. <u>Key actions to progress CIP schemes to fully developed</u> • Continue engagement with Site Leadership Teams and align with site delivery plans. • Progress SGUH Quality Impact Integrated Assessment (QIIA). • Confirm acute capacity reduction requirements and consultation approach for ESTH. • Develop implementation and benefits realisation plan. • Align delivery with ICB Frailty Business Case investment and confirm workforce and clinical capacity requirements.
2. **Transforming Outpatients and New Models of Care**	Alex Shaw	• A new outpatient model achieved through changes to follow-up activity, referral management/diversion and estates rationalisation. • Re-investment of savings to reduce waiting times/achieve constitutional standards. • New, digitally enabled models of community care. • New community care models, built collaboratively with Place-based partners, including outreach from acute hospital staff. • Deliver improvements in performance and support delivery of the 2026/27 medium term plan.	• Programme has moved into early delivery, recruitment of staff into key posts a critical priority. • A range of opportunities have been identified against the CIP savings assumption, with benefits quantification and validation continuing. • Key enabling initiatives including AVT, e-Triage/SPOA, Patient Portal and Integrated Neighbourhood Pathways continue to progress and are expected to support future productivity and access improvements. <u>Key actions to progress CIP schemes to fully developed</u> • Schedule finance review meeting as a priority to work though benefits and financial assumptions. • Complete workbook development (implementation plan, risks and benefits) for review. • Develop communications plan. Confirm schemes requiring QIIA and progress development, including associated finance PIDs and required approvals/sign-offs.

Portfolio Snapshot – (2/5)

Transformation Programme	SRO	Expected Benefits / Outcomes	Key Progress and Priorities
3. Clinical Workforce Transformation	Elaine Clancy	• Transformation of the deployment of the clinical workforce, building on the programmes already underway in 2025/26 (including medical workforce productivity). • Critical foundations and controls to support sustainable workforce transformation in place. • Clinicians are enabled to operate at the top of their licence, through the use of technology and newer clinical roles. • Deliver improved staff satisfaction and support delivery of the 2026/27 medium term plan.	• Programme has progressed into delivery, with key workforce transformation initiatives now underway; mobilisation of transformation resource and planning for the September 2026 SRO transition remain important enablers of successful delivery and benefits realisation. • Medical rostering implementation remains on track, with the first cohort expected to go live in August 2026, supporting future workforce productivity and efficiency improvements. <u>Key actions to progress CIP schemes to fully developed</u> • Continue engagement and scoping to understand opportunities. • Finalise all workstream plans. • Complete programme plan and benefits realisation plan. • Commence EQIA and Finance PID development. • Confirm financial benefits associated with ETOC and SafeCare and financial modelling.
4. Corporate Services Transformation	Mark Bagnall	• Corporate services redesign, adoption of digital technology (including AI/RPA), self-service solutions, closer integration of services across gesh and SWL and estates rationalisation. • Approximately 25% reduction in cost over the medium term, whilst sustaining or improving Administrative & Clerical staff satisfaction in the long term. • Focus on areas where a single Corporate Services programme adds value across gesh, including shared AI solutions and the combined use of the gesh estate to support delivery of the 2026/27 medium term plan.	• Programme has progressed into delivery, with four of five workstreams now active and delivery activity underway. A transformation resource bid is being developed to support programme delivery, capacity and pace of implementation across workstreams. • Delivery remains on track for the August 2026, including the launch of the Digital and Copilot pilot (pending investment required). <u>Key actions to progress CIP schemes to fully developed</u> • Progress the sale of under-utilised asset through the required processes and approvals to secure the planned financial benefit. • Finalise the programme delivery plan to support implementation of schemes. • Establish a benefits realisation plan to support delivery programme ambitions. • Develop and implement a communications plan to support programme delivery, awareness and engagement. • Secure approval for the required transformation resource and technology investment required to enable programme delivery. • Develop EQIAs and finance PIDs and secure sign-off for schemes in scope.

Portfolio Snapshot – (3/5)

Transformation Programme	SRO	Expected Benefits / Outcomes	Key Progress and Priorities
5. Admin & Clerical Workforce Transformation	Tara Argent/James Pavett-Downer	• Optimisation of the Administrative & Clerical (A&C) workforce across the Group (excluding Corporate and HR roles) through evidence-based workforce analytics and targeted efficiency interventions. • Sustainable cost reductions in A&C staffing whilst ensuring the right people, processes and technologies are in place. • Enhancement of the flow of patients and information by eliminating inefficiencies and delivering better value for money. • Reduction in duplication, improvement in task clarity and ownership, and empowerment of staff with tools and technologies, supporting delivery of the 2026/27 medium term plan	• Programme has progressed to early delivery phase with more work now focused on benefits realisation, implementation planning and specialty-level profiling. • Programme has completed the scoping and engagement phase, with efficiency opportunities identified and consolidated into a two-year high-level outline roadmap. • PA Consulting is entering a transition phase as they roll-off their support function. <u>Actions to progress CIP schemes to fully developed</u> • Strengthen delivery capacity to sustain progress and support implementation. • Develop and agree a detailed implementation plan beyond June 2026 to provide the delivery structure, milestones and accountabilities required following the conclusion of PA Consulting engagement period and transition into implementation • Reduce bank spend (known control gaps at ESTH) by managing bank usage through VCP controls and approval processes to reduce agency expenditure and deliver planned savings. • Secure agreement to proceed with the job role standardisation of administrative roles to deliver workforce efficiencies. • Mobilise process and pathway improvement initiatives, including service redesign and centralisation opportunities, to streamline delivery models and accelerate the achievement of planned benefits. • Agree to pause non-essential recruitment and bank usage where digital solutions can enable cost reduction and mobilise digital and automation initiatives scoped to enable automation. • Develop EQIAs and finance PIDs and secure sign-off for schemes in scope.

Portfolio Snapshot – (4/5)

Transformation Programme	SRO	Expected Benefits / Outcomes	Key Progress and Priorities
6. Renal Development Programme	Kate Slemeck	• Integrated gesh Renal Service located at St George's through clinical and IT integration. • Estates solution progressed by pursuing both an increase in NHP funding for the new build (Plan A) and a refurbishment of existing clinical space at St George's (Plan B).	• Programme continues to progress well, with all workstreams advancing and no material delivery risks or escalations reported. • Renewed engagement with the New Hospitals Programme. • Progress continues towards a more integrated cross-site renal service, with delivery of the shared CV5 platform on track, pathway standardisation initiatives progressing across both sites, and work commencing to define the future-state integrated renal service model and implementation roadmap. • Key priorities are to agree the future-state integrated service model and delivery approach, and to progress the standardisation of renal pathways and protocols.
7. Children's, Maternity and Neonates	Ralph Michell	• Paediatric strategy for gesh, aligned to the wider SWL Clinical Strategy. • Improvements in the collective use of theatres, tertiary paediatric portfolio, the model of care for children with complex needs, and the optimisation of secondary paediatric services. • Maternity strategy for gesh, aligned to the wider SWL Clinical Strategy, targeting quality and financial benefits. • Deliver a second phase of transformation, subject to an aligned gesh/SWL strategy expected in 2026, supporting delivery of the 2026/27 medium term plan	• Additional Transformation Fund investment is also expected to be required to support programme delivery capacity • Integration of the Children, Maternity and Neonatal programmes has progressed, with joint reporting established and a shared governance structure in development. • Programme continues to progress with high-level strategic options in development. • A key priority for maternity is to consider options for temporarily relocating services from the Women's Health Block at St Helier hospital so that the water pipes can be replaced. • Other priorities are to progress the demand and capacity modelling to inform future decision-making.
8. Surgery Strategy Optimisation	Tara Argent	• Surgery strategy for gesh, aligned to the wider SWL Clinical Strategy, targeting improvements in performance and productivity. • Better use of theatres, reduced waits for treatment, improved treatment outcomes and increase in capacity for complex care. • Delivery of the surgery strategy becomes an enabler to other schemes and their quality and financial benefits, including paediatrics and renal. • Deliver a second phase of transformation, subject to an aligned gesh/SWL strategy expected in 2026, supporting delivery of the 2026/27 medium term plan.	• Programme mobilisation continues ahead of anticipated Board approval in July, with draft Terms of Reference developed, clinical and operational leads identified, and governance arrangements being established to support delivery. • Procedure suite and theatre capacity requirements are being modelled to inform future business cases and support delivery of the agreed end-state surgical model. • Key priorities are to finalise the surgery strategy and to progress implementation planning, including decisions on theatre capacity.

Portfolio Snapshot – (5/5)

Transformation Programme	SRO	Expected Benefits / Outcomes	Key Progress and Priorities
9. Clinical Support Services (inc. pharmacy)	TBC	• Clinical Support Services across gesh are strengthened and aligned to ensure they are sustainable, resilient and consistently high quality. • Service fragility reduced, better match of capacity to demand, reduction in areas of high-cost spend and reduction of unwarranted variation in clinical practice. • Embedded Group-wide standards through a shared EPR, streamline pathways, and deliver quality and financial benefits. • Build on and support the work already being undertaken through the Pharmacy Strategy, supporting delivery of the 2026/27 medium term plan.	• Confirmation of programme leadership arrangement to be confirmed, which will enable mobilisation/future delivery.
10. Medical Specialties across ESTH	Beccy Suckling	• Programme draws on work already underway and aligned to the emerging SWL Strategy. • A more networked model of care for selected medical specialties across the Epsom and St Helier sites as part of a gesh-wide network. • Networked approaches developed in gastroenterology, respiratory and cardiology. • Improvements in service quality, resilience and financial sustainability, supporting delivery of the 2026/27 medium term plan.	• Programme governance has been strengthened, though resourcing gaps continue to pose a delivery risk and are being mitigated through alternative approaches. • Progress continues across Cardiology, Gastroenterology and Respiratory consolidation workstreams, with Cardiology demand and capacity modelling underway to support the planned December 2026 go-live and wider opportunities being explored across other specialties. • The programme plans to advance consolidation planning and further develop opportunities for gastroenterology, whilst confirming the consultation approach for cardiology, respiratory and gastroenterology services and the validation of the programme's financial benefits.
11. Quality Management System	Michael Pantlin	• Quality Management System for gesh to enable continuous improvement in the quality and experience of care. • Core functions of a Quality Management System: Quality Planning, Control, Assurance and Improvement, building on, aligning and supporting existing workstreams embedded. • Improved quality and performance insight capabilities, including measuring outcomes, value and predictive analytics. • Establish quality improvement capability across teams and engage in co-design to strengthen the leadership behaviours and culture essential to success.	• Programme has progressed into delivery, with Phase 1 planning complete and integrated delivery plans and organisational engagement due to commence across the initial pioneer processes. • Improvement capability continues to expand, with strong participation across the LEAD and APPLY programmes. • Programme capacity remains a key risk, with a Transformation Fund bid being developed to secure additional delivery resource. • Focus for the next few weeks is to develop integrated delivery plans for the initial QMS core processes and commence engagement with key organisational areas and securing additional capacity through a Transformation Fund bid.
12. Route to IHO / Merger	Michael Pantlin	• Appropriate organisational form to enable the journey to IHO status in place. • Strategic Business Case and Full Business Case setting out a clear, evidence-based rationale for exploring a merger between SGUH and ESTH. • Ensure merger would deliver improved quality, safety and sustainability of services for patients, together with the key risks, opportunities and a robust long-term financial case. • Change programme required to achieve Day 1 of the transaction and progress to IHO status.	• The Strategic Case has been submitted for review by NHS England, with feedback and approval pending. • Workstream leads are in place, and key planning materials are being developed, alongside recruitment to strengthen programme leadership. • The priority is now to put the foundations in place for delivery, including finalising implementation plans and strengthening leadership oversight.

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Recommendations

Note progress in the implementation of the Group Strategy

Group Board

Meeting in Public on Thursday, 09 July 2026

Agenda Item	5.2	
Report Title	**Surgery Strategy**	
Executive Lead(s)	Michael Pantlin, Group Deputy Chief Executive Officer	
Report Author(s)	Tara Argent, Site Chief Operating Officer – SGUH Andrew Parker, Strategy and Business Development Manager	
Previously considered by	Group Executive Committee	30 June 2026
Purpose	**For Approval / Decision**	

Executive Summary

An initial vision for the Strategy was positively discussed at the Group Board Development session in April 2026 and the content has since been further developed collaboratively by the surgical senior leadership teams of both Trusts.

The Board is asked to approve the proposed strategy which lays out the strategic intent to:

- Develop **Epsom Hospital as a centre of excellence for short-stay elective surgery.**
- Establish **St Helier Hospital as a centre of excellence for frailty care and urgent surgery.**
- Reinforce **St George's Hospital as a leading regional centre for complex and highly specialised (tertiary) surgery**.
- **Expand robotic-enabled surgery in our hospitals.**

These approaches are well supported by established evidence and successful implementation elsewhere in the NHS, including elective hub models and consolidated specialist services.

Following approval of the strategy, a transformation programme stood up to support its implementation, will further develop and work through the following with a view to seek support on the plan from the Group Executive:

- Future clinical models of care
- Workforce implications
- Financial modelling and affordability
- Equality impact assessments

Implementation of this strategy will be underpinned by a comprehensive staff, patient, public and partners engagement plan at its core, making sure we keep people informed, involve them in decisions, and carry out formal consultation where needed.

We will also look to ensure this approach aligns with the South West London Clinically Led Strategic Plan and will be delivered in partnership with our Acute Provider Collaborative colleagues to support coordinated, system-wide delivery of surgical services.

We are working with the comms team on a plan on initial engagement with the Surgery Strategy both internally, through relevant staff forums and intranet pages, and externally through a dedicated internet page with link to full strategy document and use of other media platforms. Continuous engagement will be core through the strategies implementation.

Action required by Group Board

The Board is asked to:

a. approve the proposed Group Surgery Strategy 2026-30

Committee Assurance

Committee	N/A
Level of Assurance	Not Applicable

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

There could be some financial risks to implementation of the strategy however the plan is to come back to exec with a detailed financial plan for the initial phased of implementation.

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

Currently being worked through with a view to present these at Exec within the coming months.

Legal and / or Regulatory implications

We have a statutory duty to inform, involve and engage with patients, the public and staff. Therefore implementation of this strategy will be underpinned by a comprehensive staff, patient, public and partners engagement plan at its core making sure we keep people informed, involve them in decisions, and carry out formal consultation where needed.

Equality, diversity and inclusion implications

There is potential that the location of where surgical treatment is provided will change however the plans are to keep pre and post operative care in the local hospital. Implementation of the strategy will be underpinned by

equality impact assessments and a plan to inform, involve and engage patients in our plans to transform surgical provision.
Environmental sustainability implications
n/a



Surgery strategy

2026–2030

Surgical CARE: Raising standards in the right place at the right time.

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EXECUTIVE SUMMARY

Surgical services are under increasing pressure, and the current model is no longer sustainable. Key challenges include:

- **Long waiting times** for surgery across many specialties, with some services significantly below target performance.
- **Growing demand**, driven by an ageing population and increasing clinical complexity.
- **Variation in outcomes and patient experience** between hospitals.
- **Workforce and financial pressures** across the health system

Patients have told us that **reducing waiting times is their top priority**, and addressing this is central to our strategy.

At the same time, evidence shows that **delivering the right procedures in the right settings,** including dedicated elective hubs and specialist centres, can significantly improve efficiency, outcomes, and patient experience.

In response, we are redesigning how surgical care is delivered across our hospitals to ensure patients receive faster treatment, better outcomes, and consistently high-quality care, now and in the future.

Our new **St George's, Epsom and St Helier Hospitals Group (GESH) Surgery Strategy** sets out a clear approach for the next five years. We will address challenges in surgical provision across the gesh group by maximising the St George's site's ability to carry out tertiary surgery by concentrate less complex work in centres of excellence / elective hubs at Epsom and St Helier.

Our vision

By 2030, we will operate as **a single, integrated surgical service**, delivering care in **the right place, at the right time, and to the same high standard**, regardless of where patients are treated.

Our ambition is to **raise standards, reduce waiting times, and make best use of our combined expertise and facilities** across all sites.

Our work is organised around four strategic priorities:

- We will develop **Epsom Hospital as a centre of excellence for short-stay elective surgery.**
- We will establish **St Helier Hospital as a centre of excellence for frailty care and urgent surgery.**
- We will reinforce **St George's Hospital as a leading regional centre for complex and highly specialised (tertiary) surgery**.
- We will **expand robotic-enabled surgery in our hospitals.**

These priorities will be enabled by **expanding the use of procedure suites and alternative care settings** for less complex surgery.

Within these priorities, we will take a phased approach in implementing clinically identified priorities which will be underpinned by strong clinical, operational, patient and public engagement.

This strategy lays the foundations for a more integrated future. By the end of the decade, we aim to:

- Operate as **one surgical network across multiple hospital sites** sharing workforce, expertise, and resources across the Group.
- Deliver **standardised pathways and consistent care**
- Expand innovation, including robotic surgery and new models of care

This will ensure we can **meet rising demand, improve outcomes, and provide high-quality care for our communities for years to come.**







Tara Argent:
Senior Responsible Officer for the gesh Group Surgery Strategy

Miss Andrea Sott:
Divisional Chair Planned Care ESTH
Chair GESH Surgery Clinical Standards and Strategy Group

Miss Shamim Umarji:
Divisional Chair for the Surgery, Neurosciences, Cancer and Trauma Division at St George's

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01

Where we are now

Our surgical services face growing pressure from long waits, rising demand, capacity and financial constraints and inefficient use of facilities, making a new model of care essential for meeting future patient needs.

CONTEXT AND THE CHALLENGES WE FACE

Surgical services across our hospitals are under growing pressure. While we provide a wide range of high-quality care, the way services are currently organised is not sustainable if we are to meet patients' future needs. At the same time, we have a gesh group strategy that sets out an ambition to ensure patients receive the same high standard of care across all our hospitals, while strengthening specialised services, particularly at St George's. Our medium-term plan also sets out an ambition to ensure we provide right care in the right place through changing how services are organised. The challenges we face are:

Long waiting times for surgery
Too many patients are waiting longer than they should. Waiting times remain high, with some patients waiting more than 20 weeks for surgery. Overall performance against national and local targets is below the level we expect, and there is a clear need to more timely care.

Patients have told us that reducing waiting times is their number one priority. Addressing this challenge is central to our strategy, as delays can have a significant impact on patients' health, wellbeing, and quality of life.

Growing demand and increasing complexity against a backdrop of a challenging financial landscape
Demand for surgical care will continue to grow. By 2030, a larger proportion of our population will be over 65, increasing the need for surgery for long-term conditions. In addition, patients are presenting with more complex needs, often requiring specialist care and longer recovery. At the same time there are major financial challenges which are expected to continue over the coming years which places additional strain on services and highlights the need for a more flexible and resilient model of care.

Limited capacity to meet demand
We face constraints in our ability to deliver more surgery within our current model. The pressures of balancing emergency and planned care mean that some surgical teams cannot access the theatre time they need.

Specialised services are limited by space, restricting our ability to expand complex care. This means some patients are treated outside our local area when, with the right capacity, they could be treated closer to home.

Not always delivering care in the best setting
There are opportunities to use our facilities more effectively. Some procedures that could safely be carried out in simpler settings are performed in main operating theatres, while access to newer technologies, such as robotic surgery, is limited.

National guidance shows that delivering the right procedure in the right place can improve efficiency and increase capacity. For example, moving high volumes, less complex procedures into dedicated facilities can help treat more patients and improve outcomes.

THERE ARE OPPORTUNITIES TO IMPROVE THE WAY SURGERY IS PROVIDED

Whilst there are numerous challenges to overcome this strategy seeks to make best use of the opportunities we have:

Learning from what works
Evidence shows that dedicated centres for planned surgery can deliver better outcomes and productivity. These “elective hubs” separate planned care from emergency pressures, leading to shorter waits and faster recovery. For instance, we have seen the benefits of this approach through high-performing services at the South West London Elective Orthopaedic Centre at Epsom. In the 2025, patients stayed in hospital following a hip replacement for 1.6 days vs 2.7 nationally; readmission after 30 days was 4.2% vs 5.9% nationally for hip replacement; for knee replacement it was 4.7% vs 6.5% and cancellation rate is 1.6% vs 3.7% at St George’s.

Variation in quality and outcomes
There is variation in patient outcomes across our sites. This can contribute to health inequalities, as patients may experience different standards of care depending on where they are treated, highlighting a clear opportunity for improvement, for example with emergency hip fractures. By concentrating expertise and delivering higher volumes of care in dedicated centres, we can improve consistency, strengthen specialist teams, and ensure that all patients receive the same high standard of care, regardless of where they are treated. We have set up Clinical Strategy and Standards Groups to identify areas of variation we want to tackle.

Making best use of our local expertise
Some patients travel outside South West London for specialist surgery due to capacity limitations. This can be difficult for patients and reduces our ability to provide care locally. By reorganising services, we can retain more of this care within our hospitals, improving patient experience and making better use of local expertise.

Develop and expand surgical techniques fit for the future
Innovation in surgery will be central to how we improve care for patients. By investing in modern technologies, such as robotic surgery and minimally invasive techniques, alongside new ways of working, we can deliver safer procedures, support faster recovery, improve patient experience, and develop a workforce that is skilled in delivering the most innovative care to our patients. Improving access to robotic surgery will help address health inequalities, for instance, by enabling more women to benefit from this approach, thereby reducing the current gender gap.

The case for change
These challenges mean that continuing with our current approach is not an option. We need a new model of surgical care that:

- Reduces waiting times and improves access
- Uses our facilities and workforce more effectively
- Delivers consistent, high-quality outcomes
- Meets growing demand in a sustainable way

By changing how and where surgical services are delivered, we can create a system that is better for patients, more efficient for the NHS, and sustainable for the future.

By ensuring we do the right procedure in the right setting, for the best value for patients, we can expand complex tertiary surgical work

Given the **limited number of surgical robots** in SWL, we have **robotically trained surgeons who cannot access this facility** for their patients.

330+ robotic procedures are done per year in St George's main theatres that could otherwise be done robotically at Epsom. Moving these procedures would free up capacity for more complex robotic surgery on the Tooting site.

Main Theatres

Daycase

There are 1000+ procedures carried out in day case and inpatient theatres across the gesh Group that could otherwise be done in an alternative setting. Moving this activity could free up capacity to support a gesh Group Elective hub.

Local anaesthetic procedures

The national "Right Procedure, Right Place Programme" sets out how services should optimise the use of resources by moving some local anaesthetic procedures that can be safely and effectively delivered outside a theatre environment into an alternative setting such as in procedure suites or community setting. This provides an opportunity to provide day case procedures in a more financially sustainable environment.

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02

Our vision and strategic priorities

We will operate as an integrated surgical service, delivering care in the right place, at the right time, and to the same high standard, regardless of where patients are treated.

OUR VISION, MISSION AND STRATEGIC PRIORITIES

Our vision

By 2030, we will operate as an integrated surgical service, delivering care in the right place, at the right time, and to the same high standard, regardless of where patients are treated.

Our mission

Reinforcing our tertiary centre of excellence at St George's by increasing complex surgery.

Create new surgical hubs that will be centres of excellence for non-tertiary procedures at Epsom and St Helier hospital sites

Our strategic priorities

Develop Epsom as a centre of excellence for short stay elective surgery
Epsom will become a dedicated surgical centre, with gesh robotic capabilities, providing quicker access to and faster recovery from short-stay surgery.

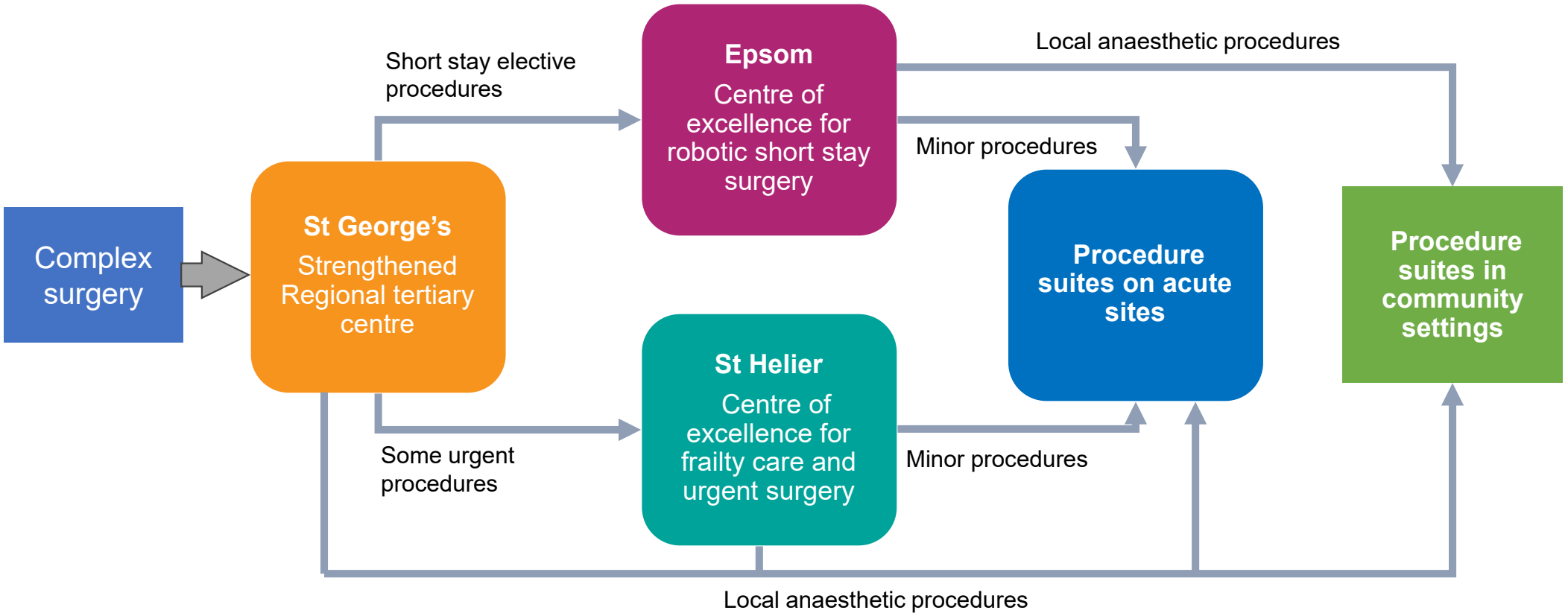
Develop St Helier Hospital as a centre of excellence for frailty care and urgent surgery
At St Helier, we will reduce unwarranted variation in some urgent surgery to give patients more consistent, high-quality care. This will help people have surgery sooner, recover more quickly, return home sooner, and reduce the risk of complications.

Strengthen St George's position as a regional centre for complex/tertiary surgery
By ensuring theatres and beds are available for complex services, we will increase capacity for highly specialised surgeries, speeding up treatment and strengthening our role as a specialist centre for complex care.

Expand robotic assisted surgery across the gesh
We aim to expand robotic-enabled surgery across the GESH hospital group to standardise access to advanced minimally invasive techniques, improve clinical outcomes, shorten hospital stays, and strengthen workforce capability

This strategy will be enabled by the **development of procedure rooms** for minor procedures ensuring these treatments are carried out in the right place increase capacity in our daycase and inpatient theatres

To support this strategic direction and involving engagement with the workforce, patients, public and partners we will initially look to make the following shifts:



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03

What we want to achieve

Each of our four priorities, with the focus areas and the key deliverables that bring it to life.

Develop Epsom as a centre of excellence for short stay elective surgery

Epsom will be a centre of excellence for planned surgery, delivering fast, high-quality, and efficient care through dedicated elective services and modern technology,

Over the next five years, Epsom Hospital will be developed as the Group's centre of excellence for planned surgery. We will expand short-stay and high-volume procedures in a dedicated elective environment, reducing waiting times, cancellations, and length of stay. We will increase the use of modern techniques, including robotic and minimally invasive surgery, while making better use of theatre capacity by bringing appropriate activity onto the site from St George's. This will enable more patients to be treated more quickly, with better outcomes and a more consistent, high-quality experience.

Key priorities We will focus on expanding high-volume planned surgery, increasing use of modern techniques such as robotics, and delivering faster, more reliable care through a dedicated elective hub model.

01 Maximise use of theatre capacity.

We will ensure theatres are used efficiently by aligning procedures to the most appropriate setting by developing procedure suites for low complexity treatments and supporting high-volume, streamlined surgical delivery.

02 Develop as a centre of excellence for planned short stay surgery

We will move appropriate procedures over from St George's creating a dedicated elective environment where patients can receive timely, high-quality care separate from emergency pressures.

03 Expand use of modern surgical techniques

We will increase the use of robotic and minimally invasive surgery, improving patient outcomes, reducing complications, supporting faster recovery.

04 Expand theatre capacity at Epsom.

We will increase the operating hours of surgical theatres so that we can align more procedures to the most appropriate setting and supporting high-volume, streamlined surgical delivery.

Our key deliverables

- **Better use of theatres**
  By developing procedure suites and concentrating some surgical procedures at Epsom we can carry out more complex procedures at St Georges.
- **Reduced waits for treatment**
  We will create an environment where surgery is not delayed by other emergency cases allowing for patients to be seen in a timely manner
- **Improved outcomes for patients**
  Concentrating high volume surgery at Epsom means staff will specialise in caring for more patients with similar conditions.
- **Increased capacity for complex care at St George's**
  Moving less complex surgery away from the tertiary centre will create capacity at St George's

Develop St Helier as a centre of excellence for frailty care and urgent surgery

A centre of excellence for frailty and urgent surgical care, delivering timely, high-quality treatment through integrated specialist teams and dedicated pathways that improve outcomes for patients

Over the next five years, we will develop St Helier Hospital as a centre of excellence for frailty and urgent surgical care by bringing services together into dedicated pathways that are designed around the needs of older patients. We will strengthen multidisciplinary teams, including surgical, medical, and therapy staff, to provide coordinated, specialist care from admission through to recovery. We will ensure timely access to surgery, the right beds, theatres, and support services. We will also adopt best practice to improve outcomes. Through targeted investment in facilities, workforce, and discharge planning, we will enable faster recovery, shorter hospital stays, and a more consistent, high-quality experience for patients.

Key priorities We will focus on delivering high-quality, timely emergency surgical care through specialist teams, improved patient flow, and consistent standards to achieve better outcomes for patients with urgent needs.

01 Improve the time patients spend in hospital beds following urgent treatment

We will reduce the time patients spend in hospital by improving post-operative pathways, accelerating recovery through specialist care, and strengthening discharge planning to ensure patients can return home safely and sooner.

02 Reduce variation and improve outcomes

We will standardise clinical pathways, adopt best practice across services were there is variation in patient outcomes, and concentrate activity to ensure consistently high standards and improved patient outcomes across the site.

03 Strengthen specialist teams and workforce sustainability

We will develop multidisciplinary teams, improve rota stability, enhance training and development opportunities, and create an environment that supports recruitment and retention of specialist staff.

04 Consolidate some specialist urgent surgical care at St Helier

We will bring together expertise and pathways in a dedicated model of care, ensuring patients with urgent surgical needs are treated by experienced specialist teams in an environment designed for high-quality urgent care.

Our key deliverables

- **St Helier as a centre of excellence**
  Develop dedicated model where some urgent surgical patients are treated by specialist teams in a high-performing, focused environment.
- **Improved outcomes for older patients**
  Implement best-practice clinical pathways and concentrate some urgent surgery at St Helier to reduce variation and deliver high-quality outcomes.
- **Enhance workforce capability**
  Concentrate specialist teams from gesh at St Helier to build resilient multidisciplinary teams delivering outstanding care for patients with similar needs.
- **Quicker discharge home**
  Deliver effective faster pathways from admission to discharge by working jointly with partners to improve patient flow

Reinforce St George's as a regional centre for complex/tertiary surgery

St George's will be strengthened as a leading regional centre of excellence for complex surgery, delivering cutting-edge care, outstanding outcomes, and timely access for patients with the most complex needs.

Over the next five years, St George's Hospital will be strengthened as the Group's centre of excellence for complex surgery. We will expand access to highly specialised services by freeing up theatre and bed capacity, enabling more complex procedures to be delivered locally. Robotic surgery will be expanded and supported with the development of specialist teams. By improving pathways, optimising use of critical care and surgical beds, and working closely with partners across South West London, we will deliver faster access, better outcomes, and a leading centre for high-quality, complex surgical care.

Key priorities We will focus on getting the basics right by strengthening the core infrastructure that underpins all digital services across gesh, delivered through a focused set of priorities.

01 Increase capacity for complex and tertiary care

We will actively look for opportunities to free up theatre and bed capacity by shifting less complex procedures to other sites and support critical services to enabling more patients to access complex surgery more quickly.

02 Strengthen as a regional centre of excellence for complex surgery

We will focus capacity on highly specialised procedures and priorities areas with the longest waits, improving access to complex care, reducing delays for patients requiring complex treatment.

03 Retain and expand complex care locally

We will work with partners to bring more specialised services closer to home, reducing the need for patients to travel outside the region for treatment.

04 Support innovation and workforce development

We will expand access to advanced surgical techniques, including robotic surgery, and support staff training and development to strengthen our position as a leading specialised centre.

Our key deliverables

- **Strengthened regional surgical centre**
  By moving surgical treatment that can be done in an environment outside a tertiary centre we will dedicate capacity to support more complex surgery
- **Reduced waits for treatment**
  We will prioritise strengthening those services with long waits for treating patients requiring complex surgery
- **Enhance workforce capability**
  By having a mobile workforce that can work across our sites they will be exposed to cutting-edge surgical techniques in complex at St George's
- **Care closer to home**
  Increasing capacity for complex surgery will enable patients from South West London and Surrey, who seek treatment elsewhere, to come to St George's for timely care.

Expand robotic assisted surgery across the gesh Group

To establish a fully robotic-enabled surgical network, expanding access to advanced, minimally invasive care that delivers better outcomes, faster recovery, and a consistently high-quality patient experience across all sites.

Over the next five years, we will scale up robotic surgery across the Group by expanding capacity across our sites, embedding robotic techniques into routine practice, and enabling more specialties to benefit from this technology. We will invest in equipment, workforce training, and dedicated pathways to ensure patients can access minimally invasive surgery more widely and equitably. By developing a connected network of robotic services, we will improve outcomes, reduce complications and length of stay, and support faster recovery for patients. This will also strengthen our clinical capability and position the Group as a leader in modern, high-quality surgical care.,

Key priorities We will expand robotic surgery across the Group to embed advanced techniques into routine care, develop a highly skilled workforce, and deliver better outcomes and faster recovery for patients.

01 Embed robotic surgery in routine clinical pathways

We will integrate robotic techniques into standard care across a wider range of specialties, ensuring more procedures are delivered using advanced technology.

02 Improve outcomes and patient experience through innovation

We will use robotic surgery to deliver safer, more precise procedures, reducing complications, shortening length of stay, and improving recovery for patients.

03 Develop a skilled and sustainable robotic workforce

We will invest in training, recruitment, and workforce development to ensure clinical teams have the expertise to deliver high-quality robotic surgery at scale.

04 Expand access and capacity for robotic surgery

We will increase the availability of robotic systems and theatre capacity across sites to enable more patients to benefit from minimally invasive surgery.

Our key deliverables

- **Established robotic surgery network**
  Develop a coordinated model across all sites, ensuring robotic capacity is aligned to clinical need.
- **Established robotic service at Epsom**
  We will concentrate robotic surgery at Epsom for procedures requiring a short hospital stay after surgery.
- **More complex robotic surgery at St George's**
  Moving less complex robotic surgery away from St George's will free up capacity for patients requiring more specialised robotically enabled care.
- **Access to minimally invasive surgery**
  Improving access to robotic surgery means that patients will be less likely to suffer from post surgery complications.

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What this means for patients

Surgical care delivered in the right place, at the right time, and to the same high standard, regardless of where patients are treated.

WHAT THIS MEANS

Patient and staff stories

What happens now – patient story

Sarah is a 52-year-old woman living in Southfields in Wandsworth, who experiences ongoing heavy bleeding and pelvic pain due to fibroids. Her symptoms are affecting her daily life and wellbeing, so her GP refers her to the gynaecology department at St George's Hospital. She attends an outpatient appointment at St George's Hospital in Tooting, a 34-minute bus journey from her home, and has further tests, including imaging and diagnostic procedures, across St George's and Queen Mary's Hospital.

Following this, she is diagnosed and advised that she needs a hysterectomy. Sarah is added to the waiting list for surgery at St George's Hospital. However, she waits longer than desired, often over 20 weeks for treatment. The day before her operation, it is cancelled due to a need to carry out more urgent complex cases as planned surgery takes place alongside urgent specialised care for patients from all over the region. Her surgery is rescheduled several weeks later. When she eventually has her operation, she stays in hospital for two to three nights before returning home. She later attends a follow-up appointment at St George's.

What could happen in future

Under our future model, Sarah's experience would be different. She would still be referred to St George's and receive her outpatient care and diagnostics locally, supported by her specialist team. When it comes to surgery, Sarah would have her hysterectomy at Epsom Hospital with the same clinical team she saw at St George's, in a dedicated elective surgical hub.

While this may involve a slightly longer journey, she would benefit from being treated in an environment designed specifically for planned surgery. Her operation could be carried out using robotic surgery, a minimally invasive technique that allows for greater precision. This can lead to fewer complications, less pain after surgery, smaller incisions, and a quicker recovery. Because elective hubs focus only on planned care, Sarah would be treated sooner and would be much less likely to have her operation cancelled at short notice. She would also typically spend less time in hospital, often returning home more quickly, supported by teams who specialise in elective recovery.

After her surgery, Sarah would return to St George's for her follow-up care, ensuring continuity with her clinical team while benefiting from faster, more reliable treatment.

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05

How we get there

Delivery depends on co-designing the surgical services of the future with our staff, patients, public and partners.

HOW WE GET THERE – The five-year roadmap

Implementation of this strategy will be **underpinned by a comprehensive staff, patient, public and partners engagement plan at its core** making sure we keep people **informed, involve them in decisions, and carry out formal consultation where needed.**

2026
Foundation

In 2026, the focus is on laying the groundwork for change.

- New **procedure rooms** will open to carry out simpler treatments using local anaesthetic.
- This will **free up operating theatres** so more patients can have daycase and inpatient surgery.
- **Robotic surgery will be embedded at Epsom**, introducing new technology to improve precision and recovery.
- A comprehensive engagement plan will be developed and will be core to successful implementation of the strategy.

2027
Reshape

In 2027, services start to shift and new models of care are introduced.

- **Epsom will become a dedicated elective (planned care) centre,** with some operations moving there from St George's.
- **Support the workforce's ability** to increase **robotic surgery** in the future and **work across our hospitals.**
- There will be **active engagement with patients, the public, and staff** about proposals to bring some clinically identified urgent surgical care together on one site.

2028
Integrate

In 2028, the changes planned in earlier years begin to take full effect.

- Some **urgent care will be consolidated at St Helier**, bringing expertise into one place.
- As services move to Epsom and St Helier, **space will be freed up at St George's.**
- This allows an **increase in more complex surgery** at St George's, making better use of specialist teams and facilities.

2029
Expand

In 2029, the benefits of earlier changes are expanded.

- **More operating capacity at Epsom** will be created by increasing the number of theatre sessions available each day.
- This means more surgery can move away from St George's to allow for **more complex care to take place.**
- This means **more patients can be treated more quickly**, helping to reduce waiting times.

2030
Optimise

By 2030, the programme focuses on strengthening and future-proofing services.

- There will be an **increase in the number of surgical robots across the group**, expanding access to advanced techniques.
- This supports **better outcomes, faster recovery, and more efficient care** for patients.

Group Board

Meeting in Public on Thursday, 09 July 2026

Agenda Item	5.3	
Report Title	Digital strategy 2026-2030	
Executive Lead(s)	Michael Pantlin, Group Deputy Chief Executive Officer	
Report Author(s)	Mark Coker – Group Chief Digital Information Officer	
Previously considered by	Infrastructure Committee	19 June 2026
Purpose	**For Approval / Decision**	

Executive Summary

This paper presents the gesh Digital and Data Strategy for 2026 to 2030, setting out the strategic direction required to support the group's transition to a single Integrated Health Organisation (IHO). It responds directly to current risks within our digital estate while enabling the transformation needed to deliver safer, more efficient and more connected care.

This strategy represents the culmination of extensive engagement undertaken throughout 2025 and early 2026, including structured input from clinical, operational and corporate leaders across gesh. It also reflects detailed discussion at a Group Trust Board development session in December 2025, with the content of the strategy heavily informed by the direction, priorities and challenges identified through that session. In addition, the strategy has been shaped through collaboration with key strategic partners, including Microsoft and Oracle, as well as colleagues across the Integrated Care Board, ensuring alignment with wider system priorities and best practice.

Recognising that successful delivery will depend on broad organisational understanding, engagement and ownership, the Digital Directorate has worked closely with the Trust's Communications Team to develop a comprehensive communications and engagement approach to support the launch and ongoing implementation of the strategy. This will ensure that the strategic priorities, planned benefits and expected outcomes are effectively communicated to staff, stakeholders and partners across the organisation and wider health and care system.

To further support engagement and accessibility, work has also been commissioned to develop a concise visual "Strategy on a Page" summary. This will provide a clear and accessible representation of the strategy's priorities, outcomes and commitments, supporting wider engagement with staff, stakeholders and partner organisations and helping to embed the strategy across the Group.

Our approach is structured around six core strategic priorities that will simplify our environment, strengthen resilience and support clinical and operational improvement:

- Safe and Secure Foundations: Strengthening infrastructure and cyber security.
- A Data Driven Organisation: Creating a single, trusted data platform and consistent insight.
- AI and Automation: Reducing administrative burden and improving productivity.
- Optimised and Integrated Digital Systems: Simplifying and connecting systems.
- A Connected Organisation: Enabling collaboration across all sites.
- A Simple and Accessible Digital Front Door: Improving access for patients and staff.

These priorities reflect the need to address a fragmented and ageing technology landscape, improve user experience and respond to increasing expectations for digital access and real time information. Importantly, they also establish the foundational building blocks required for sustained digital transformation at scale, supporting gesh's transition to a single, IHO with consistent systems, shared information and aligned ways of working.

Addressing Core Risk and Strengthening Digital Foundations
Over the next four years, a significant proportion of investment and delivery effort will focus on modernising the Group's core digital infrastructure, networks and end user technology, while further strengthening cyber security and organisational resilience. These foundational capabilities are essential to reducing operational risk, supporting safe and reliable clinical services and creating the platform required for future transformation.

Transforming Data and Decision Making
We will establish a cohesive Group wide data capability that provides timely, trusted and actionable insight. This will enable better informed decision making at every level of the organisation, support operational performance and strengthen our ability to improve outcomes for patients and populations.

Harnessing AI and Automation to Improve Productivity
Artificial intelligence and automation will be adopted in a safe, governed and clinically led way to reduce administrative burden, release staff time and improve organisational productivity. This includes technologies such as ambient voice, Microsoft Copilot and the automation of high volume, repetitive processes across corporate and clinical services.

Simplifying and Integrating the Digital Landscape
We will reduce complexity across our application estate by rationalising systems, improving interoperability and optimising the Electronic Patient Record. This will create a more integrated digital environment that supports safer care, better workflows and a more consistent experience for patients and staff.

Improving Access and Experience
We will develop a clear and accessible digital front door, centred on the NHS App, to make it easier for patients to access services, manage their care and communicate with the organisation. This will improve patient experience, reduce administrative effort and ensure that alternative routes remain available for those who need them.

Delivery, Governance and Capability
Successful delivery of this strategy will require:

- Clear prioritisation and investment decisions aligned to organisational risk, strategic objectives and measurable value.
- Robust demand, portfolio and programme management to ensure delivery capacity is focused on the highest priorities.
- An AI Centre of Excellence to provide governance, assurance and support for the safe and effective adoption of emerging technologies.
- Continued investment in digital, data and informatics capability, with clear leadership accountability across the Group.
- Strong benefits realisation arrangements that demonstrate impact against clinical, operational, workforce and financial outcomes.

Finances
Delivery of this strategy is underpinned by a number of key financial assumptions:

- From 2026/27, gesh Digital will have access to £23m of capital to support the initial phase of the digital improvement roadmap.

- This is followed by a minimum assumed capital envelope of £15m per annum across the remaining years of the strategy period to 2030.
- It is assumed that an AI and Innovation Centre of Excellence will be established as a core component of delivery. A bid to the Trust's transformation fund is planned to enhance its scale, pace and impact, although a baseline capability will be progressed within existing resources if additional funding is not secured.
- No material increase in the core digital revenue budget is assumed. Any revenue growth will be subject to robust business cases, prioritisation and affordability.
- No explicit assumptions have been made regarding national funding. However, priorities have been aligned with national direction to maximise the likelihood of securing external investment.
- Where national or additional funding is secured, this will enable faster delivery, extended scope and increased ambition, for example in areas such as patient engagement and portals.

These assumptions represent the minimum level of investment required to address current risk, stabilise the estate and deliver the planned transformation. They will require ongoing review alongside organisational priorities, affordability and system funding arrangements.

Strategic Significance
Delivery of this strategy is a critical enabler for the transition to an Integrated Health Organisation, supporting integrated care pathways, improved outcomes and reduced inequalities.

Next Steps
This strategy will strengthen organisational resilience, improve productivity and patient experience, and provide the digital, data and technology foundations required to support the delivery of the Group's strategic objectives over the next four years and beyond.

Action required by Group Board

The Board is asked to:

a. Approve the Group Digital and Data Strategy 2026-30
b. Endorse the overall strategic direction, including the six strategic pillars and the proposed pace of delivery set out within the strategy.
c. Support the key financial assumptions, including the proposed capital investment profile and the intention to secure transformation funding to establish an AI and Innovation Centre of Excellence.

Committee Assurance	
Committee	Infrastructure Committee
Level of Assurance	Not Applicable

Appendices	
Appendix No.	**Appendix Name**
Appendix 1	Group Digital and Data Strategy 2026-30

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

As set out in paper.

Legal and / or Regulatory implications

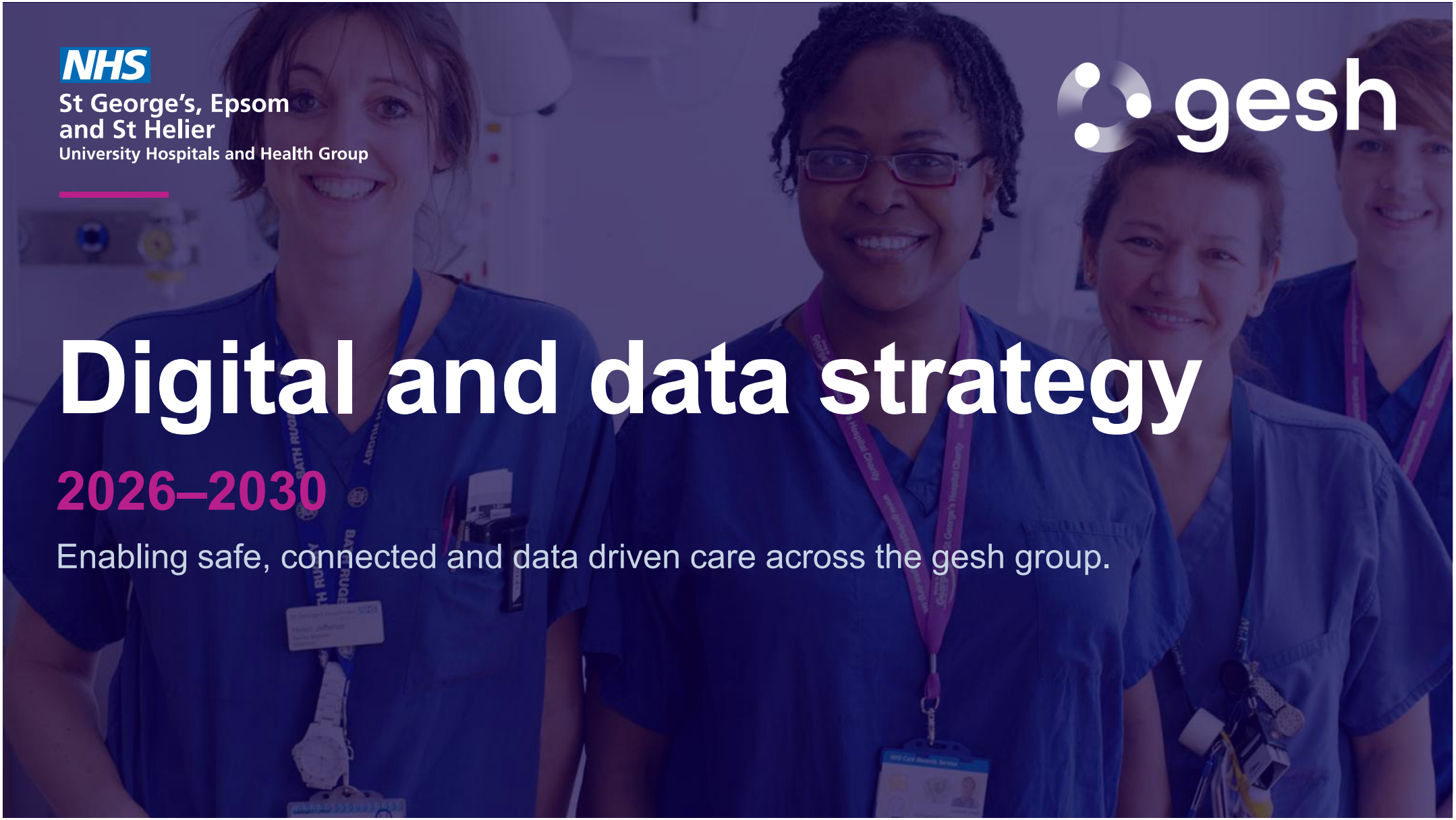
As set out in paper.

Equality, diversity and inclusion implications

N/A

Environmental sustainability implications

N/A



Digital and data strategy

2026–2030

Enabling safe, connected and data driven care across the gesh group.

FOREWORD



Matthew Shaw
Group Chief Executive Officer



Michael Pantlin
Group Deputy Chief Executive Officer

Advances in technology are providing a pivotal moment across our society and how healthcare is experienced is no exception.

Working through the development of this strategy, the most exciting potential has emerged. Patients and residents are keen to own and control more of their interactions with us and by enabling this, we also help them own more of their own health. At the same time, this strategy empowers clinicians too, so they can spend more time on what matters most – be that speaking with patients “in that moment” or using rich data reserves to drive forward prevention and research.

Compared to many other areas of society, the NHS often feels behind the times. Too many patient letters are typed and still go in the post. Mobile work-stations on wards are cumbersome and often remain plugged-in due to poor battery technology. Poor WIFI can make caring a battle and limited data sharing can augment a feeling that “the system” is conspired against us.

At gesh, we have therefore prioritised significant capital investment in the basic IT infrastructure as well as continuing to pioneer advancements – such as in ambient voice technology. Already our emergency department doctors are engaging patients first and looking at the computer later, where the conversation has been captured and actions processed for them.

The power of the group, providing outstanding care together, makes all this more possible for more patients. Our thanks therefore go to the newly formed gesh digital team and our joint clinical leaders, who built this vision and are making it a reality every day.

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EXECUTIVE SUMMARY

St George's, Epsom and St Helier Hospitals Group (GESH) is at a critical point in its development as a single, integrated organisation. The scale of our services, the diversity of our communities and the growing demand on our hospitals require a step change in how digital and data support care delivery.

Digital and data are now central to modern healthcare. They enable safer care, more efficient services and better experiences for patients and staff. However, they also introduce complexity and risk if not managed well. This strategy sets out how we will strengthen our foundations, simplify our environment and make better use of digital and data across the Group.

We recognise that our current digital environment does not yet consistently support the level of care we aspire to deliver. Fragmented systems, ageing infrastructure, variable user experience and increasing cyber risk create inefficiencies and place additional burden on staff. At the same time, expectations from patients and staff continue to grow, with increasing demand for digital access, real time information and more connected services.

In the last year, we have begun the journey of stabilising key areas of our technology environment and strengthening important capabilities, particularly in analytics and our shared electronic patient record (EPR). This provides a platform from which we can now move forward with greater pace and clarity.

This strategy sets out a clear and practical approach for the next five years. We will address critical risks in our infrastructure and cyber security, simplify and integrate our systems and establish a single, trusted data capability across the Group. Alongside this, we will adopt AI and automation to reduce administrative burden, improve productivity and support better clinical and operational decision making.

Our work is organised around six strategic priorities:

1. **Safe and secure digital foundations** that ensure systems are reliable, resilient and protect patient data.
2. **A data driven organisation** where decisions are based on timely, accurate and trusted insight.
3. **AI and automation to improve productivity** and support better clinical and operational outcomes.
4. **Optimised and integrated digital systems** that reduce duplication and enable more seamless care.
5. **A connected and collaborative organisation** where staff can work effectively across all sites.
6. **A simple and accessible digital front door** for patients and staff, centred on the NHS App and consistent digital services.

Within these priorities, we will focus on a small number of targeted investments where we expect the greatest impact. These include expanding the NHS App as our primary patient interface, deploying ambient AI to support clinical documentation, simplifying access to corporate services and making better use of our Electronic Patient Record (EPR).

Delivering this strategy will require more than technology. It will depend on strong clinical and operational engagement, clear governance and disciplined delivery. We will strengthen our digital workforce, align our programmes to organisational priorities and work closely with system partners to maximise value and interoperability.

The outcome will be a simpler, more reliable and more intelligent digital environment. This will enable staff to focus more of their time on patient care, improve experience for patients and support more proactive, equitable and efficient services across the Group.

In summary, this strategy addresses current risks, builds strong and dependable foundations and enables the transformation required to deliver high quality care for our communities, now and in the future.

01

Where we are now

A single integrated Group, serving one of the largest and most diverse populations in South West London, on digital foundations that do not yet match our ambition.

WHERE WE ARE NOW

St George's, Epsom and St Helier Hospitals Group (GESH) is entering a period of significant organisational change. **The Group is progressing its route to an Integrated Health Organisation (IHO), with a formal merger planned to create a single statutory organisation.** As a single, integrated Group, we care for one of the largest and most diverse populations in South West London. **The ambition is to enable more integrated care delivery across hospital and community settings, improve outcomes and support system level priorities including prevention, productivity and reducing health inequalities.**

This direction is set out in the GESH five year strategy, which defines a clear ambition to deliver outstanding care, together, including providing the right care, in the right place, at the right time, improving outcomes and experience, and tackling health inequalities. **Digital and data are critical enablers of these care objectives**, supporting integrated pathways, timely access to information and better informed clinical decision making across organisational boundaries.

Meeting rising demand, reducing inequalities and improving patient experience requires **digital and data services that are reliable, secure and joined up.**

Our current digital environment does not yet consistently support the level of care we aim to deliver. Across our hospitals and community services, systems remain fragmented, infrastructure is ageing and reliability is variable. Staff frequently experience slow or inconsistent access to systems and limited availability of real time information. This creates inefficiencies and reduces the time available for direct patient care and constrains our ability to deliver care in the most appropriate setting.

In 2025, the Group took an important step towards integration through the expansion of the St George's Electronic Patient Record (EPR) iClipPro to Epsom and St Helier. However, **significant work remains to stabilise, standardise and optimise the system** so it fully supports our digital priorities and the strategic objective of a shared, integrated record across the Group.

There are also material risks within our current position. **Legacy technology, ageing infrastructure and weaknesses across core networks and data centres increase exposure to operational disruption and cyber attack.** These risks have direct implications for **patient safety, service continuity and organisational resilience** and impact our ability to deliver safe, timely and effective care**.**

17,000

staff across 4 main hospital sites and community services

300

digital and data staff supporting the Group

100+

clinical systems currently supported

18,000

devices, including desktops, laptops and workstations on wheels

WHERE WE ARE NOW

Digital and data must keep pace with our scale and ambition

Digital and data are core enablers of the Group's transformation portfolio, supporting delivery of the Medium Term Plan, NHS Long Term Plan and the CARE objectives. The portfolio of transformation programmes, spanning clinical pathways, workforce, productivity and the route to an Integrated Health Organisation, is underpinned by the need for shared, reliable and accessible information.

The digital strategy will support these programmes by enabling integrated patient records, standardised pathways, improved access to real time data and digital tools that support new models of care across hospital, community and system partners. This includes supporting key programmes such as transforming outpatient services, non elective care, clinical workforce transformation, productivity improvement and the shift from hospital to community based care.

Without sustained improvement in digital capability, many of these programmes will be constrained in their ability to deliver the intended benefits in quality, access, productivity and patient experience.

This digital and data strategy is central to enabling delivery of our ambitious transformation priorities and our gesh 2030 vision to offer Outstanding Care, Together. It is critical for enabling joined up care across hospital and community settings outcomes and responding to system priorities including prevention, productivity and reducing health inequalities

WHERE WE ARE NOW

Four challenges we must address

01 Fragmented, complex landscape

200+ systems with limited interoperability make it hard to share information, coordinate care and operate efficiently.

02 Weak foundations, high risk

Ageing infrastructure and single points of failure create real risks to continuity, patient safety and cyber resilience.

03 Underinvestment & constrained capacity

Spend below national benchmarks, with demand exceeding workforce capacity, limits our ability to modernise.

04 Underutilised, fragmented data

Despite strong data assets, variation in how data is managed and used limits its potential for decision-making.

Together, we have opportunities to enable a shift to connected, data driven, patient-centred care delivered more efficiently across hospital, community and home.

02

Our vision

A digitally connected, data-driven organisation, with an accessible digital front door, making care simpler for patients and empowering staff.

OUR VISION AND MISSION

OUR VISION

A digitally connected, data-driven organisation with an accessible digital front door, making care simpler for patients and empowering staff to deliver high-quality care.

OUR MISSION

We will deliver a connected, data-driven organisation where technology supports every aspect of care. We will provide an accessible digital front door, simplify pathways and enable joined-up working across partners. By supporting staff with intuitive systems and trusted data, we will deliver safer, more personalised care and better outcomes for our communities.

OUR VISION

Six strategic priorities

Safe and secure foundations

Reliable, resilient and secure digital services that support safe care.

A data driven organisation

Trusted, timely insight to support better decisions at every level.

AI and automation

Reducing administrative burden and improving productivity through AI.

Integrated digital systems

Joined-up systems that support coordinated care across gesh.

A connected organisation

Enabling staff to work effectively across all sites and services.

An accessible front door

A clear, accessible digital front door for patients and staff.

03

What we want to achieve

Each of our six priorities, with the focus areas and the key deliverables that bring it to life.

Safe and secure digital foundations

Strengthening our digital foundations to ensure technology is reliable, secure and always works for staff and patients.

Over the next four years, we will put the right foundations in place to ensure our digital services are reliable, secure and resilient. Our aim is to create a stable, dependable digital environment where systems work consistently, risks are actively managed and staff can focus on patient care rather than technology issues. This will improve safety, strengthen cyber resilience, enhance staff experience and support better outcomes for the people we serve.

Key priorities We will focus on getting the basics right by strengthening the core infrastructure that underpins all digital services across gesh, delivered through a focused set of priorities.

01 One reliable network across all sites.

We will replace the current mix of ageing systems with a single, modern network across gesh. This will ensure consistent performance, reduce outages and allow staff to work reliably wherever they are.

02 Faster and more reliable connectivity.

We will upgrade the technology that keeps our systems running to ensure faster and more reliable connections. This will enable modern clinical systems, digital diagnostics and new ways of working such as video and remote access.

03 Reliable and resilient systems that staff can depend on.

We will improve how our systems are set up and managed, so they are stable, secure and able to grow with us. This will ensure critical services remain available and care is not disrupted, even when there are issues.

04 Modern, reliable devices for staff.

We will provide staff with fast, secure and regularly refreshed devices. This will reduce day to day technical issues, improve productivity and enable the use of new digital and AI supported tools.

05 Strong and proactive cybersecurity.

We will strengthen our approach to cybersecurity in line with NHS standards, protecting patient data and reducing risk to services. This will help ensure our systems always remain safe and available.

06 Laying the foundations for a data and AI enabled organisation.

We will put in place the infrastructure needed to support real time data, automation and AI. This will enable more advanced capabilities over time and support our ambition to become a modern, data driven organisation.

Our key deliverables

Cybersecurity enhancements

Establishment of a dedicated cyber security team to enhance resilience and reduce risk

Digital Infrastructure Building Blocks

We are modernising our network and Wi-Fi to improve performance, reliability and scalability.

Governance and Control

We are strengthening governance to improve oversight, accountability and decision making

Integration and Standardisation

Improvements to integration and standardisation to improve interoperability, reduce duplication

Together, these priorities will create a single, secure and high performing digital foundation that supports safe, seamless care and enables staff to deliver their best work every day.

A data driven organisation

Using data and insight to support better decision making and improve outcomes across the Group.

Over the next four years, we will become a data driven organisation where decisions at every level are informed by timely, accurate and trusted insight. We will make data central to understanding performance, planning services and improving care, using it to describe the past, understand the present and anticipate future demand to enable earlier intervention and more proactive care. We will create a single shared view of performance across the Group, enabling earlier action, better demand management and more equitable outcomes, while improving transparency and reducing variation. To achieve this, we will build a unified data and analytics capability providing clinicians, operational teams and leaders with reliable, actionable insight, supported by one platform, one set of standards and one coordinated workforce.

Key priorities We will build a strong, joined up data capability across the Group, bringing together people, platforms and processes to support consistent, high quality insight.

01 One team delivering data and insight across gesh.

We will bring together our analytics teams into a single, coordinated workforce with shared standards, skills and ways of working. This will reduce duplication, improve consistency and provide better support to clinical and operational teams.

02 One platform for data and analytics.

We will bring our data into a single, modern platform with common tools and definitions. This will replace fragmented systems and give staff faster access to reliable information.

03 A single, trusted view of performance.

We will establish a consistent set of metrics and reporting across the Group, ensuring decisions at every level are based on the same clear and trusted information.

04 Making it easier to access and use information.

We will provide simple dashboards, improved reporting and self service tools so staff can quickly find and use the information they need. We will also use automation and AI to reduce manual effort and simplify analysis.

05 Using data to improve patient experience.

We will use data to support clearer, more personalised communication with patients, helping reduce missed appointments and making services easier to navigate.

06 Working with partners across the wider system.

Working with regional and national partners to share data safely and adopt best practice. We will ensure the infrastructure is in place to enable research and innovation, leveraging Secure Data Environments to accelerate research and enhance data driven insight.

Our key deliverables

Unified data platform and reporting

A single platform and common reporting tools to provide trusted, consistent insight.

Real-time data and operational insight

Near real-time dashboards and alerts to support faster decisions and earlier action

Data Driven Patient Pathways

Implement predictive analytics to identify patient needs, improve performance and reduce delays.

Performance management system

A shared performance framework with common metrics, accountability and visibility of delivery.

Together, these priorities will create a single, secure and high performing digital foundation that supports safe, seamless care and enables staff to deliver their best work every day.

AI and automation to improve productivity and care

Using AI and automation to streamline processes and give staff more time to focus on patient care.

Over the next four years, we will use AI and automation to improve productivity and support better care delivery.
Our aim is to reduce unnecessary administrative work, streamline processes and make it easier for staff to do their jobs. This will free up time for patient care, improve efficiency and support safer, more consistent ways of working across the organisation.
We will take a practical and focused approach, embedding AI into everyday workflows in a way that supports staff rather than disrupts them, and delivers clear benefits for both staff and patients.

Key priorities We will use AI and automation to simplify processes, reduce administrative burden and support more proactive, efficient care.

01 Digitising and automating key processes.

We will reduce reliance on paper and manual processes by introducing digital workflows and automation where appropriate. This will improve speed, accuracy and productivity.

02 Using AI to reduce administrative burden.

We will deploy tools such as Microsoft Copilot and other generative AI solutions to support tasks such as drafting documents, summarising information and automating routine work. This will save time, reduce duplication and improve productivity across clinical and corporate teams.

03 Ambient AI to support clinical documentation.

We will introduce ambient voice technology to support the capture of clinical conversations. This will allow clinicians to focus on patients rather than screens, while generating draft clinical notes for review and approval.

04 Using AI to improve patient communication and access

We will use AI-enabled tools to give patients clearer information, support appointment management and make services easier to access and navigate

05 Robotic Process Automation for operational use

We will automate high-volume operational and administrative tasks to reduce manual effort, improve flow and free up staff time for higher-value work.

06 Scaling AI safely across the organisation.

We will put in place the governance, infrastructure and change support needed to adopt AI and automation safely, effectively and at scale.

Our key deliverables

- ✓ **Ambient AI in all clinical settings**
  Support clinical documentation and release more time for patient care
- ✓ **Microsoft Copilot for administrative use**
  Reduce routine admin effort through drafting, summarising and workflow support.
- ✓ **Centre of Excellence for AI established**
  A centre for AI and innovation established at gesh to support product development and commercialisation.
- ✓ **AI tools for appointment management**
  Improve appointment management, communication and access to services.

Together, these priorities will create a single, secure and high performing digital foundation that supports safe, seamless care and enables staff to deliver their best work every day.

gesh

What we want to achieve

Optimised and integrated digital systems

Improving and connecting our digital systems to reduce duplication and support more efficient and coordinated care.

Over the next four years, we will optimise and integrate digital systems across the group for both acute and neighbourhood care to reduce duplication, remove unnecessary variation and align around consistent workflows. We will rationalise the application landscape, simplify support across clinical and corporate functions and enable systems to communicate safely and effectively, removing the need for repeated data entry. This will reduce manual effort, improve data quality and support safer, more coordinated care, creating a more efficient digital environment for staff and a more seamless experience for patients..

Key priorities We will optimise and integrate our digital systems to reduce duplication, simplify workflows and support more coordinated, efficient care.

01 Reducing duplication across our application landscape.

We will review and rationalise systems across the Group, removing duplicate applications and consolidating where appropriate. This will reduce complexity, lower cost and improve consistency.

02 Standardising clinical and corporate workflows.

We will align how systems are used across services, introducing consistent processes and reducing unnecessary variation. This will improve efficiency and support safer, more reliable care delivery.

03 Improving integration between systems.

We will ensure our systems can communicate effectively, enabling information to flow across care settings. This will reduce repeated data entry and improve continuity of care.

04 Making better use of our Electronic Patient Record.

We will optimise our shared EPR to support consistent pathways, improved clinical decision making and more efficient workflows. This will help ensure patients receive high quality care regardless of where they are seen.

05 Supporting joined up care across the wider system.

We will enable safe and effective information sharing with partners across primary care, community and system organisations. This will support more coordinated and integrated care.

Our key deliverables

- ✓ **Unified, connected clinical systems**
  Reducing duplication by aligning clinical systems to the Group Strategy for joined up clinical services
- ✓ **Standardised system workflows to reduce unwarranted variation**
  EPR and other clinical system changes will be designed to improve efficiency
- ✓ **EPR optimised to support patient pathways and transformation**
  Support clinical decision making and improved administrative workflows for efficient patient care
- ✓ **Clinical data visible across care settings**
  Improved interoperability between care settings to support integrated care delivery

Together, these priorities will create a single, secure and high performing digital foundation that supports safe, seamless care and enables staff to deliver their best work every day.

gesh

What we want to achieve

A connected and collaborative organisation

Enabling seamless communication, collaboration and information sharing across a single, connected organisation.

Over the next four years, we will use digital technology to bring gesh together as a single, connected organisation. Our aim is to make it easy for staff to communicate, share information and collaborate across all sites and services, with seamless and secure access to the systems and tools they need. This will reduce barriers between teams, improve coordination and enable more joined up ways of working across hospital, community and corporate services. We will align systems, standardise ways of working and enable safe, real time information sharing so staff can work effectively across organisational boundaries without duplication or delay. This will create a more connected, efficient and collaborative organisation that supports better decision making, improved staff experience and more coordinated care for our patients.

Key priorities We will simplify how staff connect, communicate and access digital services across gesh.

01 One email and calendar system for all staff.

We will move to a single email and calendar platform using NHS.net across the Group. This will make it easier for staff to communicate, organise their work and collaborate across all sites and services.

02 One system for messaging and collaboration.

We will provide a single, easy to use platform for messaging, meetings and collaboration. This will reduce reliance on multiple tools and make it simpler for staff to work together in real time.

03 One consistent way to access digital services.

We will introduce a single, clear way for staff to access the systems, information and support they need. This will remove complexity, reduce time spent navigating different systems and improve day to day experience.

04 A single digital network across the organisation.

We will ensure staff can access systems and information seamlessly across all sites, supporting flexible and cross site working without barriers.

Our key deliverables

NHS.net mail for all gesh staff

NHS.net mail creates a unified digital identity, enables cross site collaboration and integration.

One unified IT network across gesh.

One shared IT network giving GESH staff secure, consistent access and simplifying operations.

Single Digital Service Desk for gesh

Single access point for staff to access digital support simplifying access and operations.

Single communication platform

A single platform for communication and collaboration based on Microsoft 365 environment.

Together, these priorities will create a single, secure and high performing digital foundation that supports safe, seamless care and enables staff to deliver their best work every day.

A simple and accessible digital front door for staff and patients

Providing a simple, consistent and accessible digital front door for both patients and staff to access care and support.

Over the next four years, we will provide a simple, accessible digital front door that improves how patients and staff access care and support. We will make it easier for patients to manage their care and for staff to access tools and information through clear, consistent channels, reducing complexity and delays. We will expand access through the NHS App and other platforms, alongside a single, consistent approach to staff access for clinical and corporate services. As more patient interactions are enabled through the digital front door, we will prioritise designing and delivering these services in ways that do not exacerbate digital exclusion. Services will remain inclusive, with appropriate alternatives to ensure no one is excluded. This will improve experience, reduce barriers and support more responsive care.

Key priorities We will simplify and standardise how patients and staff access care and support through clear, consistent digital channels.

01 The NHS App as the primary patient front door.

We will expand the use of the NHS App as the main way for patients to access services, information and support. This will provide a single, familiar entry point and improve consistency across the Group.

02 Managing appointments and communications digitally.

We will enable patients to book, change and cancel appointments, receive communications and view results digitally. This will reduce delays, improve convenience and support more responsive services.

03 Consistent digital pathways across services.

We will standardise how digital services are used across specialties, including questionnaires, referrals and “wait well” support. This will ensure patients have a consistent experience regardless of where they receive care.

04 Integration with clinical systems and patient records.

We will ensure information provided through digital channels flows directly into clinical systems and the Electronic Patient Record. This will improve data quality, reduce duplication and support safer, more coordinated care.

05 A single digital front door for staff support services.

We will introduce one platform for staff to access corporate services such as HR, IT, Finance and Estates. This will simplify access, improve response times and provide a more consistent experience.

06 Inclusive and accessible digital services for all.

We will design digital services to be accessible and easy to use, while maintaining alternative routes for those who need them. This will ensure no patient or staff member is excluded from accessing care or support.

Our key deliverables

A single access point for GESH.

A single digital front door giving GESH staff one place to access support, services and information.

90% digital access via the NHS App

By 2029, 90% of patient interactions will be through a single NHS App front door.

90% of appointments managed online

By 2027, most appointments will be managed online, reducing missed appointments by 30%.

100% standardised pathways

By 2028, all services will use standard digital pathways for consistent patient journeys.

Together, these priorities will create a single, secure and high performing digital foundation that supports safe, seamless care and enables staff to deliver their best work every day.

gesh

What we want to achieve

04

What this means for staff and patients

A more connected, responsive and patient-centred organisation, care that is safer, more efficient and more personalised.

What this means for our staff and patients

Our digital and data strategy will enable a step change in how we deliver care across the gesh Group. By combining reliable digital foundations, better use of data and modern technology, we will create a more connected, responsive and patient-centred organisation. This will support our ambition to deliver care that is **safer, more efficient and more personalised**, while improving experience and outcomes for both patients and staff.

Better, safer and more reliable care:
Patients will benefit from **more consistent and dependable services**, where systems are available when needed and information is accurate, complete and secure. This will **reduce delays and minimise risk**, supporting safer, higher quality care. For staff, reliable infrastructure, modern devices and secure systems will reduce disruption and frustration, enabling them to focus on delivering care.

More personalised and proactive care:
Using data more effectively, supported by analytics and AI, we will move towards **more proactive and preventative models of care**. Patients will experience services that are better tailored to their needs, with **earlier intervention and improved outcomes**. Staff will have access to timely, trusted information and decision support, helping them to make more informed choices and deliver more effective care.

Faster access and a clearer digital front door:
We will expand the use of the **NHS App and patient portal** to create a **clear digital front door** for our services. This will allow patients to book, change and manage appointments, access results and letters, and communicate more easily with their care teams. This will simplify how people interact with the organisation, reduce reliance on paper and telephone-based processes, and give patients **greater control**.

At the same time, integrated systems and streamlined pathways will reduce duplication and delays, creating smoother patient journeys with less need to repeat information.

For staff, improved digital access and better managed patient interactions will reduce administrative workload and make services easier to coordinate.

More joined up care across the system:
The strategy will enable a more integrated model of care, where **information flows seamlessly** across hospitals, community services and partners. This will **improve coordination and continuity of care** and reduce fragmentation. Staff will be better able to work across teams, sites and services, supported by shared systems and consistent ways of working.

More time for what matters most:
Automation and AI will reduce manual processes and administrative workload, freeing up **more time for patient care** and enabling staff to **focus on clinical care and high value activities**. For patients, this will mean more meaningful interactions, better communication and a more personalised care.

A more inclusive and accessible service:
Digital services will be designed to be **simple, accessible and inclusive**, including the patient portal, ensuring that all patients can benefit. Alternative routes to access care will remain in place so **no one is excluded**. For staff, a more intuitive and consistent digital environment will support adoption and improve overall experience across all roles.

Overall impact

Together, these changes will create a more connected, efficient and sustainable organisation, where:

- patients receive **safer, faster and more personalised care**.
- patients have **greater control through a clear digital front door**.
- staff are supported by **reliable, intuitive systems** that enable them to work effectively.
- services are **joined up, reducing complexity and improving outcomes**.

This represents a shift towards a modern, digitally enabled healthcare model that improves quality, experience and equity across the gesh Group.

WHAT THIS MEANS

Patient and staff stories

A PATIENT'S STORY - MARIA

“Everything I need is accessible, secure and simple.”

Living with a long-term cardiac condition, Maria uses her patient portal to see appointments, results and messages in one place, and completes a short questionnaire before she arrives. In clinic, her clinician has a complete, joined-up view of her care, and her plan and next steps are updated and booked before she leaves. When her symptoms change, she reports it through the portal and is reviewed quickly, allowing early advice before things worsen.

A NURSE'S STORY - EMMA

“More time on clinical judgement, less on admin.”

Emma, a clinical nurse specialist in oncology, starts her day with a prioritised view of her caseload, working from a single, comprehensive patient record. In clinic, ambient technology captures conversations and completes documentation, so she can focus fully on patients. She coordinates complex pathways using shared, real-time systems and responds early to alerts, ending the day with no backlog and no after-hours admin.

05

How we get there

Delivery depends on more than technology, a skilled workforce, a phased roadmap, and disciplined governance.

HOW WE GET THERE

A skilled and empowered digital workforce

Building the capability, capacity and culture to deliver secure, reliable and user-centred services across gesh.

Build skills and capacity

Technical, analytical and clinical informatics skills to deliver transformation at scale.

Security & safety by design

Cyber security and information governance built into every service and decision.

Leadership & accountability

Clear roles and governance for digital, data and cyber across the Group.

User experience & adoption

Training, support and intuitive systems so staff use digital tools confidently.

A responsive digital function

Visible, engaged teams responsive to operational needs, with clear support routes.

Continuous learning

A culture of development and innovation to adapt to AI and new technologies.

HOW WE GET THERE

The five-year roadmap

2026
Foundation

Secure, In 2026, the focus is on putting the basics in place to support future digital services.

•A **strong, secure digital backbone** will be established, including new infrastructure and a **dedicated cybersecurity team**.

•**Core systems and governance** will be strengthened to ensure safe, reliable use of data and technology..

•A **unified data platform** will begin development, alongside improved access to real-time operational data.

•**AI tools such as Microsoft Copilot** will be introduced to support staff with administrative work.

2027
Connect

In 2027, the organisation becomes more joined up and consistent.

•Staff will benefit from a **single IT network (including roll out of NHS.net), shared systems, and one digital service desk.**

•Work will progress toward a **single access point ("digital front door") for staff.**

•Processes and pathways will be standardised, with **most appointments managed online** via the NHS App.

•A **performance management system and common reporting tools** will improve how services are monitored and managed.

•A **centre of excellence for AI, Innovation and automation** will be created to support wider adoption.

2028
Integrate

In 2028, digital systems and data are brought together to transform care delivery.

•Electronic patient records (EPRs) across hospital and community services will be **integrated with Ambient AI and other AI technologies**.

•Clinical systems will be integrated across the group, supporting joined-up care.

•Pathways on **Acute and Community EPRs will be more standardised**, making care more consistent and easier to navigate.

•**Ambient AI and automation tools will be introduced across all clinical areas**, supporting clinicians and improving efficiency.

•Data will increasingly be used to design and improve patient pathways through **predictive analytics**

2029
Optimise

In 2029, the benefits of earlier changes are scaled up and optimised.

•**Clinical systems will be fully connected**, enabling seamless information sharing across services.

•A **centre of excellence for the NHS App and patient portal** will support better digital access.

•The majority of patients will be able to **access services and manage their care digitally.**

•Data and insights will be used more routinely to **improve performance and patient outcomes.**

2030
Innovate

By 2030, the organisation builds on its digital maturity to keep improving.

•Advanced **AI and automation** will be more widely used, including tools that support patient communication and access.

•Digital services will continue to evolve, becoming **more personalised, proactive, and efficient.**

•The organisation will be well placed to **adopt new technologies quickly and safely.**

HOW WE GET THERE

Capability and governance enhancements

To deliver safe, modern and efficient care, gesh requires a step change in digital, data, AI and governance capability. This will be achieved through a coordinated approach spanning prioritisation, delivery, workforce and partnerships.

A strengthened governance framework will ensure all digital, data and AI investment is aligned to strategic priorities, clinical need and risk reduction. Clear decision making routes, accountability and oversight will be established at both portfolio and programme level.

This will be supported by a structured demand management process, providing a transparent route for assessing and prioritising new initiatives based on value, risk and affordability. This enables a balanced portfolio between transformation, operational stability and technical debt.

An **AI Centre of Excellence** will be established to provide central leadership and expertise for AI adoption across the Group. The function will:

- Support identification, prioritisation and scaling of **AI use cases**.
- Provide specialist expertise in **data science, model assurance and deployment**.
- Promote **reuse of tools, platforms and patterns** to avoid duplication.
- Build **capability across clinical and operational teams** through guidance and training.
- Establish **partnerships with industry and academic organisations** to accelerate innovation and research.
- Support **product development and commerci**alisation of internally developed solutions where appropriate.

Delivery confidence will be improved through a strengthened **business management function**, coordinating procurement, finance and risk. This will support robust business cases, effective supplier engagement and disciplined programme execution. Benefits will be clearly defined and tracked against outcomes linked to patient care, productivity and staff experience.

Alongside governance and delivery improvements, the strategy places strong emphasis on capability building. Clinical and operational teams will be supported to maximise the value of digital tools, including business intelligence and AI solutions. Focus on adoption, communication and data quality will ensure benefits are realised in practice, with clinical involvement embedded in all programmes.

Partnerships with academic, industry and system organisations will support innovation, particularly in AI, automation and advanced analytics. This will be underpinned by a four year workforce plan to grow digital, data and AI capability, supported by a sustainable funding model.

The approach set out above establishes the foundations required to deliver the Group's digital strategy in a controlled and prioritised way. It ensures that investment is aligned to clinical and operational need, that delivery is governed and assured, and that capability is built alongside transformation. The following roadmap outlines how these capabilities, structures and investments will be phased over time to deliver measurable improvements in patient care, productivity and staff experience.

Group Board

Meeting in Public on Thursday, 09 July 2026

Agenda Item	5.4	
Report Title	**Group Board Assurance Framework**	
Executive Lead(s)	Stephen Jones, Group Chief Corporate Affairs Officer	
Report Author(s)	Stephen Jones, Group Chief Corporate Affairs Officer	
Previously considered by	People Committees Infrastructure Committees Quality Committees Finance & Performance Committees	18 June 2026 19 June 2026 25 June 2026 26 June 2026
Purpose	**For Approval / Decision**	

Executive Summary

This paper presents the refreshed Group Board Assurance Framework (BAF) for Board approval.

In February 2026, the Board agreed that the BAF should be comprehensively refreshed to reflect the changing strategic context facing the Group, including the NHS 10 Year Plan, the development of the Medium Term Plan and Group Transformation Programme, and wider changes in the NHS operating environment. The Board also agreed a revised approach to the BAF, based on a smaller number of clearer strategic risks, a consistent methodology for describing and assessing those risks, and stronger alignment between the Group Strategy, risk appetite, controls, assurance and mitigating actions.

Since then, each proposed strategic risk has been developed collaboratively with Executive leads using existing Board and Committee evidence and has been reviewed through the relevant Board Committees and the Group Executive Committee. This process has enabled refinement of the proposed risk scores, assurance ratings, controls, control strengths, gaps in control, mitigating actions and emerging risks to ensure that the BAF reflects the Board's current understanding of the principal risks to delivery of the CARE Strategy.

The proposed refreshed BAF comprises nine strategic risks, reduced from fourteen in the previous framework, providing a clearer and more focused view of the principal risks to delivery of the Group Strategy. The proposed strategic risk relating to Neighbourhood Health has not been included at this stage following discussion at Group Executive Committee, which concluded that the Group's strategic direction in this area requires further development before an appropriate Board Assurance Framework risk can be articulated. It is proposed that this risk is developed further and brought back to the Board at a later date.

The refreshed BAF is intended to become the Board's principal strategic assurance framework. It strengthens the alignment between the CARE Strategy, Medium Term Plan and Group Transformation Programme, provides a consistent methodology for assessing strategic risks, and enables the Board to focus on whether appropriate controls are in place, whether sufficient assurance exists, where

material gaps remain and whether mitigating actions are delivering the intended reduction in strategic risk over time.

Action required by Group Executive Committee

The Committee is asked to:

a. Approve the refreshed Group Board Assurance Framework and its adoption as the Board's principal framework for oversight of strategic risk and assurance.
b. Approve the proposed suite of nine strategic risks, together with the associated risk scores, assurance ratings, control strengths, gaps in control, mitigating actions and target risk positions – with eight having been reviewed and endorsed by the relevant Board Committee and the ninth – Transformation Delivery – reserved to the Board for decision.
c. Note that the proposed strategic risk relating to Neighbourhood Health and the Left Shift will be developed further and presented to the Board when the Group's strategic direction has matured sufficiently to support an appropriate Board-level strategic risk.
d. Agree that the refreshed Board Assurance Framework will be reviewed quarterly through the Board's Committee structure and reported to the Board as the principal mechanism for monitoring strategic risk, assurance and delivery of the CARE Strategy.

Committee Assurance

Committee	Group Board
Level of Assurance	Not Applicable

Appendices

Appendix No.	Appendix Name
Appendix 1	Group Board Assurance Framework

Implications

Group Strategic Objectives

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

Risks

The principal risk is that the refreshed Board Assurance Framework does not accurately reflect the Group's strategic risk profile, resulting in gaps in Board oversight and assurance. The purpose of the review process is to ensure that strategic risks, controls, assurances, gaps and mitigating actions are appropriately identified and aligned to the Group's strategic objectives.

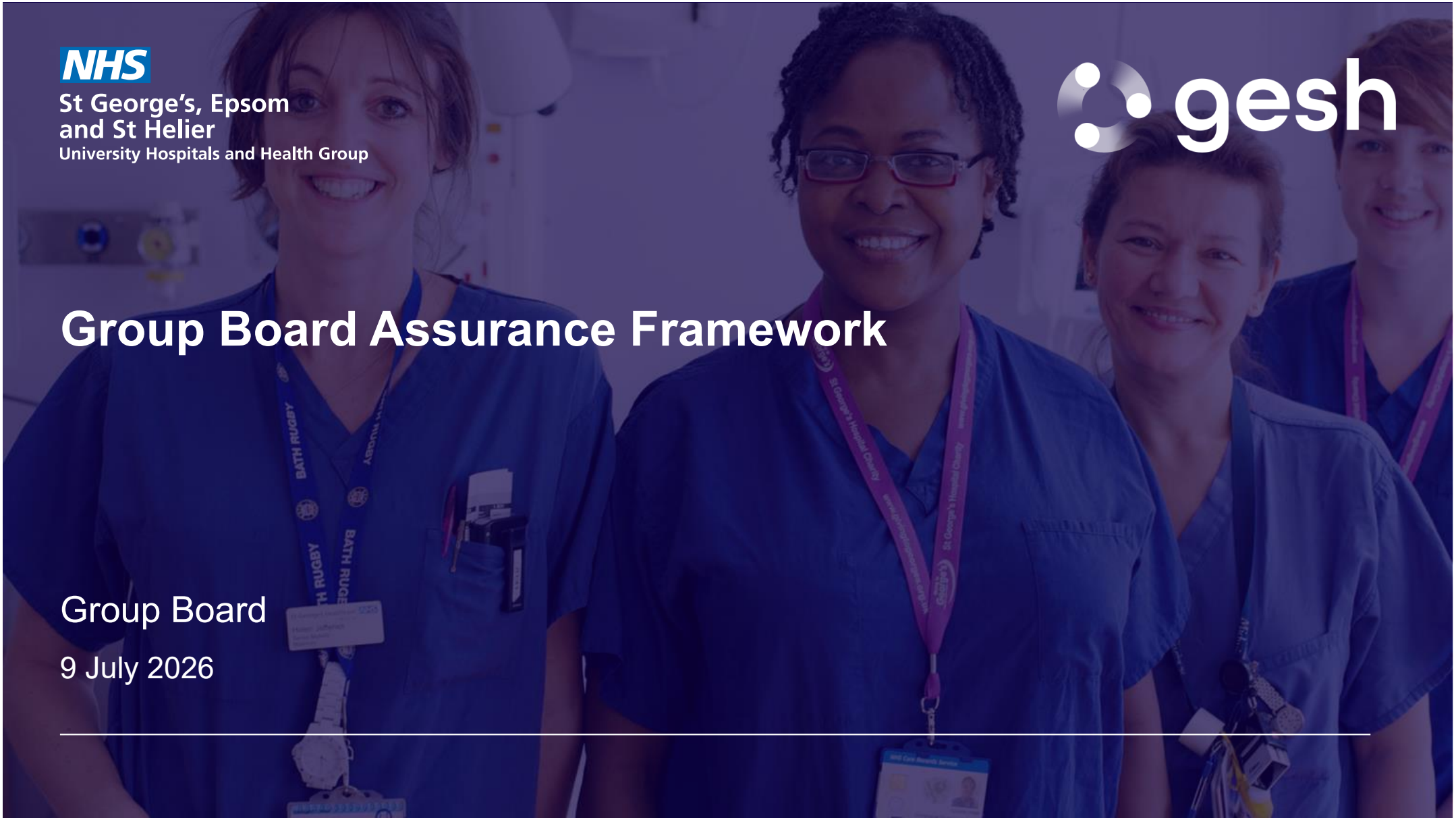
CQC Theme

☒ Safe	☒ Effective	☒ Caring	☒ Responsive	☒ Well Led

NHS system oversight framework

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

Financial implications
The paper does not seek approval of any new expenditure or financial commitments. However, there is a strategic risk focused on financial sustainability.
Legal and / or Regulatory implications
The BAF is a key component of the Group's governance and risk management framework and supports the Board in discharging its responsibilities for oversight of strategic risk and internal control. The proposals set out in this paper are intended to strengthen alignment between strategic risks, Board assurance and regulatory expectations regarding effective governance and risk management.
Equality, diversity and inclusion implications
One of the draft strategic risks presented (SR10 – Organisational Culture and Inclusion) specifically addresses inclusion, workforce equality and staff experience.
Environmental sustainability implications
There are no direct environmental sustainability implications arising from this paper.



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Group Board Assurance Framework

Group Board

9 July 2026

Group Board Assurance Framework

Executive Summary

Purpose
This paper presents the refreshed Group Board Assurance Framework (BAF) for Board approval.

Background
In February 2026, the Board agreed that the BAF should be comprehensively refreshed to reflect the changing strategic context facing the Group, including the NHS 10 Year Plan, the development of the Medium Term Plan and Group Transformation Programme, and wider changes in the NHS operating environment. The Board also agreed a revised approach to the BAF, based on a smaller number of clearer strategic risks, a consistent methodology for describing and assessing those risks, and stronger alignment between the Group Strategy, risk appetite, controls, assurance and mitigating actions.

Development of the refreshed BAF
Since then, each proposed strategic risk has been developed collaboratively with Executive leads using existing Board and Committee evidence and has been reviewed through the relevant Board Committees and the Group Executive Committee. This process has enabled refinement of the proposed risk scores, assurance ratings, controls, control strengths, gaps in control, mitigating actions and emerging risks to ensure that the BAF reflects the Board's current understanding of the principal risks to delivery of the CARE Strategy.

The proposed refreshed BAF comprises nine strategic risks, reduced from fourteen in the previous framework, providing a clearer and more focused view of the principal risks to delivery of the Group Strategy. The proposed strategic risk relating to Neighbourhood Health has not been included at this stage following discussion at Group Executive Committee, which concluded that the Group's strategic direction in this area requires further development before an appropriate Board Assurance Framework risk can be articulated. It is proposed that this risk is developed further and brought back to the Board at a later date.

The refreshed BAF is intended to become the Board's principal strategic assurance framework. It strengthens the alignment between the CARE Strategy, Medium Term Plan and Group Transformation Programme, provides a consistent methodology for assessing strategic risks, and enables the Board to focus on whether appropriate controls are in place, whether sufficient assurance exists, where material gaps remain and whether mitigating actions are delivering the intended reduction in strategic risk over time.

Recommendations
The Board is asked to:

- Approve the refreshed Group Board Assurance Framework and its adoption as the Board's principal framework for oversight of strategic risk and assurance.
- Approve the proposed suite of nine strategic risks, together with the associated risk scores, assurance ratings, control strengths, gaps in control, mitigating actions and target risk positions – with eight having been reviewed and endorsed by the relevant Board Committee and the ninth – Transformation Delivery – reserved to the Board for decision.
- Note that the proposed strategic risk relating to Neighbourhood Health and the Left Shift will be developed further and presented to the Board when the Group's strategic direction has matured sufficiently to support an appropriate Board-level strategic risk.
- Agree that the refreshed Board Assurance Framework will be reviewed quarterly through the Board's Committee structure and reported to the Board as the principal mechanism for monitoring strategic risk, assurance and delivery of the CARE Strategy.

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Background and Context

Background

Role and purpose of a Board Assurance Framework

A BAF is the Board's single, live view of the principal (strategic) risks to delivering its strategic objectives, the controls in place, the assurance the Board receives on whether those controls are working, gaps in control and assurance, and the actions to close the gaps. Put simply: "what could stop us achieving our strategy; how are we controlling that; and what reliable evidence do we, as a Board, have that those controls work?

Purpose of the BAF for the Board

- The BAF brings together in one place all of the relevant information on the risks to the delivery of the board's strategic objectives. It acts as the source of evidence the board can rely on to be confident that risks to the delivery of the board's strategic objectives are being managed and controlled effectively.
- Helps board focus attention on the few, material strategic risks that matter most for success and stewardship (quality, outcomes, workforce, finance, estates, digital, system working
- Structures assurance on a "three lines" basis (1st line – management; 2nd line – oversight / committees; 3rd line – independent), so the Board can judge whether the evidence is sufficient, continuous and reliable.
- Underpins the Well Led requirement for effective integrated governance – with boards using the BAF to identify risks to strategic delivery and adjust focus accordingly.

Where the BAF sits in NHS governance

- NHS England's Code of Governance for NHS provider trusts places risk, internal control and assurance at the heart of corporate governance; a BAF is the practical tool boards use to discharge that responsibility.
- The CQC Well Led focus on culture, governance and risk expects boards to use risk and assurance information effectively to improve care – again a core function of the BAF
- The approach is consistent with central government's Orange Book (risk governance principles; three-lines model; assurance structures.
- All trusts are required to have a BAF, although there is no national guidance on how to develop a BAF or what should be included on the BAF

In short, the BAF is the Board's strategic risk and assurance map, not an all risks catalogue. It is the primary instrument for non-executive assurance about delivery of strategy and compliance with the Well Led framework. The BAF should be a simple and comprehensive means of reporting to the board that allows for effective prioritisation, focus and management of key strategic risks, and it should be used to shape and drive the board agenda.

Background

The key elements of a good Board Assurance Framework

Involve the Board	The BAF is owned by the Board and is a key tool in enabling it to do its job. Although most of the work on the BAF will be done by Executives or Senior Managers, the Board needs to be involved from the start in developing the BAF through seminars and workshops. The Board should not see a new BAF for the first time when it is being asked to approve it.
Start with the strategy	The BAF comprises strategic risks, which relate directly to achievement of the organisation's strategy and are identified 'top down' by the Board or Executive management. Operational risks, in contrast, arise from day-to-day activities and are usually identified 'bottom up' by managers of individual services. Thus, the starting point for identifying the strategic risks should be the agreed strategic objectives. To identify risks first and then map them back to the objectives in to put the cart before the horse.
Get the balance right...	...between detail and digestibility. The BAF should be straightforward for a well-informed and conscientious non-executive director to understand. The takeaways for the reader should be what the most important strategic risks are, what is being done about them, and what more needs to be done. Hugely detailed BAFs can be difficult to digest.
Be clear about the risks	A risk is not the same as a problem or an issue. It is an uncertain event which, if it occurs, will prevent us from achieving our objectives. Some risks may actually present an opportunity. Like risks on the trust's risk registers, each of the strategic risks should be described in a sentence making clear what might happen, why, and what impact it could have e.g. "*If...then...resulting in...*" or "Cause-Risk-Effect" formulation.
Controls, assurance and actions	Understand the difference between controls, assurances and actions. The BAF comprises strategic risks, which relate directly to achievement of the organisation's strategy and are identified 'top down' by the Board or Executive management. The BAF needs to be clear about what controls are in place, how the board can be assured that the controls are working effectively, the material gaps in control for which further mitigating actions are required.
The right assurances	"Third-line" assurance that comes from outside the organisation, e.g. from regulators, auditors etc is greatly valued for its independence, but "first line" assurance (from the services themselves) and "second line" assurance (from corporate functions within the trust, such as the clinical audit team or health and safety team) also have their place. Usually, the BAF should only include those assurances which are reported to the Board or its committees.
Closing the gaps	Make it clear how the gaps will be closed and when. Where there are gaps in control measures or in assurances, the BAF should include actions to close those gaps. These actions need to be SMART: specific, measurable, achievable, relevant, and – last but not least – time-limited. Deadlines should never be set as "ongoing".
Link BAF to high level operation-al risks	Make it clear how the gaps will be closed and when. Where there are gaps in control measures or in assurances, the BAF should include actions to close those gaps. These actions need to be SMART: specific, measurable, achievable, relevant, and – last but not least – time-limited. Deadlines should never be set as "ongoing".

Background

How the BAF differs from a Corporate Risk Register

Feature	Board Assurance Framework	Corporate Risk Register
Purpose	• Board-level focus on principal strategic risks to strategic objectives, their controls and assurance	• Organisation-wide catalogue of operational and tactical risks managed day-to-day
Ownership	• Owned by the Board, and used to shape agendas, deep dives, risk appetite and escalation • Decision to include risks on the BAF, or remove or modify them (and associated risk scores and assurance ratings) is taken by the board. • Risks are identified, defined and assessed by the board and executive team (top down).	• Owned by management and used to monitor and treat operational risks • Decision to escalate risks to the corporate risk register, or to close or de-escalate risks, is taken by the executive team or by a risk management group at executive level. • Risks are usually identified by services or department and escalated to corporate level (bottom up).
Content	• Comprises only the strategic risks which prevent the organisation from achieving its strategy. • Risks are trust-wide in their scope and impact • Typically have a high current risk score by virtue of their strategic nature, but there is not usually a threshold for a risk score that must be exceeded before a risk can be included in the BAF • Each strategic risk shows controls, assurances line by line, gaps, actions and risk appetite • Typically a small number of strategic risks (typically between 8 and 12).	• Comprises operational risks arising from the organisation's day-to-day activities. • Some risks are trust-wide in nature, others are specific to particular services or departments but have been escalated to the corporate risk register because of the high level of risk or because action is required by executives, or colleagues from other services, to mitigate the risk. • Sets out controls for each risk, but rarely includes systematic assurance line by line • Typically larger number of risks (often 20-30)
Update cadence	• Quarterly board review aligned to strategic objectives	• Continuous, with escalation rules
External expectation	• Cited in NHS England's Code of Governance for NHS provider trusts and CQC well-led use of risk information	• Required by risk management policy; evidences operational risk control

Background

Why the Board decided to refresh the Board Assurance Framework

Since the BAF was agreed in March 2024, a lot has changed...



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



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

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



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



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

Reaffirming our strategy and vision for 2028

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

There was broad consensus that our vision for 2028, along with the CARE framework that underpins it, remains fit for purpose. As a result, the BAF needs to remain rooted in the CARE strategy, with the strategic risks defined in terms of the risks to the delivery of the strategy

Responding to new challenges

At the Board strategy stocktake, we agreed to refresh our approach to transformation, particularly in light of the NHS 10-Year Plan, the emerging SWL clinical strategy, and the substantial financial challenges.

NHS England required all trusts to develop new medium-term plans, and the Board agreed in July 2025 that the Group should develop that new plan to meet the evolving challenges faced by the Group – and develop a transformation programme that would ensure delivery of the medium term plan.

The Medium Term Plan and transformation programme

The Group developed a new Medium Term Plan, which was submitted to NHS England in February 2026. To support its delivery, a new Group Transformation Programme has been developed and agreed, comprising 13 workstreams, with quarterly oversight by the Board.

The MTP and Group Transformation Programme represent a major juncture in how we deliver our Group strategy. The Board agreed in February 2026 that these changes require a refresh of the strategic risks on our Group Board Assurance Framework to ensure they remain an accurate and up-to-date reflection of the principal risks we face as a Group.

Background

The principles the Board agreed for refreshing the BAF

The Board agreed the following principles for refreshing the Group Board Assurance Framework:

Fewer, clearer and more material strategic risks:
We move from 14 to c.10 strategic risks, eliminating duplication and aligning oversight with the levels that most affect outcomes, experience and financial sustainability

Directly tied to the Medium Term Plan and transformation programme:
Link the risks on our BAF to the assumptions and commitments made in our MTP and transformation programme, ensuring alignment with these while keeping the risks rooted in the strategy.

System-anchored:
The risks, like our strategy, need to be anchored in the system in which we operate, and be explicit about system dependencies.

Future focused:
The risks need to focus on the future rather than current performance – so that we can focus on what might stop us achieving our strategy rather than on what has already happened.

Dynamic and responsive to change:
The BAF needs to be a living document that changes as the risk landscape changes – risks can be added and retired as strategy evolves.

Supports assurance conversations:
The risks need to drive meaningful Board and Committee discussions about assurance, management of risks, and risk appetite.

Proportionate and sustainable to maintain:
The BAF must be practical to keep up-to-date and not create unnecessary reporting burden.

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The refreshed Group Board Assurance Framework

The refreshed Group Board Assurance Framework

Development and Committee Review

From Board direction to Board approval

Following the Board's agreement in February 2026 to refresh the Board Assurance Framework, the proposed strategic risks have been developed through a structured programme of Executive engagement and Committee review. The refreshed framework reflects the Board's strategic direction, the Group's evolving operating environment and the assurance gained through the Group's governance processes.

The refreshed BAF:

- Reduces the number of principal strategic risks from 14 to 9, providing greater Board focus on the risks that matter most to delivery of the CARE Strategy.
- Aligns each strategic risk directly to the CARE Strategy, Medium Term Plan and Group Transformation Programme.
- Applies a consistent methodology across every strategic risk, including the risk event, causes, consequences, controls, assurance, gaps and mitigating actions.
- Strengthens Board assurance through consistent assessment of risk scores, control strengths, assurance ratings, emerging risks and target risk positions.
- Clarifies Executive ownership and Committee oversight of each strategic risk, supporting quarterly review and challenge.

Development and governance

Stage	Outcome
Group Board Development (February 2026)	Agreed the principles for refreshing the BAF and endorsed the proposed strategic risk areas.
Executive Leads	Developed each strategic risk using existing Board and Committee evidence.
Group Executive Committee	Reviewed the completed framework, considered cross-cutting risks and agreed the final proposals for submission to the Board.
Board Committees	Reviewed, challenged and refined the proposed risks, controls, assurance ratings, control strengths, gaps and actions within their respective areas of responsibility.
Group Board (July 2026)	Invited to approve the refreshed Board Assurance Framework.

Committee Review Outcomes

Stage	Outcome
Finance and Performance Committee	Finance & Performance Committee reviewed and endorsed the Financial Sustainability and Timely Access to Care risks at its meeting on 26 June 2026.
Infrastructure Committee	Infrastructure Committee reviewed the Digital and Estates risks at its meeting on 19 June 2026, recommending that the target Estates risk score remains at 20, recognising that the underlying estate constraints are unlikely to reduce materially over the next two years.
Quality Committee	Quality Committee reviewed the Research and Innovation and Patient Safety and Quality risks at its meeting on 25 June 2026, increasing the proposed Patient Safety risk score from 15 to 20 to reflect recent Never Events and the continuing need to strengthen quality governance.
People Committee	People Committee reviewed and endorsed the Workforce Sustainability and Organisational Culture and Inclusion risks at its meeting on 18 June 2026.
Group Executive Committee	Group Executive Committee considered the proposed Neighbourhood Health risk and concluded that the Group's strategic direction in this area requires further development before an appropriate Board-level strategic risk can be articulated. Consequently, the refreshed BAF is presented with nine strategic risks, with Neighbourhood Health to be brought back to the Board at a future date.

BAF Methodology

How the strategic risks are assessed, scored and managed

Purpose

This methodology sets out how the Group identifies, assessed and monitors the strategic risks on the Group Board Assurance Framework in order to deliver the CARE Strategy. It ensures consistent judgement, transparency and challenge across the BAF.

Role of the BAF

The BAF is the Board's principal tool for understanding:

- The key strategic risks to the delivery of the Group Strategy
  The causes of those risks
- The controls relied upon to manage those risks
- The assurances available to the Board regarding the
- effectiveness of the controls
  Gaps in assurance
- Actions being taken to address those gaps
- The Board's overall level of assurance regarding the
- management of each strategic risk

The BAF is not intended to be an all-risks register or a substitute for operational performance and risk reporting. Its purpose is to provide a strategic view of the principal risks to the delivery of the Group's objectives.

Three Lines of Defence

Controls and assurances are mapped using the Three Lines of Defence:

First Line of Defence	Operational management controls and activities that directly manage the risk. Examples include: operational procedures, service management processes
Second Line of Defence	Oversight, governance, monitoring and challenge functions. Examples include: Board and Committee oversight, performance management arrangements.
Third Line of Defence	Independent assurance. Examples include: internal audit, external audit, regulatory inspections, independent reviews.

Risk Structure

Each strategic risk is articulated using the following structure, which is intended to improve clarity regarding both the causes and consequences of the strategic risks:

Event
The principal strategic risk

Caused by
The key factors, dependencies or circumstances that could result in the risk materialising

Results in
The principal consequences should the risk materialise

Risk Scoring

Strategic risks on the BAF are assessed using the Group's standard 5 x 5 risk scoring methodology:

IMPACT (CONSEQUENCE)
The severity of the effect on strategic objectives should the risk materialise

LIKELIHOOD
The probability of the risk materialising within the planning period



Overall Risk Score = Impact x Likelihood

Gaps in Control

Gaps in control describe weaknesses, dependencies, immaturity or deficiencies within the current control environment. They are not intended to restate the strategic risk itself, The purpose of a gap is to explain why a higher level of assurance cannot currently be achieved.

Actions to Mitigate Gaps

Actions should:

- Address identified gaps in control or assurance
- Be strategic in nature
- Be aligned to existing organisational programmes, strategies or improvement plans
- Be owned by an identified Executive lead
- Include a clear timescale for delivery

Control Strength Assessments

RATING	COLOUR	DEFINITION
Strong		Well designed, embedded and consistently operating with clear evidence of effectiveness and sustained delivery of intended outcomes.
Moderate – Strong		Largely effective and approaching strong, with only limited weaknesses remaining and good evidence of delivery.
Moderate		Generally operating as intended and providing meaningful mitigation, but improvements are required and outcomes are not yet consistently achieved.
Weak – Moderate		Control exists and provides some mitigation, but significant weaknesses, immaturity or dependency on future delivery remain.
Weak		Incomplete, immature, inconsistently applied or not yet demonstrating effectiveness.

Overall Assurance Assessments

RATING	COLOUR	DEFINITION
Substantial		High confidence that controls are effective and embedded, assurance is comprehensive and reliable, and remaining gaps are minor.
Reasonable		Good confidence that key controls are generally effective. Some gaps remain but are understood and actively managed and are unlikely to prevent delivery of strategic objectives.
Partial		Mixed confidence. Some controls are effective, but significant weaknesses, inconsistencies or assurance gaps remain. Further action is required to provide confidence in delivery of strategic objectives.
Limited		Low confidence. Significant control weaknesses and/or assurance gaps exist and there is a high risk that delivery of strategic objectives will be adversely affected without substantial intervention.
None		Insufficient assurance exists to determine whether the risk is being effectively managed. Major control and assurance gaps exist and there is little reliable evidence on which to base confidence.

BAF Methodology

How the Board uses the BAF

The Board's Role – Key questions each quarter

1. Are the risk scores changing and why?

- How have the risk scores changed since the last quarter?
- What factors have driven any changes?
- Are emerging risks or trends increasing our exposure?

2. Is assurance sufficient and reliable?

- What assurance do we have that controls are operating effectively?
- Is the assurance robust, current and triangulated across sources?
- Are assurance gaps concerning us?

3. Are gaps reducing?

- What are the key gaps in control and assurance?
- Are these gaps reducing over time?
- Do any gaps require escalation or further action?

4. Are actions delivering to plan?

- Are mitigating actions on track for delivery?
- Are any actions overdue or at risk?
- Will the actions in place reduce the risk to our target position?

5. Do we need to adapt our focus?

- Have any emerging risks become strategic risks?
- Are we focusing on the right risks?
- Do we need to change our priorities, deepen our oversight or seek further assurance?

How the BAF provides a framework for assurance and decisions

Helps set the agenda
The BAF informs the Board and Committee agendas, deep dives, and thematic reviews

Allows early intervention
Focus on leading indicators and gaps to act before risks crystallise

Focuses assurance
Directs assurance activity to the areas of greatest risk and weakest controls or assurance

Supports prioritisation
Helps the Board allocate resources, attention and escalation where they will have the biggest impact

Supports challenge
Provides a structured basis for constructive challenge of Executive and Committees

Demonstrates Accountability
Evidences to regulators, system partners and the public that the Board actively oversees its principal risks

Board Commitment
We will maintain a living BAF, reviewed quarterly, that is clear, focused and proportionate and dynamic. It will remain aligned to our CARE Strategy, Medium Term Plan and Group Transformation Programme, and to our Risk Appetite.

Review Cycle

- **Q1** (June) — Ahead of July 2026 Board
- **Q2** (Oct) — Ahead of Nov 2026 Board
- **Q3** (Dec) — Ahead of Jan 2027 Board
- **Q4** (Apr) — Ahead of May 2027 Board

Strategic Risk Dashboard

Our nine strategic risks – current position and trajectory

Strategic Objective	Strategic Risk	Current Risk Position				Trend	Target Risk Position (March 2028)				Board Committee	Executive Lead
		Impact 1-5	Likelihood 1-5	Score (I x L)	Assurance Rating		Impact 1-5	Likelihood 1-5	Score (I x L)	Assurance Rating		
Affordable Healthcare, Fit for the Future	Financial Sustainability	5	5	25	Limited	⟷	5	3	15	Reasonable	Finance & Performance	GCFO
	Transformation Delivery	5	4	20	Partial	⟷	5	3	15	Reasonable	Group Board	GDCEO
	Digital Transformation	5	4	20	Partial	⟷	5	3	15	Reasonable	Infrastructure	GDCEO
	Estates Modernisation and Infrastructure	5	4	20	Limited	⟷	5	4	20	Partial	Infrastructure	GCOFIE
	Research and Innovation	4	3	12	Partial	⟷	4	2	8	Reasonable	Quality	GCMO
Right Care, Right Place, Right Time	Timely Access to Care	5	4	20	Partial	⟷	5	3	15	Reasonable	Finance & Performance	GCFO
	Patient Safety and Quality	5	4	20	Partial	⟷	5	3	15	Reasonable	Quality	GCMO / GCNO
Empowered, Engaged Staff	Workforce Sustainability	5	4	20	Partial	⟷	5	3	15	Reasonable	People	GCPO
	Organisational Culture and Inclusion	4	4	16	Partial	⟷	4	3	12	Reasonable	People	GCPO

Strategic Risks Overview

Key Observations – July 2026

What does the refreshed Board Assurance Framework tell us?

The refreshed BAF highlights several important themes regarding the Group's current strategic risk profile:

1. **Financial sustainability and transformation dominate the strategic agenda:** The highest strategic risks relate to financial sustainability, transformation delivery, digital, estates, timely access to care, patient safety and workforce sustainability. Collectively these reflect the scale of change required to deliver the Medium Term Plan whilst maintaining safe, high-quality services.

2. **Governance arrangements are generally established, but delivery remains the principal challenge:** For most strategic risks, governance, oversight and assurance arrangements are in place and operating effectively. However, assurance remains Partial or Limited because many programmes remain in early delivery, benefits have yet to be fully realised, or significant external dependencies remain.

3. **Transformation is central to delivery of strategy:** Successful delivery of the CARE Strategy is dependent upon transformation rather than incremental improvement. Many strategic risks are interconnected and rely on successful delivery of the Group Transformation Programme, digital enablement, workforce redesign and estate modernisation.

4. **Strategic risks are increasingly interconnected:** The refreshed framework demonstrates that strategic risks should not be viewed in isolation. Financial sustainability, workforce, digital, estates, operational performance and quality are mutually dependent, reinforcing the importance of integrated Board oversight and assurance.

5. **The BAF will be a dynamic framework:** The refreshed BAF is intended to evolve alongside the Group Strategy and external environment. It will be reviewed quarterly through the Committee structure, with risks, assurance ratings and actions updated as strategic priorities and the risk landscape change.

Strategic Risks Overview

Summary of Current Position – July 2026

Strategic Risk	Current assessment	Score
Financial Sustainability The gesh Group fails to achieve financial sustainability ***caused by*** large unassured CIPs, stretching phasing of delivery, ability to manage underlying run rates with operational pressures and phased removal of deficit support funding, ***resulting in*** widening underlying deficit, cash strain, reduced investment headroom, delayed delivery of strategic priorities, and regulatory intervention	The proposed current risk score of 25 reflects the Board's assessment that financial sustainability remains the Group's most significant strategic risk. Although both Trusts improved their underlying financial positions during 2025/26 and agreed a compliant Medium Term Financial Plan, substantial underlying deficits remain and delivery depends on achieving large-scale cost improvements, productivity gains and sustained financial discipline. Early performance in 2026/27 and NHS England's decision to place the Group into Enhanced Oversight for finance reinforce this assessment. The proposed assurance rating of Limited Assurance reflects that, whilst governance, financial reporting and oversight arrangements are established, they are not yet consistently delivering the required financial improvements. Significant gaps remain in cost improvement delivery, productivity and implementation of the Medium Term Financial Plan, requiring further strengthening of controls and delivery.	Risk Score 25 Assurance Rating Limited
Transformation Delivery The gesh Group does not deliver the strategic change necessary, at the scale and pace required, to transform how it provides healthcare ***caused by*** early maturity of transformation programmes, limited leadership and organisational capacity, competing operational pressures, and dependencies on workforce, digital, estates and system partners ***resulting in*** failure to realise planned financial, operational and quality benefits, deliver the Medium Term Plan, implement sustainable new models of care and ways of working, and secure the Group's long-term clinical and financial sustainability	The proposed current risk score of 20 reflects the Board's assessment that successful delivery of the Group's transformation programme is fundamental to achieving the CARE Strategy, Medium Term Plan and long-term sustainability. Whilst a comprehensive transformation portfolio and governance framework are established, many programmes remain at an early stage and the planned financial, operational and quality benefits have yet to be fully realised. Delivery also remains dependent on organisational capacity and enabling programmes, including workforce, digital and estates. The proposed assurance rating of Partial Assurance reflects that governance, programme management and Board oversight arrangements are established and provide good visibility of delivery. However, programme maturity remains variable, benefits realisation is still developing, and there is not yet sufficient evidence that the portfolio is consistently delivering the scale of change required.	Risk Score 20 Assurance Rating Partial
Digital Transformation The gesh Group is unable to deliver a modern interoperable and resilient digital environment that enables the digital transformation necessary to deliver the MTP and new models of care ***caused by*** legacy digital infrastructure, insufficient digital capacity, low digital adoption, fragmented data architecture, cybersecurity vulnerabilities, and inadequate capital relative to need ***resulting in*** reduced clinical productivity, poor user experience, inability to realise transformational benefits, increased cyber risk, and failure to meet national digital maturity standards	The proposed current risk score of 20 reflects the Board's assessment that digital transformation is a critical enabler of the CARE Strategy, Medium Term Plan and wider transformation programme. Whilst significant progress has been made, including implementation of a shared Electronic Patient Record and strengthened digital governance, substantial work remains to modernise legacy infrastructure, improve cyber resilience and deliver the wider digital agenda. The proposed assurance rating of Partial Assurance reflects that governance, leadership and programme arrangements are established and subject to regular Board oversight. However, important gaps remain in strategic alignment, digital capacity, benefits realisation, cyber resilience and the development of a Group-wide Digital Strategy. Further work is required before the Board can conclude that digital transformation is consistently delivering the capabilities and benefits needed to support long-term organisational sustainability.	Risk Score 20 Assurance Rating Partial

Strategic Risks Overview

Summary of Current Position – July 2026

Strategic Risk	Current assessment	Score
Estates Modernisation and Infrastructure The gesh Group estate is unable to consistently support safe, effective and efficient care ***caused by*** constrained capital funding, significant backlog maintenance, ageing infrastructure, and delays to SECH preventing consolidation of major acute services ***resulting in*** safety and compliance risks, constrained capacity, service disruption, rising maintenance costs, diversion of capital from strategic priorities, and slower realisation of BYFH benefits	The proposed current risk score of 20 reflects the Board's assessment that the estate remains a significant strategic constraint on the delivery of safe, effective and efficient care. Ageing infrastructure, substantial backlog maintenance, constrained capital funding and delays to the Building Your Future Hospital programme continue to create risks to patient safety, service continuity and estate modernisation, despite established governance and maintenance arrangements. The proposed assurance rating of Limited Assurance reflects that governance, compliance, independent technical assurance and maintenance programmes provide effective oversight of estate risks. However, significant gaps remain, including insufficient capital investment, the absence of a comprehensive Group Estates Strategy, dependence on external funding for major estate transformation and continued vulnerability arising from ageing infrastructure. Consequently, further investment and estate modernisation are required before the Board can have greater confidence that the underlying strategic risks are being effectively mitigated.	Risk Score 20 Assurance Rating Limited
Research and Innovation The gesh Group fails to maximise the benefits of research and innovation for patients, staff and the organisation ***caused by*** insufficient research capacity and infrastructure, underdeveloped research and innovation partnerships, inconsistent participation in research activity, and failure to systematically adopt and spread innovation ***resulting in*** reduced access to research opportunities, poorer patient outcomes and experience, missed opportunities to reduce inequalities, lower research income and funding, and reduced ability to attract and retain high-calibre staff	The proposed current risk score of 12 reflects the Board's assessment that research and innovation are important strategic enablers of the Group's ambitions. However, the likelihood of this risk materialising is moderated by well-established research infrastructure, strong academic partnerships, active research programmes and a positive track record of research performance across both Trusts. The proposed assurance rating of Partial Assurance reflects that robust governance, research infrastructure and partnership arrangements are already in place. However, important gaps remain, including the absence of a Group-wide Research and Innovation Strategy, the need to strengthen the strategic partnership with City St George's, variation in research participation across services and opportunities to improve reporting of research impact and the adoption of innovation. Further work is therefore required before the Board can be assured that research and innovation are delivering their full strategic benefit.	Risk Score 12 Assurance Rating Partial

Strategic Risks Overview

Summary of Current Position – July 2026

Strategic Risk	Current assessment	Score
Timely Access to Care The gesh Group is unable to provide timely access to care and maintain effective patient flow across urgent, emergency, elective, diagnostic and cancer services ***caused by*** capacity constraints across beds, theatres, diagnostics and workforce, discharge delays, rising demand, and slower than planned delivery of transformation, productivity and flow improvement programmes ***resulting in*** poorer patient outcomes and experience, increased clinical risk, failure to meet constitutional standards, loss of income, reduced productivity, and regulatory intervention	The proposed current risk score of 20 reflects the Board's assessment that timely access to care remains one of the Group's most significant strategic challenges. Failure to maintain effective patient flow and deliver constitutional standards would have serious consequences for patient outcomes, clinical safety and organisational performance. Although comprehensive performance management, recovery programmes and executive oversight are established, delivery continues to be constrained by rising demand, capacity limitations and wider system pressures. The proposed assurance rating of Partial Assurance reflects that governance, recovery programmes and performance management arrangements provide the Board with regular assurance over access and flow. However, significant gaps remain, including discharge delays, operational capacity constraints, variation in performance across pathways and dependence on future transformation and productivity improvements. Consequently, there is not yet sufficient evidence that the current control framework is consistently delivering sustainable improvements in patient flow and constitutional performance.	Risk Score 20 Assurance Rating Partial
Patient Safety and Quality The gesh Group fails to maintain and improve the quality and safety of care during a period of financial pressure and transformation ***caused by*** weaknesses in quality governance, inconsistent implementation of the Quality Management System, and failure to consistently embed quality and safety within organisational decision-making ***resulting in*** avoidable harm to patients, poorer clinical outcomes, widening inequalities, poor patient experience and regulatory scrutiny	The proposed current risk score of 20 reflects the Board's assessment that maintaining and improving the quality and safety of care remains a significant strategic challenge during a period of financial pressure and organisational transformation. Whilst a comprehensive quality and safety framework is established, recent Never Events and the continuing need to strengthen quality governance demonstrate that the risk remains significant. The proposed assurance rating of Partial Assurance reflects that a broad range of controls and assurance mechanisms are established and operating effectively. However, further work is required to embed the Group Quality Management System, strengthen quality governance and continuous improvement, improve quality intelligence and reduce unwarranted variation across services and sites. Consequently, the Board has good visibility of quality and safety risks but cannot yet be assured that these arrangements are consistently delivering the intended outcomes across the Group.	Risk Score 20 Assurance Rating Partial

Strategic Risks Overview

Summary of Current Position – July 2026

Strategic Risk	Current assessment	Score
Workforce Sustainability The gesh Group is unable to deliver a sustainable, affordable and well-deployed workforce ***caused by*** workforce redesign and establishment reductions not being delivered at the pace required, continued reliance on temporary staffing, elevated sickness absence, and slower than planned workforce productivity improvements ***resulting in*** elevated workforce costs, productivity shortfalls, increased safety risk, and slower delivery of transformation and operational objectives	The proposed current risk score of 20 reflects the Board's assessment that workforce sustainability remains a critical strategic risk to delivery of the Group's Medium Term Plan and long-term financial sustainability. Failure to deliver workforce redesign, reduce reliance on temporary staffing, improve productivity and reduce sickness absence would have significant consequences for workforce affordability, service delivery and patient safety. Whilst workforce controls and performance oversight are well established, delivery remains dependent on ambitious workforce reduction and productivity assumptions. The proposed assurance rating of Partial Assurance reflects that a comprehensive workforce governance framework is in place and subject to regular Board and Committee oversight. However, significant dependencies remain, including delivery of workforce affordability plans, temporary staffing reductions, sickness improvement and workforce transformation programmes. Consequently, there is not yet sufficient evidence that the workforce and productivity improvements required to support the Medium Term Plan will be consistently achieved.	Risk Score 20 Assurance Rating Partial
Organisational Culture and Inclusion The gesh Group fails to embed an inclusive, psychologically safe and high performing culture ***caused by*** variable leadership behaviours, competing operational pressures, uneven embedding of organisational values, limited improvement capability, and barriers to speaking up and psychological safety ***resulting in*** lower staff engagement and wellbeing, higher turnover and sickness absence, weaker improvement and safety culture, failure to realise the benefits of a diverse and inclusive workforce, and reduced organisational effectiveness	The proposed current risk score of 16 reflects the Board's assessment that organisational culture and inclusion remain fundamental enablers of delivery of the Group Strategy, but that the consequences of failure are less immediate than for the principal operational risks. Variable leadership behaviours, inconsistent staff experience and barriers to psychological safety continue to present risks to staff engagement, retention, wellbeing, organisational effectiveness and the successful delivery of transformation. Whilst a comprehensive People Strategy, leadership development, EDI, Freedom to Speak Up and staff engagement framework is established, evidence of sustained improvement across all aspects of organisational culture remains mixed. The proposed assurance rating of Partial Assurance reflects that robust governance and assurance arrangements are in place, supported by Staff Survey results, WRES, WDES, Pay Gap reporting, Freedom to Speak Up reporting and People Committee oversight. However, significant gaps remain in leadership behaviours, psychological safety, workforce equality outcomes and consistency of culture across services and staff groups. Consequently, further evidence of sustained improvement is required before the Board can take Reasonable Assurance that the Group's desired culture is consistently embedded.	Risk Score 16 Assurance Rating Partial

Group Board Assurance Framework 2026/27

Strategic Risk	SR1	Financial Sustainability

Current Risk Score: 25

Assurance: Limited

Event	Caused by	Results in
The gesh Group fails to achieve financial sustainability	*Large unassured CIPs, stretching phasing of delivery, ability to manage underlying run rates with operational pressures and phased removal of Deficit support Funding*	*Widening underlying deficit, cash strain, reduced investment headroom, delayed delivery of strategic priorities, and regulatory intervention*

Strategic objective	Affordable Services Fit for the Future
Last review date	*N/A – New Risk*
Monitoring Committee	Finance & Performance Committees
Lead Executive	Group Chief Finance Officer
Risk appetite	Open (High)

Risk Score		Impact	Likelihood	Overall Risk Score	Assurance rating
Inherent	May-26	5	5	25	Limited
Current	**Jun-26**	**5**	**5**	**25**	**Limited**
Target	Mar-28	5	3	15	Reasonable

Change since last review

Month	Jun-26	Oct-26	Dec-26	Mar-27	Jun-27	Oct-27	Dec-27	Mar-28	Jun-28	Oct-28	Dec-28	Mar-29
Risk Score	25											
Assurance	Limited											

	Key controls *What are we already doing to manage the risk?*	Assurances on controls *How do we have assurance that the controls are working?*	*Line of defence*	Control Strength
1	Maintaining a long term financial plan forward view.	Delivery of the financial plan and tracking through FPC.	2nd	Weak
2	Budget holder accountability for meeting approved delegated budgets, maintaining underlying run rates and delivering CIP.	Financial performance is in line with budget/plan.	1st	Weak
3	Ensuring there is an effective control environment.	Evidenced through finance reports, audit reports and against KPIs.	2nd	Weak-Moderate
4	BAU CIP, site responsibility for identifying and delivering actions to improve the financial position.	Project Management and meeting structure in place to identify, plan and deliver transformation CIPs in line with target.	1st	Weak-Moderate
5	Transformation CIP, SRO accountability for workstreams managed within a PMO governance structure.	Project Management and meeting structure in place to identify, plan and deliver transformation CIPs in line with target.	2nd	Weak-Moderate
6	Robust understanding of cost structure and productivity.	Costing systems systems and known areas of improvement in place.	2nd	Weak-Moderate
7	Robust process for deconstructing the block contract.	Clearly defined drivers for gaps in deconstructing the block contract.	2nd	Weak-Moderate
8	Robust process to forecast and manage cash.	Daily cashflows for 13 week and rolling 12 months in place. Scenario forecasts shared with FPC.	2nd	Moderate
9	Maintaining the capacity and capability of the finance team.	Clearly defined statement of how demands on dept are meet by available resources.	2nd	Moderate
10	External engagement with SWL, NHSE London and NHS national team.	Good engagement with SWL and London. NHE London attend FPC.	3rd	Moderate-Strong

Group Board Assurance Framework 2026/27

11	Capital: clear view of future capital needs and how to meet them	Detail available of prioritised capital need together with available funding.	1st / 2nd	Weak-Moderate

Gaps in controls *What do we need to do to control the risk that we are not yet doing?*		*Linked controls*
1	Enhance level of financial support and challenge, especially embed budget holder level.	2
2	Continue challenge and continued emphasis on identification and delivery of CIP.	4,5
3	Improve understanding and actions to address variances in benchmarking.	6
4	Improve understanding and actions to address productivity.	6
5	Compliance with existing control environment.	3
6	Review finance team capacity and capability in respect of current agenda and target operating model for corporate.	9
7	Developed plans to deliver Medium Term Financial Plan	1
8	Capital funding is insufficient to meet known investment needs; BAU and developmental.	11
9	Continue focus on cash flow forecasting and triangulation between historic cash flow and known future events.	8
10	Review bottom up work driving deconstructing the block contract.	7

Material actions to address gaps in controls and assurances *What are we going to do, by when, to further manage and mitigate the risk?*		Control Gaps	**Executive Lead**	**Due date**	**Progress**
1	Embed performance accountability framework and escalation of budgets that are materially overspent through site/divisional performance meetings and Exec/Site Development Forums.	1,2	MDs and GCFO	Dec 26	Off Track
2	BAU CIP identification and delivery ongoing through Site Financial Recovery Board.	2	MDs	Mar 27	Off Track
3	Transformation SRO/CEO monthly meetings to review progress and priorities within workstreams.	2	DCEO	Mar 29	Off Track
4	Review performance against productivity metrics to support identification of areas to address inefficiency.	3,4	MDs and GCFO	Mar 27	Off Track
5	Maintain up to date forecast, risks and mitigations to delivery of the medium term plan.	7	GCFO	Jul 26	On Track
6	Complete areas identified for Group Financial Structure.	6	GCFO	Mar 27	On Track
7	Assess compliance with existing control framework.	5	GCFO	Dec 26	On Track
8	Propose and embed revised Group and Site Capital Governance to support prioritisation and risk management.	8	GCFO	Dec 26	On Track
9	Continued focus on cash management, notably cashflow forecasting, debt recovery and creditor process management.	9	GCFO	Dec 26	On Track
10	Re-visit deconstructing the block contract to identify areas that require revising to close the gap.	10	GCFO	Seo 26	On Track

Related risks on Corporate Risk Registers

Trust	Datix ID	Score	Summary risk description
SGUH/ESTH	3124/2488	25	Delivery of sustainable income and expenditure
SGUH/ESTH	3125/2489	25	Cash availability
SGUH/ESTH	3126/2490	25	Impact of constrained capital

Emerging risks

What could materially affect this risk over the next 12-24 months?

- Clear message from NHSE that the Medium Term Plans submitted need to be delivered.
- Organisational engagement given activity, workforce and quality pressures.

Group Board Assurance Framework 2026/27

Strategic Risk	SR2	Transformation Delivery

Current Risk Score: 20

Assurance: Partial

Event	Caused by	Results in
The Group does not deliver the strategic change necessary, at the scale and pace required, to transform how it provides healthcare	*Caused by early maturity of transformation programmes, limited leadership and organisational capacity, competing operational pressures, and dependencies on workforce, digital, estates and system partners*	*Resulting in failure to realise planned financial, operational and quality benefits, deliver the Medium Term Plan, implement sustainable new models of care and ways of working, and secure the Group's long-term clinical and financial sustainability*

Strategic objective	Affordable Services Fit for the Future
Last review date	*N/A – New Risk*
Monitoring Committee	Group Board
Lead Executive	GDCEO
Risk appetite	Seek (Significant)

Risk Score		Impact	Likelihood	Overall Risk Score	Assurance rating
Inherent	Jun-26	5	5	25	Limited
Current	**Jun-26**	**5**	**4**	**20**	**Partial**
Target	Mar-28	5	3	15	Reasonable

Change since last review: ⟺

Month	Jun-26	Oct-26	Dec-26	Mar-27	Jun-27	Oct-27	Dec-27	Mar-28	Jun-28	Oct-28	Dec-28	Mar-29
Risk Score	20											
Assurance	Partial											

Key controls *What are we already doing to manage the risk?*		Assurances on controls *How do we have assurance that the controls are working?*	*Line of defence*	Control Strength
1	Group Medium Tern Plan and Transformation Portfolio: Strategic portfolio of transformation programmes aligned to delivery of the CARE Strategy and Medium Term Plan.	Medium Term Plan reporting, Transformation Portfolio reporting, portfolio roadmap, Board Development Sessions.	1st / 2nd	Moderate
2	Programme governance through SROs, Steering Groups, PMO oversight and standard programme management arrangements.	Programme Highlight Reports, Steering Group reporting, SRO reviews, governance compliance reporting, PMO reporting.	1st / 2nd	Moderate
3	Delivery of the agreed transformation portfolio to realise planned strategic, operational and financial benefits.	Programme milestone reporting, delivery dashboards, programme status reports, programme risk reporting.	1st / 2nd	Weak-Moderate
4	Identification, tracking and assurance of programme benefits, productivity improvements and financial savings.	CIP maturity reporting, benefits realisation reporting, finance reporting, MTP Delivery Steering Group reporting.	1st / 2nd	Weak-Moderate
5	Deployment of transformation funding and resources to support programme delivery.	Transformation Fund reporting, business case approvals, investment monitoring, funding assurance reporting.	1st / 2nd	Moderate
6	Executive, Board and Committee oversight of portfolio delivery, risks, performance and strategic decisions.	Group Executive Committee, MTP Delivery Steering Group, Finance & Performance Committee, Board and Board Development Session reporting.	2nd	Moderate
7	Portfolio reporting, programme assurance, milestone monitoring, risk management and dependency oversight.	Portfolio dashboards, dependency reviews, programme maturity assessments, portfolio risk reporting.	2nd	Moderate

Group Board Assurance Framework 2026/27

Gaps in controls *What do we need to do to control the risk that we are not yet doing?*		*Linked controls*
1	Many transformation programmes remain in the early stages of delivery and have yet to demonstrate sustained delivery of planned outcomes and benefits.	3, 4
2	Financial, operational and quality benefits remain to be fully quantified, validated and realised, particularly cash-releasing savings required to deliver the Medium Term Plan.	4
3	The maturity of transformation programmes remains variable across the portfolio, with further work required to strengthen planning, delivery confidence and programme assurance.	2, 3, 7
4	Competing operational pressures and limited organisational capacity constrain delivery of transformation at the required scale and pace.	3, 6
5	Programme interdependencies and sequencing are not yet consistently embedded across the transformation portfolio.	2, 7
6	Successful delivery of the transformation portfolio remains dependent on wider enabling programmes, including workforce, digital, estates and system transformation.	1, 3

Material actions to address gaps in controls and assurances *What are we going to do, by when, to further manage and mitigate the risk?*		Control Gaps	Executive Lead	Due date	Progress
1	Deliver the agreed transformation portfolio and associated programme milestones in line with the Medium Term Plan.	1, 3	GDCEO	Mar-29	On Track
2	Strengthen programme benefits realisation, financial tracking and assurance to support delivery of planned transformation benefits and cash-releasing savings.	2	GDCEO / GCFO	Mar-27	On Track
3	Implement the Foundational Best Practice improvement actions to strengthen programme maturity, planning and delivery assurance across the transformation portfolio.	3	GDCEO	Mar-27	On Track
4	Align the transformation portfolio with organisational capacity through prioritisation and sequencing of programmes.	4, 5	GDCEO	Mar-27	On Track
5	Strengthen management of programme interdependencies and portfolio-level risks across the transformation portfolio.	5	GDCEO	Mar-27	On Track
6	Strengthen alignment between transformation programmes and enabling programmes across the portfolio.	6	GDCEO	Mar-27	On Track

Related risks on Corporate Risk Registers

Trust	Datix ID	Score	Summary risk description
No linked risks on the Corporate Risk Register			

Emerging risks

What could materially affect this risk over the next 12-24 months?

- National policy, planning guidance or regulatory expectations may require significant reprioritisation of the transformation portfolio.
- Financial pressures may reduce the investment available to support transformation delivery.
- Demand growth and operational pressures may reduce organisational capacity available for transformation.
- Changes arising from implementation of the NHS 10 Year Health Plan may require reprioritisation of the transformation portfolio.
- Delivery of major service reconfiguration programmes may affect the sequencing and pace of transformation across the wider portfolio.

Group Board Assurance Framework 2026/27

DigitStrategic Risk	SR3	Digital Transformation

Current Risk Score: 20

Assurance: Partial

Event	Caused by	Results in
The gesh Group is unable to deliver a modern, interoperable and resilient digital environment that enables the digital transformation necessary to deliver the MTP and new models of care	*Legacy digital infrastructure, insufficient digital capacity, low digital adoption, fragmented data architecture, cybersecurity vulnerabilities, and inadequate capital relative to need*	*Reduced clinical productivity, poor user experience, inability to realise transformational benefits, increased cyber risk, and failure to meet national digital maturity standards*

Strategic objective	Affordable Services Fit for the Future
Last review date	*N/A – New Risk*
Monitoring Committee	Infrastructure Committees
Lead Executive	Group Deputy Chief Executive Officer
Risk appetite	Open (High)

Risk Score		Impact	Likelihood	Overall Risk Score	Assurance rating
Inherent	May-26	5	5	25	Limited
Current	**Jun-26**	**5**	**4**	**20**	**Partial**
Target	Mar-28	5	3	15	Reasonable

Change since last review

⟺

Month	Jun-26	Oct-26	Dec-26	Mar-27	Jun-27	Oct-27	Dec-27	Mar-28	Jun-28	Oct-28	Dec-28	Mar-29
Risk Score	20											
Assurance	Partial											

	Key controls *What are we already doing to manage the risk?*	Assurances on controls *How do we have assurance that the controls are working?*	*Line of defence*	Control Strength
1	Board-level governance of the digital agenda established through Infrastructure Committees.	The Infrastructure Committee focuses on digital on a bimonthly basis and the Audit & Risk Committee receives quarterly reports on cyber.	2nd	Moderate
2	Executive-level governance of the digital agenda across the Group established through the Digital Governance Group.	The Digital Governance Group is established and meets monthly. Its terms of reference and membership are being refreshed to strengthen oversight.	2nd	Weak-Moderate
3	Board-level executive leadership of the digital agenda established through the Group Deputy Chief Executive Officer and Executive team sponsorship.	Executive sponsorship is in place for digital transformation, with oversight through Group governance and programme structures.	2nd	Moderate
4	Senior professional leadership of digital services established through the Group Chief Digital Information Officer and transformation leadership arrangements.	Interim and substantive leadership arrangements continue to provide direction while wider Group digital and transformation structures mature.	2nd	Moderate
5	Expertise and capacity within digital, ICT and transformation teams to deliver core programmes and service improvement.	Current team capability is strong, but capacity remains under significant pressure from the scale of operational demand and transformation requirements.	1st	Weak-Moderate
6	Agreed resourcing plans and capital investment processes are in place to support digital transformation and infrastructure priorities.	Resourcing remains under material pressure due to wider people resource constraints and competing workforce priorities across the Group.	2nd	Weak-Moderate
7	Shared Electronic Patient Record and enabling digital programmes are in place to support transformation across the Group.	EPR rollout has been delivered and post-go-live optimisation is ongoing to realise the benefits of shared systems and new ways of working.	2nd	Moderate
8	Cybersecurity, resilience and disaster recovery arrangements are in place and continue to be developed and tested.	Internal audit and management reviews provide partial assurance; disaster recovery plans require further refinement and testing.	3rd	Weak-Moderate

Group Board Assurance Framework 2026/27

Gaps in controls *What do we need to do to control the risk that we are not yet doing?*		*Linked controls*
1	Develop a Group-wide digital strategy aligned to the Medium Term Plan, known demand, affordability and available resources.	2,4,6
2	Complete integration of separate digital and ICT teams into a coherent Group-wide operating model with clear accountabilities.	4,5
3	Benefits realisation from digital investment and transformation programmes is not yet consistently evidenced and reported.	1,2,3
4	Maintain investment in cyber security, resilience and disaster recovery, including testing, remediation and horizon scanning.	8
5	Develop a clear Group-wide framework for artificial intelligence, data architecture and safe innovation.	7
6	The scale of digital ambition exceeds available capacity and resources, requiring clearer prioritisation and sequencing of delivery.	2,5,6,7

Material actions to address gaps in controls and assurances *What are we going to do, by when, to further manage and mitigate the risk?*		Control Gaps	Executive Lead	Due date	Progress
1	Develop and agree a Group Digital Strategy aligned to organisational priorities and available resources.	1	GDCEO	Jul-26	On Track
2	Complete integration of digital and ICT teams into a single Group-wide service and implement the agreed operating model.	2	GDCEO	Mar-27	On Track
3	Refresh Digital Governance Group arrangements and strengthen executive oversight of digital transformation priorities and benefits.	3	GDCEO	Oct-26	On Track
4	Develop and agree a prioritised digital transformation roadmap, including trade-offs, sequencing and benefits realisation.	6	GDCEO	Dec-26	On Track
5	Maintain focus on cybersecurity, resilience and disaster recovery, including enhanced testing, remediation and management reporting.	4	GDCEO	Dec-26	On Track
6	Develop a Group-wide framework for AI deployment, data governance and safe adoption of innovative digital tools.	5	GDCEO	Oct-26	On Track

Related risks on Corporate Risk Registers

Trust	Datix ID	Score	Summary risk description
SGUH/ESTH	3144/2514	20	Cybersecurity Attack
SGUH/ESTH	3143/2515	20	Core Network Failure
SGUH/ESTH	3142/2516	15	Data Centre Failure
SGUH	2700	16	Picture Archiving and Communication System

Emerging risks

What could materially affect this risk over the next 12-24 months?

- Mismatch between digital ambition, transformation demand and available revenue/capital resources.
- Delivery of key digital transformation programmes may take longer than planned due to operational pressures and interdependencies.
- Growing cybersecurity threats, legacy estate and resilience weaknesses could disrupt transformation and service delivery.
- National expectations for digital maturity, interoperability and data use may increase faster than local capacity to respond.

Group Board Assurance Framework 2026/27

Strategic Risk	SR4	Estates Modernisation and Infrastructure

Current Risk Score: 20

Assurance: Limited

Event	Caused by	Results in
The Group estate is unable to consistently support safe, effective and efficient care.	*Constrained capital funding, significant backlog maintenance, ageing infrastructure, and delays to SECH preventing consolidation of major acute services.*	*Safety and compliance risks, constrained capacity, service disruption, rising maintenance costs, diversion of capital from strategic priorities, and slower realisation of BYFH benefits.*

Strategic objective	Affordable Services Fit for the Future
Last review date	*N/A – New Risk*
Monitoring Committee	Infrastructure Committees
Lead Executive	Group Chief Infrastructure, Facilities & Environment Officer
Risk appetite	Open (High)

Risk Score		Impact	Likelihood	Overall Risk Score	Assurance rating
Inherent	May-26	5	5	25	Limited
Current	**Jun-26**	**5**	**4**	**20**	**Limited**
Target	Mar-28	5	4	20	Partial

Change since last review



Month	Jun-26	Oct-26	Dec-26	Mar-27	Jun-27	Oct-27	Dec-27	Mar-28	Jun-28	Oct-28	Dec-28	Mar-29
Risk Score	20											
Assurance	Limited											

	Key controls *What are we already doing to manage the risk?*	Assurances on controls *How do we have assurance that the controls are working?*	*Line of defence*	Control Strength
1	Estates Governance, Compliance and Assurance Framework – Governance, compliance and assurance of estate risks	Infrastructure Committee reporting, PAM reporting, statutory compliance reporting, fire safety, water safety, asbestos and health & safety reporting.	1st / 2nd	Moderate
2	Authorised Engineer and Independent Assurance Framework – Independent technical assurance of estate compliance	Authorised Engineer reports, specialist audits, external reviews and compliance inspections.	3rd	Moderate
3	Reactive and Planned Maintenance Framework – Planned and reactive maintenance of estate infrastructure	Maintenance performance reporting, backlog maintenance reporting, operational estates updates and engineering performance indicators.	1st / 2nd	Moderate
4	Capital Investment and Estate Modernisation Programme – Capital investment to maintain and modernise the estate	Capital programme reporting, business cases, estate strategy delivery and infrastructure programme updates.	1st / 2nd	Weak-Moderate
5	Major Estate Transformation Programme (SECH and estate reconfiguration)	Programme reporting, milestone reporting, business case development and Board oversight.	1st / 2nd	Weak-Moderate
6	Green Plan and Sustainability Framework – Sustainability and decarbonisation programmes	Green Plan reporting, sustainability metrics, ERIC reporting and programme updates.	1st / 2nd	Moderate
7	Estate Condition and Performance Intelligence Framework – Estate condition, compliance and performance intelligence	6-facet surveys, condition surveys, backlog maintenance assessments, ERIC benchmarking and estate intelligence reporting.	2nd / 3rd	Moderate

Group Board Assurance Framework 2026/27

Gaps in controls *What do we need to do to control the risk that we are not yet doing?*		*Linked controls*
1	**A Group-wide estates strategy has not yet been fully developed and implemented:** Whilst a range of estate programmes and initiatives are in place, there is currently no comprehensive Group-wide estates strategy setting out the long-term vision, priorities, investment requirements and delivery roadmap for the estate.	1, 4, 5
2	**Capital investment remains insufficient to address backlog maintenance, estate risk and strategic priorities:** Despite targeted investment and successful bids for specific schemes, available capital funding remains insufficient to address the scale of backlog maintenance, estate condition issues and wider strategic priorities. This results in continued reliance on mitigation measures and limits investment in estate modernisation, sustainability and service transformation.	4, 6, 7
3	**Estate condition remains a constraint on service delivery and modernisation:** The condition of parts of the estate continues to constrain operational flexibility, service development and the efficient delivery of care, requiring ongoing investment to maintain functionality.	3, 4, 7
4	**Long-term estate transformation remains dependent on external funding and national programme decisions:** Delivery of major estate transformation programmes, including Building Your Future Hospital, remains dependent on external funding approvals and national programme timelines.	4, 5
5	**Critical infrastructure resilience remains vulnerable in parts of the estate:** Ageing infrastructure and asset condition continue to create vulnerability across a number of critical systems, requiring ongoing mitigation and monitoring to maintain safe and effective operation.	2, 3, 7
6	**Delivery of sustainability and decarbonisation ambitions remains dependent on future capital investment:** Whilst progress is being made through the Green Plan, achievement of longer-term sustainability and decarbonisation objectives remains dependent on significant future investment and estate renewal.	4, 6

Material actions to address gaps in controls and assurances *What are we going to do, by when, to further manage and mitigate the risk?*		Control Gaps	Executive Lead	Due date	Progress
1	Develop and implement a Group-wide Estates Strategy setting out the long-term vision, priorities, investment requirements and delivery roadmap for the estate.	1	GCOFIE	TBC	TBC
2	Deliver the approved capital programme and prioritised backlog maintenance programme to address estate condition, compliance risks and operational constraints.	2, 3	GCOFIE	Mar-27	On Track
3	Develop interim estate modernisation and resilience initiatives pending Building Your Future Hospital commencement	4	GCOFIE	TBC	TBC
4	Deliver critical infrastructure replacement, resilience and compliance programmes, including priority fire, electrical and mechanical infrastructure improvements.	3, 5	GCOFIE	TBC	TBC
5	Deliver the Group Green Plan and decarbonisation programme	6	GCOFIE	TBC	TBC

Related risks on Corporate Risk Registers

Trust	Datix ID	Score	Summary risk description
SGUH	2036	15	Fire Safety
ESTH	1953	16	Fire prevention systems
SGUH	2061	15	Lack of UPS / IPS power supplies site-wide
ESTH	1951	20	Poor condition of external buildings
ESTH	1952	20	Electrical infrastructure
ESTH	1956	20	Risk of failure of mechanical bed lifts
ESTH	1954	16	Sewage and drainage
ESTH	1962	16	Risk that BYFH fails to meet objectives

Emerging risks

What could materially affect this risk over the next 12-24 months?

- Deterioration of estate condition may outpace available investment
- Failure of critical infrastructure may increase service disruption
- Capital funding pressures may constrain estate modernisation and sustainability programmes
- Changes in service demand and operational requirements may increase pressure on an already constrained estate.
- Estate failures, major works programmes or service reconfiguration may require further decant arrangements and temporary accommodation solutions, increasing cost and operational complexity.

Group Board Assurance Framework 2026/27

Strategic Risk	SR5	Research and Innovation

Current Risk Score: 12

Assurance: Partial

Event	Caused by	Results in
The gesh Group fails to maximise the benefits of research and innovation for patients, staff and the organisation.	*Insufficient research capacity and infrastructure, underdeveloped research and innovation partnerships, inconsistent participation in research activity, and failure to systematically adopt and spread innovation.*	*Reduced access to research opportunities, poorer patient outcomes and experience, missed opportunities to reduce inequalities, lower research income and funding, and reduced ability to attract and retain high-calibre staff.*

Strategic objective	Affordable Services Fit for the Future
Last review date	*N/A – New Risk*
Monitoring Committee	Quality Committees
Lead Executive	GCMO
Risk appetite	Seek (Significant)

Risk Score		Impact	Likelihood	Overall Risk Score	Assurance rating
Inherent	May-26	4	4	16	Limited
Current	**Jun-26**	**4**	**3**	**12**	**Partial**
Target	Mar-28	4	2	8	Reasonable

Change since last review



Month	Jun-26	Oct-26	Dec-26	Mar-27	Jun-27	Oct-27	Dec-27	Mar-28	Jun-28	Oct-28	Dec-28	Mar-29
Risk Score	12											
Assurance	Partial											

	Key controls *What are we already doing to manage the risk?*	Assurances on controls *How do we have assurance that the controls are working?*	*Line of defence*	Control Strength
1	Research Strategy and Governance Framework – Strategic leadership and oversight of research and innovation (including TACRI, research governance and Group oversight arrangements)	Research strategy updates, research governance reporting, TACRI reporting and Board/Committee oversight.	1st / 2nd	Weak-Moderate
2	Research Infrastructure and Delivery Framework – Infrastructure and support arrangements required to deliver research (including JRES, R&D offices and the NIHR Clinical Research Facility)	Research delivery performance, NIHR Clinical Research Facility reporting, JRES performance reporting and research governance assurance.	1st / 2nd	Moderate
3	Research Partnerships and Collaboration Framework – Collaboration with academic, NHS and industry partners (including City St George's, RRDN and South London partnerships)	Partnership performance reporting, collaborative research programmes, RRDN reporting and strategic partnership reviews.	1st / 2nd	Moderate
4	Research Workforce and Capability Framework – Research leadership, training and workforce capability (including fellowship and researcher development programmes)	Fellowship programme reporting, research training activity and workforce capability reporting.	1st / 2nd	Moderate
5	Research Performance and Participation Framework – Research participation, patient recruitment, and research performance monitoring	Research recruitment data, study participation metrics, grant funding performance and benchmarking information.	1st / 2nd	Moderate

Group Board Assurance Framework 2026/27

Gaps in controls *What do we need to do to control the risk that we are not yet doing?*		*Linked controls*
1	**A Group-wide research and innovation strategy has not yet been agreed and implemented:** Whilst research activity is well established across both Trusts, there is currently no agreed Group-wide research and innovation strategy setting out shared priorities, objectives, measures of success and arrangements for delivery.	1, 3
2	**A strategic partnership vision and delivery plan for research and innovation with City St George's has not yet been fully developed:** Whilst strong collaborative relationships exist between the Group and City St George's, opportunities remain to develop a shared strategic vision, priorities and delivery plan to maximise the benefits of research, innovation and academic partnership.	1, 3
3	**Research capacity, infrastructure and funding arrangements remain constrained in key areas:** Whilst research performance remains strong, constraints relating to workforce capacity, research support functions, infrastructure and the sustainability of research funding continue to limit opportunities for growth and participation.	2, 4
4	**Participation in research activity remains variable across services and specialties:** Research activity and participation are concentrated within a number of specialties and services, with opportunities to broaden participation and increase research activity across the Group.	5
5	**Arrangements for translating research and innovation into measurable organisational benefit continue to develop:** While the Group undertakes substantial research activity, further work is required to systematically evaluate, adopt and spread research findings to maximise benefits for patients, staff and the organisation.	2, 5
6	**Research performance and impact reporting are not yet fully developed at Group level:** Whilst research activity is monitored through a range of operational measures, opportunities remain to strengthen strategic reporting on research performance, impact, innovation and return on investment at Group level.	1, 5

Material actions to address gaps in controls and assurances *What are we going to do, by when, to further manage and mitigate the risk?*		Control Gaps	Executive Lead	Due date	Progress
1	Develop and implement a Group Research and Innovation Strategy	1	GCMO	Nov-26	On Track
2	Develop a strategic research and innovation partnership plan with City St George's	2	GCMO	TBC	TBC
3	Deliver agreed research infrastructure and workforce development initiatives	3	GCMO	TBC	TBC
4	Expand participation in research activity across services and specialties	4	GCMO	TBC	TBC
5	Develop arrangements to evaluate, adopt and spread research findings and innovation	5	GCMO	TBC	TBC
6	Develop Group-level research performance and impact reporting	6	GCMO	Mar-27	On Track

Related risks on Corporate Risk Registers

Trust	Datix ID	Score	Summary risk description
There are no research related risks on either Trust's Corporate Risk Registers			

Emerging risks

What could materially affect this risk over the next 12-24 months?

- Changes to national research funding arrangements may reduce research capacity and capability
- The opportunity presented by the City St George's merger may not be fully realised
- Workforce pressures may reduce participation in research activity
- Research infrastructure and support services may not keep pace with growth ambitions
- Competition for research funding, partnerships and research-active staff may increase
- Opportunities to adopt and spread innovation may not be realised at scale

Group Board Assurance Framework 2026/27

Strategic Risk	SR6	Timely Access to Care

Current Risk Score: 20

Assurance: Partial

Event	Caused by	Results in
The gesh Group is unable to provide timely access to care and maintain effective patient flow across urgent, emergency, elective diagnostic and cancer services	*Capacity constraints across beds, theatres, diagnostics and workforce; discharge delays; rising demand; and slower than planned delivery of transformation, productivity and flow improvement programmes*	*Poorer patient outcomes and experience, increased clinical risk, failure to meet constitutional standards, loss of income, reduced productivity and regulatory intervention*

Strategic objective	Right Care, Right Place, Right Time
Last review date	*N/A – New Risk*
Monitoring Committee	Finance & Performance Committees
Lead Executive	Site Managing Directors
Risk appetite	Cautious (Moderate)

Risk Score		Impact	Likelihood	Overall Risk Score	Assurance rating
Inherent	Jun-26	5	5	25	Limited
Current	**Jun-26**	**5**	**4**	**20**	**Partial**
Target	Mar-28	5	3	15	Reasonable

Change since last review: ⟺

Month	Oct-26	Dec-26	Mar-27	Jun-27	Oct-27	Dec-27	Mar-28	Jun-28	Oct-28	Dec-28	Mar-29	Oct-26
Risk Score	20											
Assurance	Partial											

Key controls *What are we already doing to manage the risk?*		Assurances on controls *How do we have assurance that the controls are working?*	*Line of defence*	Control Strength
1	Comprehensive operational performance management arrangements covering urgent and emergency care, elective care, diagnostics and cancer performance.	IQPR reporting, NOF reporting, national oversight framework reporting, performance trajectories and F&P Committee reporting.	1st / 2nd	Moderate
2	Group and site arrangements to manage patient flow, bed capacity, escalation and operational resilience.	Flow metrics, bed occupancy reporting, length of stay reporting, corridor care reporting, site operational reviews and patient flow reporting.	1st / 2nd	Moderate
3	Programme of work to improve RTT performance, waiting list management and elective productivity.	RTT reporting, waiting list trajectories, 52-week wait reporting, validation activity and recovery programme reporting.	1st / 2nd	Moderate
4	Improvement programmes to improve urgent and emergency care performance and reduce operational pressures.	UEC performance reporting, ED metrics, corridor care reporting, site improvement plans and operational performance reviews.	1st / 2nd	Moderate
5	Programmes to improve diagnostic and cancer pathways and recovery performance.	Cancer performance reporting, diagnostics performance reporting, pathway reviews, deep dives and recovery programme reporting.	1st / 2nd	Moderate
6	System-wide discharge and flow arrangements with partners to support timely patient discharge and capacity management.	Discharge metrics, system flow reporting, community capacity reporting, escalation reporting and system oversight arrangements.	1st / 2nd	Moderate
7	Board, Committee and Executive oversight of operational performance and delivery of constitutional standards.	F&P Committee reporting, Group Executive Committee reporting, site governance reporting, Board reporting and performance review meetings.	2nd	Moderate
8	Transformation programmes designed to improve flow, productivity, outpatient transformation, non-elective care and delivery of sustainable access improvements.	Medium Term Plan reporting, transformation programme reporting, pathway redesign reporting, productivity reporting and programme governance arrangements.	2nd	Weak-Moderate

Group Board Assurance Framework 2026/27

Gaps in controls *What do we need to do to control the risk that we are not yet doing?*		*Linked controls*
1	**Patient flow remains constrained by discharge delays and wider system capacity pressures:** Whilst patient flow and escalation arrangements are established, discharge delays and wider system constraints continue to impact bed availability, patient flow and operational performance.	2, 6
2	**Capacity constraints continue to limit operational performance and recovery trajectories:** Capacity constraints across beds, theatres, diagnostics and workforce continue to affect the Group's ability to consistently achieve constitutional standards and improve flow.	2, 3, 4, 5
3	**Benefits from transformation, productivity and left-shift programmes have not yet been fully realised:** Delivery of planned improvements in access, flow and productivity remains dependent on transformation programmes that are still in delivery or early implementation phases.	8
4	**Operational performance remains vulnerable to rising demand and external system pressures:** The Group continues to experience demand growth and external system pressures which may offset improvements delivered through internal recovery and transformation programmes.	2, 4, 6, 8
5	**Variation remains in performance across pathways, services and sites:** Whilst improvement programmes are established, performance against constitutional standards remains variable across specialties, pathways and sites, indicating that improvements are not yet consistently embedded.	1, 3, 4, 5, 7
6	**Delivery of access and flow improvements remains dependent on investment in additional capacity and performance improvement initiatives:** Achievement of recovery trajectories and constitutional standards may require continued investment in workforce, capacity and improvement initiatives at a time of significant financial constraint. Balancing performance improvement requirements with financial sustainability objectives remains an ongoing challenge.	3, 4, 5, 8

Material actions to address gaps in controls and assurances *What are we going to do, by when, to further manage and mitigate the risk?*		Control Gaps	Executive Lead	Due date	Progress
1	Deliver agreed RTT recovery trajectories and reduce long waits through waiting list validation, pathway redesign and elective productivity improvements.	2, 5, 6	MDs	Mar-27	On Track
2	Deliver urgent and emergency care improvement plans to improve patient flow, reduce corridor care and improve emergency care performance.	1, 2, 5, 6	MDs	Mar-27	On Track
3	Deliver agreed cancer and diagnostics recovery trajectories and improve performance against national standards.	2, 5, 6	MDs	Mar-27	On Track
4	Implement agreed discharge and flow improvement plans with system partners to reduce discharge delays and improve bed availability.	1, 4	MDs	Mar-27	On Track
5	Deliver non-elective transformation and pathway redesign programmes to improve access, flow and productivity.	3, 4	MD-SGUH	Mar-28	On Track
6	Deliver outpatient transformation programme to improve access, flow and productivity.	3, 4	MD-ESTH	Mar-28	On Track

Related risks on Corporate Risk Registers

Trust	Datix ID	Score	Summary risk description
SGUH	2393	20	Regularising Flow
ESTH	1943	16	Patient Flow
ESTH	1942	20	Waiting Times
SGUH	3139	16	Operational Performance – Cancer
SGUH	3140	16	Operational Performance – Constitutional Standards (UEC)
ESTH	1946	20	Cancer diagnostics waits
SGUH	2240	16	Patients waiting longer than 18 weeks for elective cardiology
SGUH	2664	16	Cancellation of elective & urgent inpatient vascular patients

Emerging risks

What could materially affect this risk over the next 12-24 months?

- Demand growth may outpace planned capacity and productivity improvements.
- Discharge delays and wider system capacity pressures may continue to constrain patient flow.
- Workforce, estate and digital constraints may limit improvements in access and flow.
- National performance expectations and regulatory scrutiny may increase faster than improvements in operational performance.

Group Board Assurance Framework 2026/27

Strategic Risk	SR7	Patient Safety and Quality

Current Risk Score: 20

Assurance: Partial

Event	Caused by	Results in
The gesh Group fails to maintain and improve the quality and safety of care during a period of financial pressure and transformation.	*Weaknesses in quality governance, inconsistent implementation of the Quality Management System, and failure to consistently embed quality and safety within organisational decision-making.*	*Avoidable harm to patients, poorer clinical outcomes, widening inequalities, poor patient experience and regulatory scrutiny.*

Strategic objective	Right Care, Right Place, Right Time
Last review date	*N/A – New Risk*
Monitoring Committee	Quality Committees
Lead Executive	GCNO & GCMO
Risk appetite	Cautious (Moderate)

Risk Score		Impact	Likelihood	Overall Risk Score	Assurance rating
Inherent	May-26	5	5	25	Limited
Current	**Jun-26**	**5**	**4**	**20**	**Partial**
Target	Mar-28	5	3	15	Reasonable

Change since last review



Month	Jun-26	Oct-26	Dec-26	Mar-27	Jun-27	Oct-27	Dec-27	Mar-28	Jun-28	Oct-28	Dec-28	Mar-29
Risk Score	20											
Assurance	Partial											

Key controls *What are we already doing to manage the risk?*		Assurances on controls *How do we have assurance that the controls are working?*	*Line of defence*	Control Strength
1	Quality Governance and Assurance Framework	Quality governance architecture and processes are defined, with clear Divisional, Site, Executive, Committee Board oversight frameworks	1st / 2nd	Weak-Moderate
2	Patient Safety Incident Response Framework (PSIRF)	Patient Safety Incident Reports, PSIRF reporting, learning response reviews and Internal Audit findings	1st / 2nd / 3rd	Moderate
3	Quality Impact Assessment Framework	Quality Impact Assessment reporting relating to Cost Improvement Programmes, winter plans, service change and transformation programmes	1st / 2nd	Moderate
4	Clinical Effectiveness and Standards Framework	NICE compliance reporting, Learning from Deaths reporting, clinical audit activity, professional standards reviews, and population health and health inequalities analysis to identify unwarranted variation in outcomes and access	1st / 2nd	Moderate
5	Clinical Quality and Safety Oversight Framework	Maternity, mortality, IPC, safeguarding, medicines, VTE, falls and other specialist quality assurance reports	1st / 2nd	Moderate
6	Quality Intelligence and Performance Reporting Framework	IQPR quality and safety metrics, mortality indicators, patient safety metrics and trend reporting	2nd	Moderate

Group Board Assurance Framework 2026/27

Gaps in controls *What do we need to do to control the risk that we are not yet doing?*		*Linked controls*
1	**Quality governance arrangements are not yet consistently embedded across the Group:** Whilst governance arrangements have been strengthened, variation remains in the maturity and consistency of quality governance arrangements across services, sites and divisions.	1, 6
2	**A Group Quality Management System has not yet been fully implemented and embedded:** Development of a Group Quality Management System remains in progress and a consistent approach to quality planning, assurance, improvement and learning is not yet fully embedded across the organisation.	1, 4
3	**Continuous improvement capability and approaches are not yet consistently embedded across the Group:** Approaches to quality improvement, learning and continuous improvement remain variable across services and sites, limiting the pace and consistency of improvement.	1, 4
4	**Quality intelligence and triangulation are not yet fully mature:** The organisation receives a significant volume of quality, safety and performance information. Further development is required to strengthen triangulation, improve insight and support earlier identification of emerging quality and safety risks.	5, 6
5	**Assurance regarding the quality impact of major transformation and financial recovery programmes continues to develop:** QIA processes are established. However, the organisation continues to strengthen its ability to assess, monitor and evaluate the quality impacts of transformation and financial recovery programmes.	3
6	**Unwarranted variation remains in quality and safety outcomes between services, sites and population groups:** Quality intelligence, clinical assurance activity and health inequalities reporting continue to identify unwarranted variation in quality, safety and outcomes across services, sites and patient groups.	4, 5, 6

Material actions to address gaps in controls and assurances *What are we going to do, by when, to further manage and mitigate the risk?*		Control Gaps	Executive Lead	Due date	Progress
1	Deliver the Quality Governance Improvement Plan	1, 5	GCNO / GCMO	Dec-26	On Track
2	Develop and implement the Group Quality Management System	2, 3	GDCEO	Mar-28	On Track
3	Deliver the Group Quality Priorities 2026/27	3, 4	GCNO / GCMO	Mar-27	On Track
4	Strengthen Quality Impact Assessment processes and arrangements	5	GCNO / GCMO	Mar-27	Off Track
5	Deliver improvement actions arising from internal and external reviews	1, 5, 6	GCNO / GCMO	TBC	TBC
6	Strengthen the identification and reduction of unwarranted variation and health inequalities	6	GCMO	Mar-28	On Track

Related risks on Corporate Risk Registers

Trust	Datix ID	Score	Summary risk description
SGUH/ESTH	2923/2255	20	Emergency Department Overcrowding
SGUH	2976	16	Maternity Services – Safety and Regulatory Standards
SGUH	2393	20	Regularising Flow
ESTH	1943	16	Patient Flow
ESTH	1948	16	Caring for adult mental health patients in ED and wards

Emerging risks

What could materially affect this risk over the next 12-24 months?

- Financial recovery and transformation programmes may increase quality and safety risk
- Increasing service demand and operational pressures may affect quality and safety outcomes
- Regulatory and external review findings may identify additional quality and safety improvement requirements
- Workforce pressures may affect quality improvement capacity and capability
- Unwarranted variation and health inequalities may become more pronounced during periods of change

Group Board Assurance Framework 2026/27

Strategic Risk	SR8	Workforce Sustainability

Current Risk Score: 20

Assurance: Partial

Event	Caused by	Results in
The gesh Group is unable to deliver a sustainable, affordable and well-deployed workforce.	*Workforce redesign and establishment reductions not being delivered at the pace required, continued reliance on temporary staffing, elevated sickness absence, and slower than planned workforce productivity improvements.*	*Elevated workforce costs, productivity shortfalls, increased safety risk, and slower delivery of transformation and operational objectives.*

Strategic objective	Empowered, Engaged Staff
Last review date	*N/A – New Risk*
Monitoring Committee	People Committees
Lead Executive	Group Chief People Officer
Risk appetite	Averse (Low)

Risk Score		Impact	Likelihood	Overall Risk Score	Assurance rating
Inherent	May-26	5	5	25	Limited
Current	**Jun-26**	**5**	**4**	**20**	**Partial**
Target	Mar-28	5	3	15	Reasonable

Change since last review: ⟺

Month	Jun-26	Oct-26	Dec-26	Mar-27	Jun-27	Oct-27	Dec-27	Mar-28	Jun-28	Oct-28	Dec-28	Mar-29
Risk Score	20											
Assurance	Partial											

	Key controls *What are we already doing to manage the risk?*	Assurances on controls *How do we have assurance that the controls are working?*	*Line of defence*	Control Strength
1	Workforce Controls and Establishment Management	Workforce establishment, recruitment and WTE reduction performance monitored against plan.	1st / 2nd	Moderate
2	Temporary Staffing Reduction Programme	Delivery of temporary staffing reduction targets and internal audit findings.	1st / 2nd / 3rd	Weak-Moderate
3	Attendance Management and Wellbeing Framework	Workforce availability and sickness trends monitored through People Committee reporting.	1st / 2nd	Moderate
4	Clinical Workforce Transformation Programme	Workforce productivity and transformation benefits monitored through programme governance.	1st / 2nd	Weak-Moderate
5	Admin and Clerical Workforce Transformation Programme	Workforce analytics, workforce/finance reconciliation, productivity opportunities and programme delivery reporting.	1st / 2nd	Weak-Moderate
6	Corporate Services Transformation Programme	Delivery of workforce optimisation, role redesign and productivity improvements.	1st / 2nd	Weak-Moderate
7	Workforce Performance Oversight	Routine oversight of workforce performance, risks and emerging pressures.	2nd	Moderate
8	Integrated Workforce and Financial Planning	Monitoring of workforce assumptions underpinning financial recovery and MTP delivery.	2nd	Weak-Moderate

Group Board Assurance Framework 2026/27

Gaps in controls *What do we need to do to control the risk that we are not yet doing?*		*Linked controls*
1	**Workforce affordability plans remain dependent on significant workforce reduction delivery:** A substantial proportion of planned workforce reductions and associated savings have yet to be realised.	1, 8
2	**Workforce productivity improvements are not yet evidenced at the scale required:** Planned benefits from workforce deployment, job planning, rostering optimisation, skill mix redesign, digital enablement and new ways of working remain largely unproven and are not yet embedded at scale.	4, 5, 6, 8
3	**Temporary staffing reductions remain challenging: D**elivery of planned reductions is reliant on improvements in workforce availability, sickness absence, substantive recruitment, workforce deployment and productivity.	2, 3
4	**Sickness absence remains above planned levels:** Sickness absence remains above target across the Group and is a key dependency for workforce availability, workforce productivity and temporary staffing reduction assumptions.	3, 7
5	**Workforce transformation programmes remain at an early stage of maturity:** The transformation programmes which underpin workforce productivity and affordability assumptions remain in mobilisation or early delivery phases, with benefits realisation largely dependent on future delivery.	4, 5, 6
6	**Workforce and financial plans remain highly interdependent:** Achievement of workforce, productivity and efficiency targets is dependent on concurrent delivery across multiple programmes.	1, 8

Material actions to address gaps in controls and assurances *What are we going to do, by when, to further manage and mitigate the risk?*		Control Gaps	Executive Lead	Due date	Progress
1	Deliver establishment management and workforce affordability plans underpinning the MTP and financial recovery programme.	1, 6	GCPO / GCFO	Mar-27	Off Track
2	Implement actions to reduce reliance on bank and agency staffing and deliver NHSE temporary staffing targets.	3, 4	GCPO	Mar-27	Off Track
3	Deliver sickness reduction and workforce wellbeing actions to improve workforce availability.	4	GCPO	Dec-26	On Track
4	Implement workforce deployment, job planning, rota management and workforce productivity improvements through the Clinical Workforce Transformation Programme.	2, 5	Programme SRO – GCNO	Mar-28	On Track
5	Implement workforce optimisation, role redesign, workforce analytics and productivity improvements through the A&C Workforce Transformation Programme.	2, 5	Programme SRO – COO-SG	Mar-28	On Track
6	Implement workforce redesign, operating model changes and digital enablement through the Corporate Services Transformation Programme.	2, 5	Programme SRO – GCOFIE	Mar-28	Off Track

Related risks on Corporate Risk Registers

Trust	Datix ID	Score	Summary risk description
SGUH/ESTH	3115/2493	20	Sickness Absence Rates
SGUH/ESTH	3129/2149	20	Industrial Action
SGUH/ESTH	2787/2173	16	Corporate Services Integration
ESTH	1930	16	Medical Staffing Shortages
ESTH	2073	20	Soft Facilities Management Staff Terms and Conditions

Emerging risks

What could materially affect this risk over the next 12-24 months?

- National workforce and employment policy changes may adversely affect workforce affordability and delivery assumptions.
- Industrial action or wider workforce relations pressures may affect workforce availability, productivity and financial performance.
- Workforce supply constraints in key staff groups may limit the organisation's ability to achieve workforce redesign and temporary staffing reduction plans.

Group Board Assurance Framework 2026/27

Strategic Risk	SR9	Organisational Culture and Inclusion

Current Risk Score: 16

Assurance: Partial

Event	Caused by	Results in
The gesh Group fails to embed an inclusive, psychologically safe and high performing culture	*Variable leadership behaviours, competing operational pressures, uneven embedding of organisational values, limited improvement capability, and barriers to speaking up and psychological safety*	*Lower staff engagement and wellbeing, higher turnover and sickness absence, weaker improvement and safety culture, failure to realise the benefits of a diverse and inclusive workforce, and reduced organisational effectiveness*

Strategic objective	Empowered, Engaged Staff
Last review date	*N/A – New Risk*
Monitoring Committee	People Committees
Lead Executive	Group Chief People Officer
Risk appetite	Cautious (Moderate)

Risk Score		Impact	Likelihood	Overall Risk Score	Assurance rating
Inherent	May-26	4	5	25	Limited
Current	**Jun-26**	**4**	**4**	**16**	**Partial**
Target	Mar-28	4	3	12	Reasonable

Change since last review: ⟺

Month	Jun-26	Oct-26	Dec-26	Mar-27	Jun-27	Oct-27	Dec-27	Mar-28	Jun-28	Oct-28	Dec-28	Mar-29
Risk score	16											
Assurance	Partial											

Key controls *What are we already doing to manage the risk?*		Assurances on controls *How do we have assurance that the controls are working?*	*Line of defence*	Control Strength
1	Implementation of the Group People Strategy 2024-26 and associated delivery programme	Regular People Strategy progress reports to People Committee demonstrating delivery against strategic priorities and workforce outcomes	1st / 2nd	Moderate
2	Group-wide leadership, organisational development and performance framework to support development of inclusive and high-performing teams.	Reports on talent development, leadership initiatives, performance and development processes, and organisational development programmes.	1st / 2nd	Weak-Moderate
3	Implementation of the Group EDI Strategy, Inclusion Board and associated action plans.	WRES, WDES, Pay Gap reporting and EDI progress reports reviewed by People Committee and Board.	2nd / 3rd	Weak-Moderate
4	Group Freedom to Speak Up arrangements and processes supporting speaking up, psychological safety and organisational learning.	Quarterly FTSU reports, thematic analysis of concerns raised, and Staff Survey raising concerns indicators.	2nd / 3rd	Weak-Moderate
5	Structured staff engagement programme including Staff Survey, listening activities and staff involvement mechanisms.	Annual NHS Staff Survey results and associated action plans reviewed by People Committee and Board.	1st / 2nd	Weak-Moderate
6	Group health and wellbeing programme supporting staff wellbeing, attendance and resilience.	Health and wellbeing reports, sickness absence trends and workforce metrics reviewed by People Committee.	1st / 2nd	Moderate
7	Routine oversight of workforce performance indicators including turnover, sickness, retention and temporary staffing.	Workforce KPI reports reviewed regularly by People Committee.	1st / 2nd	Moderate
8	Regular Board and People Committee oversight of culture, inclusion, staff experience and workforce risks.	Biannual/quarterly review of strategic risks, Board reporting and Committee deep dives.	2nd	Moderate

Group Board Assurance Framework 2026/27

Gaps in controls *What do we need to do to control the risk that we are not yet doing?*		*Linked controls*
1	**Shared values and behavioural expectations are not yet consistently embedded across the Group:** The organisations do not yet have a consistently embedded set of values and behavioural expectations Group-wide, contributing to variation in culture, staff experience and leadership behaviours.	1, 2, 5
2	**Leadership behaviours and management capability remain inconsistent:** There is evidence of variation in staff experience, management conduct concerns, FTSU themes and employee relations issues, suggesting leadership behaviours and management capability are not yet consistently aligned with the Group's desired culture.	2, 5, 7
3	**People and Organisational Development capacity may be insufficient to deliver the scale of cultural change required:** Current People, OD and EDI capacity may not be sufficient to support the scale and pace of leadership, culture, inclusion and workforce transformation required across the Group.	1, 2, 3, 8
4	**Psychological safety and speaking up culture are not yet consistently embedded:** Although Freedom to Speak Up arrangements are mature and accessible, Staff Survey results, FTSU themes and internal audit findings indicate that confidence to speak up and challenge remains variable across services and staff groups.	4, 5
5	**Progress on inclusion and workforce equality remains uneven:** Despite established EDI programmes and governance arrangements, WRES, WDES and Pay Gap reporting continue to demonstrate inequalities in staff experience, representation and career progression across parts of the organisation.	3, 2
6	**Organisational culture is experienced inconsistently across staff groups and services:** Staff Survey, FTSU, WRES, WDES and other assurance sources indicate variation in staff experience, engagement, inclusion and psychological safety between different staff groups, professions and services.	2, 3, 4, 5

Material actions to address gaps in controls and assurances *What are we going to do, by when, to further manage and mitigate the risk?*		Control Gaps	Executive Lead	Due date	Progress
1	Develop and embed a consistent Group-wide values and behaviours framework	1, 2	GCPO	Dec-26	Off Track
2	Strengthen leadership capability and management practice	2, 3	GCPO	Mar-28	On Track
3	Deliver the EDI improvement programme (inc. Inclusion Board)	5	GCPO	Mar-28	Off Track
4	Deliver the Staff Survey improvement plan	4, 6	GCPO	Mar-27	On Track
5	Strengthen People, OD and EDI capacity to deliver cultural transformation	3	GCPO	Sep-26	On Track
6	Implement a Group Freedom to Speak Up Strategy and strengthen organisational learning	4, 6	GCCAO	Dec-26	On Track

Related risks on Corporate Risk Registers

Trust	Datix ID	Score	Summary risk description
SGUH/ESTH	881/2491	16	Bullying and harassment
SGUH/ESTH	3115/2493	20	Sickness absence rates
SGUH/ESTH	1978/2070	16	Raising concerns
SGUH	2532	16	Capacity within the Employee Relations team
SGUH	2334	16	Violence and aggression against staff
ESTH	2073	20	Soft Facilities Management Staff Terms & Conditions

Emerging risks

What could materially affect this risk over the next 12-24 months?

- Workforce redesign, organisational change and financial pressures may adversely affect staff engagement, wellbeing and organisational culture.
- Increasing demands associated with transformation, financial recovery and service change may exceed current leadership capacity and capability.
- Failure to improve staff experience may impact recruitment, retention and workforce stability.
- Increasing concerns relating to management conduct, bullying and harassment may impact psychological safety and confidence in organisational processes.