Group Board

Agenda

Meeting in Public on Friday, 11 September 2026, 12:00 – 15:40

Wandsworth Professional Development Centre, Building 1, Burntwood School, Burntwood Lane, SW17 0AQ

Introductory items					
Time	**Item**	**Title**	**Presenter**	**Purpose**	**Format**
12:00	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
12:05	1.5	Feedback from the Inclusion Board	Inclusion Board members	Discuss	Verbal
12:20	1.6	Group Chief Executive Officer's Report	GCEO	Review	Report

Priority Matters for the Board					
Time	**Item**	**Title**	**Presenter**	**Purpose**	**Format**
12:30	2.1	Water Safety in St Helier E Block	GCEO / MD-ESTH	Review	Report

Quality and Safety					
Time	**Item**	**Title**	**Presenter**	**Purpose**	**Format**
12:45	3.1	Quality Committees Report	Committee Chair	Assure	Report
12:55	3.2	Perinatal Sub-Committee Report	GCMidO	Review	Report
13:05	3.3	NHS 10 Point Plan for Maternity & Neonatal Services: Baseline Benchmarking Review	GCMidO	Approve	Report
13:15	-	*Break*			

Finance and Performance					
Time	**Item**	**Title**	**Presenter**	**Purpose**	**Format**
13:50	4.1	Finance and Performance Committees Report	Committee Chair	Assure	Report
14:00	4.2	Integrated Finance Report – Month 4	IGCFO	Review	Report
14:10	4.3	Integrated Quality and Performance Report	GDCEO	Review	Report

People and Culture					
Time	**Item**	**Title**	**Presenter**	**Purpose**	**Format**
14:30	5.1	People Committees Report	Committee Chair	Assure	Report

People and Culture					
Time	**Item**	**Title**	**Presenter**	**Purpose**	**Format**
14:40	5.2	Equality, Diversity and Inclusion (EDI) Overview, including approval of our 2026 WRES and WDES reports	GCPO	Approve	Report

Infrastructure					
Time	**Item**	**Title**	**Presenter**	**Purpose**	**Format**
14:55	6.1	Infrastructure Committee Report	Committee Chair	Assure	Report

Closing items					
Time	**Item**	**Title**	**Presenter**	**Purpose**	**Format**
15:05	7.1	New Risks and Issues Identified	Chair	Note	Verbal
	7.2	Reflections on the Meeting	Chair	Note	Verbal
	7.3	Questions from members of the public and Governors of St George's*	Chair	Review	Verbal
	7.4	Any Other Business	All	Note	Verbal
15:15	7.5	Patient Story	CNOs	Discuss	Verbal
15:40	-	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
Natalie Armstrong	Non-Executive Director – ESTH and SGUH	NA
Mark Bagnall*^	Group Chief Facilities, Infrastructure and Environment Officer	GCFIEO
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
Theresa Matthews*	Site Chief Nursing Officer – ESTH	SCNO-ESTH
Khadir Meer^	Associate Non-Executive Director – SGUH	KM
Azara Mukhtar	Group Chief Finance Officer	AMr
Andrew Murray	Non-Executive Director ESTH and SGUH	AMy
Michael Pantlin*^	Group Deputy Chief Executive Officer	GDCEO
Thirza Sawtell*	Site Chief Executive Officer – Integrated Care	SCEO-IC
Nicola Shopland^	Site Chief Nursing Officer – SGUH	SCNO-SGUH
Kate Slemeck^	Site Chief Executive Officer – SGUH	SCEO-SGUH
Victoria Smith*^	Group Chief People Officer	GCPO
Rebecca Suckling*	Interim Site Chief Executive Officer – ESTH	ISCEO-ESTH
Claire Sunderland Hay^	Associate Non-Executive Director – SGUH	CSH
In Attendance		
Kelly Brown	Senior Corporate Governance Manager	SCGM
Michelle Cudjoe	Group Chief Midwifery Officer	GCMidO
Steve Walters	Group Deputy Director of Governance, Risk and Assurance	GDDGRA
Apologies		
Anna Macarthur^*	Group Chief Communications Officer	GCCO
Leonie Penna*	Non-Executive Director SGUH and ESTH (Associate)	LP
Bidesh Sarkar	Non-Executive Director – ESTH and SGUH	BS
Phil Wilbraham*	Associate Non-Executive Director – ESTH	PW
Observers		
Zahra Abbas	Inclusion Board Member, Strategy and Planning Manager	ZA
Elyscia Howell	Inclusion Board Member, Group Head of Complaints & PALS	EH
Michelle Ellis	Appointed Governor, St George's University of London	ME
John Hallmark	Public Governor, Wandsworth	JH
Jackie Parker	Public Governor, Wandsworth	JP
Sunil Dasan	Consultant in Emergency Medicine, SGUH	SD
Hugh Taylor	Lead, external governance review	HT

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

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

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

Minutes of Group Board Meeting

Meeting in Public on Thursday, 09 July 2026, 12:45 – 16.50

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

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 – ESTH & SGUH	NA
Pankaj Davé	Non-Executive Director – ESTH & SGUH	PD
Richard Jennings	Group Chief Medical Officer	GCMO
Stephen Jones*^	Group Chief Corporate Affairs Officer	GCCAO
Yin Jones	Non-Executive Director – ESTH & SGUH	YJ
Khadir Meer^	Associate Non-Executive Director – SGUH	KM
Andrew Murray	Non-Executive Director – ESTH & SGUH	AM
Michael Pantlin*^	Group Deputy Chief Executive Officer	GDCEO
Leonie Penna*	Non-Executive Director – SGUH & ESTH (Associate)	LP
Bidesh Sarkar	Non-Executive Director – ESTH & SGUH	BS
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
Mark Coker	Group Chief Digital Information Officer *(item 5.3)*	GCDIO
Michelle Cudjoe	Group Chief Midwifery Officer *(item 3.5)*	GCMidO
Anna Macarthur	Group Chief Communications Officer	GCCO
Theresa Matthews	Site Chief Nursing Officer – ESTH	CNO-ESTH
Ralph Michell	Group Chief Transformation Officer	GCTO
Nicola Shopland	Site Chief Nursing Officer – SGUH	CNO-SGUH
APOLOGIES		
Mark Bagnall*^	Group Chief Facilities, Infrastructure and Environment Officer	GCFIEO
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 Chief Nurse, CWDT, SGUH	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

** 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
Ahead of the formal meeting in public, Board members undertook a series of visits to services across the Queen Mary's Hospital site and also joined colleagues attending the Big Thank You event. Members then provided brief feedback from the visits at the start of the meeting: • **Rehabilitation Services, Vitali Clinic and rehabilitation ward (Andrew Murray, Natalie Armstrong, GDCEO, IGCFO):** Members were impressed by the range and quality of specialist rehabilitation services, including the spasticity service, amputee rehabilitation and the therapeutic environment provided within the rehabilitation ward. Staff highlighted significant difficulties with patient transport, including vehicles failing to arrive or being unsuitable for patients using specialist wheelchairs. Members also heard concerns following the cessation of a virtual service for patients with functional neurological conditions and agreed that the circumstances and the quality impact assessment underpinning that change should be understood further. • **Prosthetics and Orthotics (Pankaj Davé, Leonie Penna, GCMO, GCPO):** Members described a highly specialist and distinctive service, supported by an experienced and committed workforce. Particular concerns were raised about the future pipeline of skilled technicians and the challenges associated with an ageing workforce. Members also noted that the workshop was not climate controlled, which affected both staff working conditions and, during periods of high temperature, some of the technical processes used in manufacturing prosthetics and orthotics. • **Gait Laboratory (Bidesh Sarkar, Phil Wilbraham, MD-ESTH, GCCAO):** Members were impressed by the specialist assessment and treatment provided and by the positive feedback from patients. Staff highlighted the age of some of the laboratory's camera and software technology, which increased the amount of manual analysis required, together with the challenges associated with maintaining resilience within a small specialist workforce. • **Mary Seacole Ward (Yin Jones, GCEO, MD-SGUH, CNO-ESTH):** Members observed a positive, rehabilitation-focused environment and strong engagement from staff. The team highlighted delays in arranging social care packages as a barrier to discharge and raised the loss of access to psychological support for some patients following transfer from an acute hospital to Queen Mary's. Members noted that work was underway to understand the level of psychological support required. The Chair thanked all colleagues who had hosted the visits and asked that the issues raised be followed up through the appropriate operational routes.

1.0	INTRODUCTORY ITEMS
1.1	**Welcome, introductions and apologies**
	The Chair formally opened the meeting in public and welcomed Board members, attendees, members of the Inclusion Board, St George's Governors and members of the public. He particularly welcomed Nicola Shopland and Theresa Matthews, who were attending in support of the Group nursing leadership arrangements in the absence of the Interim Group Chief Nursing Officer. Apologies were noted from Mark Bagnall, Elaine Clancy and Thirza Sawtell.

	The Chair noted that this would be the final Board meeting for Lizzie Alabaster as Interim Group Chief Finance Officer and Alex Shaw as Interim Managing Director of ESTH. He also noted that, although unable to attend the meeting, Elaine Clancy would conclude her period as Interim Group Chief Nursing Officer before the next scheduled Board meeting. The Chair thanked all three for their contribution to the Group, including their willingness to step into interim leadership roles, and wished them well for the future.
1.2	**Declarations of Interests**
	The Board noted the standing declarations of interest relating to shared Group roles across the two Trusts. The Board noted Yin Jones' declaration, made earlier in the day, that she had been appointed as a Deputy Lieutenant for Greater London. The GCCAO would ensure that the Register of Interests was updated accordingly. No other new declarations of interest were made.
1.3	**Minutes of the Previous Meeting**
	The minutes of the meeting held on 8 May 2026 were **APPROVED** as a true and accurate record, subject to a minor amendment to record that Yin Jones had also participated in the Emergency Department and Urgent Treatment Centre visit.
1.4	**Action Log and Matters Arising**
	The Board reviewed the Action Log and received the following updates: • **GB26.01.08/02 – Recurrent and non-recurrent savings:** The Board noted that the requested analysis of recurrent and non-recurrent savings had now been incorporated into the Month 2 Integrated Finance Report at item 3.2. The action was therefore **CLOSED**. • **PUBLIC20250901.1 – Mandatory and Statutory Training:** The GCPO advised that the national review of mandatory training was nearing completion and that good progress was being made in aligning requirements across the Group. Some differences remained in areas including resuscitation and fire safety training, where the two Trusts currently operated different models. A substantive update would be brought through the Group's governance arrangements by November 2026 at the latest. The action would remain open. • **PUBLIC20241107.2 – Freedom to Speak Up / Interstitial Lung Disease:** The GCCAO advised that the ILD report at item 2.1 set out the steps taken to strengthen speaking-up arrangements within the ESTH respiratory service and the wider Group arrangements now in place to support Freedom to Speak Up. Further work to strengthen speaking-up culture would continue through the Group-wide Well-Led improvement programme and the development of a new Group Freedom to Speak Up Strategy, which was currently under development and would be presented to the Board later in the year. The Board noted that these arrangements provided an established route for continuing oversight of the remaining improvement work and agreed that the original action could therefore be **CLOSED**, with the Group Well Led improvement plan and Group FTSU strategy to be added to the Board forward plan for later in 2026/27.

2.0	Priority Matters for the Board
2.1	Interstitial Lung Disease (ILD) & RCP Invited Review - Update
	The GCMO presented the final report of the Royal College of Physicians (RCP) Invited Review into the care provided to patients with Interstitial Lung Disease (ILD) by a former consultant at St Helier Hospital. He described the findings as extremely difficult and upsetting. Of the 28 applicable cases reviewed, seven patients had experienced moderate clinical harm and 12 severe clinical harm; in three cases, failings in care may have contributed to premature death. The principal failings included delayed or absent MDT referral, failure to offer evidence-based treatments and the use of treatment or advice not supported by established evidence. The GCMO formally apologised to the patients and bereaved families affected, emphasising that they had been entitled to trust both their doctor and the organisation providing their care and had been let down. The GCEO reinforced the apology on behalf of the organisation and Board, and highlighted wider learning about the importance of effective multidisciplinary oversight and strong professional relationships within clinical teams. The GCMO advised that all patients then receiving ILD care had been reviewed in 2024 and treatment corrected where necessary. The subsequent RCP review had been commissioned to assess the extent of historic harm. Members noted that the sample included both cases where concerns had already been identified and randomly selected cases; the findings therefore indicated that further historic harm might remain unidentified. A further review would consequently be undertaken of the remaining ILD cases, using the RCP methodology and harm classifications, together with selected cohorts of other patients treated by the former consultant where potential concerns had been identified. All patients whose care had been considered by the RCP, or their bereaved next of kin where appropriate, had been contacted before publication and informed of the individual findings. The wider ILD cohort had also been contacted and advised of the further review. AM challenged the timescale and resourcing of the further reviews, particularly given the possibility that additional findings of harm could require the programme to expand. The GCMO advised that patients and families had been given a cautious estimate of one to two years for completion of the overall programme, although the organisation would seek to complete the work within approximately six to twelve months if practicable. Five appropriately experienced consultants had agreed to participate, with additional multidisciplinary input also being identified. The Board considered the wider organisational learning. The GCMO acknowledged that there had been missed opportunities to respond earlier and more decisively to concerns about the former consultant; the RCP had similarly concluded that concerns raised between 2019 and 2022 had not been adequately addressed. Members emphasised the need for staff to have confidence both that concerns would be heard and acted upon and that those speaking up would be appropriately supported. The Chair reinforced the Board's collective apology and sought confirmation of the position regarding the former consultant. The GCMO confirmed that the consultant had been prevented from seeing patients at the Trust from January 2023, had ceased to be employed by the Trust in April 2023 and had been formally referred to the GMC, which continued its investigation with restrictions on the consultant's practice. The Chair then tested the Board's assurance against each of the areas identified in the report. In relation to speaking up, AM considered that the right actions had been identified but that continued oversight was required. The GCCAO advised that, while arrangements within the

	respiratory service had strengthened, wider Group challenges remained and recommended partial assurance. The GCEO similarly supported partial assurance regarding the Group's arrangements for earlier identification of clinicians departing from safe practice. The Board: • **NOTED** the RCP Invited Review Report; • **SUPPORTED** the planned further review of the remaining ILD cases and selected cohorts of other patients treated by the former consultant; • **AGREED REASONABLE ASSURANCE** that patients and families had been communicated with appropriately and Duty of Candour discharged where information was available; appropriate next steps were in place to identify further harm; the RCP recommendations had been, or were being, acted upon; and the current ESTH respiratory service was providing safe care; and • **AGREED PARTIAL ASSURANCE** regarding the wider Group arrangements to support staff to speak up and to identify at an earlier stage clinicians whose practice might be departing significantly from accepted standards. The two areas of partial assurance would remain subject to continued organisational work and oversight through the established governance arrangements.
2.2	**Water Safety, E block, St Helier Hospital**
	The GCEO introduced the item and emphasised the Group's commitment to transparency with staff, patients and wider stakeholders. The GCEO was clear that no final decision had been made on whether services would need to move from E Block or where any temporary relocation might take place. He explained that the Group's preference was, first, to keep services in E Block if the necessary remedial works could be undertaken safely; if that was not possible, to retain services elsewhere on the St Helier site wherever practicable; and only then to consider alternative locations. The MD-ESTH advised that services in E Block remained safe to operate at present, supported by enhanced surveillance and microbiological monitoring, point-of-use filtration, water treatment measures and strengthened governance. These mitigations controlled the current risk but did not resolve the underlying problem of ageing water infrastructure. The current assessment was that full replacement of the pipework would be extremely difficult to undertake safely while services remained in occupation, given the age and construction of the building, incomplete knowledge of some pipe routes and the presence of asbestos. Given the significance of that conclusion, further independent assurance was being sought to test whether the required works could nevertheless be undertaken safely with services remaining operational. In parallel, the organisation was developing potential temporary relocation options should decant prove necessary, including use of existing and modular accommodation at St Helier and, only if required, alternative locations with system partners. Any option would need to take account of clinical dependencies, patient access, equality and health inequality impacts, workforce implications, operational deliverability and timescales. Andrew Murray welcomed the clearer articulation of the current approach. He emphasised the need genuinely to assess the risks of all options and to continue listening to staff and stakeholder feedback. Leonie Penna sought explicit clarification of the current position, noting that the verbal update differed in emphasis from the published paper. The GCEO confirmed that the verbal update reflected the organisation's current position and reiterated that the paper should not be read as indicating that a decision had already been reached on relocation.

	The Chair highlighted the scale and complexity of the issue. The GCEO confirmed that any sustainable solution was likely to require significant capital and support from wider NHS partners, and that any permanent reconfiguration of commissioned services would not be a decision for the Trust alone. He also emphasised that the work underway was a response to the water safety issue and was not part of a predetermined plan to reconfigure maternity services. The Board **NOTED** that: • services in E Block remained safe to operate at present with the mitigations in place; • further independent assurance was being obtained on whether the required remedial works could safely be undertaken while services remained in occupation; • potential temporary relocation options would continue to be developed, with priority given to retaining services on the St Helier site wherever possible; and • no decision had been reached on whether services would need to relocate or on any future location. A further update would be brought to the Board as the independent assurance and options work progressed.
3.0	**GROUP LEADERSHIP AND PERFORMANCE**
3.1	**Group Chief Executive Officer's Report**
	The GCEO highlighted confirmation of £57 million national investment to redevelop the Emergency Department at St Helier Hospital and updated the Board on the recent visit by the Secretary of State for Health and Social Care to St George's, during which the Group's use of Ambient Voice Technology was demonstrated. He had also raised the St Helier infrastructure challenges and the pressures associated with caring for patients experiencing mental health crisis within emergency departments. The GCEO welcomed the Group-wide Big Thank You Week, thanked the hospital charities for their support and noted the re-establishment of the Group Leadership Forum, including work to strengthen accountability and decision-making. The Chair commended the recent performance of the St George's Emergency Department, while the GCEO also recognised the improvement work underway at ESTH. In response to a question on the recent ESTH CQC Well-Led inspection, the GCEO advised that the formal report had not yet been received; initial verbal feedback had been positive overall and no enforcement action had arisen. Members also discussed continuing challenges around discharge and access to social care, noting work with local authority and system partners to improve discharge pathways, community frailty support and admission avoidance. The Board **NOTED** the report.
3.2	**Month 2 Finance Report**
	The IGCFO presented the Month 2 financial position and reported that both Trusts remained on plan. She cautioned, however, that this had required a greater use of non-recurrent measures than anticipated: approximately 45% of efficiency delivery to date was non-recurrent, compared with around 25% assumed in the plan. This increased the risk to delivery of the year-end position.

	The Group Executive remained committed to delivering the agreed financial plan but recognised the material challenge involved and the need to strengthen recurrent efficiency delivery. The Chair noted the significance of the financial challenge and that the Board would need to maintain increasingly close oversight as the year progressed. The Board **NOTED** the Month 2 financial position and the material pressure on the year-end forecast.
3.3	**Integrated Quality and Performance Report (IQPR)**
	The GDCEO presented the Integrated Quality and Performance Report and highlighted the final 2025/26 NHS Oversight Framework position. Both Trusts had achieved an underlying Segment 2 assessment, reflecting improvement across a number of operational measures, although application of the financial override resulted in an overall Segment 3 rating. Members welcomed the underlying improvement. The MD-SGUH reported continued strong urgent and emergency care and improving elective performance. Cancer performance was improving, although the 62-day standard remained challenging particularly in lung and thoracic pathways, while diagnostic waits were affected by difficulties recruiting sonographers. The MD-ESTH reported that all three principal cancer standards had been achieved for a third consecutive month, alongside improved theatre utilisation and elective performance. Data-quality issues continued to affect aspects of the patient tracking list. Phil Wilbraham noted that sickness absence had increased across both Trusts and the two community partnerships and sought assurance that this did not represent a reversal of the previous improving trend. The GCPO advised that sickness absence followed a marked seasonal pattern, with March to May generally representing the lowest point in the annual cycle. Nevertheless, absence remained an important organisational priority. A more detailed review of sickness absence management was planned through the People Committees, supported by the findings of a recent internal audit. The Board **NOTED** the IQPR, welcoming the improvements achieved across a number of operational measures while recognising the areas requiring sustained focus.
3.4	**Epsom and St Helier UEC Recovery Plan**
	The MD-ESTH presented the recovery plan and explained that urgent and emergency care performance had been materially affected by changes introduced from April 2026, including implementation of the UTC-first model and replacement of the previous ED same-day emergency care arrangements. These changes had initially reduced reported four-hour performance because more patients appropriately remained on the four-hour clock, but had also delivered important improvements in patient flow and quality. In particular, the routine use of same-day emergency care areas to accommodate patients awaiting admission had been substantially reduced, corridor care had improved and overall time in the department had reduced. The MD-ESTH emphasised that the revised clinical model was considered the right approach, notwithstanding the short-term impact on the headline four-hour standard. The recovery plan focused on stronger senior clinical and operational leadership at the front door, improved streaming and use of ambulatory pathways, faster specialty response, strengthened

	real-time management of patients and continued work on data quality. The plan set a trajectory back to around 70% performance, with further improvement towards 78%, in line with the operating plan. Lower- and no-cost actions were being prioritised first, although some additional investment was likely to be required. Yin Jones sought confirmation that the improvement being reported was consistent with the planned trajectory. The MD-ESTH confirmed that performance had improved from the low point following implementation of the new model and that recent weekly performance had moved back into the 70% range, in line with the recovery plan. The Board **APPROVED** the ESTH Urgent and Emergency Care Recovery Plan and noted the improvement trajectory and the continuing need for close oversight of delivery.
3.5	**Maternity Services Report**
	3.5.1 Perinatal Quality Oversight Model The GCMidO presented the quarterly Perinatal Quality Oversight Model report, which had been considered in detail by the Quality Committee, and highlighted a more recent thematic escalation from Maternity and Newborn Safety Investigations (MNSI) relating to fetal monitoring at SGUH. MNSI had reviewed recommendations arising from investigations over a number of years and identified a recurring theme relating to fetal monitoring. The organisation had undertaken a fresh review of the effectiveness of the relevant actions, sought independent input from regional maternity colleagues and submitted its response within the required timeframe. Andrew Murray noted that fetal monitoring had also featured in previous regulatory findings and sought clearer assurance about the current position. The GCMidO advised that the principal issue identified through the latest review related less to the technical interpretation of CTGs than to clinical decision-making and escalation where professional views differed. Measures introduced included a process for seeking a second clinical opinion where there was disagreement between clinicians and regular CTG huddles designed to strengthen oversight and mitigate human factors such as fixation and distraction. The detailed MNSI escalation and response would be reviewed through the July Maternity Sub-Committee. The Board **NOTED** the Perinatal Quality Oversight Model report and the further assurance work underway in response to the MNSI escalation. **3.5.2 Ockenden Nottingham and Amos National Maternity and Neonatal Reviews** The GCMidO summarised the implications of the recently published Ockenden Nottingham Maternity Review and Valerie Amos National Maternity and Neonatal Review, noting common themes around culture and leadership, multidisciplinary working, governance, listening to women and families, health inequalities and safe clinical pathways. Many of these themes were already reflected in the Group's maternity improvement programmes, with further benchmarking underway. The Group was also responding to NHS England's 10 immediate priorities for the first 100 days. NA sought assurance about the impact of successive national reviews and improvement requirements on maternity staff. The GCMidO described the support and engagement being provided to teams. PD asked how the Board would know whether maternity culture was genuinely improving; the GCMidO emphasised triangulation of quantitative and qualitative intelligence from staff, women and families.

	LP highlighted the cumulative resource implications for senior maternity leaders, while AM stressed that delivery could not rest predominantly with midwifery leadership. The GCMO confirmed that strong medical leadership at Group, site and divisional level was equally essential to improving maternity culture and safety. The Board: • **NOTED** the findings of the Ockenden Nottingham and Valerie Amos reviews; • **NOTED** NHS England's 10-point programme for the first 100 days; and • **AGREED** to receive assurance on delivery during the first 100 days and quarterly thereafter through the Quality Committee and Board.
4.0	**Committee Assurance and Oversight**
4.1	**Quality Committees Report**
	Andrew Murray, Co-Chair of the Quality Committees, presented the report and noted that maternity services and Interstitial Lung Disease had already been considered substantively earlier in the meeting. He therefore highlighted two principal areas requiring Board attention. First, the Committees remained concerned about the continuing occurrence of Never Events, particularly the recurring themes of retained foreign objects and wrong-site surgery. Although the Committees were satisfied that individual events were being investigated and that learning was taking place, the recurrence of events meant that sustained improvement had not yet been demonstrated. The Committees had therefore taken limited assurance in relation to the management of Never Events. AM advised that an external review of theatres at ESTH would be commissioned. In addition, AM, LP, the GCMO and GCNO would agree what further oversight and assurance were required to give the Committees greater confidence that effective action was being taken to prevent recurrence. Never Events would continue to be reviewed at each Quality Committee meeting. Second, AM highlighted the Committee's review of the Patient Safety and Quality strategic risk within the refreshed Board Assurance Framework. The Committee had not supported a proposed reduction in the likelihood score at this stage and had retained the overall risk score at 20. Members considered that a reduction should only be contemplated once there was clearer evidence that the Quality Governance Improvement Programme was embedded, fundamentals of care were improving and the cultural improvement programme had matured. The Board **NOTED** the Quality Committees Report and the areas of assurance and escalation highlighted by the Committee.
4.2	**Finance and Performance Committee**
	Bidesh Sarkar, Chair of the Finance and Performance Committees, presented the report and highlighted that NHS England had placed the Group into formal enhanced financial oversight, reflecting concerns about the Group's financial trajectory, underlying run-rate and pace of delivery of both business-as-usual and transformation savings. He emphasised that this represented the first stage of enhanced oversight and that NHS England had described the arrangements as intended to provide additional support and challenge. NHS England would continue to attend the Finance and Performance Committees and other relevant Group governance meetings.

	The Committees had also considered performance issues relating to children's therapies in Sutton and urgent and emergency care at ESTH, both of which would return for more detailed review during the autumn. BS advised that the Committees had reviewed the strategic risks relating to timely access to care and financial sustainability and had not recommended changes to the current risk scores. The Committees had, however, requested greater clarity on the "path to green" for each risk, setting out the actions and milestones required to move from the current position to the agreed target and enabling progress to be tracked more effectively. The Chair drew an important distinction between the effectiveness of the Group's financial control environment and assurance regarding delivery of the financial plan. He noted that the Board could take assurance that the system of internal financial control was adequate and operating effectively, supported by the recent clean year-end accounts. However, given the scale of the deficit challenge and the significant uncertainty around delivery of the current financial plan, the Board recognised that assurance regarding financial sustainability and delivery remained limited. The Board **NOTED** the Finance and Performance Committees Report, the enhanced financial oversight arrangements and the limited assurance regarding delivery of the financial plan.
4.3	**People Committees**
	Yin Jones, Chair of the People Committees, presented the report and advised that the Committee had taken substantial or reasonable assurance across most areas considered, but limited assurance in relation to the workplace wellbeing element of the NHS 10 Point Plan for Improving Resident Doctors' Working Lives. The Committee had heard directly from the St George's resident doctor representative, who highlighted continuing concerns about the basic working environment, including insufficient seating, broken IT equipment and inadequate secure storage. Members welcomed the GCEO's direct involvement in addressing these issues and noted that a dedicated steering group would meet on 22 July to agree both immediate improvements and longer-term estates actions. The GCPO also highlighted work to identify and address interpersonal and teamworking difficulties within medical teams earlier. She noted the learning from ILD that poor professional relationships and dysfunctional teamworking could be an early warning indicator of wider service risk, and advised that mediation and early conflict-resolution arrangements were being strengthened. The Chair concluded that, although areas of weakness remained, the Committee had identified a credible programme of action and the Board could therefore take reasonable assurance overall from the Committee's oversight. The Board **NOTED** the People Committees Report and the areas of assurance and escalation highlighted.
4.4	**Infrastructure Committees**
	Phil Wilbraham and Claire Sunderland Hay presented the report of the Infrastructure Committees. PW highlighted delays and contractual issues affecting the new SGUH ITU development, while noting progress with the Epsom photovoltaic scheme and fire-safety improvements across ESTH.

	The Committees had also reviewed the strategic risk relating to estates modernisation and infrastructure. PW advised that the Committee had questioned whether the proposed reduction in risk was realistically achievable given the underlying condition of parts of the estate, particularly at St Helier, and the scale of backlog maintenance and asset replacement requirements. CSH highlighted the Committee's consideration of the Digital Strategy, noting the importance of aligning the strategy with the available capital envelope and ensuring that investment addressed both immediate digital risk and the longer-term transformation priorities of the Group. The GCEO returned to the wider question of infrastructure risk and suggested that the Group needed a more explicit understanding of its risk appetite for operating services from ageing infrastructure, particularly where backlog maintenance continued to increase over time. The discussion highlighted the broader question of the Group's overall risk appetite and the value of further Board consideration. A wider discussion on risk appetite was already scheduled as part of the Board development programme later in the year. The Board: • **NOTED** the Infrastructure Committees Report and the areas of assurance and escalation highlighted; • **RECEIVED** the Infrastructure Committees' Annual Report; and • **APPROVED** the revised Infrastructure Committees' Terms of Reference.
5.0	**STRATEGY AND RISK**
5.1	**Group Strategy Update**
	The GDCEO presented the six-monthly update on delivery of the Group Strategy. Progress across the transformation portfolio was variable: the more mature programmes were further advanced, but a number of schemes were not yet delivering at the pace assumed within the current year's financial plan. The Group was therefore strengthening portfolio discipline, including pausing or narrowing lower-priority activity so that organisational capacity could be focused on the programmes with greatest impact. Discussion focused on the balance between the pace of change required by the financial position and the need to engage staff effectively in designing and delivering transformation. Members reflected on Inclusion Board feedback that understanding of the Group's strategic direction was less consistent below senior leadership level. The MD-SGUH and GCEO emphasised the importance of sequencing change carefully, maintaining clinical credibility and demonstrating that alternative models were safe and effective before existing capacity was reduced. Members also recognised the need to adjust programmes where expected benefits were not being realised. The Board **NOTED** the update and the continuing focus on portfolio prioritisation, delivery of the highest-impact transformation programmes and strengthening the Group-wide narrative and staff engagement supporting delivery.
5.2	**Group Surgery Strategy**
	The GDCEO introduced the proposed Group Surgery Strategy and welcomed Andrea Sott, Consultant Orthopaedic Surgeon and Chair of the Surgery Clinical Strategy and Standards Group, who outlined the clinically led work underpinning its development. The strategy proposed making greater use of the respective strengths of the Group's hospital sites: developing Epsom as a centre of excellence for short-stay elective surgery, strengthening St Helier's role in frailty and urgent surgery, reinforcing St George's as the principal site for

	complex and highly specialised tertiary surgery, and expanding access to robotic-assisted surgery and cross-site clinical working. AM welcomed the overall direction but challenged the strategy to make its intended quality benefits more explicit, emphasising that consolidation of activity would not of itself improve care. He highlighted the need to demonstrate improvements in clinical outcomes, patient safety and experience, and to strengthen the focus on the wider peri-operative pathway. Andrea Sott confirmed that national benchmarks, local outcomes and identified variation between sites were already being used to shape the programme. LP challenged the emphasis on robotic-assisted surgery, stressing that the objective should be to provide the most appropriate evidence-based operation for each patient, rather than increasing robotic activity as an end in itself. Andrea Sott agreed and described the Group governance arrangements for robotic surgery, including multidisciplinary review, training and clinical oversight. Members also discussed implementation, benefits realisation and investment priorities. The GDCEO confirmed that further capacity, capital and financial modelling would form part of implementation. The Board **APPROVED** the Group Surgery Strategy, noting that implementation would require continued development of quality outcome measures, benefits realisation, workforce and financial implications, and ongoing clinical engagement.
5.3	**Group Digital Strategy**
	Mark Coker, the Group Chief Digital Information Officer (GCDIO), presented the proposed Digital and Data Strategy 2026–2030, developed through engagement with clinical, operational and corporate teams. The strategy aimed to balance the need to remediate the Group's fragmented and ageing digital infrastructure with the opportunities presented by EPR optimisation, data, AI and automation. CSH emphasised that reliable digital infrastructure was foundational to delivery of the Group's wider strategy. AM welcomed the engagement undertaken to develop the strategy and sought assurance that staff involvement would continue through implementation; the GCDIO highlighted the new Group-wide digital experience survey and ongoing frontline engagement. PD raised the complexity of the existing application landscape and the challenge of system rationalisation and interoperability. The GCDIO confirmed that work was underway to simplify and optimise the digital environment, while continuing to progress innovation rather than waiting for all legacy issues to be resolved. Members also sought assurance that increased use of the NHS App and other digital channels would not disadvantage people affected by digital exclusion. The GCDIO confirmed that alternative routes would remain available and that support would be needed for patients who wished to use digital services but lacked confidence or access. The Board **APPROVED** the Group Digital and Data Strategy 2026–2030.
5.4	**Group Board Assurance Framework**
	The GCCAO presented the refreshed Group Board Assurance Framework (BAF), developed following the Board's earlier agreement to simplify and strengthen its approach to strategic risk. The proposed framework reduced the number of strategic risks from 14 to nine, with eight having

	been reviewed by the relevant Board Committees and the cross-cutting Transformation Delivery risk reserved to the Board. The GCCAO advised that the refreshed BAF was intended to become the Board's principal framework for oversight of strategic risk and assurance, more explicitly linking the CARE Strategy, Medium Term Plan and Transformation Programme. The GCCAO emphasised that the BAF should be used actively to shape the Board and Committee agenda, focus assurance activity and support early intervention and prioritisation. Some mitigating actions required further refinement, particularly to provide a clearer "path to green" demonstrating how the Group expected to move from the current position towards the agreed target risk and assurance levels. AM sought clarification regarding the changed numbering of the strategic risks compared with those previously considered by the Quality Committees. The GCCAO explained that the proposed tenth risk relating to Neighbourhood Health and the Left Shift had not been included at this stage. The Executive considered that both the national position and the Group's own strategic direction required further development before a sufficiently meaningful Board-level strategic risk could be articulated. The risk would therefore be developed further and brought back to the Board during the year. The Board: • **APPROVED** the refreshed Group Board Assurance Framework and its adoption as the Board's principal framework for oversight of strategic risk and assurance; • **APPROVED** the suite of nine strategic risks, including the associated risk scores, assurance ratings, controls, gaps, mitigating actions and target positions; • **NOTED** that a strategic risk relating to Neighbourhood Health and the Left Shift would be developed further and presented to the Board when the Group's strategic direction was sufficiently mature; and • **AGREED** that the BAF would be reviewed quarterly through the Board Committee structure and reported to the Board as the principal mechanism for monitoring strategic risk, assurance and delivery of the CARE Strategy.
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 Group's existing risk and assurance arrangements. No new risks or issues were identified.
6.2	**Reflections on meeting**
	At the invitation of the Chair, members reflected on the effectiveness of the meeting. BS highlighted the significant volume of Board papers and the risk that excessive information could hinder effective scrutiny. The Chair agreed and noted that the external review of Board and governance effectiveness planned for later in the year would consider the volume and effectiveness of Board reporting. AM welcomed the quality of discussion and constructive challenge, and questioned whether Committee reports should routinely carry a single overall assurance rating where assurance varied materially between individual items. The Chair agreed that this should be reviewed.

	Members also reflected on the seriousness of the Interstitial Lung Disease findings and the Board's accountability to patients, welcoming the open consideration of the issue in public.
6.3	**Questions from the public and St George's Governors**
	The Chair invited questions from the St George's Governors present. No questions were raised.
6.4	**Any Other Business**
	The Chair confirmed that no items of other business had been raised.
6.5	**Patient Story**
	The Chair welcomed **Savio Barros**, together with **Rose Southby, Lead Urology Nurse**, to share his experience of the prostate cancer pathway at St George's and Queen Mary's Hospital. Rose Southby briefly outlined the nurse-led elements of the pathway, including rapid assessment, transperineal biopsy, survivorship follow-up and specialist support after treatment. Mr Barros described many aspects of his care very positively, particularly the professionalism, compassion and responsiveness of his Clinical Nurse Specialist and the wider urology and pelvic health teams. He also raised concerns about gaps in communication, inaccuracies in clinical correspondence, incorrect advice regarding post-operative medication and repeated cancellation of a specialist follow-up appointment without adequate explanation. The GCEO apologised for these aspects of Mr Barros's experience and emphasised that patients should not have to repeatedly pursue the organisation for information or follow-up care. Members noted the importance of understanding whether the issues raised reflected wider service or capacity problems affecting other patients. The Chair thanked Mr Barros for sharing both the positive and negative aspects of his experience. Nicola Shopland and the urology team agreed to meet with him following the meeting to address the outstanding concerns and identify any wider learning for the service.
CLOSE	
The meeting closed at 16:50.	

DRAFT

Group Board (Public) - 11 September 2026

Action Log

ACTION REFERENCE	MEETING DATE	ITEM NO.	ITEM	ACTION	WHEN	WHO	UPDATE	STATUS
PUBLIC20250901.1	09-Jan-25	3.6	Group Freedom to Speak Up Report	The Mandatory Training Group to review the current mandatory training requirements package to ensure there is a consistent approach to MAST across the group, particularly in key areas such as Freedom to Speak Up training. (GCPO)	~~6 Nov 2025~~ ~~4 Sept 2025~~ ~~Spring 2026~~ 5 November 2026	GCPO	Update on 9 July 2026: The GCPO advised that the national review of mandatory training was nearing completion and that good progress was being made in aligning requirements across the Group. Some differences remained in areas including resuscitation and fire safety training, where the two Trusts currently operated different models. A substantive update would be brought through the Group's governance arrangements by November 2026 at the latest.	NOT YET DUE

Group Board

Meeting in Public on Friday, 11 September 2026

Agenda Item	1.6	
Report Title	**Group Chief Executive Officer's Report**	
Executive Lead(s)	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

The period since the July Board meeting has seen significant change and continued progress across the Group. We have welcomed new members of the Executive Team and are preparing for further leadership changes over the coming months, while continuing to focus on improving care, strengthening organisational culture and ensuring that the Group is financially and operationally sustainable.

This report highlights the next phase of our work on culture, including development of a single Group values and behaviours framework and targeted work to strengthen our People function. It also updates the Board on our wider commitment to living within our means.

There are also important developments for patients and communities, including plans for a new Mental Health Emergency Department at St George's. The report additionally covers changes in South East and South West London ICB leadership arrangements and forthcoming opportunities to engage with and celebrate colleagues, members and the wider public.

Action required by Group Board

The Group Board is asked to:

a) **note** the organisational, workforce, patient care and system developments set out in the report; and
b) **note** the continuing work to strengthen culture, leadership and the People function, support financial sustainability, improve services for patients and deepen engagement with colleagues and communities.

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 report highlights key strategic and organisational issues, including workforce and culture, financial sustainability, and delivery of service improvements.

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 report includes workforce and service developments with financial implications; detailed financial performance and recovery are considered elsewhere on the Board agenda.

Legal and / or Regulatory implications

The report includes matters relevant to CQC oversight, workforce arrangements and wider NHS requirements; no separate legal decision is sought through this report.

Equality, diversity and inclusion implications

Culture, values and People-function developments have important EDI implications and will be progressed through inclusive engagement and appropriate equality assessment.

Environmental sustainability implications

No material direct implications arise from this report; relevant service and organisational developments will continue to take account of sustainability requirements.

Group Chief Executive Officer's Report

Group Board, 11 September 2026

1.0 Purpose of paper

1.1 This report provides an update on significant developments across the Group since the previous public meeting of the Board in July 2026. It focuses particularly on our people and culture, leadership, financial sustainability, developments in patient care and experience, and our engagement with partners, colleagues and communities.

2.0 Key Issues

Leadership changes

2.1 We continue to strengthen and refresh the Group's senior leadership. Azara Mukhtar joined us in August as Group Chief Finance Officer, bringing more than 30 years of NHS experience, including 13 years as a Finance Director. I have been pleased to see Azara spending her first weeks meeting teams and getting out across our services, alongside beginning the important work of strengthening our financial planning and recovery.

2.2 We have also agreed to rename our Site Managing Director roles as Site Chief Executive Officers. This better reflects the breadth of responsibility and accountability carried by these roles and brings our terminology more closely into line with a number of other NHS groups. The underlying responsibilities and reporting arrangements are unchanged.

2.3 Chinyama Okunuga will join us in October as Site Chief Executive Officer for Epsom and St Helier, with Rebecca Suckling continuing to provide interim leadership until Chin arrives, following the departure of Alex Shaw last month. In November, we will also welcome Tracy Luckett as Group Chief Nursing Officer, bringing significant experience of nursing leadership, patient safety, workforce development and quality improvement from Great Ormond Street Hospital.

2.4 Elaine Clancy has completed her period as Interim Group Chief Nursing Officer and is taking up a new role as Chief Nurse and Quality Officer across the South West and South East London ICBs. I would like to thank Elaine for the contribution she has made to gesh and particularly for her continued emphasis on strengthening the nursing voice and ensuring colleagues feel able to speak up and challenge. Until Tracy arrives, Nicola Shopland and Theresa Matthews, Site Chief Nursing Officers for St George's and Epsom and St Helier respectively, will jointly provide cover for the Group Chief Nursing Officer responsibilities.

2.5 Victoria Smith will leave the Group on 6 November after more than two years as Group Chief People Officer. We are beginning the process of identifying her successor, including considering the approach to recruitment over the coming weeks. Vic has led the People function through a considerable period of organisational change and I would like to thank her for her contribution to bringing teams across the Group closer together and strengthening our approach to people and organisational development.

Culture, values and behaviours

2.6 Culture remains one of our most important priorities. As St George's, Epsom and St Helier and our community services increasingly work together, it is important that colleagues experience consistent expectations about how we work, lead and behave, wherever they are based.

2.7 We are therefore beginning the next phase of work to develop a single Group-wide values and behaviours framework, replacing the separate arrangements currently in place across the two Trusts. We have selected Kaleidoscope Health to provide external support to this work. The framework will be developed with meaningful involvement from colleagues across the Group and will build on the work already undertaken through our Living Our Values programme.

2.8 This needs to be about much more than agreeing a new set of words. The aim is to create a framework that colleagues recognise and which becomes visible in how we recruit, induct, develop and lead people and how we work with one another every day. The Board will also have an important role in shaping and modelling this work. Our new Board development programme will include an early focus on values, behaviours and the Board's role in leading organisational culture.

2.9 We will also continue the gesh Leadership Development Forum, following its first formal meeting in June. The next session is planned for early October and will continue the work of developing stronger connections and common leadership expectations across the Group.

Strengthening the People function

2.10 Alongside the wider cultural programme, we are reviewing the capacity of our People function, particularly Employee Relations and HR Business Partnering. As we undertake significant organisational and workforce change, managers need timely, high-quality advice and colleagues need confidence that concerns can be addressed as early and effectively as possible.

2.11 We are therefore considering targeted additional investment in these areas. Strong and responsive HR services are not in themselves the answer to organisational culture, but they are an important foundation for it: helping managers deal with issues earlier, supporting change well and ensuring that formal processes are handled promptly, fairly and consistently.

Financial sustainability and MARS

2.12 Living within our means remains one of the Group's most important priorities. The detailed financial position is considered elsewhere on the Board agenda, but the requirement is clear: alongside strong day-to-day financial control we need to increase the pace at which transformation and productivity improvements translate into sustainable reductions in our underlying cost base.

2.13 One element of this work is the Mutually Agreed Resignation Scheme (MARS), which the Board approved in July. The voluntary scheme opened for applications on 10 August and closes on 20 September. It is intended to help reduce our recurring workforce costs while enabling colleagues who wish to leave the organisation voluntarily to apply to do so. Applications will be considered during October as part of the wider work to align our workforce with the Group's future operating model and financial position.

New Mental Health Emergency Department at St George's

2.14 I am very pleased that we have secured an initial £1.9 million to progress plans for a new Mental Health Emergency Department at St George's. A busy acute Emergency Department is not always the right environment for somebody experiencing a mental health crisis, and the new service will provide a calmer and more appropriate setting while also helping to reduce pressure on the existing ED.

2.15 The service is being developed with South West London and St George's Mental Health NHS Trust and other NHS partners, with specialist mental health teams providing the clinical staffing. It will be located as close as possible to the existing Emergency Department to enable patients to move quickly to the right environment. Patients, carers and people with lived experience will be directly involved in shaping the model. The next stage of national funding approval is expected in October, with the investment due to be made by March 2028.

CQC Well-Led Inspection – Epsom and St Helier

2.16 The Care Quality Commission undertook its Well-Led inspection of Epsom and St Helier in May 2026. We are still awaiting the draft inspection report for factual accuracy checking, which we expect to receive imminently. Once that process is complete and the report has been finalised and published by the CQC, we will bring the findings and our response in full to the Board.

South East and South West London ICB arrangements

2.17 South West London and South East London ICBs are moving to closer working through a formal clustering arrangement. The organisations remain separate statutory ICBs, with their own Boards and legal responsibilities, and there are no plans to merge. They now share a single Chair, Sir Richard Douglas, Chief Executive, Andrew Bland, and Executive Team, while existing place-based leadership arrangements in South West London remain unchanged. The new shared leadership arrangements are now substantially in place.

2.18 This is an important development for gesh. Many of our strategic priorities depend upon strong partnership with the ICB, including neighbourhood health, service transformation, capital investment and the wider shift towards providing more care closer to home. We will continue to work closely with the new shared leadership arrangements while maintaining the strong relationships we have with individual places and partners across South West London.

Staff engagement and recognition

2.19 The week of our last Board meeting in July also marked our first Group-wide Big Thank You Week, bringing colleagues together across our hospitals and community services to recognise the contribution they make every day. With support from our hospital charities, activities took place across the Group, including wellbeing events, team celebrations and opportunities to thank colleagues personally, alongside more than 10,000 meals and ice creams for staff working across different sites and shift patterns.

2.20 I particularly valued the opportunity to spend time with teams throughout the week, hearing directly about their work and recognising the commitment, compassion and teamwork that underpin the care we provide. A number of Board members were also able to take part in the celebrations at Queen Mary's Hospital, Roehampton, and I wanted to share a few photographs from across the week which capture some of those moments.

2.21 The Big Thank You was deliberately intended to be more than a single week of celebration. Recognition, appreciation and feeling valued are important parts of the culture we want to build across gesh. The challenge now is to make recognising good work and thanking colleagues part of how we work throughout the year, rather than something reserved for a particular event.

2.22 More than 800 nominations, recognising over 630 individuals and teams, were received for this year's gesh CARE Awards. The quality and breadth of the nominations are a powerful reminder of the extraordinary work taking place across our hospitals and community services. The finalists and highly commended colleagues will be celebrated at our biggest CARE Awards ceremony yet on 23 September at the Kia Oval.

2.23 Our regular Executive Question Time continues to provide an important opportunity for colleagues to hear directly from the Executive Team and to ask challenging questions. More than 850 colleagues joined the August session, submitting over 100 questions on issues including finance, workforce change, digital developments and staff experience. The next session will take place on 17 September.

2.24 Later this month we will also hold the Epsom and St Helier Annual Public Meeting and the St George's Annual Members' Meeting on 16 and 30 September respectively, alongside publication of our 2025/26 Annual Reports. These meetings provide an important opportunity to account publicly for our performance, hear directly from members and communities and look ahead to the priorities for the coming year. Publication of the Annual Reports alongside the September meetings is part of the agreed annual reporting timetable.

3.0 Recommendations

3.1 The Group Board is asked to:

a) **note** the organisational, workforce, patient care and system developments set out in the report; and
b) **note** the continuing work to strengthen culture, leadership and the People function, support financial sustainability, improve services for patients and deepen engagement with colleagues and communities.

Group Board

Meeting on Friday, 11 September 2026

Agenda Item	2.1	
Report Title	**Water safety in St Helier E Block**	
Executive Lead(s)	Michael Pantlin, Group Deputy Chief Executive Officer	
Report Author(s)	Programme team	
Previously considered by	Group Executive Committee	1 September 2026
Purpose	**For Noting**	

Executive Summary

Since the Board's last meeting, we have continued to engage with our people and stakeholders to hear different perspectives and explore the options available for the future of E Block. At its previous meeting, the Board recognised the constructive conversations that had already taken place, and this engagement has continued to build on that work.

We would like to thank our people for taking the time to engage with the programme team and share their views, experience and insight to help inform what we do next. We are also grateful to stakeholders who have written to and met with us to discuss the options available. We appreciate the open and constructive conversations that have taken place. These discussions are helping to shape our understanding of the options and are informing our decision-making process.

E Block at St Helier Hospital continues to operate safely following the implementation of extensive water safety mitigations in response to contamination identified within the building's ageing water infrastructure. However, both internal and external advice remain clear that these measures are temporary controls and that full replacement of the water system is required as a long-term solution.

Following the Board's previous discussion, a substantial programme of work is underway to develop a robust options appraisal for the permanent remediation of E Block. This includes independent expert review of whether the required pipe replacement could be undertaken while services remain in the building, assessment of the ongoing sustainability of current mitigations and evaluation of temporary accommodation options across St Helier, Epsom and St George's sites.

Emerging findings suggest there is unlikely to be a definitive technical point at which current water safety mitigations can no longer be relied upon. Instead, the Board will ultimately need to consider the increasing residual risk associated with prolonged reliance on temporary controls and determine when that risk outweighs the disruption associated with implementing a permanent solution.

A wide range of options are currently being assessed. These include the potential for in-situ remediation, temporary relocation of services within the St Helier estate, creation of modular accommodation, and dispersal of activity across South West London providers.

No preferred option has yet been identified. Further independent expert advice, estates assessments, workforce modelling, capacity analysis and equality impact assessments are required before a

decision can be made. It is anticipated that the key next step will be the development of a reduced number of credible and deliverable options for Board consideration in October/November 2026.

Action required by Group Board

The Group Board is asked to note the update.

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 key risk for the Board to manage is the impact on patient safety if the current temporary mitigations to water safety risks in E block are relied on for too prolonged a period and then fail. This would result in the emergency closure or decant of services in an unplanned way and is likely to be significantly more disruptive than a planned approach.

In the long term, the solution to this risk is to decant E block and undertake a full refurbishment of the water infrastructure. The options for delivering this decant are associated with a range of different risks, as described 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

The options thus far explored for delivering a decant of E block all have capital implications, as set out in the paper. In some cases, these are expected to be very significant.

Legal and / or Regulatory implications

The Board has an obligation to provide services in a safe, compliant environment.

National maternity standards and RCOG guidance emphasise the need for timely access to obstetric, midwifery, anaesthetic and neonatal expertise for women requiring emergency maternity assessment.

Where emergency and maternity services are not co-located, robust clinical pathways and rapid access arrangements are required to mitigate risk
Equality, diversity and inclusion implications
Any changes to our service configuration have the potential to impact on health inequalities, including those linked to protected characteristics. A detailed Equality Impact Assessment will be required before a decision can be made.
Environmental sustainability implications
To be advised.

Water Safety in St Helier E-Block

Group Board, 11 September 2026

Contents

1. Background

E Block at St Helier Hospital houses maternity, neonatal, gynaecology and assisted conception services. During 2024, enhanced water quality monitoring identified pseudomonas and legionella contamination associated with the building's ageing and corroded water infrastructure.

A comprehensive programme of mitigations has been implemented, and services remain safe to operate at the current time. Independent expert advice has been taken to inform understanding of the ongoing effectiveness of the current mitigation measures, but experts have been unable to provide a precise timeframe for how long these controls can safely remain in place.

Until a permanent solution has been completed, there remains a risk of a failure of the water testing that would result in an emergency closure of the building. The Trust's assessment is that a planned approach to addressing the underlying issues presents lower risk than delaying action until a more urgent response becomes necessary. Alongside the work we are undertaking on a planned response, the Trust is ensuring that we have robust business continuity plans which would be enacted in the result of an emergency closure.

As there is no clear technical end point the Board will need to exercise judgement regarding the level of residual risk it is prepared to accept and the timing of transition to a permanent solution.

Initial assessments concluded that replacing the pipework while services remain operational could be challenging due to extensive embedded pipework, the potential presence of asbestos, and the risk of contamination during construction. The Board has commissioned independent review of options to safely undertake the works, as well as options to accommodate services elsewhere temporarily while this work is undergoing.

This paper outlines the progress to date, the next steps and timeline to provide the Board with sufficient information to reach make a recommendation.

2. Developing a robust options appraisal

2.1 Developing a long list of options

A wide range of stakeholders have been involved in shaping the options we are now considering, including our people, service users and external partners. Their views, alongside advice from independent experts and the experience of our clinical, operational and estates teams, are helping us to understand what is both possible and practical.

This work is continuing at pace. Our aim is to develop a clear and robust options appraisal that will enable us to recommend the best approach for addressing the long-term water infrastructure issues in E Block.

At this stage, three main approaches are being developed, with a number of variations within each:

- **Keep services in E Block while the work is carried out.** Undertake the necessary water infrastructure replacement while services continue to operate in the building.
- **Fully decant the building.** Temporarily relocate all services (elsewhere on the St Helier site, and/or other sites in South West London) so that the work can be carried out in an empty building.
- **A hybrid approach.** Temporarily relocate some services to create space for a rolling programme of works, allowing work to take place in vacant areas while other services continue to operate in the building.

To help us understand how feasible each of these approaches would be, we have commissioned two independent expert reviews alongside detailed work by our clinical and operational teams.

Currie & Brown provide project management, cost management and advisory services and have extensive experience supporting NHS and other healthcare organisations with major capital investment, service transformation and estates projects.

Their healthcare planning team also brings direct clinical and NHS operational experience, including experience of developing new models of care and supporting complex healthcare projects. Their input will help us assess the practical, operational and estates implications of the options being considered.

They are also assessing whether there are suitable temporary locations within the GESH footprint that could accommodate E Block services if relocation is required. This work is helping us understand not just what space is available, but what would be needed to make each option work safely and effectively.

The assessment includes:

- Reviewing the spaces suggested by stakeholders and exploring different ways they could be configured to accommodate services.
- Checking these spaces against relevant Hospital Building Note (HBN) requirements and other regulatory standards.
- Identifying where a service might be able to operate safely with less space than the HBN guidance suggests, where this could be supported by an appropriate derogation or operational arrangement.
- Highlighting any risks or limitations that may be considered unacceptable for an NHS Board to take on.

- Providing high-level estimates of the costs associated with the different decant options.

Teams from both external organisations have already started engaging with colleagues across clinical, operational and estates teams to understand how the different options could work in practice. This engagement will be an important part of the assessment, ensuring that the options are grounded in the reality of delivering services safely.

The reports are expected in early September. Their findings will help shape the next stage of the options appraisal, and may identify further work that needs to be undertaken by our internal teams before the options can be fully assessed.

CPC Project Services are an independent project management company with extensive project and cost management experience in the healthcare sector working on several commissions at any one time with clients including St Georges University Hospital, Great Ormond Street Hospital, Imperial College Healthcare Trust, Oxford University Hospital, Buckinghamshire Healthcare NHS Trust, and West Hertfordshire Hospitals NHS Trusts. Their current projects include large new build facilities, refurbishment projects, managing and delivering infrastructure upgrade and backlog maintenance programmes, feasibility studies, and master planning.

CPC has been working directly with the clinical teams for each service operating from E Block to understand the practical risks associated with the three options. Workshops have been held with each team to explore what each approach would mean for patients, staff and the safe delivery of services.

The workshops will identify the key risks associated with each option, as well as any measures that could be put in place to reduce or manage those risks. CPC will then combine this feedback with its engineering and programme expertise to complete a feasibility assessment of whether the work could be carried out while services remain in the building.

This work will help us understand:

- Whether it is technically and operationally possible to undertake the work while some or all services remain in E Block.
- What risks we would need to accept and what mitigations would need to be in place.
- Whether the work could be delivered through a phased approach, with services moved incrementally as different areas become available.
- Whether there are any risks that CPC considers would be beyond the level that an NHS Board should reasonably accept.

Alongside this, demand and capacity modelling is underway for maternity services, with support from the Acute Provider Collaborative (APC), Croydon University Hospital and Kingston Hospital. This is looking at whether there is capacity at other hospitals to provide temporary support if we cannot identify a suitable solution within the Trust, or if there were an unexpected failure of the existing water system.

The potential to use capacity across other hospitals will be considered alongside the other options, so that the Board has a clear understanding of the full range of possible approaches and their implications.

2.2 Developing a Shortlist of Preferred Options

The Board will need to make its decision based on a thorough options appraisal, with all viable options properly assessed and the risks and implications clearly understood. At the same time, we need to be mindful of the risks associated with relying on temporary water safety measures for a prolonged period. It is therefore important that we balance the need to do the work properly with the need to reach a decision in a reasonable timeframe.

The proposed approach is to take the longlist of options developed through the work so far and narrow this down to a smaller shortlist of credible and deliverable options. These options can then be assessed in greater depth, allowing the Board to make a well-informed decision on the preferred approach.

Once the externally commissioned work is complete, we expect some options to be ruled out. This could be because they are not technically or operationally feasible, or because of factors such as the time needed to implement them, cost, risk or the impact on services.

The findings from the external reviews, alongside our own clinical, operational and estates assessments, will then be brought together to develop a shortlist of credible and deliverable options for the Board to consider in October.

The longlist will be reviewed by an advisory group from across the organisation, including clinical and estates colleagues. This will provide a balanced view of the options and help ensure that the shortlist is based on the best available evidence and expertise.

The aim is to move from the wide range of scenarios currently being considered to a smaller number of realistic options that can be properly assessed. This will allow us to undertake more detailed work on the potential impact of each shortlisted option, including wider engagement with our people and the public, quality impact assessments and equality impact assessments.

2.2.1 Quality Integrated Impact Assessment and Equality Impact Assessment

After the long list has been reduced to a shortlist, a Quality Integrated Impact Assessment (QIIA) will be undertaken as part of the options appraisal process to assess the potential impact of each option on patient safety, clinical quality, patient experience and service delivery. Given the nature of the E Block water issues, particular consideration will be given to infection prevention and control requirements, the safety and wellbeing of women and babies, and the continuity and resilience of services throughout implementation. The QIIA will ensure that quality considerations are assessed alongside financial, operational and technical factors when determining the preferred option.

The assessment will be completed with relevant clinical and operational stakeholders, including maternity and neonatal services, infection prevention and control, estates and quality teams. Any risks, benefits and mitigating actions identified through the QIIA will be used to inform the preferred option and support governance decision-making.

Similarly, after the long list of options has been reduced to a shortlist, an Equality Impact Assessment (EIA) will be developed as part of the options appraisal process.

A key component of this work is travel-time analysis for different maternity relocation and dispersal scenarios in some of the options on the longlist. Particular attention is being given to understanding the impact on vulnerable groups, those with protected characteristics, and communities that may experience disproportionate barriers to accessing care.

The development of our QIIA and EQIA will be iterative, with an initial assessment supporting the Board to choose a preferred option from the shortlist, and a revised assessment (informed by wider subsequent engagement) coming to the Board before a decision is made.

2.2.2 Listening to our people and stakeholders

Engagement is central to the work we are doing to understand the options for E Block. We want to make sure that the people who use and deliver these services, as well as our wider stakeholders and communities, have meaningful opportunities to share their experiences, raise concerns and help shape what happens next.

We are putting a number of ways in place to listen and make sure that feedback is properly considered:

- Regular staff meetings are underway, and we have established a staff representation group that brings together colleagues from the services affected, alongside representatives from the Maternity and Neonatal Voices Partnership (MNVP). This provides a regular forum for colleagues to share their experience, ask questions and help us understand what each option would mean in practice.
- There is a staff forum with the Chief Executive every other week and with the women and children's leadership team every other week
- We have set up an advice line for patients and families to ask questions, share concerns and provide feedback. We are also preparing to use community social media channels to talk to and hear from people who have used these services in the past, are using them now, or may need to use them in the future.
- We are developing an engagement and communications plan for September and October to ensure we hear from a broad range of voices, including system partners, primary care, local communities, patients, Healthwatch, commissioners and other stakeholders.
- Before a final option is selected, we will ensure we have support of the regulators who govern our services such as Integrated Care Boards (ICB's), NHS England, the Care Quality Commission (CQC) and the Human Fertilisation & Embryology Authority (HFEA).
- Engagement will not be a one-off exercise. Feedback from our people, patients and stakeholders will be brought into the options appraisal and used to test and refine the options as the work progresses. We will also keep people informed about what we have heard, how their views have influenced the work and where decisions still need to be made.

The aim is not to communicate the options, but to listen to the people who know these services best and use their experience and insight to help shape the best solution.

3. Next steps and timeline

3.1 Next steps

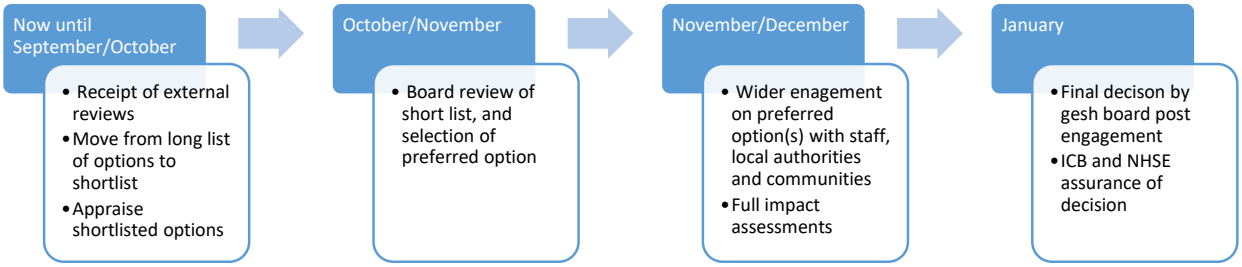
The next stage of the work is about bringing together the evidence, expert advice and, importantly, what we have heard from our people, patients and stakeholders. We want to make sure that we do not simply identify an option that is technically possible, but one that is safe, workable and right for the people who use and deliver these services.

- Receive and review the independent expert report on the feasibility of undertaking water infrastructure replacement while services remain operational within E Block, including assessment of phased and rolling decant approaches.
- Receive and review the externally commissioned estates assessments for decant options across gesh sites.
- Complete the assessment of capacity across other South West London hospitals, including whether they could provide temporary support if this is needed.
- Review all options at that stage to recommend any to be removed from the longlist, to allow for more in-depth review of the remaining feasible options.
- Look in detail at what each option would mean for our services, including workforce, estates, equipment and IT requirements for maternity, neonatal, gynaecology, assisted conception and outpatient services.
- Assess the impact on equality and access, including travel times and the potential impact on vulnerable people and communities experiencing health inequalities.
- Continue staff engagement through regular briefings and the staff reference group, including engagement with the Maternity and Neonatal Voices Partnership. The experience of our staff will be vital in helping us understand what could work safely and effectively in practice.
- Develop a stakeholder engagement and communications plan covering patients, local communities, Healthwatch, commissioners, local authorities and south west London partners.
- Bring together the outputs of the independent reviews, clinical assessments, operational modelling and stakeholder engagement to develop a shortlist of realistic and deliverable options.
- Present a shortlist of options, including associated risks, benefits, costs, implementation requirements and recommended next steps, for Board consideration in October/November 2026.

Engagement will remain central to this work. We know that there is no easy answer and that any change could have an impact on our staff, patients, families and local communities. Taking the time to listen, understand different perspectives and be open about the choices we face will help us make the best possible decision.

Ultimately, we want the outcome to be one that is not only safe and sustainable, but one that works for local people and gives our communities confidence that their voices have been heard and genuinely considered in the decision.

3.2 Timeline



Group Board Meeting (Public)

Meeting on Friday, 11 September 2026

Agenda Item	3.1	
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 Leonie Penna, Non-Executive Director	
Previously considered by	n/a	-
Purpose	**For Assurance**	

Executive Summary

This report sets out the key issues considered by the Quality Committees at their meetings in July and August 2026 and the matters the Committees wish to bring to the attention of the Group Board. These include:

1. Mortuary Assurance Report Committees members approved the mortuary assurance statements for NHSE.

2. Maternity Services Report: Members discussed a proposed change in approach to maternity governance and reporting now that the maternity leadership team has been fully recruited to. The Committees approved the terms of reference for the newly established Perinatal Subcommittee.

3. St Helier Frailty Unit Fall: Quality Investigation Report: Committees members held a substantial discussion regarding the report detailing findings from the investigation into the serious incident within the Frailty Unit. The investigation did not find evidence of widespread severe patient harm, but there are significant concerns regarding leadership, escalation processes, culture and behaviours. Learning identified including the need to redevelop the escalation and governance processes and to improve nighttime leadership for staff. A further report was requested from the members to detail findings from the culture review and clinical learning.

Action required by Group Board

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

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, 11 September 2026

1.0 Purpose of paper

1.1 This report sets out the key issues considered by the Quality Committees at its meetings in July and August 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 the period, the Committees considered the following items of business:

30 July 2026	27 August 2026
• gesh Safety and Compliance Report • Integrated Quality and Performance Report: Quality Metrics Focus • Mortuary Assurance Report • ESTH CQC Core Services Review Outcome following December 2025 Visit • Annual Report on Clinical Audit & Annual Audit Programme • Health Inequalities Report • Quality and Safety Strategy • Quality Priorities Quarterly Review	• gesh Safety and Compliance Report • Integrated Quality and Performance Report: Quality Metrics Focus • St Helier Frailty Unit Fall: Quality Investigation Report • Maternity Services Report • Clinical Ethics Committee Annual Report • Allied Health Professionals Strategy Update

2.2 The Committees was quorate at both meetings.

3.0 30 July 2026 Key issues for assurance and review

3.1 Mortuary Assurance Report

3.1.1 The Committees received the report which detailed the findings of the David Fuller Inquiry and the Nottingham University Hospitals Maternity Review.

3.1.2 Committee members noted CCTV compliance concerns in the report, requesting confirmation that the previously identified issues had been resolved.

3.1.3 When discussing the absence of human tissue authority (HTA) reportable incidents at ESTH, it was clarified that incidents had occurred, but none met the threshold for external reporting. A review of these incidents confirmed the classification was appropriate. Committees members noted that there has been insufficient oversight of HTA at the Committees, agreeing that this will be added to the forward planner to ensure this issue receives appropriate oversight. GCMO also agreed to develop broader regulatory oversight reporting including HTA, MHRA and HSE enforcement activity.

3.1.4 Committees members **agreed to approve** the assurance statements detailed below:
.

‘The roles and responsibilities between the relevant teams responsible for mortuary care, including estates, safeguarding, pathology, bereavement, mortuary and corporate services, are clear, understood and are tested on a regular basis. The Board has undertaken a review of progress against the 29 recommendations immediately relevant to the NHS as made by the Fuller Inquiry. Where the Trust is not fully meeting a specific recommendation, a time-limited action plan is in place to close any gaps. In line with updates to the NHS Safeguarding Accountability and Assurance Framework, executive leadership has been reviewed with clear oversight of arrangements for the safeguarding of people after they die.’

‘The Board can assure itself the organisation has a plan in place to ensure the effective oversight of matters relating to mortuaries, related storage areas (or wider facilities) where the deceased are cared for, including the correct information and governance arrangements. If it cannot, it has identified the actions necessary to address this and a plan is in place to implement them as a matter of urgency. For all issues related to estates, there is an agreed timeline in place to undertake a self-assessment against the latest version of the NHS Premises Assurance Model and submit data within the current window (closing 8 September 2026), ensuring that your plan includes PAM sign-off from your Board prior to submission.’

3.2 Patient Safety and Compliance Report

3.2.1 During the reporting period, one Never Event was reported at ESTH relating to an implant/prosthesis mismatch, and two Never Events and two Patient Safety Incident Investigations (PSIIs) remain under review at SGUH. Learning from these incidents continues to be embedded through theatre safety improvement programmes, governance oversight and review of local and Group-wide safety processes. A planned CQC engagement meeting took place at St George’s Hospital on 15 July 2026, focusing on Never Events, organisational learning and safety culture. A further CQC IR(ME)R inspection of Breast Imaging services is scheduled for 5 August 2026

3.2.2 The Committees discussed a patient Safety Incident regarding an incorrect genetic diagnosis leading to a mastectomy. Members sought assurance that immediate actions had been implemented now, rather than waiting upon the completion of the PSII investigation. Assurance was given that immediate actions have been taken, including:

- Mandatory confirmation of clinical genetics before accepting referrals for risk-reducing surgery.
- Genetic status rechecked for patients waiting over 12 months.
- A review of all patients currently on waiting lists.
- Establishment of monthly MDT.

3.2.3 Committees members highlighted the requirement to incorporate maternity pathways within Martha's Rule implementation, asking if this is underway, It was confirmed that for SGUH, the maternity-specific requirements are already embedded following previous maternal death review work. Work is also underway to incorporate maternity-specific requirements for ESTH.

3.2.4 When discussing theatre safety and wrong-site procedures, the key themes identified were staff not consistently being present throughout procedures and a need to repeat safety checks when personnel change. To mitigate these issues, there is an increased scrutiny of compliance with safety pauses and an increased focus on high-volume theatre areas.

3.3 Annual Report on Clinical Audit & Annual Audit Programme

3.3.1 Members were advised that during 2025/26 the integration of both SGUH & ESTH clinical audit teams into one group clinical audit team continued. A full plan was developed for integration of functions and reporting. The report provided an overall picture of performance but also included information at Trust level for governance purposes. Over the year SGUH participated in 74 national clinical audits and NCEPOD studies, whilst ESTH participated in 57. Across the group 555 local audits were registered, covering a wide range of the services offered across gesh. SGUH had 426 local audits registered, whilst ESTH had 129 local projects registered.

3.3.2 Members expressed concern that ESTH did not participate in the national ILD Audit. GCMO advised that the participation decision was not escalated to executive level and upon reflection it was clear that the governance arrangements for audit participation require strengthening as non-participation in national audits should always be escalated to executives.

3.3.3 The Committees noted that St George's reported six deviations from NICE guidance, expressing concern about the governance arrangements for approving and overseeing such deviations. GCMO advised he would review the deviations and report back to the Committees on the reasons as to why.

3.3.4 The Committees requested that GCMO review the governance arrangements for NICE guidance compliance and deviations and present an update report on audit, national audit participation and NICE compliance back within 4 months.

Assurance rating: Reasonable Assurance Committee considered audit arrangements generally appropriate but identified several governance improvements requiring follow-up.

3.4 Quality and Safety Strategy and Quality Priorities

3.4.1 Members welcomed the report, requesting that an updated roadmap showing progress against the multi-year strategy be included in a future report. Members agreed it would also be beneficial to demonstrate the evidence of the impact of the mitigations, rather than solely detailing the process completion.

3.4.2 When discussing the priorities, Committees members agreed that there was evidence of strong governance and oversight arrangements**.** It was noted that some priorities remain behind trajectory although there are management actions in place to mitigate this.

3.4.3 **Assurance rating:** Members agreed that the assurance level will be reviewed at the quarter 2 update.

3.5 Health Inequalities Report

3.5.1 Committees members welcomed the report, expressing encouragement to strengthen engagement with community organisations, governors, primary care and local authorities to.

3.6 The committees noted the ESTH CQC Core Services Review Outcome following December 2025 Visit and the IQPR.

5.0 27 August 2026 – Key issues for assurance and review

5.1 Patient Safety Incident Report

5.1.1 Members welcomed the report, noting that that there were no new never events in the reporting period.

5.1.2 When discussing pressure ulcers, it was noted that an external review of pressure ulcer management at ESTH has now been commissioned, with the terms of reference having been

agreed. Feedback on the outcomes of the external review is expected to be reported to the Committees in October 2026.

5.1.3 Significant concern was raised regarding a proposal to provide additional private physiotherapy services for inpatients by utilising bank physios with a private practice billing process. Concerns included the creation of inequity between patients and the perception that NHS therapy provision is inadequate. Executive colleagues confirmed this option is not being progressed.

5.2 St Helier Frailty Unit Fall: Quality Investigation Report

5.2.1 Committees members held a substantial discussion regarding the report detailing findings from the investigation into the serious incident within the Frailty Unit. The investigation did not find evidence of widespread severe patient harm, but there are significant concerns regarding leadership, escalation processes, culture and behaviours. Learning identified including the need to redevelop the escalation and governance processes and to improve nighttime leadership for staff. A further report was requested from the members to detail findings from the culture review and clinical learning.

5.2.2 **Assurance rating:** Committees members concluded that more information is required before an assurance rating could be agreed. It was agreed that a further report will be presented to the Committee which details the following:

- Findings from culture and behavior reviews.
- Consolidated clinical learning.
- Trust-wide implications and learning.
- Actions designed to prevent recurrence.
- Improved explanation of how similar issues would be detected in future.

5.3 Maternity Services

5.3.1 Committee members received the report in a newly agreed format following the establishment of the Perinatal Subcommittee. Members emphasized the continued implementation of CNST Year 8 compliance plans and to ensure leaders submit NHS England benchmarking report by the September deadline.

5.3.2 Committees members agreed the terms of reference for the Perinatal Subcommittee.

5.3.3 Assurance rating: Committees members agreed reasonable assurance against the maternity report.

5.4 Allied Health Professionals (AHP) Strategy Update

5.4.1 Members welcomed the report, which detailed the development of workforce and quality dashboards, along with the significant contribution to prevention and community-based care.

5.4.2 It was noted that the AHP turnover remains high at approximately 25% which has led to an introduction of a preceptorship programme, which is expected to improve retention and support newly qualified staff.

5.5 Integrated Quality Performance Report

5.5.1 Committees members received the report, noting concern that maternity post-partum haemorrhage (PPH) rates have elevated. Leadership confirmed that a thematic review is

underway and multiple contributory factors are being explored. The findings will be reported through the maternity governance processes.

6.0 Recommendations

6.1 The Group Board is asked to note the issues escalated by the Quality Committees to the Group Board and note the update on wider issues discussed at the Committees meetings in July and August 2026

gesh Perinatal Subcommittee

Terms of Reference

1. Name

This group shall be known as the **gesh Perinatal Subcommittee**

2. Purpose

The gesh Perinatal Subcommittee is established as a formal Subcommittee of the gesh Quality committee to provide strategic oversight, assurance, and coordination of maternity and newborn services across the Group.

The Subcommittee will support the delivery of safe, equitable, high-quality, and sustainable maternity and newborn services through:

- Oversight of quality, safety, performance, workforce, and transformation
- Monitoring compliance with national standards, regulatory requirements, and best practice
- Providing assurance to the Quality committee regarding maternity and newborn governance and improvement
- Supporting consistency and shared learning across all hospitals within the Group
- Promoting a culture of continuous improvement, transparency, and compassionate care

The Subcommittee does not replace individual hospital accountability for operational delivery, governance, or statutory responsibilities.

2. Establishment and Authority

- The gesh Perinatal Subcommittee is accountable to the Quality Committee.
- Each hospital within the Group retains accountability for:
    - Operational management of its services
    - Local governance and risk management
    - Regulatory compliance
    - Delivery of agreed performance standards
    - Escalation and management of local incidents and concerns

The gest Perinatal Subcommittee provides overarching strategic oversight and group-level assurance.

3. Authority

The gesh Perinatal Subcommittee is a formally delegated Subcommittee of the Quality Committee and is authorised by the Quality Committee to:

- Request information, reports, and assurance from site maternity leadership teams
- Commission reviews, audits, or deep dives into areas of concern
- Escalate significant risks or concerns to the Quality Committee
- Make recommendations relating to maternity strategy, improvement priorities, and governance arrangements
- Oversee implementation of group-wide maternity improvement programme.

4. Objectives

The gesh Perinatal Subcommittee will:

4.1 Quality and Safety

- Scrutinise quarterly maternity and neonatal quality and safety information (including training, workforce, care bundles and service user themes)
- Monitor maternity and newborn quality and safety indicators across the Group
- Review trends in incidents, complaints, claims, mortality, morbidity, and learning
- Oversee implementation of national maternity safety initiatives and recommendations
- Ensure systems are in place for effective escalation and risk management
- Escalate risks and unmet actions to the Quality Committee and Trust Board.

4.2 Assurance and Governance

- Provide assurance to the Quality Committee regarding maternity performance and governance
- Ensure appropriate governance frameworks operate consistently across hospitals
- Monitor compliance with regulatory and accreditation requirements

4.3 Strategic Oversight

- Make recommendations in relation to transformation programmes and service redesign initiatives
- Promote standardisation where appropriate while recognising local context

4.4 Learning and Improvement

- Facilitate shared learning and dissemination of best practice across sites
- Oversee thematic reviews and quality improvement programmes
- Encourage innovation and evidence-based practice

4.5 Workforce and Culture

- Review workforce metrics, staffing, training, retention, and wellbeing
- Promote multidisciplinary collaboration and psychological safety
- Support leadership development within maternity services

4.6 Service User Voice

- Review themes arising from feedback, complaints, and engagement activity
- Challenge services constructively where improvements are needed
- Support co-production as needed

5. Responsibilities

The Subcommittee will receive and review:

- Hospital maternity PQOM reports
- National and local Quality and safety dashboards
- Serious incident and thematic learning reports
- Maternity and neonatal outcome data
- Workforce and staffing reports
- Regulatory inspection outcomes
- Progress against strategic priorities and improvement programmes
- Risk registers and escalation reports
- Patient experience and engagement reports
- Care bundles

The Subcommittee will ensure:

- Appropriate escalation of significant concerns
- Clear accountability for actions
- Tracking and monitoring of agreed improvement actions

4. Membership and Attendance

Core Membership

- Group Chief Nursing Officer (Chair)
- Group Medical Director (Co-Chair)
- Group Chief Midwifery Officer
- Board Level Non-Executive Safety Champion
- Group Director of Quality and Safety Governance
- Representatives from each hospital:
    - Managing Director
    - Chief Nurse
    - Chief Medical Officer
    - Divisional Chairs
    - Director of Midwifery
    - Neonatal Lead

  - Lead Obstetrician
  - Maternity Governance Lead
  - Maternity General Manager
- Workforce/HR Representative
- Maternity and Neonatal Voices Partnership Chairs
- Programme/Transformation Lead (where applicable)
- Operational – Head of Midwifery
- Obstetrics - Clinical Director

In Attendance (as required)

- Digital/Information representative
- Safeguarding Lead
- Consultant Midwives
- External advisors or subject matter experts

Attendance Expectations:

- All core members are expected to regularly attend and contribute to the discussion of clinical safety risks, escalation routes, and action planning.
- Additional attendees may be invited to provide expertise or insights as needed for specific agenda items or emerging risks.

5. Quorum

The meeting will be quorate when the following are present:

- Chair or Co- Chair
- At least one executive representative and one non-executive
- At least one member of the SLT from each site
- One senior clinical representative
- One MNVP representative

If a meeting is not quorate, discussions may proceed but decisions and formal assurances must be deferred.

6. Meeting Format and Frequency

- Meetings will be held bi-monthly ahead of the Quality Committee.
- Extraordinary meetings may be convened by the Chair if required.
- Annual strategic development sessions may also be held.

7. Submission of papers and updates

Key updates will be compiled and communicated as follows:

- A gesh Perinatal Subcommittee report summarising key MIS requirements, decisions, exceptions and actions will be submitted to the Quality Committee
- Action plans and progress updates from each meeting will be documented and shared with all relevant stakeholders.
- Regular status updates on ongoing actions and safety priorities will be provided at each meeting to ensure timely follow-through and accountability.
- Additional submissions or updates will be made to relevant committees or leadership teams as needed, based on urgent issues or cross-group concerns.

8. Review of Meeting effectiveness and Review of Terms of Reference

The effectiveness of the gesh Perinatal Subcommittee will be regularly reviewed to ensure it is meeting its objectives, contributing to the improvement of clinical safety across the Group and preventing duplication. This review will include:

- **Annual review of meeting effectiveness**
- **Feedback from members**: All core members will provide input on the meeting format, content, and outcomes to ensure continuous improvement in the group's operations.
- **Review of Terms of Reference (ToR)**: The ToR will be reviewed annually to ensure they remain aligned with the evolving needs of the Group and reflect any changes in governance, clinical safety priorities, or strategic direction.
- **Actionable improvements**: Based on the review, adjustments will be made to the meeting structure, membership, frequency, or scope as needed to enhance the group's effectiveness in driving clinical safety.

The review will be led by the Group Chief Nurse and Group Chief Medical Director, and any recommendations for changes to the ToR or meeting structure will be brought forward to the Quality Committee for approval.

Document Control

Profile	
Document name	gesh Perinatal Subcommittee Terms of Reference
Version	1
Executive Sponsors	Group Chief Nursing Officer and Group Chief Medical Officer
Author	Group Chief Midwifery Officer
Approval	
Date of gesh Quality Group approval	TBC
Date of Group Executive approval	TBC
Date for next review	

Group Board Meeting (Public)

Meeting on Friday, 11 September 2026

Agenda Item	3.2	
Report Title	**gesh Perinatal Subcommittee Report**	
Executive Lead(s)	Michelle Cudjoe, Group Chief Midwifery Officer	
Report Author(s)	Michelle Cudjoe, Group Chief Midwifery Officer	
Previously considered by	Quality Committees	27 August 2026
Purpose	**For Assurance**	

Executive Summary

1.0 Purpose

This report is submitted to provide the Board with a summary of the Perinatal Subcommittee meeting.

The inaugural Perinatal Subcommittee meeting was held on 27 July 2026 and was established to provide oversight of maternity and neonatal quality, safety and governance. The Subcommittee can provide reasonable assurance regarding current arrangements across gesh maternity.

Three strategic issues require continued Board oversight:

1. Organisational culture at SGUH
2. MNSI escalation relating to CTG interpretation at SGUH
3. Delivery risks associated with the Maternity Incentive Scheme Year 8 requirements.

Recommendation / Board Action Required:

1. The board is asked to note the establishment of the first subcommittee meeting, its Terms of Reference and the planned reporting arrangements through the Quality Committee. The Terms of reference was approved at QCIC on 27th Aug 2026
2. Receive reasonable assurance regarding maternity governance, workforce, and safety oversight arrangements.
3. Note the ongoing executive oversight of the three strategic issues highlighted above.

2. Matters Considered by the Subcommittee

Agenda Item	Summary of discussion	Outcome
Terms of Reference	The committee agreed that there was good engagement and collaboration with key stakeholders in relation to the ToRs. The committee confirmed that the forum needs to be called a Subcommittee of the QCIC.	• In view of the change of Title (from Board Subcommittee to QCIC subcommittee) the group CMidO has since had confirmation that subject to Board approval of the ToRs, the reporting format will meet the requirements of NHSR. • The frequency of the subcommittee has been increased to monthly and the name changed to Perinatal Subcommittee to align with national requirements. • Executive colleagues to confirm shared accountability of chair/ deputy chair
Strategic Overview	The group CMO provided a verbal update in relation to external oversight of each service. 1. **ESTH** remains on the Enhanced Safety Oversight Programme and had a positive site visit by the Regional Team with no further actions. 2. **SGUH** is on the MatNeoIst intensive programme. Reviews by the national Maternity Improvement Team remains positive with the service commended for progress made in the last three months. 3. A written brief was shared in relation to the Amos and Ockenden reports and the NHSE 10-point plan.	• The services are benchmarking against the 10-point plan.
MIS Year 8 Update	Each site provided an overview of compliance against the Year 8	• A new recommendation within the Maternal Care

	standards noting potential areas of risk. The Year 8 standards have been completely revised with several new requirements which the services are working towards. 1. ESTH and SGUH: Confirmed a minimum of 90% compliance with training for all required staff groups. The end of June 2026 was the Trust selected checkpoint at which compliance was declared. The final checkpoint will be at the end of November 2026.	bundle linked to the administration of low molecular weight heparin in early pregnancy for high-risk groups presents a shared challenge across the group and required collaborative work with primary health, ED and Early pregnancy units. The services are developing implementation plans aligned to MIS timescales of March 2027. As ICBs no longer hold the formal oversight role, quarterly oversight of both the Maternal care and saving babies lives care bundles will continue through the Perinatal Subcommittee
Culture Improvement Plans	At the subcommittee meeting each service presented its Culture improvement plan. Each plan is different given the differing needs of the services. Additionally, the improvement plan at ESTH was launched two years ago following an appreciative inquiry. The key areas of focus within the ESTH plan includes staff wellbeing, career/succession planning and leadership development. At St Georges a similar appreciative inquiry was undertaken in 2024, but the work was paused in 2025. The improvement plan was relaunched after engaging with users and staff at the recent engagement session. The priorities for St Georges are in response to the previous appreciative inquiry, feedback from anonymous concerns, staff surveys, an independent review of the fetal medicine unit as well as leadership observations. The current area of focus	• Highlight reports to be developed for each service to demonstrate the impact of interventions

	includes: a series of interventions such as civility saves lives training, leadership development and coaching as well as individual reviews as required.	
Health Equity Plans	Reducing inequalities in maternity outcomes and experience remains a key national priority. Local data mirrors national evidence regarding poorer outcomes among ethnically diverse and socioeconomically disadvantaged populations. At the Subcommittee each service presented its Health Equity plan. A group wide paper was also shared outlining the agreed group wide areas of priority required to reduce unwarranted variation. The maternity Health Equity task and finish group meets monthly to review and progress priority areas. Using local population demographics to understand and target efforts to support a reduction in inequities in experience and outcomes is a shared priority. To this end a gesh Health Equity dashboard is being developed. This will enable services to adopt the 3N methodology – Notice, Name and Narrow	• Service leads to ensure that local plans are in alignment with group wide priorities.
Integrated Workforce Plans	• A detailed integrated workforce paper was presented for each site which demonstrated that overall workforce assurance is positive. **Maternity** • A small positive variance at SGUH against BR plus • A small deficit at ESTH in relation to staffing uplift against BR plus. **Neonatal Nursing** • A deficit in neonatal nursing at SGUH against BAPM guidance and an approved action plan in place	• Key exceptions remain neonatal nursing, demand and capacity modelling at SGUH, inclusion of anaesthetic assistants – all subject to reporting through the Subcommittee

	• ESTH compliant against BAPM with action plan in place to strengthen resilience. **Neonatal Medical** • SGUH and ESTH compliant and fully aligned to BAPM. **Obstetrics SGUH** • Consultant Presence Audit to be reviewed and brought back. • Compliance declared with compensatory rest and long-term locums **Obstetrics ESTH** • Consultant presence confirmed as compliant. • Compliance declared with compensatory rest and long-term locums **Anaesthetics** • Compliance declared with dedicated Anaesthetists at both Trusts. • Anaesthetic Assistants not included in either report. **Demand and Capacity Modelling** • The ESTH demand and capacity review paper concluded that current planned Caesarean Sections can be accommodated within existing theatre capacity. Actions and learning from the review are being taken forward by the site teams.	
Audit of Mortuary Services	The findings of the David Fuller Inquiry and the Nottingham University Hospitals Maternity Review have reinforced the importance of robust governance, security, dignity and oversight arrangements within mortuary services. NHSE requested a review of mortuary services with board level confirmation by 31st July 2026. In response both SGUH and ESTH undertook the requested review and	• Group Chief Medical Officer to report back to NHSE by 31st July 2026

	provided board assurance in relation to mortuary services and Human Tissue Authority (HTA) licence compliance.	
MNSI escalation	An escalation of concern was received from MNSI on 24 June 2026 relating to recurring themes identified from investigations (dating back to 2018) concerning CTG interpretation and failure to follow Trust guidance. A formal response was submitted within the required timescales, with an updated action plan covering all relevant MNSI cases since January 2025. A panel review from MNSI resulted in a request for further assurance in relation to strategic oversight.	A meeting has been arranged with MNSI- scheduled for 18th August. An updated report will be shared at the next Subcommittee.

3. Key Issues for the Board's Attention

Issue 1: Culture

- Background: A number of concerns have been raised through independent channels relating to organisational culture at SGUH. Common themes relate to psychological safety, professional behaviours and interpersonal conflict. These themes are being managed through the SGUH culture improvement plan and are subject to executive oversight.
- Subcommittee discussion: On reviewing the culture improvements plans at the subcommittee, a request was made for clarification of issues of concerns and whether these differ across the sites. The emerging themes and escalations from SGUH are listed above.
- Risk/Implication: There is a recognised association between poor culture, ineffective teamwork and reduced safety. Indeed, the recent Amos report describes culture as a safety issue which should be treated as such. Consequently, this is being managed as a strategic quality and safety risk with executive oversight.
- Controls/Mitigation: Several interventions are being/have been implemented including coaching and support, leadership development interventions, civility/ behavioural initiatives and executive oversight through the subcommittee.

Board Assurance: Reasonable assurance provided with further evidence of the impact of interventions requested by the subcommittee.

Issue 2: MNSI Escalation

- Background: An escalation of concern was received from MNSI on 24 June 2026 relating to recurring themes identified from historical investigations (dating back to 2018) concerning actions related to CTG interpretation and failure to follow Trust guidance. The Trust has acknowledged historical delays in implementing some of its agreed actions.
- Subcommittee discussion: The escalation requires assurance that historical actions have been implemented and will be sustained. The Trust has implemented several actions to strengthen oversight and delivery. Key stakeholders will meet with MNSI on 18th August 2026.
- Risk/Implication: Failure to implement and sustain learning may increase the likelihood of safety incident.
- Controls/Mitigation:

    - Establishment of the Maternity Subcommittee
    - Appointment of a substantive Governance leadership
    - Establishment of substantive Director of Midwifery and group CMidO leadership, providing clear executive accountability for delivery of actions.
    - Review of governance and action tracking processes.

Board Assurance: Reasonable assurance provided pending further engagement with MNSI in August 2026 after which a report and revised action plan will be presented to the September Perinatal Subcommittee. It is worthy of note that no new themes have been identified beyond those already recognised, the focus is on demonstrating sustained implementation and oversight.

Issue 3: MIS Year 8

- Background: The MIS Year 8 standards represent a new set of national safety and assurance standards that organisations are expected to meet.
- Subcommittee discussion: Each Trust presented a mid-point gap analysis to ensure compliance but more importantly to continue to strengthen the safety and quality of maternity services.
- Risk/implication: The introduction of Pulse Oximetry and a new recommendation for early thromboprophylaxis within the Maternal Care bundle represent a risk to compliance at both Trusts. Failure to meet MIS Year 8 requirements may impact on scheme compliance and associated assurance requirements.
- Controls/Mitigation: A structured implementation plan has been requested for current areas of non-compliance. Given changes to the ICBs formal oversight of compliance will be undertaken at the Subcommittee with onward exception reporting to the board.

Board Assurance: Reasonable assurance provided and focused delivery plans have been requested for areas not yet fully compliant.

Decisions Made by the Perinatal Subcommittee

List of formal decisions or approvals within the committee's delegated authority.

- Approved: Name and Frequency of Subcommittee meeting - increased to monthly
- Noted: Training compliance at the June self-check point for both Trusts.
- Noted: Mortuary reviews to be presented to GEC by Group Chief Medical Officer ahead of 31st July 2026
- Requested: Integrated workforce plans to include anaesthetic assistant availability in line with MIS requirements and be brought back to the September meeting.
- Deferred: SGUH Consultant presence audit

Action required by Group Board

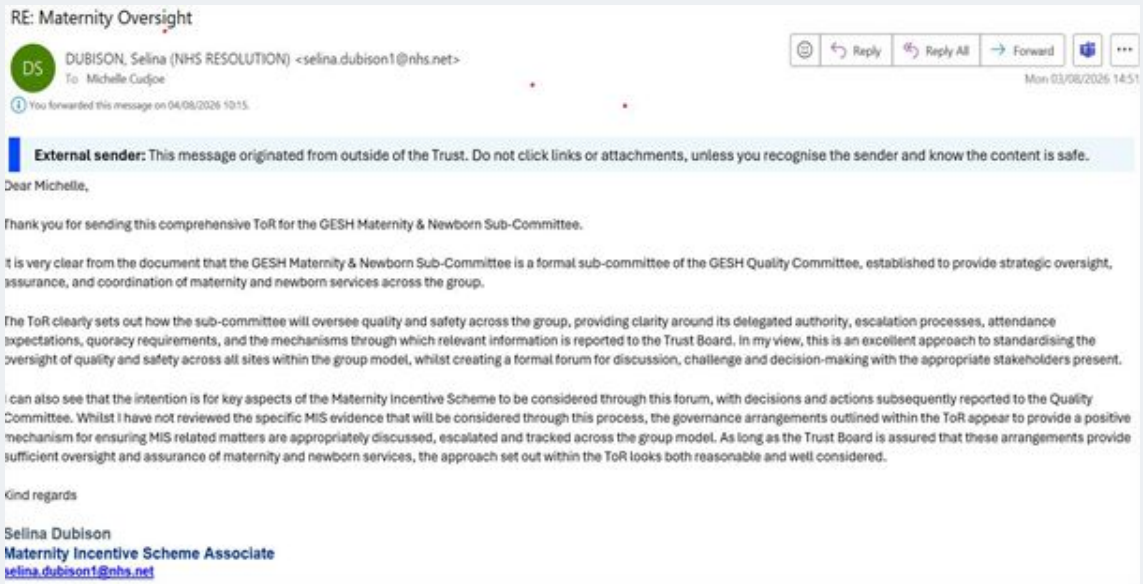
The Board is asked to:

a. Confirm assurance.

Committee Assurance	
Committee	gesh Quality Group
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	NSHR Response to Maternity Oversight at Subcommittee



RE: Maternity Oversight

DUBISON, Selina (NHS RESOLUTION) <selina.dubison1@nhs.net>
To Michelle Cudjoe

Reply | Reply All | Forward

Mon 03/08/2026 14:51

You forwarded this message on 04/08/2026 10:15.

External sender: This message originated from outside of the Trust. Do not click links or attachments, unless you recognise the sender and know the content is safe.

Dear Michelle,

Thank you for sending this comprehensive ToR for the GESH Maternity & Newborn Sub-Committee.

It is very clear from the document that the GESH Maternity & Newborn Sub-Committee is a formal sub-committee of the GESH Quality Committee, established to provide strategic oversight, assurance, and coordination of maternity and newborn services across the group.

The ToR clearly sets out how the sub-committee will oversee quality and safety across the group, providing clarity around its delegated authority, escalation processes, attendance expectations, quoracy requirements, and the mechanisms through which relevant information is reported to the Trust Board. In my view, this is an excellent approach to standardising the oversight of quality and safety across all sites within the group model, whilst creating a formal forum for discussion, challenge and decision-making with the appropriate stakeholders present.

I can also see that the intention is for key aspects of the Maternity Incentive Scheme to be considered through this forum, with decisions and actions subsequently reported to the Quality Committee. Whilst I have not reviewed the specific MIS evidence that will be considered through this process, the governance arrangements outlined within the ToR appear to provide a positive mechanism for ensuring MIS related matters are appropriately discussed, escalated and tracked across the group model. As long as the Trust Board is assured that these arrangements provide sufficient oversight and assurance of maternity and newborn services, the approach set out within the ToR looks both reasonable and well considered.

Kind regards

Selina Dubison
Maternity Incentive Scheme Associate
selina.dubison1@nhs.net

Appendix 2	List of papers shared at QCIC • Amos and Ockenden Briefing paper • ESTH: Demand and Capacity Modelling • MIS Year 8: Update papers for ESTH and SGUH • ESTH: Benchmarking against Maternal Care Bundle • Integrated Workforce Plans for ESTH and SGUH • Group overarching culture paper and culture improvement plans for SGUH and ESTH • Group overarching Health Equity Plan and Health Equity plans for SGUH and ESTH • SGUH MNSI escalation of concern and responding action plan • SGUH and ESTH: Mortuary Audits • Perinatal Subcommittee TORs

Implications

Group Strategic Objectives

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

Risks

CQC Theme

☒ Safe	☒ Effective	☒ Caring	☒ Responsive	☒ Well Led

NHS system oversight framework

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

Financial implications

Legal and / or Regulatory implications

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 promote inclusive workforce practices through staff networks and equitable access to professional development. These actions collectively support the maternity objective to reduce health inequalities and ensure all service users receive safe, respectful and responsive maternity care.
Environmental sustainability implications
None noted

Group Board Meeting (Public)

Meeting on Friday, 11 September 2026

Agenda Item	3.3	
Report Title	Board Briefing: 10-Point Plan Baseline Benchmarking Review	
Executive Lead(s)	Elaine Clancy, Interim Group Chief Nursing Officer	
Report Author(s)	Michelle Cudjoe group CMO	
Previously considered by	n/a	07 September 2026
Purpose	**For Approval / Decision**	

Executive Summary

Purpose

To provide the Board with a consolidated view of strengths and shared areas for improvement arising from the baseline assessments undertaken across both organisations against the NHS 10-Point Plan for Maternity and Neonatal Services. Once approved, the benchmarking will be shared with corresponding supporting evidence as requested by NHSE by 24th September 2026.

The Board is asked to approve submission of the benchmarking returns to NHS England.

Executive Summary

The Board can take assurance that both organisations have established strong governance, safety and leadership arrangements. There is also evidence of robust board-level accountability for maternity and neonatal services with the introduction of the Perinatal Subcommittee.

Whilst governance and safety frameworks are well established, many of the newer preventative and improvement-focused elements of the 10-Point Plan such as Martha's rule are not yet fully embedded.

The benchmarking identifies three shared priorities requiring accelerated improvement:

1. Listening to women and families

2. Reducing inequalities
3. Strengthening maternity triage services

These priorities align closely with existing local improvement work and current national priorities following the Amos and Ockenden reviews.

Areas of Strength

1. Strong Governance and Board Accountability

Both organisations demonstrate clear board-level accountability for maternity and neonatal services, with established executive oversight via the Perinatal Subcommittee and multidisciplinary governance arrangements. ESTH evidences a mature "quad" leadership model, whilst this has been recently implemented at SGUH.

2. Effective Incident Learning and PSIRF Implementation

ESTH and SGUH both report compliance with PSIRF requirements and demonstrate established arrangements for:

- Thematic review of incidents and complaints.
- Duty of Candour processes.
- Learning dissemination.
- Family engagement following adverse events.
- Board oversight of safety learning.

3. Post-Death Care and National Mortuary Requirements

ESTH and SGUH both report compliance with post-death care assurance requirements and have completed the required national assurance processes concerning mortuary standards and implementation of national recommendations.

Shared Areas Requiring Board Focus

1. Listening to Women and Families

This is the most consistent theme across both assessments.

Key gaps include:

- Limited real-time patient experience intelligence.
- Variable MNVP engagement.
- Inconsistent use of patient feedback in governance structures.
- Lack of fully triangulated reports bringing together experience, outcomes and quality intelligence.

- Limited evidence of direct board scrutiny of patient experience

Martha's Rule

Implementation activity is underway, rollout remains at an early stage and further work is required around:

- Staff awareness.
- Operational processes.
- Escalation mechanisms.
- Patient communication.

It is worthy of note that National rollout is still in the implementation phase.

2. Health Inequalities

ESTH and SGUH both acknowledge that further work is required to move from reporting inequalities to demonstrating action and impact.

Common challenges include:

- Development of organisational inequality dashboards.
- Use of ethnicity and deprivation data.
- Demonstrating board action in response to identified variation.
- Implementation of national equity programmes

3.Triage Services

Triage emerges as the weakest shared area of compliance. National benchmarking and performance metrics are not yet fully established

Common issues include:

- Incomplete benchmarking against the national specification.
- Limited board oversight of performance metrics.
- Physical space (SGUH)
- Workforce requirements
- Lack of established reporting on waits, delays and outcomes.

This aligns directly with national concerns regarding safe and responsive maternity triage.

Strategic Board Priorities

Based on the findings, Board attention should focus on three gesh-wide priorities:

Priority 1

Strengthen mechanisms for listening to women and families

- Real-time feedback.
- MNVP engagement.
- Demonstrating impact of patient voice
- Implement Martha's rule (National rollout is still in the implementation phase)

Priority 2

Accelerate maternity equity delivery

- Dashboards
- Action plans and coproduction action in response to identified variation
- Deliver implementation of the Perinatal Equity and Anti-Discrimination Programme.

Priority 3

Improve maternity triage assurance

- Benchmarking completion and implementation.
- Develop Performance metrics.
- Board level oversight.

Board Assurance Statement

Overall, the benchmarking provides assurance that both organisations have strong foundations in governance, safety learning, accountability and oversight. The greatest opportunity for improvement now lies in strengthening patient voice, reducing inequalities, and improving evidence of safe, responsive triage services (addressing workforce sustainability).

These themes would form the basis of a shared improvement programmes across gesh during 2026/27. Progress against these priorities will be monitored through site governance structures and the Perinatal Subcommittee, with a further update to the Board following submission of the December 2026 progress return.

The existing governance infrastructure provides a strong platform from which to deliver the wider 10-Point Plan.

The Board is asked to:

- Note the findings of the baseline benchmarking exercise.
- Take assurance regarding current compliance with the NHS 10-Point Plan.
- Endorse the three Group-wide improvement priorities.

- Approve submission of the benchmarking returns to NHS England by 24 September 2026.

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

Appendices	
Appendix No.	**Appendix Name**
Appendix 1	ESTH Benchmarking SGUH Benchmarking

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

10-Point Plan for Maternity & Neonatal Services

How to Use This Template

The adoption and implementation of the 10 point plan in response to Baroness Amos' Independent Investigation into Materntiy and Neonatal Services in England is the responsibility of each organisation and ttrustrusts must demonstrate compliance with the 10 Point Plan .

The reporting template is a tool designed to support a baseline assessment against the 10 point plan and support reporting to region and national teams. It is ordered as per the 10 point plan and allows for evidence of compliance, gaps in compliance, mitigations and comments to be recorded in text format. This template is intended to be built ar governance structures. The use of the reporting tool is compulsory and should be used by Trust Boards to assure against the actions.

Trust boards should complete tab 1. Submission A-Baseline once only and returned to regional teams by **Friday 25 September 2026**. Tab 2. Submission B-Progress Report, should be completed by **Thursday 31 December 2026**. Each return should be completed once and returned regionally for assurance. Regional teams will provide further detail or submission process. Both submissions must be signed off by the trust board. Boards should provide visible ownership and scrutiny of the 10 Point Plan actions and should continue to use existing board or committee governance for detailed review of progress, evidence improvement and risk management, in line with the MIS. Regional teams will r and, where necessary, provide constructive challenge, identify where trusts might need additional support and escalate significant concerns for discussion at national level.

Action 4 of the 10 point plan 'Amos into action' an NHS-wide open conversation for all our staff to help shape real and sustainable change in services will be led by the NHS England national team. Although this is not featured within the reporting template, Trust Boards should ensure staff are supported and enabled to engage with this work.

The Evidence Log should be used to reference or embed the evidence for each action. The location or link reference should clearly identify where the evidence can be found; assurance notes should explain what the evidence demonstrates; and the evidence quality field should indicate whether the evidence is strong, adequate, limited or not avail may support more than one deliverable where appropriate.

The compliance rating column allows for the selection of a RAG rating for each criteria using a drop-down list. Specifically: not applicable, non-compliant, partially compliant and compliant.

Source: https://www.england.nhs.uk/long-read/publication-of-baroness-amos-independent-investigation-into-maternity-and-neonatal-services-in-england/

1. Summary tab: Provides instructions for completion and an overview of the key metrics for 1. Baseline assessment and 2. Progress Report. Please note all tables are automated and the information should pull directly from the relevant tabs.
2. Submission A Baseline Assessment tab: Record the trust's starting position against each of the 10 actions before improvement work begins. To be completed once and returned **Friday 25 Sept 2026**
3. Submission B Progress Report tab: One row per deliverable/scoping prompt (24 in total); Baseline Compliance tab updated automatically, all other columns to be manually updated. To be completed once and returned **Thursday 31 Dec 2026**
4. Evidence Log tab: Log supporting evidence against each action number; reference the Evidence ID in the Baseline Assessment and Progress Tracker tabs as required.
5. Evidence examples: Provides some example areas of evidence submission to be considered.

Rating definitions:
RAG guide: Red = no route to compliance or immediate safety risk. Amber = plan in place but gaps/risks remain. Green = evidence confirms requirement met or on track.

The **baseline compliance / compliance ratings** should be used to provide a consistent assessment of the current level of compliance against each requirement. Ratings should be based on available evidence, professional judgement and the extent to which the requirement has been fully implemented, embedded and sustained.
Not applicable: The requirement does not apply to the service, pathway, function or organisation being assessed. *For example, trusts may not yet be eligible for onboarding onto the PEADP programme at the time of submission therefore 'Not applicable' would be apply*.
Non-compliant: There is no, or very limited, evidence that the requirement has been met.
Partially compliant: There is evidence that some elements of the requirement have been met, but implementation is incomplete, inconsistent or not yet fully embedded.
Compliant: There is sufficient evidence that the requirement has been fully met and is being implemented consistently

Name of trust or organisation:
Report prepared by:
Report date:
Reporting period covered:

Baseline Assessment		
Key Metrics		
Total deliverables		26
Compliance	0. Not applicable	0
	1. Non-compliant	0
	2. Partially compliant	0
	3. Compliant	0
Regional Match	Regional match - Yes	0
	Regional match - No	0

Summary by Action - Baseline		Compliance			
Action	Total	Not applicable	Non-compliant	Partially compliant	Compliant
1. Listening to women and families by rolling out Martha's Rule	1	0	1	0	0
2. Listen to women and their families using real-time and transparently reported outcomes and experience and clinical audit that are acted upon at board level	3	0	0	3	0
3. Dual board-level accountability between medical directors and chief nursing officers for maternity and neonatal care	2	0	0	1	1
5. Addressing inequalities in maternity and neonatal outcomes	3	0	0	3	0
6. Ensuring 24/7 safety and responsiveness of services	7	0	1	2	4
7. Trust review of homebirth services	2	1	0	0	1
8. Responding to incidents, complaints and concerns with humanity and candour	3	0	0	0	3
9. Deliver safe and effective triage in maternity services	3	0	2	1	0
10. Post death care	2	0	0	0	2

Submission A: Baseline Assessment (Starting Position Against the 10-Point Plan)

This template should be completed once and submitted on the **Friday 25th September 2026**. It is intended to provide a baseline assessment of delivery against the 10-point plan actions and is separate to the tab 2. Progress Report submission.

Columns K & L should be used by regional teams only to provide independent assessment against Trust Board assurance.

The RAG rating should describe delivery risk and confidence: red where there is no credible route to compliance or an immediate safety risk; amber where a plan is in place but gaps or risks remain; and green where evidence confirms the requirement is met or on track. A completed review alone should not result in a greenrating if significant residual risk remains.

Baseline compliance definitions
The baseline compliance / compliance ratings should be used to provide a consistent assessment of the current level of compliance against each requirement. Ratings should be based on available evidence, professional judgement and the extent to which the requirement has been fully implemented, embedded and sustained.

Not applicable: The requirement does not apply to the service, pathway, function or organisation being assessed. *For example, trusts may not yet be eligible for onboarding onto the PEADP programme at the time of submission, therefore 'Not applicable' would be apply.*
Non-compliant: There is no, or very limited, evidence that the requirement has been met.
Partially compliant: There is evidence that some elements of the requirement have been met, but implementation is incomplete, inconsistent or not yet fully embedded.
Compliant: There is sufficient evidence that the requirement has been fully met and is being implemented consistently.

Report signed off by Trust Board (named Exec):

Trust Board sign off date:

Trust Board Assurance Template

No.	Deliverable / Scoping Prompt	Baseline Compliance Rating	Baseline Evidence Reference *Please input reference number as listed in 3. Evidence Log tab*	Gaps in Assurance *Please provide detail of any gaps in assurance*	Improvement Actions (Including Temporary Mitigations)	Comments
1. Listening to women and families by rolling out Martha's Rule						
1.1	Has the trust commenced rollout of Martha's Rule across maternity and neonatal services?	Non-compliant		This has not yet been rolled out.	The plan is to roll out Martha's rule in perinatal services; there are no current mitigations in place.	
2. Listen to women and their families using real-time and transparently reported outcomes and experience, and clinical audit that are acted upon at board level.						
2.1	Has the trust established a monthly cycle of collecting and analysing the latest available maternity and neonatal clinical audit and patient outcome & experience data representative of the local population, including but not limited to, FFT, CQC survey findings when available, local intelligence from MNVPs and targeted outreach?	Partially compliant	EV-01, EV-02, EV-03, EV-10, EV-11	The PQOM is currently presented to the sub-committee of the Board Quarterly and includes all of the required information. A maternity Dashboard is compiled monthly and presented at the monthly Unit Meeting along with an audit report. We also have a monthly Perinatal Meeting where this could be discussed but there is no fixed regular agenda item to discuss patient experience audit. Outcomes are currently discussed via the monthly DIRG report. Neonates Partially compliant - Monthly NQGR agenda and minutes, risk report presented at monthly perinatal meeting. Reported quaterly to the board via Divisional Performance, Quality and Safety Report. Monthly oversite of NNAP clinical audit data. Spreadsheets from NMVP feedback.	To add as a regular agenda item to the Perinatal Meeting. The current mitigation is that all aspects of the service are discussed and reported on quarterly. Monthly reporting is also occuring but is not consolidated into one meeting agenda.	
2.2	Does the trust board receive and publish a regular summary report that brings these sources of intelligence together, and can it demonstrate the decisions, actions or escalation resulting from its scrutiny, including how progress and impact are tracked?	Partially compliant	EV-01	Locally we submit the PQOM to the Group Chief Midwifery Officer for presenting to the Board. Group Chief Midwifery Officer to provide her summary report and also confirm whether the Trust publish this report.		
2.3	Does the report identify variation in outcomes and experience by ethnicity and deprivation, including any important gaps or limitations in the available data, and can the board demonstrate how the trust is responding to the variation identified?	Partially compliant	EV-01, EV-13	The PQOM is evidence of our quarterly reporting and includes outcomes by ethnicity and deprivation. Trust Board to provide evidence of how they are responding to the findings of the report. Neonatal Not Compliant- NNAP captures some ethnicity data. Targeted audits have highlighted inequalities requiring QI work.	Creation of neonatal dashboard breaking down audit and feedback into ethnity and depravation catergories.	
3. Dual board-level accountability between medical directors and chief nursing officers for maternity and neonatal care						
3.1	Has the trust board established clear joint accountability for maternity and neonatal services with Medical Directors and Chief Nurses holding a shared responsibility?	Compliant	EV-06	N/A	N/A	We have a well-established 'quad' consisting of the Medical Director, Associate Director of Nursing for Neonatology, the Director of Midwifery and the Division Director of Operations. They have regular meetings and the ToRs of these meetings have been presented as evidence.
3.2	Do Directors of Midwifery and Clinical Directors leading maternity and neonatal services attend boards and take part in discussions when maternity and neonatal matters are on the agenda?	Partially compliant		Currently only the Group Chief Midwifery Officer is invited to attend the Board Sub-Committee (GCiC).	The Group Chief Midwifery Officer currently attends on behalf of the DoM at each site, so this needs to be extended to include the DoMs.	
5. Addressing inequalities in maternity and neonatal outcomes						
5.1	Has the trust board ensured that provision is in place to allow staff to be released for the Perinatal Equity and Anti-Discrimination Programme with full participation across multidisciplinary teams?	Partially compliant		Template returned and introductory webinar scheduled for 9th Sept 2026	Webinar booked for 9th Sept and programme commences in January 2027 for ESTH	
5.2	Can the trust board demonstrate that the trust is regularly reviewing and acting on trends identified by their inequalities data dashboards every 6 months?	Partially compliant	EV-01	The PQOM should include a specific focus on this every 6 months, with reference to the national dashboards. Neonatal - non-compliant. Neonatal do not currently have an inequalities data dashboard.	This is currently included in a limited way in the quarterly PQOM but needs a closer review every 6 months. This should probably be a separate paper from the PQOM and produced from the EDI workstream.	
5.3	Has the trust board approved a plan to implement the Maternal Care Bundle by March 2027?	Partially compliant	EV-04	The assessment tool has been completed but the plan to agree compliance still needs to be developed and approved by the Trust Board.		
6. Ensuring 24/7 safety and responsiveness of services						
6.1	Is the trust complying with the RCOG "Roles and Responsibilities of the Consultant providing acute care" standard? In line with MIS Year 8, is there a minimum ≥80% consultant presence in defined acute care situations?	Compliant	EV-05	N/A	N/A	
6.2	Is the trust ensuring locum certification and maintaining a local (trust-specific), continuously updated database of all short-term locums (≤2 weeks) working on tier 2/3 obstetric rotas? *(In line with MIS Year 8)*	Compliant	EV-07	N/A	N/A	Evidence as for CNST Year 8.
6.3	Does the trust have a clear plan for a fully funded neonatal nursing and medical establishment that aligns with the relevant BAPM standards for their unit designation and the neonatal nursing workforce calculator output (2020)? *(In line with MIS Year 8)*	Compliant	EV-08	N/A Neonatal partially compliant - medical workforce cross site requires assurance to be provided. Neonatal nursing - fully compliant at St Helier, Partially compliant at Epsom due to increase acuity/activity.	N/A Epsom SCBU acuity and activity presentation and risk assessment included as evidence. Do we need to devise an non-compliant action plan.	6-monthly staffing report.

6.4	Does the trust have a fully funded midwifery establishment that aligns with a Birthrate Plus (BR+) review completed within the last three years as a minimum baseline, with further adjustments based on the professional judgement of the Director and Head of Midwifery? *(In line with MIS Year 8)*	Partially compliant	EV-08	Birthrate+ was received in early 2026 and we are currently not fully established.	We are continuing to use Bank and Agency to backfill staffing shortfalls, whilst a business case to increase staffing is being prepared.	
6.5	Do the trust's obstetric services have a duty anaesthetist available 24/7 in line with ACSA standards 1.7.2.1 and a trained anaesthetic assistant available 24/7 in line with ACSA standards 1.3.1.2? *(In line with MIS Year 8)*	Compliant	EV-09	N/A	N/A	Sample rota showing 24/7 cover provided for evidence.
6.6	Does the trust board oversee workforce acuity, service pressures and escalation activity across maternity and neonatal services, ensuring they can a) respond to periods of increased demand, reduced workforce availability or changing clinical risk; b) address local gaps and c) eliminate siloed working, so that services can consistently and safely respond to the needs of women, babies and families?	Partially compliant	EV-11, EV-14	Neonatal - daily sitrep as evidence. Neonatal OPEL used if needed at daily site calls.	Trust implementation of not covering first episode of sickness with bank staff may impact on non clinical staff i.e. Matron/ PDN avalability to respond to increased activity and acuity. The impact of this polict is not formally currently recorded.	
6.7	Has the trust board undertaken a review of internal resource deployment, including consideration of a) whether roles not directly supporting frontline delivery can be redirected to strengthen service provision; b) where specialist posts exist (including in bereavement care and infant feeding), what education and training is required to ensure other staff have the knowledge and skills to ensure that care is not compromised when the specialist midwives are not immediately available; c) the impact of redeployment across the service.	Non-compliant			See above improvement action for 6.6	
7. Trust review of homebirth services						
7.1	Has the trust board received, scrutinised and actioned an urgent review of homebirth services in line with the letter of the Chief Midwifery Officer and the regional chief midwife of 26 November 2025?	Compliant	When did this go to SLT? National review assured ESTH are compliant			
7.2	Where significant risks and mitigations have been identified, has an action plan with agreed timescales to mitigate and remove the risks been agreed and shared with the Regional NHSE team?	Not applicable				
8. Responding to incidents, complaints and concerns with humanity and candour						
8.1	Does the trust have the Patient Safety Incident Response Framework (PSIRF) embedded within Maternity and Neonatal Services through clearly defined governance processes? Is the learning, any actions and outcomes regularly reviewed, shared with women and families, and routinely monitored at trust board through board safety reporting?	Compliant	Evidence can include Maternity-specific PSIRP, Maternity-specific policy, PQOM, MIRP, DIRG, CIRG, open and honest letters and evidence of PMRT/DOC letters etc.	N/A		
8.2	Does the trust review complaints and concerns thematically, with learning actions and improvement plans monitored for impact? Are the themes and learning actions routinely reported to the trust board?	Compliant	EV-01	N/A		
8.3	Does the Trust have embedded processes for open learning and compassionate debriefing, with staff supported to engage effectively with women and families, use feedback to inform practice, provide each family with a key contact, and ensure early duty of candour by a senior manager?	Compliant	Monday Meetings, monthly governance meetings, message of the week, safety huddles, newsletters, open and honest/PMRT letters with key contact information and DoC letters signed by DoM.	Neonates - Partially compliant - regular verbal DoC on unit - documentation format clear on badger, not consistenly filled in.	DoC - SOP for medical and nursing DoC needed.	
9. Deliver safe and effective triage in maternity services						
9.1	Has the trust board completed and reported to NHSE regions an audit, including dedicated staffing and clinical capacity with a focus on ensuring that maternity triage services are consistently safe, responsive and appropriately resourced?	Non-compliant				
9.2	Does the board have clear oversight of triage quality and performance, supported by regular data on waiting times, assessment and review times, redeployment, delays and outcomes with a focus on inequalities?	Non-compliant				
9.3	Is the trust on track to implement improvements in line with national triage guidance to ensure women have consistent access to high-quality, responsive triage across the NHS within 12 months?	Partially compliant				
10. Post death care						
10.1	Has the trust board completed an assurance statement and submitted it by 31 July 2026?	Compliant	presented to sub committee in Ju	Get evidence from Debra when she sends out minutes to embed		
10.2	Has the board assured itself that it is continuing regular overersight and implementations of national actions and reccomendations around matters relating to morturaries including review of incident records over the past 10 years?	Compliant	as above			

on progress against the baseline assessment. Where a deliverable has already been reported as achieved in the baseline
nd should indicate where any progress updates are required.

e or an immediate safety risk; amber where a plan is in place but gaps or risks remain; and green where evidence confirms
sidual risk remains.

Current Status	RAG	Evidence ID *Please input reference number as listed in 3. Evidence Log tab*	Key Gaps / Risks	Improvement action required	Due Date(s)

Evidence Log - Supporting Evidence Submission

The evidence log should be used to list and reference the evidence for each action. The location or link reference should clearly identify where the evidence can be found; assurance notes should explain what the evidence demonstrates. The evidence quality field should indicate whether the evidence is strong, adequate, limited or not available. Evidence may support more than one deliverable where appropriate. Trusts are encouraged to use existing evidence and established governance documentation wherever possible. Trusts should use the minimum evidence necessary to demonstrate assurance.

Log each piece of supporting evidence here. Reference the Evidence ID against the relevant row in the Baseline Assessment and Progress Report as needed. Please note the evidence submitted should be accessible externally (to the trust).

Evidence ID	Action No	Evidence Type	Document / Meeting / Dataset	Date	Owner	Location / Link Reference	Assurance Notes	Evidence Quality
EV-01	2.1	Q1 PQOM	Document	8/26/2026	Laura Rowe	X:\TrustShared\Womens & Childrens Services\Maternity Clinical Governance\CNST\10 Point Plan\Evidence	The is the quarterly PQOM to the Board Suv-Committee	Limited
EV-02	2.1	Dashboard	Document	8/26/2026	Laura Rowe	X:\TrustShared\Womens & Childrens Services\Maternity Clinical Governance\CNST\10 Point Plan\Evidence	This is monthly Maternity Dashboard which includes inequalities data and outcomes. This is discussed monthly at the unit meeting.	Adequate
EV-03	2.1	Meeting Agenda	Meeting	8/26/2026	Laura Rowe	X:\TrustShared\Womens & Childrens Services\Maternity Clinical Governance\CNST\10 Point Plan\Evidence	The is an example of the monthly unit meeting agenda showing that the dashboard, audit, CQC etc. are shared and discussed.	Limited
EV-04	5.3	Maternal Care Bundle Tool	Implmentation Tool	8/26/2026	Diane Weir	X:\TrustShared\Womens & Childrens Services\Maternity Clinical Governance\CNST\10 Point Plan\Evidence	This is the current implementation tool.	Limited
EV-05	6.1	Consultant attendance Audit Tool	Document	8/26/2026	Laura Rowe	X:\TrustShared\Womens & Childrens Services\Maternity Clinical Governance\CNST\10 Point Plan\Evidence	This audit is completed monthly.	Strong
EV-06	3.1	Quad Meeting ToRs	Document	8/27/2026	Kathryn Hughes	X:\TrustShared\Womens & Childrens Services\Maternity Clinical Governance\CNST\10 Point Plan\Evidence	Regular meetings are established	Strong
EV-07	6.2	Presentation	Document	8/27/2026	Sai Gnanasambanthan	X:\TrustShared\Womens & Childrens Services\Maternity Clinical Governance\CNST\10 Point Plan\Evidence	Assurance that we are currently compliant.	Strong
EV-08	6.3	Staffing Report	Document	8/27/2026	Elizabeth Cullen	X:\TrustShared\Womens & Childrens Services\Maternity Clinical Governance\CNST\10 Point Plan\Evidence	Example of the 6-monthly staffing report.	Strong
EV-09	6.5	Rota	Document	8/27/2026	Suman Biswas	X:\TrustShared\Womens & Childrens Services\Maternity Clinical Governance\CNST\10 Point Plan\Evidence	Sample rota to demonstrate 24/7 rotal cover.	Strong
EV-10	2.1	NQGR TOR	Document	8/28/2026		X:\TrustShared\Womens & Childrens Services\Childrens Services\NNU\10-Point Plan Evidence	Regular meetings are established	Strong

EV-11	2.1	NQGR agenda	Document	8/28/2026		X:\TrustShared\Womens & Childrens Services\Childrens Services\NNU\10-Point Plan Evidence	This is an example of the monthly agenda showing that clinical audit, NMVP feedback and FFT are discussed.	Adequate
EV-12	6.6	Neonatal OPEL	Document	8/28/2026	Victoria Hakewill	X:\TrustShared\Womens & Childrens Services\Childrens Services\NNU\10-Point Plan Evidence		Limited
EV-13	2.3	Audit presentation	Document	8/28/2026	Arun Kundu	X:\TrustShared\Womens & Childrens Services\Childrens Services\NNU\10-Point Plan Evidence	Re-admission audit highlight a variation in outcomes by ethnicity, need to addd evidence of presentation to the board.	Limited
EV-14	6.6	Neo/Paeds SitRep	Document	8/28/2026	Jean Regan	X:\TrustShared\Womens & Childrens Services\Childrens Services\NNU\10-Point Plan Evidence	Example of Daily SitRep sent to the board 08:00 and 16:00	Adequate
EV-15								
EV-16								
EV-17								
EV-18								
EV-19								
EV-20								
EV-21								
EV-22								
EV-23								
EV-24								
EV-25								
EV-26								
EV-27								
EV-28								
EV-29								
EV-30								

Evidence: examples

This section is designed to support trust boards in identifying appropriate evidence to support their assurance assessments. We encourage trusts to make use of existing data sources and processes wherever appropriate to support their assurance. There may also be instances where an individual item e.g. board report may account for evidence against multiple deliverables. The model board report is available for use on the Futures platform . Trusts not already using the model board report may wish to adopt this template.

It should be noted that Trusts are not required to provide all suggested evidence to evidence compliance**. Trust should use the minimum amount of information to demonstrate compliance.**

Action		Deliverable	Suggested evidence
Action 1	1.1	The trust continuing to make progress with rollout of Martha's Rule across maternity and neonatal services?	• Trusts are not asked to submit any evidence for this action as data will be collected via the national Martha's rule programme team. It is however expected that providers attend the launch webinar to undertstand process and next steps and continue work with the Martha's rule team to commence roll out.
Action 2	2.1	The trust continued to operate a monthly cycle of collecting and analysing the latest available maternity and neonatal clinical audit, patient outcome and experience data, including but not limited to, FFT, CQC survey findings when available, local intelligence from MNVPs and targeted outreach?	• Analytical reports
	2.2	The trust board continuing to receive and publish a regular report that brings these sources of intelligence together, and can it demonstrate the decisions, actions or escalation resulting from its scrutiny, including how progress and impact are tracked?	• Board report and minutes
	2.3	The insight and audit data presented by ethnicity and deprivation and does the board scrutinise variation?	• Board report and minutes • Quarterly MIS thematic report
Action 3	3.1	Has the trust board established clear joint accountability for maternity and neonatal services with Medical Directors and Chief Nurses holding a shared responsibility?	• Board ToR • Job plans
	3.2	Do Directors of Midwifery and Clinical Directors leading maternity and neonatal services attend boards and take part in discussions when maternity and neonatal matters are discussed?	• Job plans • Minutes of Executive board meetings
Action 5	5.1	Have staff been released to complete the Perinatal Equity and Anti-Discrimination Programme with full participation across multidisciplinary teams?	• Board report and minutes
	5.2	The trust board regularly reviewing and acting on trends identified by their inequalities data dashboards every 6 months?	• Board report • Quarterly MIS thematic report • Equity dashboard reports • Core20PLUS5 reporting • Maternity equity action plans
	5.3	Is the trust board receiving reviewing and acting on (at the relevant delegated committee) quarterly reports on implementation of the Maternal Care Bundle?	• Maternal Care Bundle implementation plans. • Board Report • MIS return
Action 6	6.1	Is the trust complying with the RCOG "Roles and Responsibilities of the Consultant providing acute care" standard? In line with MIS Year 8 is there a minimum ≥80% consultant presence in defined acute care situations?	• Workforce plan • Biannual workforce papers • Staff experience survey • Cappuccini-style assurance exercise
	6.2	The trust ensuring locum certification and maintaining a local (trust-specific), continuously updated database of all short-term locums (≤2 weeks) working on tier 2/3 obstetric rotas? *(In line with MIS Year 8)*	• Database
	6.3	The trust have a clear plan for a fully funded neonatal nursing and medical establishment that aligns with the relevant BAPM standards for their unit designation and the neonatal nursing workforce calculator output (2020)? *(In line with MIS Year 8)*	• Workforce plan • Biannual workforce papers • BAPM workforce standards compliance • Staff experience survey
	6.4	The trust have a fully funded midwifery establishment that aligns with a Birthrate Plus (BR+) review completed within the last three years as a minimum baseline, with further adjustments based on the professional judgement of the Director and Head of Midwifery? *(In line with MIS Year 8)*	• BR+ review and workforce plan • Biannual workforce papers • Staff experience survey
	6.5	The trust's obstetric services have a duty anaesthetist available 24/7 in line with ACSA standards 1.7.2.1 and a trained anaesthetic assistant available 24/7 in line with ACSA standards 1.3.1.2?	• Workforce plan • Biannual workforce papers • Cappuccini-style assurance exercise
	6.6	Does the trust board oversee workforce acuity, service pressures and escalation activity across maternity and neonatal services, ensuring they can a) respond to periods of increased demand, reduced workforce availability or changing clinical risk; b) address local gaps and c) eliminate siloed working, so that services can consistently and safely respond to the needs of women, babies and families?	• Board report and minutes • Biannual workforce papers • Cappuccini-style assurance exercise
	6.7	Has the trust board undertaken a review of internal resource deployment, including co sideration of a) whether roles not directly supporting frontline delivery can be redirected to strengthen service provision; b) where specialist posts exist (including in bereavement care and infant feeding), what education and training is required to ensure other staff have the knowledge and skills to ensure that care is not compromised when the specialist midwives are not immediately available; c) the impact of redeployment across the service.	• Board report and minutes • Biannual workforce papers • Cappuccini-style assurance exercise
Action 7	7.1	Is the board assured that any actions identified through the urgent review of homebirth services have been completed and services are safe and of high quality?	• Board report and minutes
	7.2	Where significant risks have been identified, have they been communicated with the Regional NHSE team?	• Correspondence
Action 8	8.1	Does the trust have the Patient Safety Incident Response Framework (PSIRF) embedded within Maternity and Neonatal Services through clearly defined governance processes? Is the learning, any actions and outcomes regularly reviewed, shared with women and families, and routinely monitored at trust board through board safety reporting?	• Board report and minutes • A Trust-wide SOP for PSIRF is implemented across Maternity and Neonatal Services • PSIRF implementation within Maternity and Neonatal Services, governance and review processes. • Process for sharing outcomes and learning from PSIRF reviews with women and families. • Mechanisms to identify, monitor and learn from positive practice and areas of improvement.
	8.2	Does the trust review complaints and concerns thematically, with learning actions and improvement plans monitored for impact? Are the themes and learning actions routinely reported to the trust board?	• Board report and minutes • Thematic reviews of complaints and concerns using a learning-focused and inquisitive approach. • Recommendations arising from thematic reviews are monitored, reviewed and acted upon.
	8.3	Does the Trust have embedded processes for open learning and compassionate debriefing, with staff supported to engage effectively with women and families, use feedback to inform practice, provide each family with a key contact, and ensure early duty of candour by a senior manager?	• Board report and minutes • Debrief guidance • Education and Training for Staff involved in debriefing women and families
Action 9	9.1	Has the trust board completed and reported to NHSE regions an audit, including dedicated staffing and clinical capacity with a focus on ensuring that maternity triage services are consistently safe, responsive and appropriately resourced?	• Triage Benchmarking tool completed template
	9.2	Does the trust board have clear oversight of triage quality and performance, supported by regular data on waiting times, assessment and review times, redeployment, delays and outcomes?	• Board paper
	9.3	Is the trust on track to implement improvements in line with national triage guidance to ensure women have consistent access to high-quality, responsive triage across the NHS within 12 months?	• Plan and progress reports
Action 10	10.1	Board assurance statement completed and submitted by 31 July 2026	• Assurance statement
	10.2	Has the board assured itself that it is continuing regular overersight and implementations of national actions and reccomendations around matters relating to morturaries including review of incident records over the past 10 years?	•Board Report •Review report

10-Point Plan for Maternity & Neonatal Services

How to Use This Template

The adoption and implementation of the 10 point plan in response to Baroness Amos' Independent Investigation into Materntiy and Neonatal Services in England is the responsibility of each organisation and ttrustrusts must demonstrate compliance with the 10 Point Plan .

The reporting template is a tool designed to support a baseline assessment against the 10 point plan and support reporting to region and national teams. It is ordered as per the 10 point plan and allows for evidence of compliance, gaps in compliance, mitigations and comments to be recorded in text format. This template is intended to be built ar governance structures. The use of the reporting tool is compulsory and should be used by Trust Boards to assure against the actions.

Trust boards should complete tab 1. Submission A-Baseline once only and returned to regional teams by **Friday 25 September 2026**. Tab 2. Submission B-Progress Report, should be completed by **Thursday 31 December 2026**. Each return should be completed once and returned regionally for assurance. Regional teams will provide further detail or submission process. Both submissions must be signed off by the trust board. Boards should provide visible ownership and scrutiny of the 10 Point Plan actions and should continue to use existing board or committee governance for detailed review of progress, evidence improvement and risk management, in line with the MIS. Regional teams will r and, where necessary, provide constructive challenge, identify where trusts might need additional support and escalate significant concerns for discussion at national level.

Action 4 of the 10 point plan 'Amos into action' an NHS-wide open conversation for all our staff to help shape real and sustainable change in services will be led by the NHS England national team. Although this is not featured within the reporting template, Trust Boards should ensure staff are supported and enabled to engage with this work.

The Evidence Log should be used to reference or embed the evidence for each action. The location or link reference should clearly identify where the evidence can be found; assurance notes should explain what the evidence demonstrates; and the evidence quality field should indicate whether the evidence is strong, adequate, limited or not avail may support more than one deliverable where appropriate.

The compliance rating column allows for the selection of a RAG rating for each criteria using a drop-down list. Specifically: not applicable, non-compliant, partially compliant and compliant.

Source: https://www.england.nhs.uk/long-read/publication-of-baroness-amos-independent-investigation-into-maternity-and-neonatal-services-in-england/

1. Summary tab: Provides instructions for completion and an overview of the key metrics for 1. Baseline assessment and 2. Progress Report. Please note all tables are automated and the information should pull directly from the relevant tabs.
2. Submission A Baseline Assessment tab: Record the trust's starting position against each of the 10 actions before improvement work begins. To be completed once and returned **Friday 25 Sept 2026**
3. Submission B Progress Report tab: One row per deliverable/scoping prompt (24 in total); Baseline Compliance tab updated automatically, all other columns to be manually updated. To be completed once and returned **Thursday 31 Dec 2026**
4. Evidence Log tab: Log supporting evidence against each action number; reference the Evidence ID in the Baseline Assessment and Progress Tracker tabs as required.
5. Evidence examples: Provides some example areas of evidence submission to be considered.

Rating definitions:
RAG guide: Red = no route to compliance or immediate safety risk. Amber = plan in place but gaps/risks remain. Green = evidence confirms requirement met or on track.

The **baseline compliance / compliance ratings** should be used to provide a consistent assessment of the current level of compliance against each requirement. Ratings should be based on available evidence, professional judgement and the extent to which the requirement has been fully implemented, embedded and sustained.
Not applicable: The requirement does not apply to the service, pathway, function or organisation being assessed. *For example, trusts may not yet be eligible for onboarding onto the PEADP programme at the time of submission therefore 'Not applicable' would be apply*.
Non-compliant: There is no, or very limited, evidence that the requirement has been met.
Partially compliant: There is evidence that some elements of the requirement have been met, but implementation is incomplete, inconsistent or not yet fully embedded.
Compliant: There is sufficient evidence that the requirement has been fully met and is being implemented consistently

Name of trust or organisation:
Report prepared by:
Report date:
Reporting period covered:

Baseline Assessment		
Key Metrics		
Total deliverables		26
Compliance	0. Not applicable	0
	1. Non-compliant	0
	2. Partially compliant	0
	3. Compliant	0
Regional Match	Regional match - Yes	0
	Regional match - No	0

Summary by Action - Baseline		Compliance			
Action	Total	Not applicable	Non-compliant	Partially compliant	Compliant
1. Listening to women and families by rolling out Martha's Rule	1	0	0	1	0
2. Listen to women and their families using real-time and transparently reported outcomes and experience and clinical audit that are acted upon at board level	3	0	1	1	1
3. Dual board-level accountability between medical directors and chief nursing officers for maternity and neonatal care	2	0	0	0	2
5. Addressing inequalities in maternity and neonatal outcomes	3	0	0	2	1
6. Ensuring 24/7 safety and responsiveness of services	7	0	0	3	4
7. Trust review of homebirth services	2	0	0	1	1
8. Responding to incidents, complaints and concerns with humanity and candour	3	0	0	0	3
9. Deliver safe and effective triage in maternity services	3	0	1	2	0
10. Post death care	2	0	0	0	2

Submission A: Baseline Assessment (Starting Position Against the 10-Point Plan)

This template should be completed once and submitted on the **Friday 25th September 2026**. It is intended to provide a baseline assessment of delivery against the 10-point plan actions and is separate to the tab 2. Progress Report submission.

Columns K & L should be used by regional teams only to provide independent assessment against Trust Board assurance.

The RAG rating should describe delivery risk and confidence: red where there is no credible route to compliance or an immediate safety risk; amber where a plan is in place but gaps or risks remain; and green where evidence confirms the requirement is met or on track. A completed review alone should not result in a greenrating if significant residual risk remains.

Baseline compliance definitions
The baseline compliance / compliance ratings should be used to provide a consistent assessment of the current level of compliance against each requirement. Ratings should be based on available evidence, professional judgement and the extent to which the requirement has been fully implemented, embedded and sustained.

Not applicable: The requirement does not apply to the service, pathway, function or organisation being assessed. *For example, trusts may not yet be eligible for onboarding onto the PEADP programme at the time of submission, therefore 'Not applicable' would be apply.*
Non-compliant: There is no, or very limited, evidence that the requirement has been met.
Partially compliant: There is evidence that some elements of the requirement have been met, but implementation is incomplete, inconsistent or not yet fully embedded.
Compliant: There is sufficient evidence that the requirement has been fully met and is being implemented consistently
Report signed off by Trust Board (named Exec):

Trust Board sign off date:

Trust Board Assurance Template

No.	Deliverable / Scoping Prompt	Baseline Compliance Rating	Baseline Evidence Reference *Please input reference number as listed in 3. Evidence Log tab*	Gaps in Assurance *Please provide detail of any gaps in assurance*	Improvement Actions (Including Temporary Mitigations)	Comments
1. Listening to women and families by rolling out Martha's Rule						
1.1	Has the trust commenced rollout of Martha's Rule across maternity and neonatal services?	Partially compliant	Chelone Lee-Wo	Patient wellness question outstanding Further staff education required- currently only shared via email	EPR service change request is being submitted Safety Champions meeting dedicated to Martha's Rule 21st September	
2. Listen to women and their families using real-time and transparently reported outcomes and experience, and clinical audit that are acted upon at board level.						
2.1	Has the trust established a monthly cycle of collecting and analysing the latest available maternity and neonatal clinical audit and patient outcome & experience data representative of the local population, including but not limited to, FFT, CQC survey findings when available, local intelligence from MNVPs and targeted outreach?	Non-compliant	Matrons	MNVP services paused since June 2026 owing to a payment issue. Poor uptake of FFT. ? outputs from last CQC survey	MNVP meeting arranged to review Health Equity Whose Shoes. Exploring the introducition of a Patient Feedback Call. Introduction of Intentional rounding , walking the patch an dMartha's rule.QI plan with milestones to be developed and presented to Perinatal Subcommittee	
2.2	Does the trust board receive and publish a regular summary report that brings these sources of intelligence together, and can it demonstrate the decisions, actions or escalation resulting from its scrutiny, including how progress and impact are tracked?	Compliant	Michelle Cudjoe	Trust board receives a quarterly traingulated report that includes inteligence from claims, complaints, PMRT and MNSI reports. Need to include more real time patient experience	Summary report on patient experience to be developed	
2.3	Does the report identify variation in outcomes and experience by ethnicity and deprivation, including any important gaps or limitations in the available data, and can the board demonstrate how the trust is responding to the variation identified?	Partially compliant	Michelle Cudjoe	Whilst the patient experienc report does not specifically include data on ethnicity and depiravation this is reported on separately.	To include specific information on ethnicity and deprivation in patient experience reports and equity dashboard to be published	
3. Dual board-level accountability between medical directors and chief nursing officers for maternity and neonatal care						
3.1	Has the trust board established clear joint accountability for maternity and neonatal services with Medical Directors and Chief Nurses holding a shared responsibility?	Compliant	Michelle Cudjoe	Launch of Perinatal Subcommitte co-chaired by CNO and CMO- ToR		
3.2	Do Directors of Midwifery and Clinical Directors leading maternity and neonatal services attend boards and take part in discussions when maternity and neonatal matters are on the agenda?	Compliant	Michelle Cudjoe	Minutes of Subcommittee and Board meetings		
5. Addressing inequalities in maternity and neonatal outcomes						
5.1	Has the trust board ensured that provision is in place to allow staff to be released for the Perinatal Equity and Anti-Discrimination Programme with full participation across multidisciplinary teams?	Compliant	Adaline Hugh	Attendees identified and committment given regarding attendance in the London cohort		
5.2	Can the trust board demonstrate that the trust is regularly reviewing and acting on trends identified by their inequalities data dashboards every 6 months?	Partially compliant	Michelle Cudjoe	Unable to use National dashboard as MIS does not contain required data. Meanwhile a local dashboard is being developed to demonstrate review of trends	Dashboard to be presented at next T&F	
5.3	Has the trust board approved a plan to implement the Maternal Care Bundle by March 2027?	Partially compliant	Chloe Foster	Benchmarking still underway, risks identified with ED MEWS, VTE and Whooley Questions. Benchmarked position being presented to Subcommittee on 7th Sept 2026	Develop and present implementation plan to Perinatal Subcommittee	
6. Ensuring 24/7 safety and responsiveness of services						
6.1	Is the trust complying with the RCOG "Roles and Responsibilities of the Consultant providing acute care" standard? In line with MIS Year 8, is there a minimum ≥80% consultant presence in defined acute care situations?	Partially compliant	Hugh Byrne	Audit in progress for submission to Sept Subcommittee	Re-audit to include all criteria points	
6.2	Is the trust ensuring locum certification and maintaining a local (trust-specific), continuously updated database of all short-term locums (≤2 weeks) working on tier 2/3 obstetric rotas? *(In line with MIS Year 8)*	Compliant	Hugh Byrne	Database exists and sat with service management team. Presented to Perinatal Sub-committee 7th September	Upload evidence	
6.3	Does the trust have a clear plan for a fully funded neonatal nursing and medical establishment that aligns with the relevant BAPM standards for their unit designation and the neonatal nursing workforce calculator output (2020)? *(In line with MIS Year 8)*	Compliant	Anita D'Souza	Action plan completed and shared with Trust Board and ODN		
6.4	Does the trust have a fully funded midwifery establishment that aligns with a Birthrate Plus (BR+) review completed within the last three years as a minimum baseline, with further adjustments based on the professional judgement of the Director and Head of Midwifery? *(In line with MIS Year 8)*	Compliant	Adaline Smith	Report submitted to subcommittee in July 2026		
6.5	Do the trust's obstetric services have a duty anaesthetist available 24/7 in line with ACSA standards 1.7.2.1 and a trained anaesthetic assistant available 24/7 in line with ACSA standards 1.3.1.2? *(In line with MIS Year 8)*	Compliant	Sarah Hammond	Awaiting Evidence for Anaesthetic Assistant. Compliant with 1.7.2.1. Additional anaesthetic assistant evidence presented to Perinatal Subcomittee 7th September	Upload evidence	
6.6	Does the trust board oversee workforce acuity, service pressures and escalation activity across maternity and neonatal services, ensuring they can a) respond to periods of increased demand, reduced workforce availability or changing clinical risk; b) address local gaps and c) eliminate siloed working, so that services can consistently and safely respond to the needs of women, babies and families?	Partially compliant	Paul and Marie	Report presented to subcommittee . In July 2026 awaiting demand and capacity modelling		

6.7	Has the trust board undertaken a review of internal resource deployment, including consideration of a) whether roles not directly supporting frontline delivery can be redirected to strengthen service provision; b) where specialist posts exist (including in bereavement care and infant feeding), what education and training is required to ensure other staff have the knowledge and skills to ensure that care is not compromised when the specialist midwives are not immediately available; c) the impact of redeployment across the service.	Partially compliant	Fiona Walkinshaw	Br plus review identified a small surplus in clinical roles and an equally smal shortfall in specialist roles. This needs to be addressed within the existing funded establishment	Re-review required to address current establishment differences in the November amended Midwifery workforce review	
7. Trust review of homebirth services						
7.1	Has the trust board received, scrutinised and actioned an urgent review of homebirth services in line with the letter of the Chief Midwifery Officer and the regional chief midwife of 26 November 2025?	Partially compliant	Maria Brown	A review was undertaken in November 2025. This now needs to be reviewed an updated as required	Re-review of homebirth review and action plan to ensure up-to-date and accurate to current service.	
7.2	Where significant risks and mitigations have been identified, has an action plan with agreed timescales to mitigate and remove the risks been agreed and shared with the Regional NHSE team?	Compliant	Michelle Cudjoe	To be uploaded to Futures		
8. Responding to incidents, complaints and concerns with humanity and candour						
8.1	Does the trust have the Patient Safety Incident Response Framework (PSIRF) embedded within Maternity and Neonatal Services through clearly defined governance processes? Is the learning, any actions and outcomes regularly reviewed, shared with women and families, and routinely monitored at trust board through board safety reporting?	Compliant	Melissa Claridge	Thematic reviews and a triangulated learning report is shared on a quarterly basis with the Board. This is included in the Quarterly PQOMs The Q1 report will be shared at the next Perinatal Subcommittee		
8.2	Does the trust review complaints and concerns thematically, with learning actions and improvement plans monitored for impact? Are the themes and learning actions routinely reported to the trust board?	Compliant	Melissa Claridge	As above		
8.3	Does the Trust have embedded processes for open learning and compassionate debriefing, with staff supported to engage effectively with women and families, use feedback to inform practice, provide each family with a key contact, and ensure early duty of candour by a senior manager?	Compliant	Melissa Claridge	Each case is allocated a key contact witihn the Governance team. DOC process in place and reviewed at Trust SLT. Birth choices/ reflections led by Consultant Midwives an obstetric consultant and PMAs.	DOC needs to specifically state who is the named contact for patients.	
9. Deliver safe and effective triage in maternity services						
9.1	Has the trust board completed and reported to NHSE regions an audit, including dedicated staffing and clinical capacity with a focus on ensuring that maternity triage services are consistently safe, responsive and appropriately resourced?	Partially compliant	Emma Caldwell/ Jeanette Hennes	Currently being undertaken	Complete and present the audit for Triage resources	
9.2	Does the board have clear oversight of triage quality and performance, supported by regular data on waiting times, assessment and review times, redeployment, delays and outcomes with a focus on inequalities?	Non-compliant	Michelle Cudjoe	Quarterly triage performance to be presented at Perinatal Subcommittee on a quarterly basis and exceptions to board	Present quarterly report of triage performance	
9.3	Is the trust on track to implement improvements in line with national triage guidance to ensure women have consistent access to high-quality, responsive triage across the NHS within 12 months?	Partially compliant	Olivia Harris/ Adaline Smith	Benchmarking done, action plan to be developed and approved	Develop action plan to address gaps for benchmarking	
10. Post death care						
10.1	Has the trust board completed an assurance statement and submitted it by 31 July 2026?	Compliant	Adaline Smith	Report submitted to Periantal Subcommittee and GEC		
10.2	Has the board assured itself that it is continuing regular overersight and implementations of national actions and reccomendations around matters relating to morturaries including review of incident records over the past 10 years?	Compliant	Michelle Cudjoe	On eaction linked to additional CCTV is being explore at SGUH		

on progress against the baseline assessment. Where a deliverable has already been reported as achieved in the baseline
nd should indicate where any progress updates are required.

e or an immediate safety risk; amber where a plan is in place but gaps or risks remain; and green where evidence confirms
sidual risk remains.

Current Status	RAG	Evidence ID *Please input reference number as listed in 3. Evidence Log tab*	Key Gaps / Risks	Improvement action required	Due Date(s)

Evidence Log - Supporting Evidence Submission

The evidence log should be used to list and reference the evidence for each action. The location or link reference should clearly identify where the evidence can be found; assurance notes should explain what the evidence demonstrates. The evidence quality field should indicate whether the evidence is strong, adequate, limited or not available. Evidence may support more than one deliverable where appropriate. Trusts are encouraged to use existing evidence and established governance documentation wherever possible. Trusts should use the minimum evidence necessary to demonstrate assurance.

Log each piece of supporting evidence here. Reference the Evidence ID against the relevant row in the Baseline Assessment and Progress Report as needed. Please note the evidence submitted should be accessible externally (to the trust).

Evidence ID	Action No	Evidence Type	Document / Meeting / Dataset	Date	Owner	Location / Link Reference	Assurance Notes	Evidence Quality
EV-01	3.1	Terms of Reference	Perinatal Subcommitte	8/14/2026	MC			
EV-02	3.2	Minutes	Minutes of Perinatal Subcommittee and Board	8/14/2026	MC			
EV-03								
EV-04								
EV-05								
EV-06								
EV-07								
EV-08								
EV-09								
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EV-29								
EV-30								

Evidence: examples

This section is designed to support trust boards in identifying appropriate evidence to support their assurance assessments. We encourage trusts to make use of existing data sources and processes wherever appropriate to support their assurance. There may also be instances where an individual item e.g. board report may account for evidence against multiple deliverables. The model board report is available for use on the Futures platform . Trusts not already using the model board report may wish to adopt this template.

It should be noted that Trusts are not required to provide all suggested evidence to evidence compliance**. Trust should use the minimum amount of information to demonstrate compliance.**

Action		Deliverable	Suggested evidence
Action 1	1.1	The trust continuing to make progress with rollout of Martha's Rule across maternity and neonatal services?	• Trusts are not asked to submit any evidence for this action as data will be collected via the national Martha's rule programme team. It is however expected that providers attend the launch webinar to undertstand process and next steps and continue work with the Martha's rule team to commence roll out.
Action 2	2.1	The trust continued to operate a monthly cycle of collecting and analysing the latest available maternity and neonatal clinical audit, patient outcome and experience data, including but not limited to, FFT, CQC survey findings when available, local intelligence from MNVPs and targeted outreach?	• Analytical reports
	2.2	The trust board continuing to receive and publish a regular report that brings these sources of intelligence together, and can it demonstrate the decisions, actions or escalation resulting from its scrutiny, including how progress and impact are tracked?	• Board report and minutes
	2.3	The insight and audit data presented by ethnicity and deprivation and does the board scrutinise variation?	• Board report and minutes • Quarterly MIS thematic report
Action 3	3.1	Has the trust board established clear joint accountability for maternity and neonatal services with Medical Directors and Chief Nurses holding a shared responsibility?	• Board ToR • Job plans
	3.2	Do Directors of Midwifery and Clinical Directors leading maternity and neonatal services attend boards and take part in discussions when maternity and neonatal matters are discussed?	• Job plans • Minutes of Executive board meetings
Action 5	5.1	Have staff been released to complete the Perinatal Equity and Anti-Discrimination Programme with full participation across multidisciplinary teams?	• Board report and minutes
	5.2	The trust board regularly reviewing and acting on trends identified by their inequalities data dashboards every 6 months?	• Board report • Quarterly MIS thematic report • Equity dashboard reports • Core20PLUS5 reporting • Maternity equity action plans
	5.3	Is the trust board receiving reviewing and acting on (at the relevant delegated committee) quarterly reports on implementation of the Maternal Care Bundle?	• Maternal Care Bundle implementation plans. • Board Report • MIS return
Action 6	6.1	Is the trust complying with the RCOG "Roles and Responsibilities of the Consultant providing acute care" standard? In line with MIS Year 8 is there a minimum ≥80% consultant presence in defined acute care situations?	• Workforce plan • Biannual workforce papers • Staff experience survey • Cappuccini-style assurance exercise
	6.2	The trust ensuring locum certification and maintaining a local (trust-specific), continuously updated database of all short-term locums (≤2 weeks) working on tier 2/3 obstetric rotas? *(In line with MIS Year 8)*	• Database
	6.3	The trust have a clear plan for a fully funded neonatal nursing and medical establishment that aligns with the relevant BAPM standards for their unit designation and the neonatal nursing workforce calculator output (2020)? *(In line with MIS Year 8)*	• Workforce plan • Biannual workforce papers • BAPM workforce standards compliance • Staff experience survey
	6.4	The trust have a fully funded midwifery establishment that aligns with a Birthrate Plus (BR+) review completed within the last three years as a minimum baseline, with further adjustments based on the professional judgement of the Director and Head of Midwifery? *(In line with MIS Year 8)*	• BR+ review and workforce plan • Biannual workforce papers • Staff experience survey
	6.5	The trust's obstetric services have a duty anaesthetist available 24/7 in line with ACSA standards 1.7.2.1 and a trained anaesthetic assistant available 24/7 in line with ACSA standards 1.3.1.2?	• Workforce plan • Biannual workforce papers • Cappuccini-style assurance exercise
	6.6	Does the trust board oversee workforce acuity, service pressures and escalation activity across maternity and neonatal services, ensuring they can a) respond to periods of increased demand, reduced workforce availability or changing clinical risk; b) address local gaps and c) eliminate siloed working, so that services can consistently and safely respond to the needs of women, babies and families?	• Board report and minutes • Biannual workforce papers • Cappuccini-style assurance exercise
	6.7	Has the trust board undertaken a review of internal resource deployment, including co sideration of a) whether roles not directly supporting frontline delivery can be redirected to strengthen service provision; b) where specialist posts exist (including in bereavement care and infant feeding), what education and training is required to ensure other staff have the knowledge and skills to ensure that care is not compromised when the specialist midwives are not immediately available; c) the impact of redeployment across the service.	• Board report and minutes • Biannual workforce papers • Cappuccini-style assurance exercise
Action 7	7.1	Is the board assured that any actions identified through the urgent review of homebirth services have been completed and services are safe and of high quality?	• Board report and minutes
	7.2	Where significant risks have been identified, have they been communicated with the Regional NHSE team?	• Correspondence
Action 8	8.1	Does the trust have the Patient Safety Incident Response Framework (PSIRF) embedded within Maternity and Neonatal Services through clearly defined governance processes? Is the learning, any actions and outcomes regularly reviewed, shared with women and families, and routinely monitored at trust board through board safety reporting?	• Board report and minutes • A Trust-wide SOP for PSIRF is implemented across Maternity and Neonatal Services • PSIRF implementation within Maternity and Neonatal Services, governance and review processes. • Process for sharing outcomes and learning from PSIRF reviews with women and families. • Mechanisms to identify, monitor and learn from positive practice and areas of improvement.
	8.2	Does the trust review complaints and concerns thematically, with learning actions and improvement plans monitored for impact? Are the themes and learning actions routinely reported to the trust board?	• Board report and minutes • Thematic reviews of complaints and concerns using a learning-focused and inquisitive approach. • Recommendations arising from thematic reviews are monitored, reviewed and acted upon.
	8.3	Does the Trust have embedded processes for open learning and compassionate debriefing, with staff supported to engage effectively with women and families, use feedback to inform practice, provide each family with a key contact, and ensure early duty of candour by a senior manager?	• Board report and minutes • Debrief guidance • Education and Training for Staff involved in debriefing women and families
Action 9	9.1	Has the trust board completed and reported to NHSE regions an audit, including dedicated staffing and clinical capacity with a focus on ensuring that maternity triage services are consistently safe, responsive and appropriately resourced?	• Triage Benchmarking tool completed template
	9.2	Does the trust board have clear oversight of triage quality and performance, supported by regular data on waiting times, assessment and review times, redeployment, delays and outcomes?	• Board paper
	9.3	Is the trust on track to implement improvements in line with national triage guidance to ensure women have consistent access to high-quality, responsive triage across the NHS within 12 months?	• Plan and progress reports
Action 10	10.1	Board assurance statement completed and submitted by 31 July 2026	• Assurance statement
	10.2	Has the board assured itself that it is continuing regular overersight and implementations of national actions and reccomendations around matters relating to morturaries including review of incident records over the past 10 years?	•Board Report •Review report

Group Board

Meeting on Friday, 11 September 2026

Agenda Item	4.1	
Report Title	**Report from Finance and Performance Committee**	
Executive Lead(s)	Azara Mukhtar, GCFO	
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 July and August (3rd September) 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	Choose an item.
Level of Assurance	Limited Assurance: The report and discussions did not provide sufficient assurance that, whilst the system of internal control is adequate and operating effectively, the current financial deficit plan is deliverable without significant improvements.

Appendices	
Appendix No.	**Appendix Name**
Appendix 1	[Add name or delete if not required]
Appendix 2	[Add name or delete if not required]
Appendix 3	[Add name or delete if not required]

Implications

Group Strategic Objectives

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

Risks

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

SR 7 – Timely access to Care

SR2 - Financial Sustainability

CQC Theme

☐ Safe	☒ Effective	☐ Caring	☐ Responsive	☒ Well Led

NHS system oversight framework

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

Financial implications

The Finance and Performance Committee oversees the group finances of both trusts and as such reviews and pursues assurance on both the current year and medium-term plan as well as any business cases, both capital and revenue that falls within its delegated limits.

Legal and / or Regulatory implications

The committee considered the National Oversight Framework ratings for both trusts and the risks for year end cash and performance and reputational issues.

Equality, diversity and inclusion implications

n/a

Environmental sustainability implications

n/a

Finance and Performance Committee Report
Group Board, 11 September 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 July and August (3rd September) 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 31st July and 3rd September 2026, the Committee considered the following items of business:

31st July 2026	3rd September 2026
PUBLIC MEETING • GCFO/DCEO report • IQPR • Deep dive- ESTH Discharges & UEC Oversight Exit Criteria • Integrated Finance report M3 • Medium Term Plan delivery	**PUBLIC MEETING** • GCFO/DCEO report • IQPR • Integrated Finance report M4* • Medium Term Plan delivery • Capital Update

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

2.2 The Committee was quorate for both meetings.

4.0 Sources of Assurance

4.1

a) Integrated Finance Report M4

The Committee noted that both Trusts are on plan at M4. However, the adverse unmitigated year to date position at both Trusts was noted at £11.9m for ESTH and £13.3m for SGH. This had been mitigated by brought forward and additional non-recurrent benefits year to date.

b) Medium-Term Financial plan (MTFP) delivery

There is material pressure on the year end forecast considering the step up in CIP target at M4 and M7. The Group executive remains committed to work to deliver the financial plan as agreed but recognises there are material challenges in achieving that and is working to refine a series of forecast scenarios of risks and mitigations. The GCFO has recommended, and the Committee has agreed, that the current MTFP is focussed on 2026/27 delivery and that this will be amalgamated into the in-year reporting from M5 with the MTFP being refreshed in Q3 when the recurrent exit run rate is more clearly defined. The Finance and Performance Committee reinforced the

need to work towards that and asked for assurance on CIP plans and recurrent exit run rate at its next meeting.

c) Operational Performance

The Committee noted the good work going on across operational performance, with particular focus on urgent and emergency care performance at both organisations. UEC performance was below plan at both organisations although a recovery plan has been developed to support performance against trajectory by the end of Q2.

ESTH and SGUH achieved the three key cancer standards in June 2026. At SGUH, the 62-day cancer standard remains challenged with Radiology workforce pressures presenting a risk to Breast performance, with mitigation plans and recruitment underway.

For non-urgent elective care (RTT), both Trusts delivered their planned performance for June 2026 in relation to 18-week performance and 52-week waits. Whilst RTT performance continues to exceed MTP trajectories across both trusts, risks remain around rising demand, capacity and workforce constraints in key specialties, and reliance on recovery and transformation programmes to sustain progress. These are being actively managed through targeted recovery plans and enhanced operational oversight.

Diagnostic performance at SGH has been impacted by non-obstetric ultrasound that has been heavily impacted by Sonographer shortage with recruitment efforts remaining unsuccessful. Mitigating actions continue to focus on workforce sustainability and capacity optimisation to support service recovery.

Elective access for children's services at Sutton Health and Care remains a challenge, with 52.8% of children waiting 18 weeks or less to start treatment against a target of 78%. Rising demand and increasing complexity continue to drive the long waits in Speech and Language Therapy. A committee deep dive is scheduled for September 2026.

Non-executive directors recognised the significant work being done to deliver performance levels in the current environment.

d) Capital update

The Committee was updated on current progress with capital expenditure, where delays to projects have manifested in significantly lower spend than plan to date. It was agreed that a complete update would be provided to the next Infrastructure Committee on how this would be accelerated.

5.0 Risk Implications

5.1 The Committee did not consider any changes necessary to recommend to Group Board on the BAF operational-related risk SR 7 – Timely access to Care. The score remains '20' and Partial assurance. The target for the March 2028 is '15' and Reasonable assurance.

5.2 The Committee did not consider any changes necessary to recommend to Group Board on the BAF finance risk SR2 - 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 July and August (3rd September) 2026.

Group Board Meeting (Public)

Meeting on Friday, 11 September 2026

Agenda Item	4.2	
Report Title	**Finance Report – Month 4 2026/27**	
Executive Lead(s)	Azara Mukhtar, Group Chief Finance Officer	
Report Author(s)	Azara Mukhtar, Group Chief Finance Officer Robert Chidlow, Site Chief Finance Officer – ESTH George Harford, Site Chief Finance Officer – SGUH	
Previously considered by	Finance & Performance Committee	3 September 2026
Purpose	**For Review**	

Executive Summary

Both organisations remain on plan at M4, albeit using higher levels of non-recurrent measures than planned.

While the trusts remain on plan at month 4 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 and is working to refine a series of forecast scenarios of risks and mitigations. 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 note the paper.

Committee Assurance	
Committee	Group Board (Public)
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. The gaps in assurance are identified and understood.

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

Implications

Group Strategic Objectives

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

Risks

As set out in paper.

CQC Theme

☐ Safe	☐ Effective	☐ Caring	☐ Responsive	☐ Well Led

NHS system oversight framework

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

Financial implications

As set out in paper.

Legal and / or Regulatory implications

As set out in paper.

Equality, diversity and inclusion implications

As set out in paper.

Environmental sustainability implications

N/A

gesh

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

Finance Report M4
Public Board

Date: 10 September 2026

M4 CIP

Reported position to NHSE – mitigations applied

CIP	YTD Plan £'m	Actual £'m	Variance £'m	Annual Plan £'m	Forecast £'m	Variance £'m
Pay - Recurrent	3.99	2.57	(1.42) A	25.02	22.82	(2.20) A
Non-pay - Recurrent	5.18	3.55	(1.63) A	19.52	18.09	(1.43) A
Income - Recurrent	0.79	0.22	(0.58) A	4.45	4.32	(0.13) A
Recurrent Efficiencies	**9.96**	**6.34**	**(3.62) A**	**49.00**	**45.24**	**(3.76) A**
Pay - Non-recurrent	0.82	1.48	0.66 F	6.71	7.85	1.15 F
Non-pay - Non-recurrent	1.35	3.34	1.99 F	6.04	8.72	2.68 F
Income - Non-recurrent	0.16	0.09	(0.07) A	1.41	1.34	(0.07) A
Non-Recurrent Efficiencies	**2.33**	**4.90**	**2.58 F**	**14.16**	**17.92**	**3.76 F**
Total Efficiencies	**12.29**	**11.24**	**(1.05) A**	**63.15**	**63.15**	**(0.00) A**

Efficiency Progress	Pay £'m	Non Pay £'m	Income £'m	Total £'m
Fully Developed	13.57	16.43	1.82	31.82
Plans in Progress	12.54	8.40	2.25	23.19
Opportunity	5.12	1.24	1.78	8.14
Unidentified	0.00	0.00	0.00	0.00
Total	**31.22**	**26.08**	**5.85**	**63.15**

CIP		YTD Plan £m	Actual £m	Variance £m	Annual Plan £m	Forecast £m	Variance £m
Pay - Recurrent		5.67	1.91	(3.76) A	34.03	34.03	0.00 F
Non-pay - Recurrent		4.54	2.55	(1.99) A	27.22	27.22	0.00 F
Income - Recurrent		1.14	1.31	0.17 F	6.81	6.81	0.00 F
Recurrent Efficiencies		11.34	5.76	(5.58) A	68.06	68.06	0.00 F
Pay - Non-recurrent		1.89	3.95	2.06 F	11.35	11.35	0.00 F
Non-pay - Non-recurrent		1.51	2.88	1.36 F	9.08	9.08	0.00 F
Income - Non-recurrent		0.37	0.56	0.19 F	2.27	2.27	0.00 F
Non-Recurrent Efficiencies		3.78	7.39	3.62 F	22.70	22.70	0.00 F
26-27 CIP		**15.12**	**13.15**	**(1.97) A**	**90.75**	**90.75**	**0.00 F**
FYE25-26 (Recurrent)		4.60	4.60	0.00 F	13.80	13.80	0.00 F
NHSE CIP metric		**19.72**	**17.75**	**(1.97) A**	**104.55**	**104.55**	**0.00 F**

Efficiency Progress	Pay £m	Non Pay £m	Income £m	Total £m
Fully Developed	12.58	13.66	6.30	32.54
Plans in Progress	20.14	16.81	5.55	42.51
Opportunity	11.21	2.67	1.83	15.71
Unidentified				0.00
Total	**43.93**	**33.14**	**13.67**	**90.75**

CIP commentary

ESTH

- ESTH has not fully delivered its CIP in month 4, with slippage of £1.1m against planned transformation schemes.
- The Trust is £3.62m adverse on recurrent CIP efficiencies, partially offset by £2.58m favourable position on non-recurrent efficiencies.
- 50% of ESTH CIP is now fully developed across BAU in divisions and transformation programmes.
- Of the BAU 5% CIP within divisions, 60% is now fully developed, with a further 17% plans in progress. There remains £8m (21%) of opportunity to be developed into schemes.
- Divisions continue to present their schemes to the ESTH SLT Financial Recovery Board which meets on a weekly basis.
- Planned care and Medicine divisions have £5m of schemes to identify. Within Corporate divisions, Estates and Facilities are £1m short on developed schemes, but have over delivered in the year to date with the benefit of non recurrent climate levy reimbursements.

SGH

- SGH has not fully delivered its CIP in month 4, with slippage of £1.46m against planned transformation schemes and £0.50m against BAU target meaning a £1.97m variance overall.
- The Trust is £5.58m adverse on recurrent CIP efficiencies, partially offset by £3.62m favourable position on non-recurrent efficiencies.
- 36% of SGH CIP is now fully developed across BAU in divisions and transformation programmes.
- Of the BAU 5% CIP within divisions, 52% is now fully developed, with a further 16% plans in progress. There remains £16m (32%) of opportunity to be developed into schemes.
- Divisions continue to present their schemes to the Thursday Site review meetings which meet on a weekly basis.
- The three main clinical divisions have £19m of schemes to identify. Within Corporate divisions, Estates and Facilities are £1.5m over on total schemes with a shortfall of £2.6m in Other Corporate.

M4 ESTH

Reported position to NHSE – mitigations applied

M4 Commentary

The Trust was on plan in July, however on an underlying basis the Trust is adverse by £3.2m in month:

- £1.1m adverse on transformation CIP mitigated by slippage on the cost of delivery;
- £0.54m underlying planning gap, £1.1m baseline pressures, £0.25m SWL pathology and Soft FM pressure mitigated by NR income brought forward, £1.4m VAT rebate, £0.8m mental health patient income and further inflation and cost reserve release.

Performance £'m	YTD Plan	Actual	Variance	Annual Plan	Forecast	Variance
Income	249.19	254.67	5.48 F	750.20	752.17	1.97 F
Total Pay	**(170.97)**	**(175.12)**	**(4.15) A**	**(503.75)**	**(504.95)**	**(1.20) A**
Non-Pay	(83.22)	(84.62)	(1.39) A	(239.13)	(239.82)	(0.68) A
Non Operating Items	(2.44)	(2.37)	0.07 F	(7.32)	(7.40)	(0.08) A
Performance Target	**(7.44)**	**(7.44)**	**0.00 F**	**0.00**	**0.00**	**0.00 F**
DSF	(11.44)	(11.44)	0.00 F	(34.33)	(34.33)	0.00 F
Excluding DSF	**(18.89)**	**(18.89)**	**0.00 F**	**(34.33)**	**(34.33)**	**0.00 F**

Workforce	YTD Plan £'m	Actual £'m	Variance £'m	Annual Plan £'m	Forecast £'m	Variance £'m
Substantive	(150.73)	(151.83)	(1.10) A	(453.61)	(454.01)	(0.40) A
Bank	(18.13)	(21.14)	(3.01) A	(46.34)	(47.14)	(0.80) A
Agency	(1.42)	(1.46)	(0.04) A	(3.80)	(3.80)	0.00 F
Total	**(170.97)**	**(175.12)**	**4.15 A**	**(503.75)**	**(504.95)**	**1.20 A**

Workforce	YTD Plan WTE	Actual WTE	Variance WTE	Move From M3 WTE	Plan M12 26-27 WTE	Move to M12 Plan WTE
Substantive	6,413	6,388	25 F	33 F	6,396	8 F
Bank	756	923	(167) A	-23 A	842	(81) A
Agency	53	41	12 F	13 F	44	3 F
Total	**7,222**	**7,352**	**(130) A**	**23 F**	**7,282**	**(70) A**

YTD Commentary

Income

- Income is £5.5m favourable YTD, with patient care income £5.6m favourable and other operating income £0.2m adverse.
- Patient Care income is favourable due to the bringing forward of non recurrent income and the release of provisions post contract agreement which had mitigated risk of claw back of prior year and £0.8m for a mental health patient which has been billed to commissioners in respect of being in ESTH care in excess of 12 months which continues to be an inappropriate care setting for their needs.
- Other Operating Income is driven by undelivered CIP

Non pay & Non-Operating Items

- Non-Pay & Non-Operating items are £1.4m adverse YTD. This is driven by £1.8m on clinical supplies of which £0.5m is in Theatres and £0.3m in Renal; £1.1m on drugs of which £0.7m is in Medicine. These overspends are mitigated by non pay reserve slippage. This is offset by £2.1m favourable variance due to the delay in TUPE

Pay and workforce

- Pay is £4.2m adverse to plan YTD of which bank spend is £3.0m adverse with £0.7m due to industrial action. The Trust's bank expenditure is driven by growing Nursing Enhanced care costs (£0.6m in July).
- Medicine division is £2.4m adverse across all specialties and Planned Care is £0.7m adverse. Substantive is £1.1m adverse and agency is marginally over plan.
- ESTH bank spend as a proportion of pay of 12% continues to be an outlier to SWL (7.8%) and London (7.2%) averages.
- Trust is 130 WTE adverse to plan in M4, 70 WTE is due to a shortfall in TUPE to St Georges which has only been 30 WTE out of the planned 100 WTE so far. This has caused a unfavourable variance of £2.1m offset by non pay.
- The movement from M3 of 23 is due to reduced agency and substantive.
- A reduction of 70 WTE is required to deliver the year end WTE plan, although this is not adjusted for TUPE shortfall.

M4 SGH

Reported position to NHSE – mitigations applied

M4 Commentary

The Trust is on plan in month although CIP is £2.0m adverse offset by Non-CIP mitigations. The Trust is forecasting being on plan for the year end in line with NHSE expectations. On an underlying basis the Trust is adverse by £5.0m:

- £2.9m adverse on recurrent CIP and
- £0.3m adverse on planned non recurrent CIP (mitigated by £1.2m of central non-recurrent CIPs released from cost pressure/inflation reserves to ensure the overall CIP variance is £2.0m adverse).
- £1.8m baseline pressure, mitigated by £1.8m NR benefit phasing, £1.7m NR technical stretch and £0.2m of further inflation release (hence non-CIP is £2.0m favourable).

Performance	YTD Plan £m	Actual £m	Variance £m	Annual Plan £m	Forecast £m	Variance £m
Income	435.39	434.57	(0.82) A	1,308.61	1,308.61	0.00 F
Total Pay	(283.93)	(282.11)	1.82 F	(828.05)	(828.05)	0.00 F
Non-Pay	(158.98)	(159.98)	(1.00) A	(460.16)	(460.16)	0.00 F
Non Operating Items	(7.06)	(7.06)	0.00 F	(20.40)	(20.40)	0.00 F
Performance Target	**(14.58)**	**(14.58)**	**0.00 F**	**0.00**	**0.00**	**0.00 F**
DSF	(7.21)	(7.21)	0.00 F	(21.63)	(21.63)	0.00 F
Excluding DSF	**(21.79)**	**(21.79)**	**0.00 F**	**(21.63)**	**(21.63)**	**0.00 F**

Workforce YTD	YTD Plan £m	Actual £m	Variance £m	Annual Plan £m	Forecast £m	Variance £m
Substantive	(264.68)	(261.35)	3.33 F	(776.37)	(775.50)	0.87 F
Bank	(15.59)	(18.15)	(2.56) A	(42.39)	(43.26)	(0.87) A
Agency	(2.58)	(1.55)	1.03 F	(6.04)	(6.04)	0.00 F
Other Pay	(1.08)	(1.07)	0.02 F	(3.25)	(3.25)	0.00 F
Total	**(283.93)**	**(282.11)**	**1.82 F**	**(828.05)**	**(828.05)**	**0.00 F**

Workforce	YTD Plan WTE	Actual WTE	Variance WTE	Move from M3 WTE	Plan M12 26-27 WTE	Move to M12 plan WTE
Substantive	10,209	10,119	90 F	7 F	10,084	(35) A
Bank	753	763	(9) A	(58) A	787	24 F
Agency	24	54	(31) A	4 F	52	(2) A
Total	**10,986**	**10,936**	**50 F**	**(48) A**	**10,923**	**(13) A**

YTD Commentary

Income

- Income is £0.8m adverse YTD, with patient care income £2.9m favourable and other operating income £3.7m adverse. Underlying Income pre-mitigation is £2.9m adverse.
- Patient Care income is driven by £0.8m industrial action income recognition, £1.6m of brought forward non-recurrent benefits and £0.5m of additional technical benefits.
- Other Operating Income is driven by £2.1m TUPE income not received from ESTH (offset by pay) and £1.6m of income underperformance offset by costs underspends driven by R&I/SWLP/Commercial Pharmacy.

Non pay & Non-Operating Items

- Non-Pay & Non-Operating items are £1.0m adverse YTD. This is driven by £0.8m of undelivered CIP target, £1.1m of energy costs increases from the War in the Middle East and other Corporate costs, and £2.2m of pressures in Medicine and Surgery divisions, partially offset by £1.0m release of non-pay inflation, £1.6m of brought forward non-recurrent benefits and £0.5m of additional technical benefits.

Pay and workforce

- Pay is £1.8m favourable to plan YTD due to £2.1m of brought forward non-recurrent benefits, £0.7m of additional technical benefits, £2.1m of TUPE expenditure not incurred from ESTH (offset in income) and £0.6m of favourable R&I/SWLP variance offset in other income. This is partially offset by £1.0m under-delivery of CIP, £0.8m of Industrial Action costs, £1.1m of medical pay pressures and £1.0m of ward nursing pressures.
- Substantive and Agency are below plan, although bank remains ahead of plan owing in part to M1 industrial action.
- Trust is 50 WTE favourable to plan in M4. The variance is mainly explained by TUPE shortfall of 65 WTE partially offset by under-delivery of CIP WTE.
- The movement from M3 of 48 is due to a deterioration in bank WTE.
- A reduction of 13 WTE is required to deliver the year end WTE plan, although this is not adjusted for TUPE shortfall.

Group Board

Meeting on Friday, 11 September 2026

Agenda Item	4.3	
Report Title	**Group Integrated Quality & Performance Report (IQPR)**	
Executive Lead(s)	Michael Pantlin, Group Deputy Chief Executive Officer	
Report Author(s)	Ed Nkrumah, Group Director of Performance & PMO	
Previously considered by	Finance & Performance Committees	03 September 2026
Purpose	**For Review**	

Executive Summary

Oversight and Assurance

The supporting guidance and data relating to the NHS Oversight Framework (NOF) for 2026/27 published in June 2026 are yet to be released. Locally, the readiness assessment continues with updates to the Integrated Quality and Performance Report (IQPR) where data is available.

ESTH remains under Level 3 Oversight (enhanced regional oversight) for Urgent and Emergency Care performance. The next monthly meeting with NHSE taking place on 26 August will focus on progress against the oversight exit criteria metrics and 4-hour performance recovery actions.

Preparations for the next quarterly NHS Oversight Framework meeting with NHSE on 18 September has commenced. The meeting will cover finance, workforce, access, quality and safety, and merger.

Patient Safety

In July 2026, no Never Events were reported across gesh. One Patient Safety Incident Investigation (PSII) was declared at SGUH, relating to a neonatal death on the Delivery Suite. The PSII concerns learning and guidance on the use of AmniSure in the diagnosis of possible preterm spontaneous rupture of membranes (SROM) and bleeding in pregnancy. The investigation is underway, led by an independent panel chair with an external reviewer.

At SGUH, Category 3 pressure ulcers remain elevated, with twelve Category 3 and zero Category 4 cases reported, four of which were acquired within Critical Care areas. A review meeting has been arranged to identify themes, share learning and support improvement. At ESTH, a reduction in pressure ulcers has been observed, with two Category 3 and zero Category 4 cases recorded in July 2026. Themes identified to date include variation in the completion of skin assessments, delayed recognition of deterioration, and opportunities to strengthen escalation processes.

At Sutton, Category 3 and 4 pressure ulcers had previously increased, driven by higher Tissue Viability Nurse activity in complex reviews, escalation from care homes and more consistent reporting. July 2026 shows an improved position, suggesting early impact from actions including monthly

Pressure Ulcer Assurance meetings, strengthened PCN clinical leadership and embedded preventative practices.

VTE risk assessment compliance at SGUH and ESTH remained below the 95% target in July 2026. Revised NHSE guidance on measuring compliance against the 14-hour assessment requirement, changing the start point from ward admission to decision to admit takes effect from July 2026, with a submission date of October 2026. This is likely to adversely affect performance at both sites. Across gesh, several actions are underway to mitigate this impact, including a shared digital VTE risk assessment tool developed to improve compliance, continued work to improve Medication Administration Tool (MAT) compliance with a focus on underperforming areas, and VTE lead clinicians working with key stakeholders to jointly understand the challenges and support further development.

At the same time, work continues to improve delirium screening and assessment rates for patients aged 65 and over. Collaborative work between the Dementia and Delirium Clinical Nurse Specialists (CNS) and the Frailty Consultants, focused sessions on delirium assessment for both acute medical units at the start of July 2026, and the planned relaunch of John's Campaign including a QIP to improve completion of hospital passports have contributed to a much-improved position at both SGUH and ESTH in July 2026.

Effectiveness of Care

The Summary Hospital-level Mortality Indicator (SHMI) shows that the mortality rate for the 12 months to March 2026 has moved into the "Higher than Expected" range for ESTH. This change appears to be driven by a reduction in the expected death rate, while observed deaths remain broadly stable. The timing suggests a potential link to the EPR go-live. The implementation may have affected the patient risk profile captured in the SHMI dataset, including clinical documentation practices, coding depth and accuracy, comorbidity capture, diagnosis coding, and the iClip-to-HES data interface. Further investigation and data analysis are required to confirm the underlying root cause(s).

Patient Experience

Both SGUH and ESTH delivered 100% acknowledging complaints within 3 working days in July 2026 and

90% of complaints were responded to within 35 working days at SGUH, and 84% at ESTH against the target of 85%. Improvement plans are in place to address workforce capacity pressures, strengthen divisional ownership and improve the timeliness and quality of responses.

There remains an ongoing challenge with Friends and Family Test (FFT) response rates across both sites, particularly at ESTH, where implementation of iClip and GATHER has significantly impacted participation rates, which remain below pre-implementation levels. Work underway includes a review of ESTH outpatient activity codes within FFT text messages and comparative analysis of text messaging volumes across SGUH and ESTH. Given the scale of change required, sustained improvement is likely by April 2027.

Operational Performance

ESTH and SGUH achieved the three key cancer standards in June 2026. At SGUH, the 62-day cancer standard remains challenged with Radiology workforce pressures presenting a risk to Breast performance, with mitigation plans and recruitment underway.

For non-urgent elective care (RTT), both Trusts delivered their planned performance for June 2026 in relation to 18-week performance and 52-week waits. The proportion of patients treated within 18

weeks improved, while fewer than 1% of patients were waiting longer than 52 weeks, reflecting the sustained delivery of the substantial gains achieved over the past year. Whilst RTT performance continues to exceed MTP trajectories across both trusts, risks remain around rising demand, capacity and workforce constraints in key specialties, and reliance on recovery and transformation programmes to sustain progress. These are being actively managed through targeted recovery plans and enhanced operational oversight.

At ESTH, following the impact of the earlier iCLIP innovation release, the RTT PTL size continued to reduce in June 2026 and, despite remaining above trajectory following EPR-related impacts, the Trust remains on track to deliver its trajectory for 2026/27.

Diagnostic performance at SGUH is significantly below plan, driven by non-obstetric ultrasound that has been heavily impacted by Sonographer shortage with recruitment efforts remaining unsuccessful. Mitigating actions continue to focus on workforce sustainability and capacity optimisation to support service recovery.

Elective access for children's services at Sutton Health and Care remains a challenge, with 52.8% of children waiting 18 weeks or less to start treatment against a target of 78%. Rising demand and increasing complexity continue to drive the long waits in Speech and Language Therapy. However, there has been progress in reducing children's long waits, with 52+ week waits falling from 106 in June 2026 to 79 at the end of July 2026. Harm reviews are ongoing, and an improvement plan is in place alongside a system health pathway review (gesh-Sutton Alliance Board-SHC).

For Urgent and Emergency Care (UEC), SGUH delivered 79.3% against the ED 4-hour standard in July 2026, below plan due to persistent flow pressures and delays in mental health bed availability. Targeted operational, workforce and system-wide actions are in place to address these challenges, with performance expected to recover to trajectory during August 2026. Performance at ESTH remains challenged delivering a performance of 67.8% which was below revised 72% plan. Performance has recently been impacted by 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. An Urgent Emergency Care (UEC) recovery plan has been developed to support performance against trajectory by the end of Q2.

The 2-hour urgent community response target of 70% was met at both Surrey Downs and Sutton Health Care. Improvement work within the *Home from Hospital* model is underway to enhance productivity, efficiency, and performance. At Sutton Health, service adjustments are being implemented alongside ongoing improvement initiatives which will support sustained performance from September 2026

Sickness absence levels remain high across gesh, adversely impacting performance, quality and efficiency. The sickness absence improvement programme (SAIP) is progressing which will support sustainably reduced absence rates.

Action required by Group Board

The Group Board is asked to note this paper.

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

Appendices	
Appendix No.	**Appendix Name**
Appendix 1	None

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				
N/A				
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)

July 2026

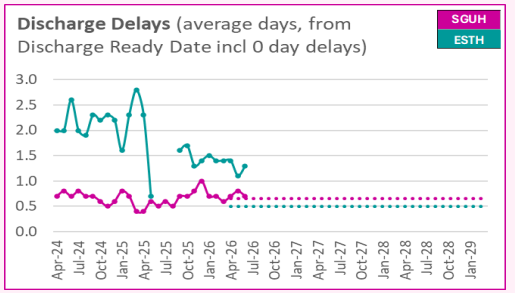
Email: gesh.performance@stgeorges.nhs.uk

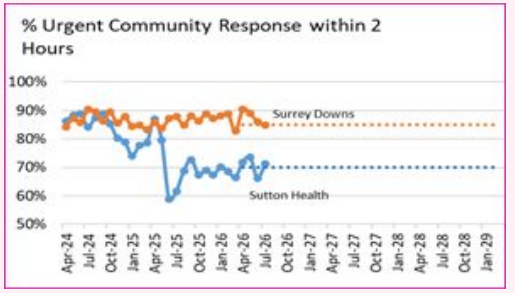
Our Strategy | Medium-Term Plans | Board to Ward Priorities

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

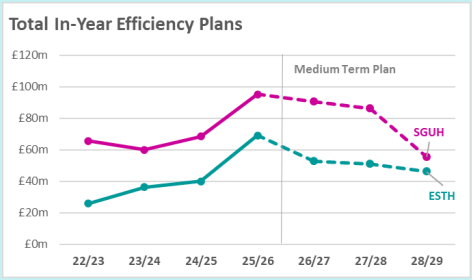
Board to Ward Priorities for 2026/27: Board Objectives

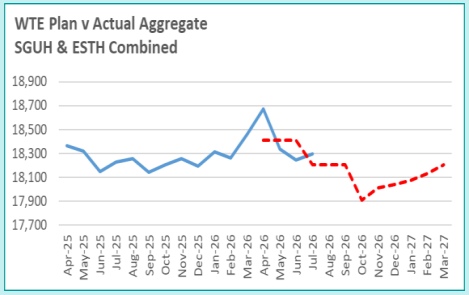
Work with other teams to reduce delays in patient journeys through our services: optimise admission avoidance services and reduce delayed discharges to top-quartile performance





Live within our means, reducing our costs: Deliver the Efficiency Programme



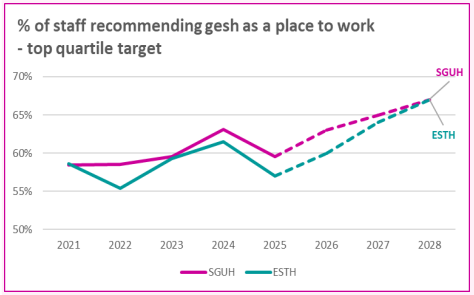


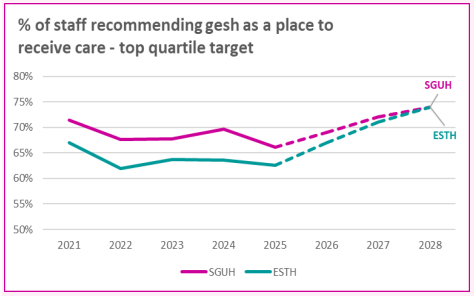
Minimise risk of harm from delays in care: Work towards eliminating Corridor Care & RTT Long Waits

Emergency Department Corridor Care (Average daily count)

	July 2026 Actual	2026/27 Plan	Medium Term Plan
SGUH	22	tbc	Corridor care elimination timeline under review
ESTH	36	30	Corridor care elimination timeline under review

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.





Executive Summary
Safe, High-Quality Care

St George's Hospital

- **Never Events:** There were no Never Events declared in July 2026
- **Patient Safety Incident Investigations (PSII)** - One PSIIs was declared in July 2026, relating to a Neonatal death on the Delivery Suite and the Learning and guidance on the use of AmniSure in the diagnosis of possible preterm spontaneous rupture of membranes (SROM) and bleeding in pregnancy. This has been disseminated using the Safety Spotlight.
- **VTE Risk Assessments:** Assessment rates remain below the 95% national target at 86.8%. Revised NHSE measurement guidance is expected to affect reported performance from Q2. The gesh thrombosis groups are implementing improvements to digital workflows to support increased compliance.
- **Pressure Ulcers:** In July 2026, there were twelve category 3 pressure ulcers. Of these twelve, four were in Critical Care areas. These are being investigated within the clinical areas.
- **SHMI:** Remains as expected. Recent increases relate to the migration of Same Day Emergency Care activity data to the Emergency Care Dataset (ECDS) as expected.
- **Delirium Assessments:** Subject matter experts continue to work with medical colleagues to support use of the delirium assessment as part of usual admissions processes. Findings of a recent audit will be shared in August 2026.
- **Infection Control**: Neonatal Unit (NNU) MRSA Outbreak: 12 colonised cases identified since December 2025, with the last positive case on 6 May 2026. No clinical infections reported. Programme of decant/ refurbishment works/ cleaning including HPV completed across all HDUs and ITUs.
- **Complaints:** In July 2026 90% of complaints were responded to within 35 working days at SGUH and the recent increase in formal complaints is driven by multiple factors. An action plan remains in place to address staffing shortfalls and restore targets.
- **Friends and Family Test:** Scores show normal variation and remain comparable with peer organisations. While response rates in some areas are below expectations, work is underway to review targets and identify opportunities to improve engagement, supporting progress towards our ambitions for the year.

Epsom & St Helier

- **Never Events and PSIIs:** There were no Never Events or PSIIs declared in July 2026
- **VTE Risk Assessments:** Assessment rates remain below the national 95% target, at 81.6% in July 2026. Review of discrepancies within low-risk cohort completed with changes proposed awaiting approval. Progress remains limited however, a Trust-wide prevention audit has now been completed, with results pending. Revised NHSE measurement guidance is expected to impact performance from Q2.
- **Pressure Ulcers:** There were two category 3 pressure ulcers and zero category 4 pressure ulcers in July 2026. This is a sudden increase in these categories of pressure ulcer. Concerns were raised in May regarding the impact of changes to hybrid mattresses, and a review is currently underway to assess any potential contributing factors. Current themes identified include inconsistencies in skin checks and late identification and escalation of skin damage.
- **SHMI–** The SHMI index is now in the "higher than expected" range. This appears to be due to a lower expected death rate rather than an increase in actual deaths, which have remained stable. Further analysis is needed to understand the cause.
- **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. NICU MRSA outbreak involving two babies, all babies on the unit screened, no new cases identified. Awaiting strain type to confirm linkage.
- **Delirium Assessments:** Improvement and Educational work is ongoing with collaboration between the Dementia and Delirium Clinical Nurse Specialist and a Frailty Consultant. An audit of assessment completion in patient notes took place in July 2026.
- **Complaints:** Complaints responded to within 35 working days increased to 84% in July 2026; however, this remains below target. An action plan remains in place to drive further improvement.
- **Friends and Family Test** scores remain broadly in line with peer organisations, while response rates remain low in areas. Proposed internal targets and trajectories are being discussed to support delivery of our annual ambition.

Executive Summary

Operational Performance & Productivity

St George's Hospital

Successes

- Performance continues to outperform Medium Term Plan (MTP) trajectories for Referral to Treatment (RTT) and 52-week waits. Focus remains on sustaining progress through productivity-led transformation, supported by specialty-level RTT improvement plans and enhanced oversight through close monitoring of key performance metrics.
- All cancer performance standards against MTP were achieved in June 2026: 84.8% for 28-day Faster Diagnosis Standard and 79.5% for 62 Day pathway .
- Theatre utilisation remains in the top national quartile, with ongoing work to reduce variation and improve consistency across specialties.
- Progress has been made on the DNA reduction programme, with four initiatives progressing to pilot phase to improve attendance and maximise capacity.
- Three transformation programmes are supporting the transition into winter, including a NEL programme aligned to GIRFT and NHS England guidance to eliminate corridor care through coordinated system initiatives

Challenges

- Cancer performance remains challenged within Upper Gastrointestinal services, although the endoscopy backlog continues to reduce. Radiology workforce pressures present a risk to Breast performance, with mitigation plans and recruitment underway
- Diagnostics Waits: performance remains challenged by capacity constraints and workforce shortages across key services, particularly Ultrasound, creating a risk to MTP delivery in the coming months. Mitigating actions remain focused on strengthening workforce capacity and maximising service resilience through recruitment, retention, and additional capacity solutions.
- July 2026 four-hour performance improved to 79.3%, although remained below plan. A range of operational, workforce and system-wide improvement initiatives are being implemented to address flow and capacity challenges, with performance expected to meet plan during August 2026.
- Length of stay remains above target, but improvement is expected through NHSE-aligned corridor care reduction initiatives as part of the gesh Non-Elective Transformation Programme.
- Recruitment of the Outpatient Transformation Project Manager will provide dedicated leadership to drive the Patient-Initiated Follow-Up programme. Work is underway to increase uptake through pathway expansion, validation and wider pilot programmes, supported by a standardised Group-wide approach.

Epsom & St Helier

Successes

- All cancer performance standards were achieved in June 2026: 87.6% for 62 day and 91.6% for 28-day Faster Diagnosis Standard.
- RTT performance improved again in June 2026 (66.9%), exceeding the 66.1% Medium Term Plan trajectory. The Trust also overachieved the end-of-June 2026 52-week wait target, with 513 patients waiting over 52 weeks for treatment, against a target of 531.
- Diagnostic performance remained stable in June 2026 (6.2%), continuing to over-achieve the 8.4% Medium Term Plan trajectory.
- Theatre utilisation remains above 80%, supported by the Theatre Huddle, revised performance meeting proforma and refreshed Golden Patient initiatives.
- PIFU remains above the national target of 5% in June 2026, achieving 6.1%,.
- DNA rates remain stable, and we are evaluating the potential introduction of DNA calling, beginning with a pilot in Cardiology
- Ambulance handovers exceeding 45 minutes fell to 2.5% in July 2026, improving from 4.1% in June and significantly outperforming the 6% target. This was supported by a continued reduction in average handover times, which decreased by a further 2 minutes to 20 minutes during July 2026.
- Non-Elective length of stay reduced by a further 0.5 days from 11 days in June 2026 to 10.5 days in July 2026, exceeding planned annualised trajectory by 0.4 days

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
- 4-hour performance remained static at 67.8% in July 2026, which is off trajectory against the revised plan of 72% for July 2026. Recent deterioration in performance is driven by the decommissioning of Emergency department Same Day Emergency Care (SDEC) and a move to the Urgent Treatment Centre (UTC) first model. An Urgent Emergency Care (UEC) recovery plan has been developed to support performance against trajectory by the end of Q2.
- Average daily corridor count reduced from 39 to 36, whilst this is above the ambition this is representative of the focused action plans in place to reduce corridor care across both sites.
- The gesh-wide Non-Elective Transformation Programme is currently underway, underpinned by complementary ESTH and Place-based initiatives. The programme will enable delivery of the 2026/27 Urgent and Emergency Care (UEC) Transformation workstreams while maintaining alignment with national, regional, and local priorities.

Executive Summary
Integrated Care Services

Quality & Safety

A slight decrease in Category 3 pressure ulcers across Sutton Health and Care (SHC) and Surrey Downs Health and Care (SDHC) as plans are implemented across areas of concern and practice This overseen via enhanced clinical leadership and oversight. A deep dive has been completed and will be presented at the September 2026 ESTH Patient Safety Quality Group (PSQG)

Sutton Health & Care (SHC) Specific

- Safety and control indicators – no incidence of MRSA, *C. difficile and* E. coli . Reablement ward IPCC remains an area of concern on Ward Accreditation – but improving .
- Patient Experience Review demonstrated strong overall performance, with an average 98% patients rating services as good or very good. However, engagement is low overall.
- Primary themes around complaints received are 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 occurrence reported in July 2026.
- The annual Patient Experience Review demonstrated strong overall performance, with an average of 96.2% of patients rating services as good or very good.
- Primary themes around the complaints received are 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 July 2026, 2-hour Urgent Community Response (UCR) performance exceeded plan achieving 71.2%. Recent variation in performance against plan has been driven by the implementation of the SWL Integrated Care Coordination Hub, which has resulted in a greater proportion of referrals being received later in the day.
- The decrease in Virtual Ward admissions and lower occupancy rates 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 high, with an improvement plan and wider pathway review underway. Demand continues to be impacted by increasing complexity of need. At the end of July 2026, 79 children had waited over 52 weeks seeing a positive improvement, while 52.8% were seen within 18 weeks. Harm reviews continue to support patient safety.

Surrey Downs Health & Care (SDHC)

- 2 –hour Urgent Community Response (UCR) performance remains strong, achieving 84.8% in July 2026.
- Waiting list performance remains strong; however, demand for services is increasing and there are staffing challenges in some specialist roles, such as Podiatry.

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	Benchmark
Never Events	Jul 26	2	0	0			N/A
Patient Safety Incident Investigations	Jul 26	2	1	0			N/A
Moderate and Severe Harm from Falls	Jul 26	4	0	2			N/A
Pressure Ulcers - Acquired Category 3	Jul 26	6	12	7			N/A
Pressure Ulcers - Acquired Category 4	Jul 26	1	0	0			N/A
Infection Control - Number of MRSA	Jul 26	0	0	0			2nd Quartile
C.difficile infections versus threshold (rolling 12 months)	Jul 26	46	46	43			3rd Quartile
Ecoli infections versus threshold (rolling 12 months)	Jul 26	100	97	107			2nd Quartile
Delirium Assessment (Medical) Compliance 65+ within 24 hours of admission	Jul 26	6.5%	8.3%	-		-	N/A
30-Day Emergency Readmission Rate	Jun 26	8.6%	8.2%	-		-	N/A
VTE Risk Assessment	Jul 26	85.7%	86.8%	95.0%			Lowest Quartile
Mortality - SHMI	Mar 26	0.93	0.95	-		-	As Expected
Complaints - Responded to within 35 working days	Jul 26	77.2%	90.0%	85.0%			N/A
Complaints - Acknowledgement within 3 working days	Jul 26	99.2%	100.0%	100.0%			N/A
Number of complaints not completed within 6 months from date of receipt	Jul 26	4	4	0			N/A
Friends and Family Test - Inpatients Score	Jul 26	98.0%	98.0%	-		-	N/A
Friends and Family Test - Emergency Department Score	Jul 26	75.1%	75.1%	-		-	N/A
Friends and Family Test - Outpatients Score	Jul 26	95.1%	95.1%	-		-	N/A
Friends and Family -Inpatient Response Rate	Jul 26	31.4%	34.2%	-		-	N/A
Friends and Family -Emergency Department Response Rate	Jul 26	9.2%	7.2%	-		-	N/A
Friends and Family - Outpatient Response Rate	Jul 26	10.3%	8.1%	-		-	N/A

Epsom & St Helier

Latest Month	Previous Month Measure	Latest Month Measure	Target	Variation	Assurance	Benchmark
Jul 26	1	0	0			N/A
Jul 26	0	0	0			N/A
Jul 26	2	0	1			N/A
Jul 26	3	2	5			N/A
Jul 26	1	0	0			N/A
Jul 26	1	0	0			3rd Quartile
Jul 26	48	45	46			2nd Quartile
Jul 26	59	61	54			2nd Quartile
Jul 26	9.6%	19.2%	-		-	N/A
Jun 26	12.8%	12.5%	-		-	N/A
Jul 26	88.4%	83.4%	95.0%			Lowest Quartile
Mar 26	1.16	1.17	-		-	Higher than Expected
Jul 26	73.0%	84.0%	85.0%			N/A
Jul 26	99.0%	100.0%	100.0%			N/A
Jul 26	3	4	0			N/A
Jul 26	93.0%	93.0%	-		-	N/A
Jul 26	75.9%	75.0%	-		-	N/A
Jul 26	93.0%	93.0%	-		-	N/A
Jul 26	11.0%	11.0%	-		-	N/A
Jul 26	1.0%	4.0%	-		-	N/A
Jul 26	4.0%	3.67%%	-		-	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	Jul 26	1.6%	3.9%		3.3%	Jul 26	2.9%	2.6%		3.1%
% Births Post Partum Haemorrhage >1.5 L	Jul 26	4.4%	6.1%		3.0%	Jul 26	3.9%	3.1%		3.0%
Stillbirths per 1,000 births rolling 12 months	Jul 26	2.6	2.6	L	3.5	Jul 26	0.00	0.00		2.85
Neonatal deaths per 1,000 births rolling 12 months	Jul 26	4.5	5.0	H	2.4	Jul 26	0.00	0.00		1.12
Maternal Deaths	Jul 26	0	0	-	N/A	Jul 26	0	0	-	N/A
ITU Admissions	Jul 26	0	0	L	N/A	Jul 26	1	1	-	N/A
HIE (Hypoxic ischaemic encephalopathy) per 1000 births and rolling 12 months	Jul 26	0.7	0.7	H	N/A	Jul 26	0.9	0.6	H	N/A
PSII- National Reporting (MNSI referrals)	Jul 26	0	0	-	N/A	Jul 26	0	0	-	N/A
PSII – Local PSIIs	Jul 26	0	1	-	N/A	Jul 26	0	0		N/A
Friends and Family Test - Maternity Births Score	Jul 26	100.0%	100.0%		N/A	Jun 26	100.0%	100.0%		N/A
Friends and Family - Maternity Births Response Rate	Jul 26	0.5%	0.5%	L	N/A	Jul 26	5.2%	2.0%		N/A
Maternity Appraisal Rate	Jul 26	73.5%	75.0%	-	N/A	-	-	-	-	N/A
Maternity Vacancy Rate	Jun 26	7.9%	7.9%	-	N/A	-	-	-	-	N/A
Maternity Turnover Rate	Jun 26	8.0%	8.1%	-	N/A	-	-	-	-	N/A

Maternity PSIIs are a subset of total Trust PSIIs
Metrics '-' work in progress
Maternity: data quality issues identified and are being worked through with the Maternity and BI Team

Integrated Care Quality Dashboard

Patient Safety and Experience

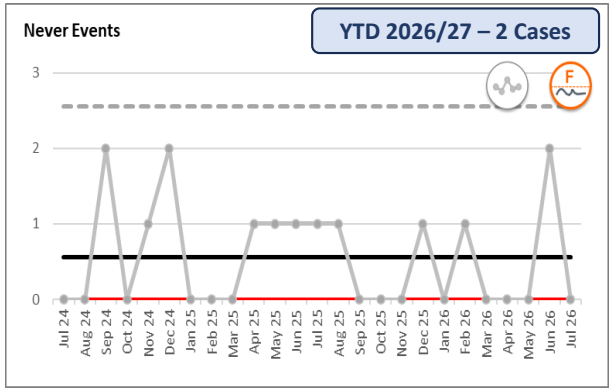
KPI	Sutton Healthcare Latest month	Sutton Healthcare Previous Month Measure	Sutton Healthcare Latest Month Measure	Sutton Healthcare Target	Sutton Healthcare Variation	Sutton Healthcare Assurance	Surrey Downs Latest month	Surrey Downs Previous Month Measure	Surrey Downs Latest Month Measure	Surrey Downs Target	Surrey Downs Variation	Surrey Downs Assurance
Patient Safety Incidents Investigated	Jul 26	0	0	0			Jul 26	0	0	0		
Number of Falls with Harm (Moderate and Above)	Jul 26	0	0	-	L	-	Jul 26	2	0	-		-
Pressure Ulcers Category 3	Jul 26	11	9	-	H	-	Jul 26	7	8	-		-
Pressure Ulcers Category 4	Jul 26	0	1	0	H		Jul 26	2	1	0		
Infection Control - Number of MRSA	Jul 26	0	0	0	L	P	Jul 26	0	0	0	L	P
Infection Control - Number of Cdiff	Jul 26	0	0	-	L	-	Jul 26	0	0	-	L	-
Infection Control - Number of Ecoli	Jul 26	0	0	-	L	-	Jul 26	0	0	-	L	-
Community Friends and Family - Community Score	Jul 26	98%	98%	-	H	-	Jul 26	95.9%	96.2%	-	H	-
Community Friends and Family - Response Rate	Jul 26	0.97%	0.61%	-		-	Jul 26	9.2%	9.3%	-		-

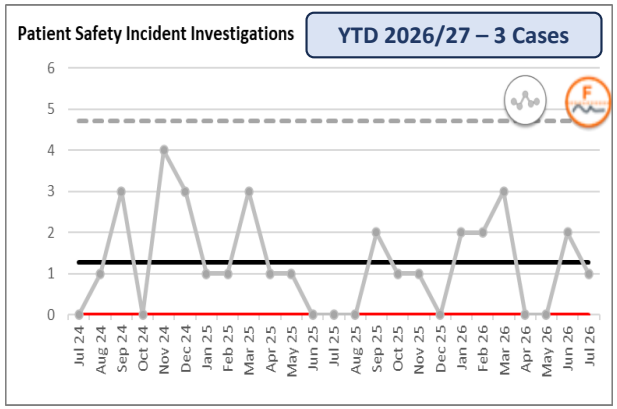
- Community FFT is a subset of Epsom and St Heliers FFT data.
- IC (Dorking and Molesey Hospitals – community do not have set national trajectories for HCAIs although all cases are reviewed and investigated)

Safe, High-Quality Care

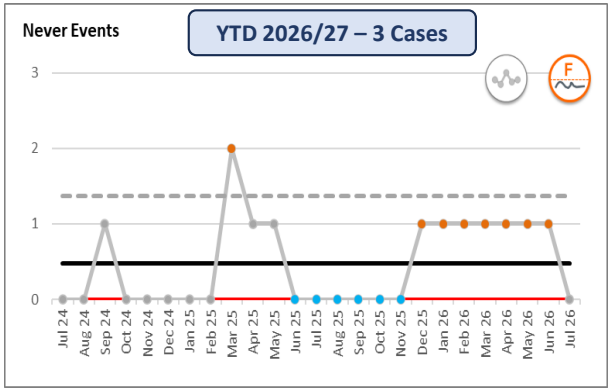
Overview of Incidents | SGUH and ESTH

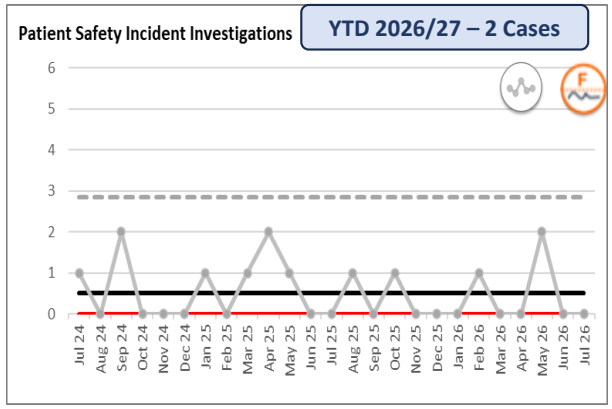
St George's





Epsom & St Helier





Summary and Actions:

SGUH

Never Events: No Never Events were declared in July 2026

Patient Safety Incident Investigations: One PSIIs was declared in July 2026, relating to a Neonatal death on the Delivery Suite.

- Learning and guidance on the use of AmniSure in the diagnosis of possible preterm spontaneous rupture of membranes (SROM) and bleeding in pregnancy has been disseminated using the Safety Spotlight.
- Formal guidance on the Senior House Officer (SHO) role in Delivery Suite triage and the medical management of miscarriage with SROM is also being developed.
- A PSII investigation is being undertaken to identify all the relevant learning and to determine from that learning what further risk mitigating actions, if any, need to be undertaken in due course. The PSII will be led by an independent panel chair, and an external reviewer will also support the investigation process.

ESTH

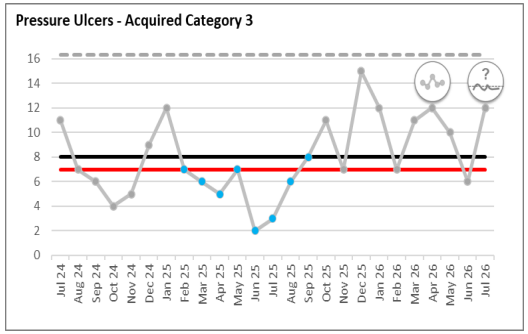
Never Event- No Never Events were declared in July 2026

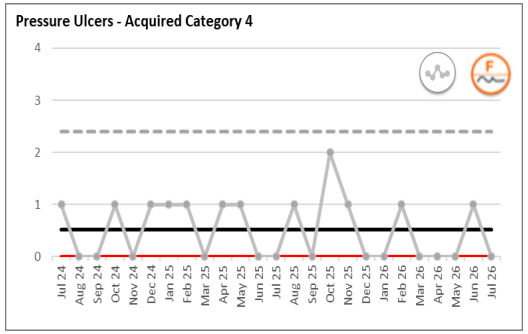
Patient Safety Incident Investigations : No PSIIs were declared in July 2026

Safe, High-Quality Care

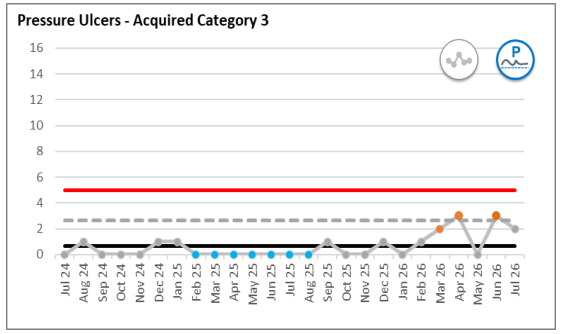
Exception Report | SGUH and ESTH - Category 3 & 4 Pressure Ulcers

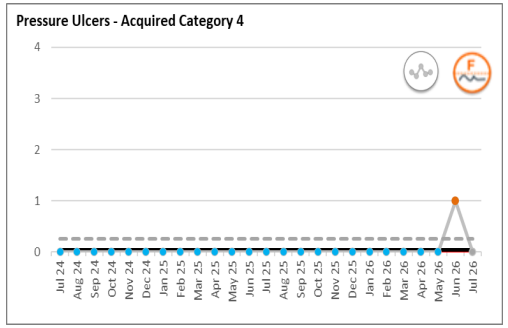
St George's





Epsom & St Helier

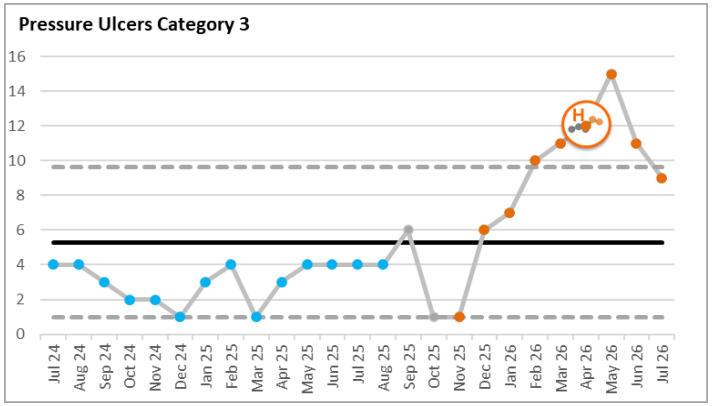


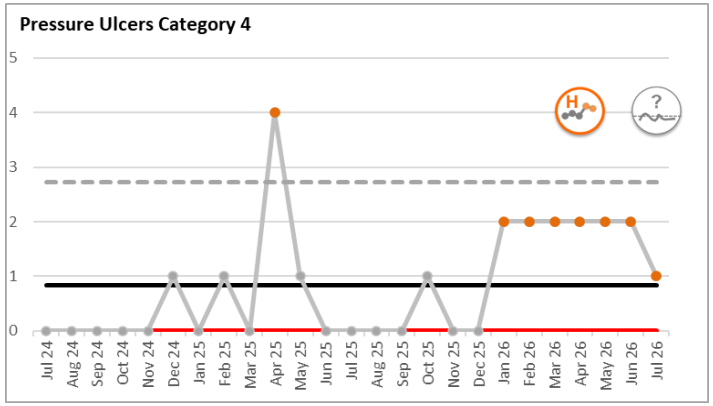


Site & Metric	Cause of variance/ non-compliance	Actions: Completed since last update, New, and Ongoing	Recovery Date
SGUH Pressure Ulcers Category 3: 12 Category 4: 0 **Data Quality:** Sufficient for assurance	Of the 12 pressure ulcers, four were acquired in Critical Care areas. Two of these were identified in the same patient, one patient has subsequently died, and one ulcer was identified following step-down to a ward. A review meeting has been arranged to identify themes, share learning and agree improvement actions. The plaster cast cluster has been reviewed. Two of the four pressure ulcers were unrelated to casts, while the remaining two identified no lapses in care.	• A new hybrid pressure-relieving mattress is being rolled out across general inpatient areas, with St James Wing completed and Lanesborough Wing currently underway • Thematic review meeting took place in July to discuss recent increase in pressure ulcers within the Acute Admissions Unit. • The pressure ulcer governance working group continues. Draft final process proposals are due in for Site sign off in October. • Teaching sessions will be introduced in the Plaster Room, and technicians will review inpatients within 24 hours of cast application.	Sept 2026. Being reviewed at Site level
ESTH: Pressure Ulcers Category 3: 2 cases Zero Category 4 pressure ulcer **Data Quality:** Sufficient for assurance	One patient has acquired two category 3 pressure ulcers (SWARM scheduled). Nine Category 2 pressure and Four Deep tissue injuries. Out of the 14 acquired pressure ulcers two were medical device related (Mimi J collar & Catheter). Current themes do not suggest a link between acquired pressure ulcers and the implementation of Hybrid mattresses. The sacrum and heels remain the most common sites of ulcer development. This month, four acquired pressure ulcers occurred at Epsom (Hybrid mattresses) compared with nine at St Helier (Dynamic mattresses). It remains too early to determine whether the recent increase is directly associated with the use of Hybrid mattresses.	• Meeting held to evaluate the current situation and focussing on arising/ identifies themes: aiming at increase ownership and from divisional level • Division level: Staff to revisit Pressure ulcer modules on re-categorisation of pressure ulcers, escalation and referral process. • Tissue viability enabling collaborative working Emergency Department on Categorisation on pressure ulcers/ escalation and referral process • PUSG meeting held on monthly basis to discuss arising themes and improvement • 320 Hybrid mattresses and 160 pumps currently in circulation at Epsom sites. • Trust-acquired pressure ulcers continue to be reviewed in line with PSIRF, with SWARMs undertaken where appropriate to identify learning and improvement opportunities	Oct 2026. Being reviewed at site level.

Safe, High-Quality Care

Exception Report| Sutton Health & Care | Category 3 & 4 Pressure Ulcers



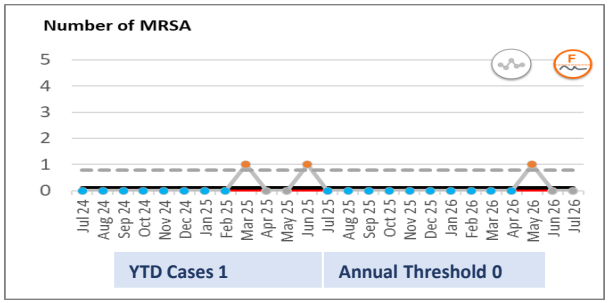


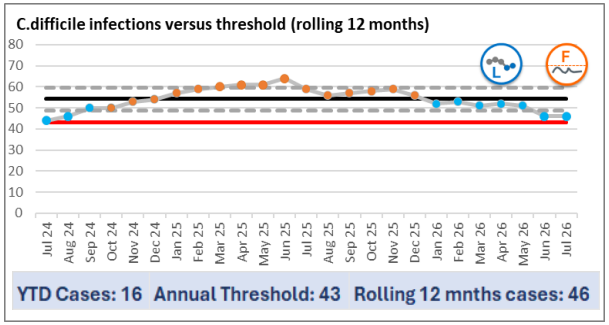
Site & Metric	Cause of variance/ non-compliance	Actions: Completed since last update, New, and Ongoing	Recovery Date
Sutton Health Pressure Ulcers Category 3 & 4 In July 2026, there were 2 Category 3 pressure ulcers and zero Category 4. Special cause variation of a CONCERNING nature. **Data Quality:** Sufficient for assurance	Category 3 and 4 pressure ulcers have shown an upward trend since December 2025, driven by factors such as increased Tissue Viability Nurse (TVN) activity, more complex reviews, and also more consistent reporting practices.	• 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 • Targeted interventions and PSIRF action plan in place • A deep dive of activity has been completed and will be presented at ESTH Patient Safety Quality Group (PSQG) in September 2026. • A deep dive of activity has been completed and will be presented at ESTH Patient Safety Quality Group (PSQG) in September 2026. • Additional assurance measures are now in place alongside PSIRF action plan to ensure senior nursing review of all Cat 3 & 4 ulcers	Aug 2026

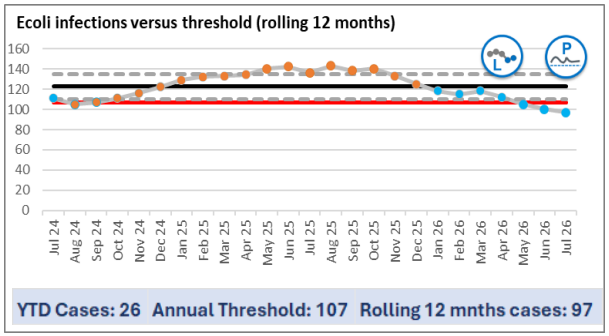
Safe, High-Quality Care

Overview Infection Prevention and Control |SGUH and ESTH

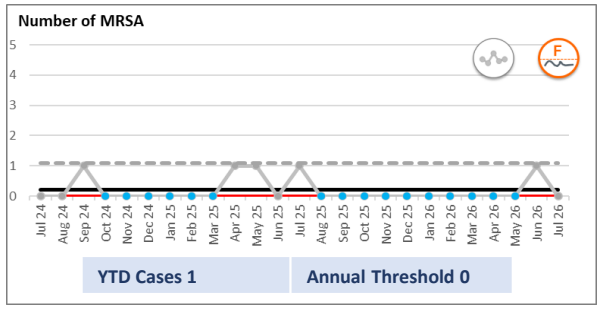
St George's

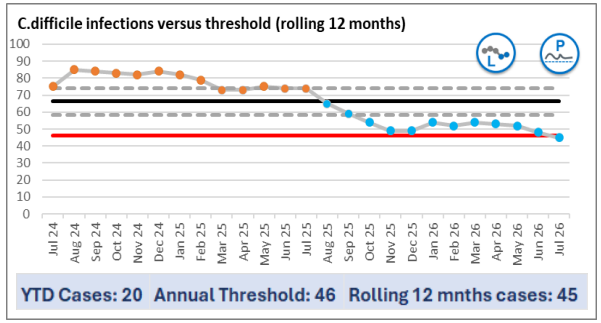


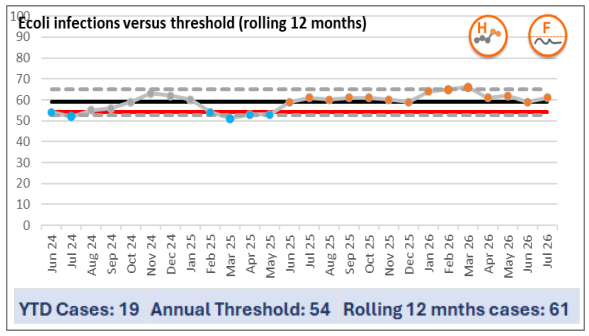




Epsom & St Helier







Summary with cause of variance / non-compliance

New charts are in line with National Oversight Framework showing Rolling 12 months

SGUH

- 0 MRSA BSI cases in July 2026. Total cases YTD 1
- 5 C. difficile cases in July 2026 : Total cases YTD 16; Rolling12mths - 1.07
- 8 E-Coli cases in July 2026: Total cases YTD 26; Rolling12mths 0.91
- Multidisciplinary C. difficile ward rounds and learning reviews continue.
- Enhanced environmental decontamination utilising Hydrogen Peroxide Vapour (HPV) is in place post-discharge/transfer.
- 12 MRSA cases since December 2025 (last positive: 6th May 2026), no clinical infections. Action plan included bay-by-bay decanting for ventilation review, cleaning and refurbishment, followed by a deep clean and HPV decontamination, completed end of July 2026.

ESTH

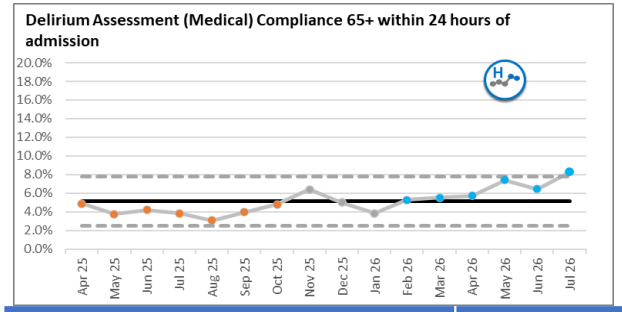
- 0 MRSA BSI in July 2026: Total cases YTD 1
- 8 C. diff cases in July 2026: Total cases YTD 20. Rolling 12mths- 0.96
- 9 E-Coli cases in July 2026; Total cases YTD 19 Rolling 12mths- 1.13
- Ongoing surveillance and infection prevention measures remain in place to minimise the risk of cross-infection
- Water safety risks remain under active monitoring through the Water Safety Group and Senior Leadership Team, with weekly meetings supporting oversight and progression of plans for E Block. Reassuringly, no clinical infections associated with the water safety issues have been reported during the reporting period.
- NICU MRSA outbreak involving two babies; unit-wide screening identified no further cases. Ribotyping confirmed cross-transmission. Both babies were treated and discharged home clinically well.
- High Consequence Infectious Disease (HCID) pathway appropriately activated; testing was negative and Influenza A and Adenovirus diagnosed. Debrief identified improvements required in HPV management, area closure and communication, with actions underway to address these

13

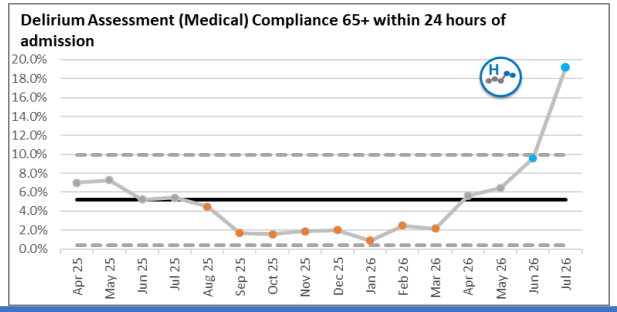
Safe, High-Quality Care

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

St George's



Epsom & St Helier



Data Quality Notice: The charts now show the percentage of admitted patients aged over 65 who received a delirium assessment by a doctor, 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.

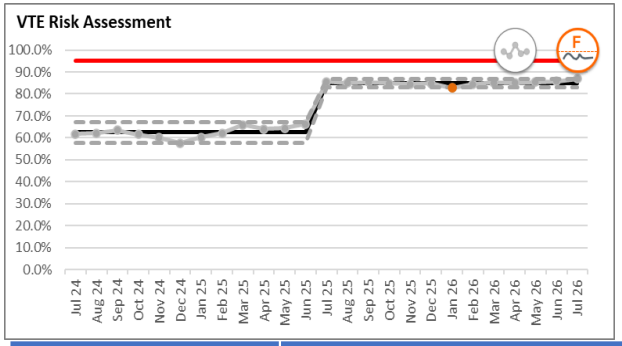
Please note this metric differs from the dementia assessment metric previously mandated by NHSE, which has now been discontinued.

Site & Metric	Cause of variance/ non-compliance	Actions: Completed since last update, New, and Ongoing	Recovery Date
SGUH: Delirium Assessment Medical within 24 hrs – 5.94% Delirium Assessment Nursing within 24 hrs – 36.87% RADAR Compliance (Daily Ax) – 9.4% Data Quality – under review	• In July, 57.44% of eligible patients received a delirium assessment, with 41.34% completed within 24 hours of admission. Only 5.94% were completed by a medical clinician within 24 hours • Use of the delirium assessment proforma is not currently part of the 'business as usual' process. It is only possible to measure completion of the proforma and not when this is documented as free-text in the electronic patient record . • 11th June 2026 trust-wide audit: delirium diagnosis 16% (n=120), Delirium Assessment completion 19%, 4AT/CAM-ICU completion 26% (n=195) — showing a gap between completion and recording of assessments. Trust wide audit shows that 4AT is being completed by Older Persons Assessment and Liaison, team working out of ED to prevent admission, speed up discharge • Nursing RADAR workflow not working as planned	• Delirium Lead attended Divisional Governance Groups • MDT teaching event delivered by founder of John's Campaign held during Friday Focus • Relaunch of John's Campaign planned including QIP to improve completion of hospital passports • National Audit of Dementia Census data uploaded onto web platform.	A gesh-wide review is currently underway
ESTH: Delirium Assessment Medical within 24 hrs – 19.17% Delirium Assessment Nursing within 24 hrs – 47.98% RADAR Compliance (Daily Ax) – 18.793% Data Quality – under review	• In July 2026, 79.08% of eligible admitted patients were assessed for delirium using at least one of the assessment methods available on iCLIP. Of which 47.98% were completed within 24 hours of admission. 19.27% were completed by a medical clinician within 24 hours showing positive improvement. • Use of the delirium assessment proforma is not currently part of the 'business as usual' process. It is only possible to measure completion of the proforma and not when this is documented as free-text in the electronic patient record	• Joint improvement and education work by the Dementia and Delirium Clinical Nurse Specialist and Frailty Consultant, including delirium assessment training for both Acute Medical Units in July 2026 • Medical led audit completed in ED and acute medical areas to engage staff and explore barriers to completion; audit will also look at completion of 4AT outside of the delirium assessment proforma (free text in clerking); findings expected in September 26	

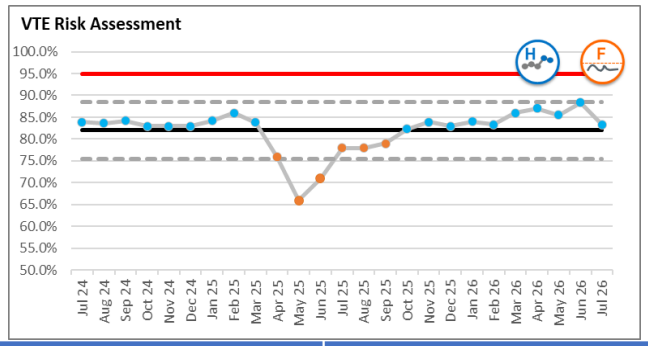
Safe, High-Quality Care

Exception Report| SGUH & ESTH - VTE Risk Assessment Rates

St George's



Epsom & St Helier

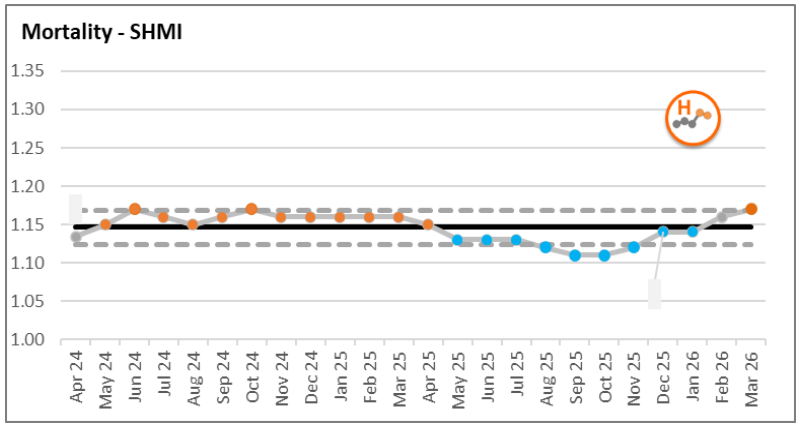


- **National guidance update**: NHSE has revised its guidance on measuring compliance against the requirement to assess patients within 14 hours, changing the start point from ward admission to the decision to admit to align with NICE guidance.
- **Data collection change:** The national VTE Risk Assessment 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. Current report, old logic applied.
- **Key implication:** Changes to reporting logic will 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 86.8%. Not meeting target of 95% **Data Quality:** Sufficient for assurance	Rates remain below the 95% national target at 86.8% in July 2026. Work is underway to reinstate the VTE champion network, which will drive local improvements directly on wards through the MDT and at board rounds. The GESH-wide review of the VTE risk assessment digital workflow remains critical to addressing this performance gap..	• A shared digital VTE risk assessment tool, with supporting rules and controls, is being developed to improve compliance. The change freeze has now been lifted, and this is a current priority. Work also continues to improve Medication Administration Tool (MAT) compliance, with targeted support directed at underperforming areas.	under review to align with updated guidance.
ESTH: VTE 82.9% Not meeting target of 95% **Data Quality:** Sufficient for assurance	• Rates remain below the 95% national target at 82.9% in July 2026. The reduction is due to a change in national guidance applied from 1st of July 2026, where VTE risk assessments are measured within 14 hours of decision to admit. (previously admission to designated ward) • Low-risk cohort using SGUH process now in place in ESTH. • A review for complete change is currently awaiting Site CMO approval .	• Subject matter experts to resume updating the VTE risk assessment based on user feedback in collaboration with SGUH • Retrospective Audit on VTE Risk Assessment and Thromboprophylaxis prescribing against National guidelines completed and results will be presented to NMEC this month • VTE lead clinician working with new SGUH HTC Lead and VTE colleagues to jointly understand some of the challenges in getting further improvement. • Planned Care is collaborating with VTE CNS to review this change is properly implemented to elective admissions.	

Safe, High-Quality Care

Exception Report | ESTH- SHMI

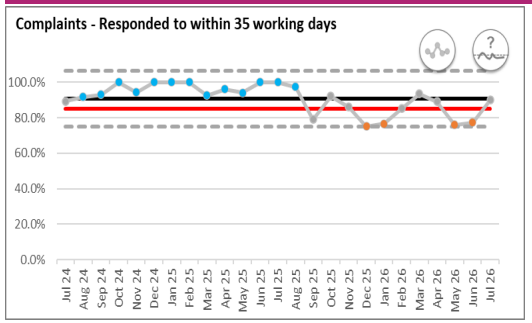


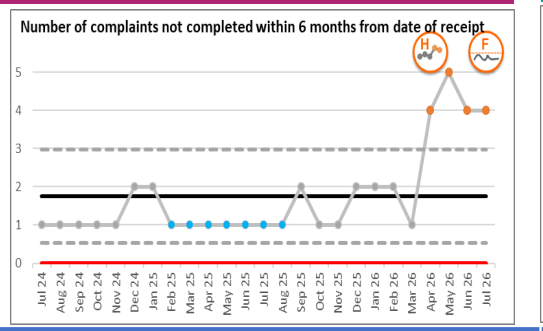
Site & Metric	Cause of variance/ non-compliance	Actions: Completed since last update, New, and Ongoing	Recovery Date
ESTH SHMI performance has increased to 1.17 showing Special cause variation of a CONCERNING nature. **Data Quality:** Under review.	The SHMI index is now within the "higher-than-expected" range and is showing special cause variation of a concerning nature. Recent increase is driven by a reduction in the expected rate, **while observed deaths remain broadly stable.** Early analyses indicate the reduction in modelled expected deaths is attributable to data quality issues linked to the implementation of the new EPR. The most recent SHMI period covers April 2025 to March 2026. An unusual reduction in expected deaths during November and December 2025, compared with previous years' seasonal patterns, has contributed to the higher SHMI score Potential changes following EPR implementation may have affected the patient risk profile captured in the SHMI dataset, including: Clinical documentation practices, Coding depth and accuracy, Comorbidity capture, Diagnosis coding, The iClip-to-HES data interface	• Further analysis is being planned by the Business Intelligence team, with support from the Group Mortality & Effectiveness team. • The planned change to SDEC data reporting, due to be implemented by April 2027, is being taken into consideration when determining the approach and timing of the detailed analyses.	to be confirmed

Safe, High-Quality Care

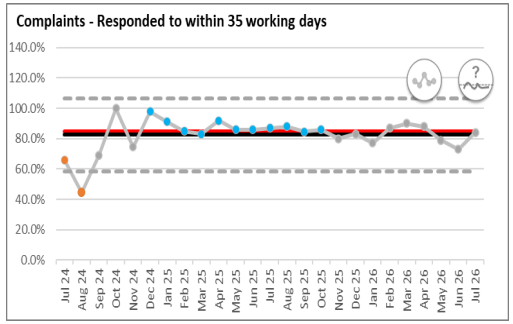
Exception Report| SGUH & ESTH Complaints

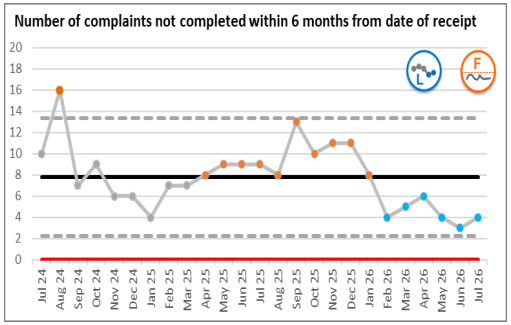
St George's





Epsom & St Helier



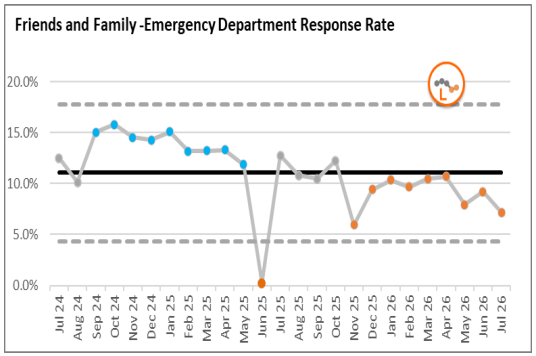


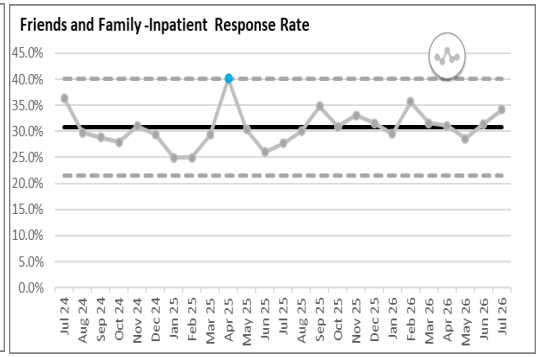
Site & Metric	Cause of variance/ non-compliance	Actions: Completed since last update, New, and Ongoing	Recovery Date
Complaints responded to within 35 working days achieved by SGUH with ESTH below target Complaint's not completed within 6 months of receipt, both SGUH and ESTH not meeting target. ESTH showing improving trend	In July 2026 90% of complaints were responded to within 35 working days at SGUH, and 84% at ESTH against the target of 85%. Both SGUH and ESTH delivered 100% acknowledging complaints within 3 working days in July 2026. At SGUH , 4 complaints were not completed within 6 months not meeting target in July 2026. At ESTH the trend continues to improve with 4 complaints unresolved beyond 6 months in July 2026, against a target of zero Performance has been impacted by; • Staffing shortages within the complaints team including sickness have caused some delays in response times • increase in the number of formal complaints received at both sites showing a rise above average over the last 6 months which appears to be multifaceted • lack of timely responses from the divisional teams to progress a complaint response • complex external causes	• An action plan is ongoing to address staffing shortages through permanent recruitment, including filling newly established posts. • Bank backfill has also been requested to support service delivery while staffing gaps are addressed through ongoing recruitment efforts. • Teams are prioritising the resolution and closure of outstanding complaints while ensuring accurate and complete recording within Datix. • Review and analysis of complaints to understand any emerging themes • Complaints reviewed weekly with the Divisions to track progress and provide support / advice if necessary • Divisional action plans are in place to address significant delays, with complaint response responsibilities transitioning to divisional teams. This will help identify targeted training needs to improve response quality, timeliness, and backlog management. • Administrative processes have been streamlined to support the timely logging and allocation of complaints, enabling divisions to dedicate more time to investigating concerns and preparing responses. • A gesh Complaints Policy and Standard Operating Procedure are being developed to strengthen complaint handling processes and ensure consistency across services.	October 2026

Safe, High-Quality Care

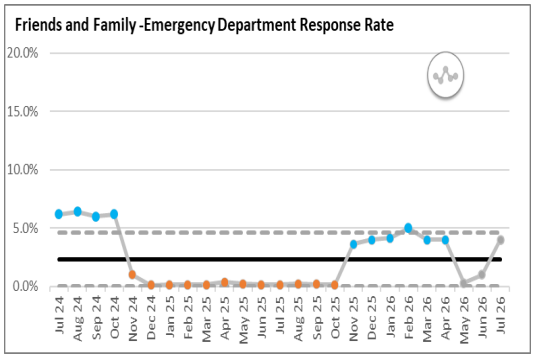
Exception Report| SGUH and ESTH FFT Response Rates

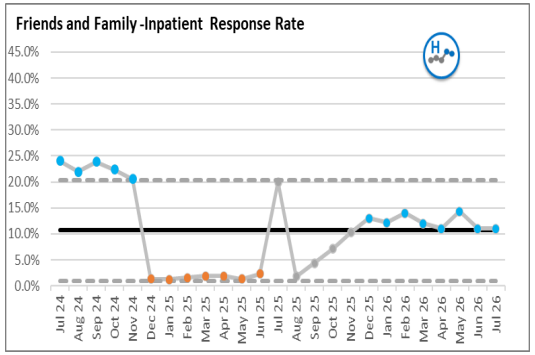
St George's





Epsom & St Helier





Site & Metric	Cause of variance/ non-compliance	Actions: Completed since last update, New, and Ongoing	Recovery Date
Response rates at SGUH and ESTH show special cause variation of a concerning nature for ED ESTH	While there is no national requirement for FFT response rate targets, our benchmarking indicates that response rates, particularly within Emergency Department and Inpatient services remain comparatively low There is an ongoing challenge with FFT response rates across both sites, although the issue is particularly pronounced at ESTH. The implementation of both iClip and GATHER has had a significant impact on participation rates, which have yet to return to pre-implementation levels and remain an area of concern Given the scale of the required changes, and the associated resource implications, sustained improvement is expected to take time. Consideration is therefore being given to delaying the introduction of a internal response rate target for six months, allowing improvement actions to embed. An alternative approach would be to introduce a phased trajectory with agreed incremental improvements over a defined period.	Significant work is underway however, the required changes have both time and resource implications, and meaningful improvement is likely to take time. To support improvement, the following actions are underway: • A review of the outpatient activity codes (ESTH) included within FFT text messages to assess the representation of services and departments. • Comparative analysis of FFT text messaging volumes across both SGH and ESTH sites. • Ongoing discussions regarding the establishment of Group-wide FFT participation targets. These actions will help inform opportunities to improve participation and ensure a consistent approach across the Group and allow time for the establishment of a formal response rate target or phased trajectory	April 2027

Section 2.1:
Operational Performance

Operational Performance

Overview Dashboard – Acute Trusts

KPI	St George's Latest month	St George's Previous month measure	St George's Lastest month measure	St George's Monthly MTP Trajectory	St George's Variation	St George's Assurance	St George's Benchmark	Epsom & St Helier Latest month	Epsom & St Helier Previous month measure	Epsom & St Helier Lastest month measure	Epsom & St Helier Monthly MTP Trajectory	Epsom & St Helier Variation	Epsom & St Helier Assurance	Epsom & St Helier Benchmark
RTT - % of waits over 52 weeks	Jun 26	0.83%	0.82%	0.97%	L	P	2nd Quartile	Jun 26	0.9%	0.9%	1.0%	L	P	2nd Quartile
RTT - Percentage of waits within 18 weeks	Jun 26	63.10%	64.80%	59.77%	H	P	3rd Quartile	Jun 26	66.8%	66.9%	66.1%	H	P	2nd Quartile
Waiting List Community - Percentage of waits within 18 weeks	Jun 26	82.8%	78.2%	78.0%	H	P	TBC							
Cancer - 28 Day Faster Diagnosis Standard	Jun 26	81.8%	84.8%	80.0%	H	P	Top Quartile	Jun 26	90.7%	91.6%	80.0%	H	P	Top Quartile
Cancer - 31 Day Decision To Treat to Treatment Standard	Jun 26	97.4%	97.2%	96.1%		P	2nd Quartile	Jun 26	100.0%	99.1%	98.6%		P	Top Quartile
Cancer - 62 Day Referral to Treatment Standard	Jun 26	72.6%	79.5%	75.0%		P	2nd Quartile	Jun 26	86.0%	87.6%	78.0%		P	Top Quartile
Diagnostics - 6 Week Waits	Jun 26	13.3%	15.5%	4.5%	H	F	3rd Quartile	Jun 26	6.6%	6.2%	8.6%		P	2nd Quartile
4 Hour Operating Standard	Jul 26	75.2%	79.3%	81.0%		F	Top Quartile	Jul 26	67.9%	67.8%	72.0%		F	Lowest Quartile
4 Hour Operating Standard - Paediatrics <16 years	Jul 26	91.2%	91.4%	94.5%		F	2nd Quartile	Jul 26	83.9%	82.6%	85.0%		F	Lowest Quartile
Over 12 Hours in ED from arrival (%) Type 1	Jul 26	8.3%	6.5%	9.3%		P	2nd Quartile	Jul 26	19.0%	19.8%	14.4%	H	F	Lowest Quartile
Emergency Department Corridor Care (Average Daily Count)	Jul 26	20	22	-		-	TBC	Jul 26	39	36	-	L	-	TBC
Ambulance handovers over 45 minutes	Jul 26	8.4%	8.4%	6.4%		F	3rd Quartile	Jul 26	4.1%	2.5%	6.0%	L	P	3rd Quartile
Ambulance average Handover Time (min)	Jul 26	00:24:15	00:24:38	00:21:45	H	F	2nd Quartile	Jul 26	00:22:29	00:21:11	00:22:00		P	2nd Quartile

Targets based on monthly 2026/2027 Medium Term Plan submissions
Benchmark Position in arrears in line with model hospital publication dates

Operational Performance

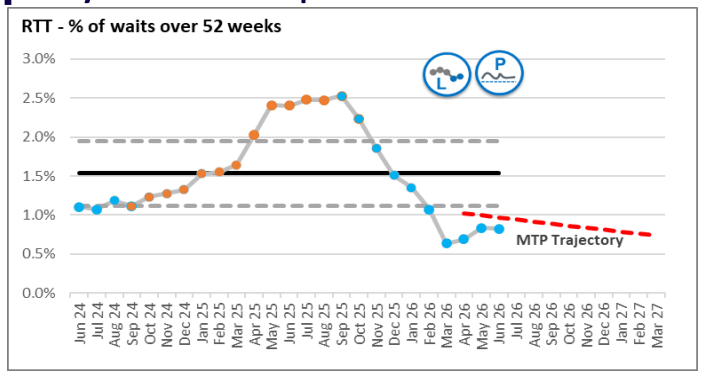
Overview Dashboard – Integrated Care

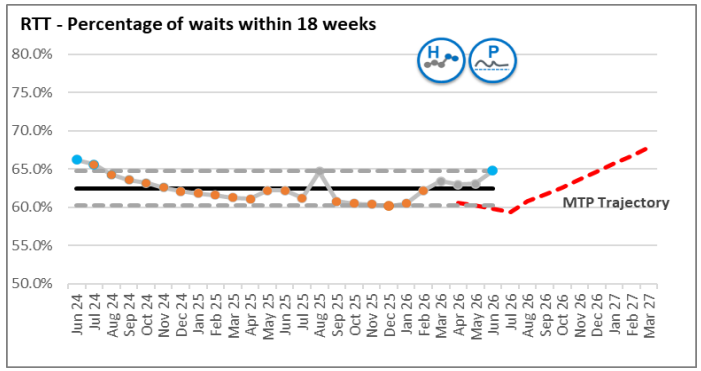
KPI	Sutton Healthcare						Surrey Downs					
	Latest month	Previous Month Measure	Latest Month Measure	Target	Variation	Assurance	Latest month	Previous month measure	Lastest month measure	Target	Variation	Assurance
Two hour UCR performance	Jul 26	66.2%	71.2%	70.0%		P	Jul 26	86.4%	84.8%	70.0%		P
Virtual ward - Bed Occupancy	Jul 26	63.5%	68.2%	85.0%		F	Jul 26	100.0%	88.9%	80.0%		P
Virtual ward - Average Length of Stay	Jul 26	5.4	6.2	-		-	Jul 26	11.6	8.0	-		P
% of Intermediate care beds occupied by patients without criteria to reside	-	-	-	-	-	-	Jul 26	8.0%	5.8%	-		-
Waiting List Community - Waits over 52 weeks	Jul 26	109	82	0	H	F	Jul 26	0	0	0		P
Waiting List Community - Percentage of waits within 18 weeks	Jul 26	85.8%	86.1%	78.0%	H	P	Jul 26	97.8%	97.5%	78.0%		P
Waiting List Community Children - Waits over 52 weeks	Jul 26	106	79	0	H	F						
Waiting List Community Children - Percentage of waits within 18 weeks	Jul 26	52.1%	52.8%	78.0%		F						

% 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



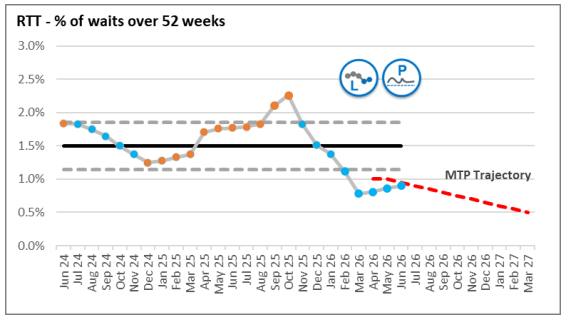


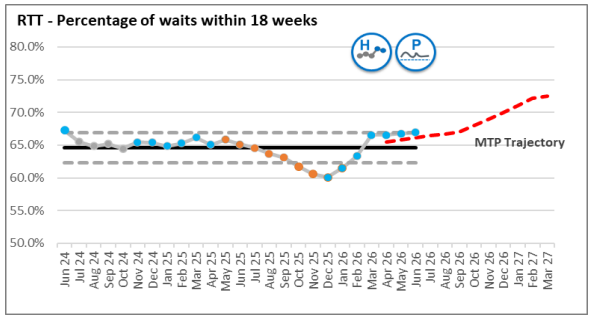
Site & Metric	Cause of variance/ non-compliance	Actions: Completed since last update, New, and Ongoing	Recovery Date

SGUH
 	
Meeting MTP Trajectories
 	
Data Quality: Sufficient for assurance
	At the end of June 2026, 570 patients were waiting for more than 52 weeks, 0.82% of the total PTL. Performance continues to exceed plan against our 2026/27 MTP trajectory. The largest proportion of patients currently in this cohort are within; Cardiology (108) and Gynae (89), Max Fax (83) .
	
	18 Week Performance for June 2026 delivered 64.8% ahead of the June 2026 MTP plan of 59.77%.
	
	SGUH is currently performing better than its MTP trajectory. However, these metrics are being closely monitored, particularly in light of the seasonal risk during the summer months due to patient choice.
		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 2026, Source Group completed the validation of 23,100 patient pathways in the 18-40 week cohort.
			Delivering against MTP Plan 2026/27

Operational Performance

Key Metrics| ESTH Referral to Treatment RTT

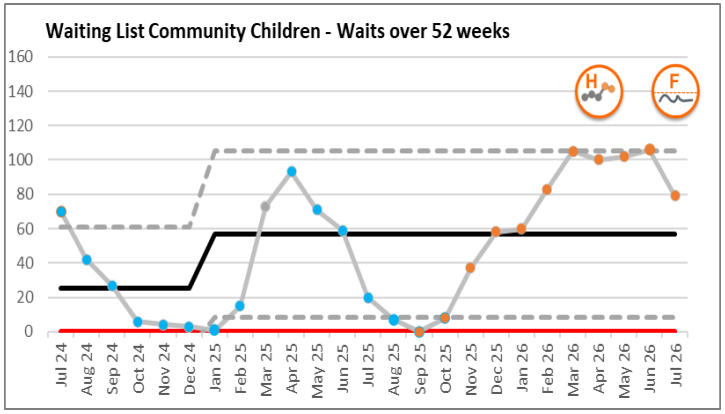


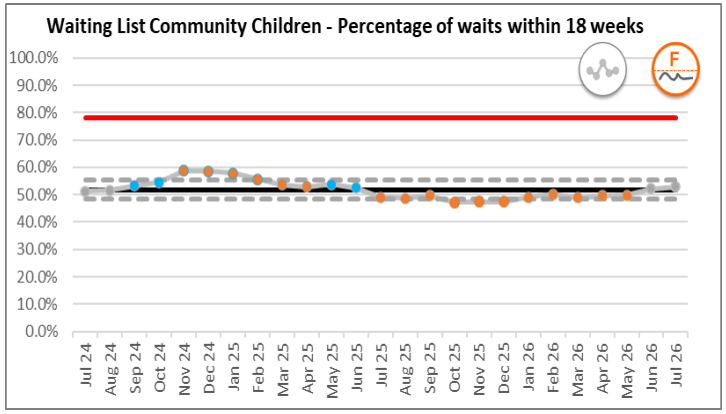


Site & Metric	Cause of variance/ non-compliance	Actions: Completed since last update, New, and Ongoing	Recovery Date
ESTH Total waits over 52 weeks – overachieved monthly trajectory of 531 Percentage within 18 weeks – overachieved monthly trajectory of 66.1%	• ESTH exceeded both the June 2026 RTT trajectory (66.9% against 66.1%) and the 52-week wait trajectory (513 against a target of 531), remaining ahead of the planned trajectory despite an overall increase in 52-week waits. • The overall RTT PTL reduced again from 57,374 to 57,011 during June 2026, although it remains above plan following the impact of the earlier iCLIP innovation release. • Cardiology remains the principal specialty risk due to sustained outpatient demand, Cardiac MRI capacity constraints and ongoing workforce challenges. • Gynaecology and General Surgery continue to experience demand and capacity pressures but remain subject to active recovery plans.	**Total RTT PTL** –Reduced again from 57,374 in May to 57,011 in June, although remaining above the planned trajectory following EPR implementation, associated data quality issues and the iCLIP innovation release. The Trust has rebalanced its recovery approach to prioritise PTL reduction while maintaining RTT performance in line with plan. Recovery actions, including additional validation resource, external support, increased capacity (subject to continued RTCS funding), targeted pathway validation and strengthened operational oversight, are expected to return the PTL to trajectory by December 2026. The Trust remains on track to deliver its Year 1 MTP RTT trajectory. **Long Waiters -52WW** - Recovery plans remain in place across the most challenged specialties. • **Cardiology:** The service remains under sustained pressure, with outpatient waits of around 20 weeks and a CMRI backlog of 361 patients. New Consultant posts have been approved with job plans being designed. CMRI capacity at Epsom is increasing, although outsourcing remains necessary, with no immediate resolution available. Data quality, management of the large PTL and staffing vacancies continue to impact performance, with limited resource available to support recovery and PTL management. • **Gynaecology:** Recovery remains challenged by rising demand and workforce constraints, although 52+ and 65+ week breaches continue to reduce. Sustaining progress requires focus on patients without treatment plans to prevent further breaches. Additional capacity has been requested, while some clinics are being redirected to support Cancer performance. Recovery actions include daily validation, active management of long waiters and capacity optimisation across Cancer and RTT priorities. • **General Surgery:** RTT recovery remains constrained by capacity. UGI waits are now 20 weeks, with 86 patients awaiting hot gallbladder surgery and 48 abdominal wall cases requiring two-consultant lists. Summer recovery funding is available, but uptake remains limited, presenting a risk to backlog reduction. Weekly PTL reviews and clinical engagement are improving long-wait performance and reducing 52- and 65-week breaches.	52WW + RTT performance trajectories achieved in June 2026. Total RTT PTL to achieve trajectory by December 2026.

Operational Performance

Exception Report| Sutton Health – Community Services Children's Waiting Times



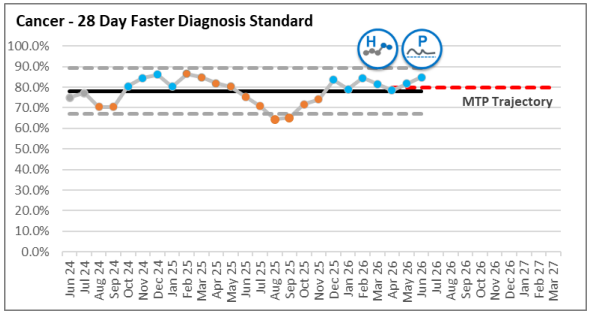


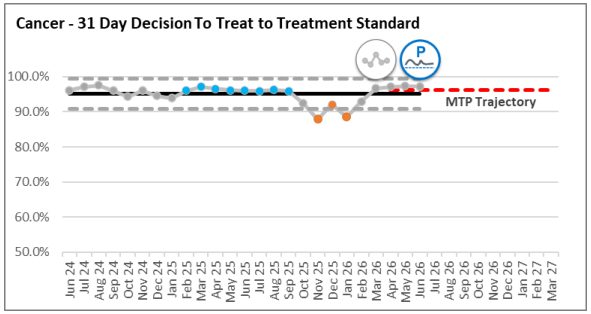
Site & Metric	Cause of variance/ non-compliance	Actions: Completed since last update, New, and Ongoing	Recovery Date

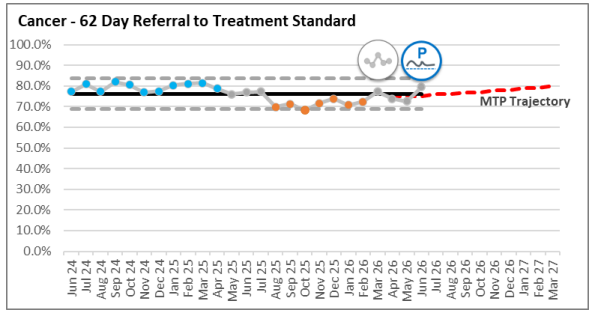
Sutton Health & Care waits over 52 weeks -
 	
Variation of a CONCERNING nature.
 	
Data Quality: Sufficient for assurance
	Of the children's community waiting list, 79 patients are waiting for more than 52 weeks. a reduction compared to 106 children reported at the end of June 2026.
	
	Increased waiting lists and long waits reflects the national trend of increasing waits over the last 18 months driven by 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 has seen slight improvement however remains low at 52.8%, a stable but underperforming position.
	
	[To note – the overall community waiting list performance for Sutton including children's and adults 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.
		  ○ The CQC-OFSTED review is being taken forward by the SEND partnership forum (Sutton) with the ICB. There is a particular focus on dysphagia and SLT/OT CYP.
		  ○ An internal gesh pathway delivery review is also being taken forward by SHC with ESTH: exploring capacity/demand management and remodelling transformation alongside a targeted action & improvement plan.
			TBC and dependant on wider SWL plan

Operational Performance

Key Metrics| SGUH - Cancer Performance Standards



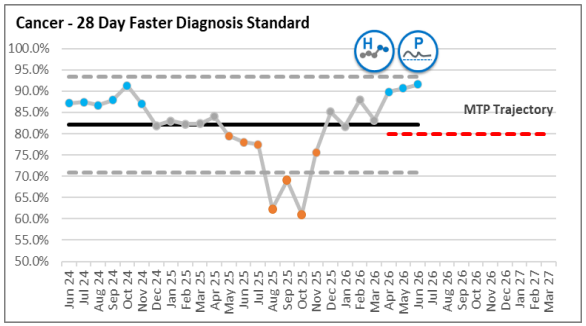


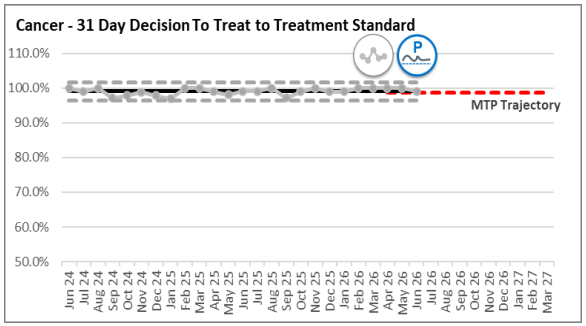


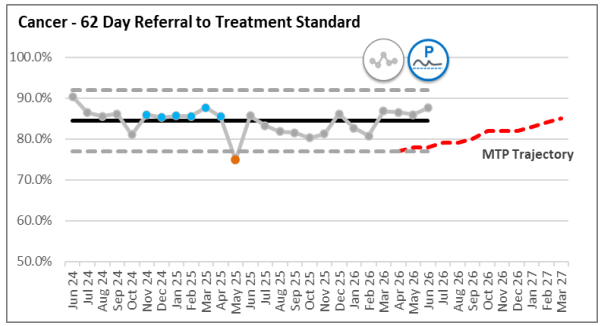
Site & Metric	Cause of variance/ non-compliance	Actions: Completed since last update, New, and Ongoing	Recovery Date
SGUH 28 Day FDS – Meeting MTP 62-Day standard Meeting MTP **Data Quality:** Sufficient for assurance	**FDS performance** remains ahead of MTP in June 2026 at 84.8%. UGI continues to be challenged, however the backlog of endoscopy wait has been reduced. **62 Day June 2026 (79.5%):** Performance exceeded MTP trajectory of 75% achieving 79.5% . Key challenges were diagnostic constraints in Lung (including navigational bronchoscopy) and access to Thoracic Theatres; a high volume of breaches were seen in H&N, Urology (renal) and late transfers out/patient choice delays in Gynaecology. Within Breast Services, Radiology workforce pressures may impact performance in September 2026, the challenges are a combination of staffing sickness absence, and the loss of two Consultant Radiologist posts following retirement	**Dermatology**: The recovery plan continues to progress, with the Minor Operations backlog reducing from 140 to 60 patients and administrative recruitment improving booking timeliness **Head and Neck (H&N)**: Pathway improvements continue, with progress monitored through established workstreams and capacity strengthened through the recruitment of a Clinical Nurse Specialist to support the Telephone Assessment Clinic (TAC) model **Lower GI:** Recruitment is underway for a Lead Advanced Clinical Practitioner and a Gastrointestinal Lead Clinical Nurse Specialist to strengthen clinical leadership and integrated working across the service. **Pathology**: A new Pathology performance dashboard is now live, giving teams daily visibility of reporting activity and supporting improved performance monitoring, operational oversight, and governance. **Breast Services**: Radiology workforce pressures may impact performance in September 2026. To mitigate the immediate impact, additional weekly imaging clinics and reporting sessions have been implemented, across the next two months. Longer Term, recruitment is underway, with interviews for the vacant Consultant Radiologist posts scheduled for 21 August 2026. Performance and workforce capacity will remain under close review, with further action taken as required **Urology**: The RMP led urinary biomarker programme remains at an early stage of development. A supporting case study has been submitted and awaiting approval through the RMP governance process. **Cancer SMART (Sever Mental Illness Access Rapid Treatment)** is underway, recruitment to new peer support worker in progress. Education on the new access policy and business case for substantive workforce and commissioning is in progress. **Cancer Performance Improvement Programme** is underway, focused on streamlining performance management frameworks across administrative functions.	Delivering against MTP Plan 2026/27

Operational Performance

Key Metrics| ESTH - Cancer Performance Standards



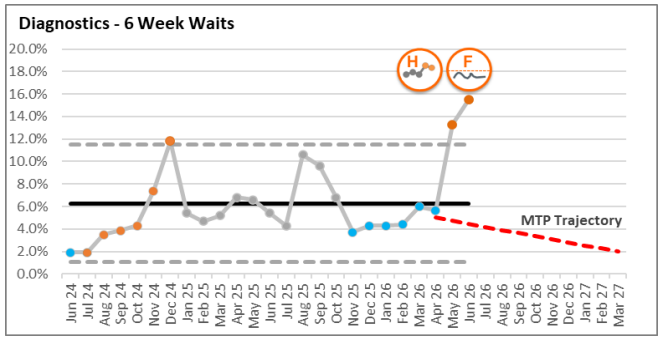




Site & Metric	Cause of variance/ non-compliance	Actions: Completed since last update, New, and Ongoing	Recovery Date
28 Day FDS Meeting MTP	**Haematology (71.4%):** Complex diagnostic pathways. **Lower GI (80%):**Limited Capacity for endoscopy.	**Haematology:** Two breaches due to complex diagnostic pathways (low case numbers). **Lower GI**: Limited capacity for endoscopy bookings has contributed to longer waiting times for colonoscopy and sedation procedures. Additional short-notice sessions have been added to help reduce waiting times and improve access.	Delivering against MTP
62 Day Standard Meeting MTP **Data Quality:** Sufficient for assurance	**Lung (62.5%):** Delays to external diagnostic. **Haematology (81.3%):**Complex diagnostic pathways. **Gynaecology (62.5%):** Limited capacity for GA and outpatient hysteroscopy services has contributed to delays in the diagnostic pathway. **Upper GI (80%):** Complex diagnostics and capacity challenges.	**Lung:** Imperial has commenced navigational bronchoscopy, provided additional capacity, reducing pressure on Brompton. Radiology staffing is now fully established, enabling a slight increase in CT-guided biopsy capacity. SWL-wide benchmarking of the lung pathway is underway to improve patient flow and reduce pathway delays. **Haematology** : Complex pathways requiring multiple diagnostic tests have contributed to delays. Breach assessments have been completed, with a further review planned with the Haematology team to identify opportunities to streamline and improve the pathway. **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. **Upper GI:** Upper GI was impacted by endoscopy capacity and external EUS diagnostic delays. Patient pathways are being reviewed to identify opportunities for earlier diagnostic requests and reduce delays in transfer of care to RMH.	

Operational Performance

Exception Report| SGUH Diagnostic Performance

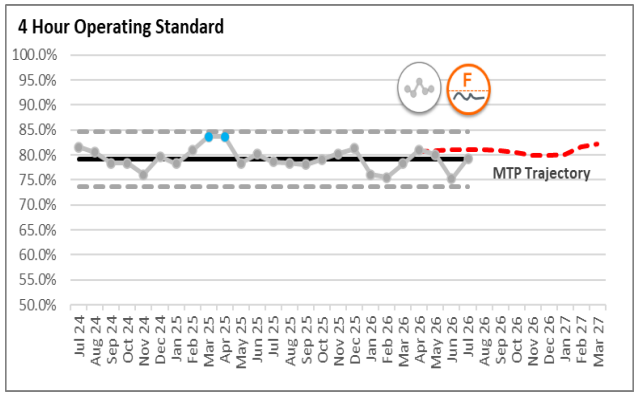


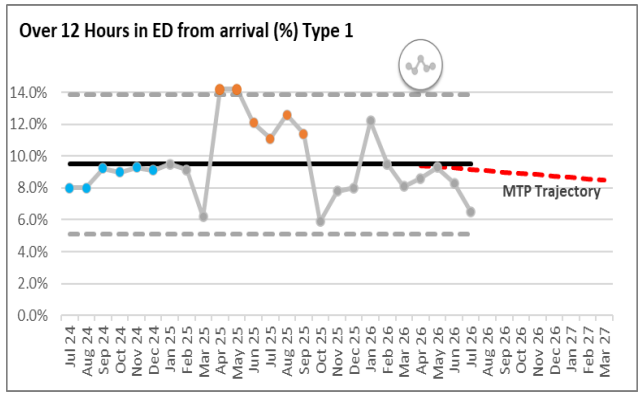
Modality	6 Week Breaches	>6 Week Performance
Non-obstetric ultrasound	1972	24.0%
Respiratory physiology - sleep studies	198	30.1%
Cardiology - echocardiography	116	7.1%
Magnetic Resonance Imaging	76	2.7%
Gastroscopy	64	12.9%
Colonoscopy	47	15.8%
Flexi Sigmoidoscopy	19	18.4%
Neurophysiology - peripheral neurophysiology	14	4.5%
Cystoscopy	6	6.0%
Urodynamics - pressures & flows	6	11.5%
Cardiology - electrophysiology	1	100.0%
Computed Tomography	1	0.1%
Audiology - Audiology Assessments	0	0.0%
DEXA Scan	0	0.0%

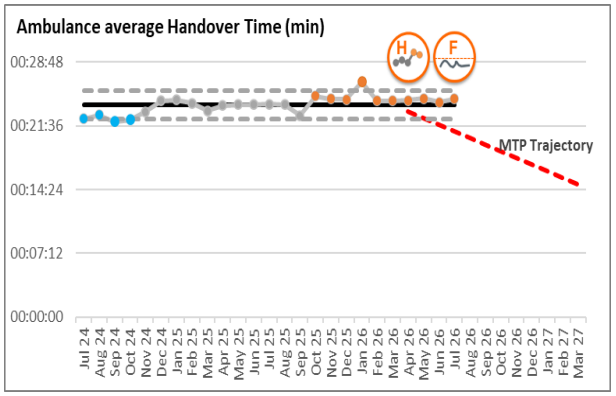
Site & Metric	Cause of variance/ non-compliance	Actions: Completed since last update, New, and Ongoing -	Recovery Date
SGUH Special cause variation of a CONCERNING nature– Not meeting MTP **Data Quality**: Sufficient for assurance	June 2026 diagnostic performance showed a further increase in waits exceeding six weeks, rising to 15.5% against the MTP target of 4.46%. Continued capacity constraints and workforce pressures remain key drivers of underperformance and present a risk to the delivery of future MTP trajectories **Non-Obstetric Ultrasound:** Rising demand and a significant sonographer shortage are impacting performance, with breaches reaching approximately 1,972 at the end of June 2026 and projecting 2,600 by the end of July 2026. Recruitment efforts have remained unsuccessful despite multiple campaigns, with candidates often accepting roles elsewhere due to recruitment and retention premiums **Respiratory Sleep Studies –** Capacity for sleep studies had reduced significantly, from 80 studies per week to approximately 20 to 25. This reduction reflects a move away from home-based multichannel studies (external) driven by financial constraints. **Echocardiography** – Staffing vacancies earlier in the year led to capacity constraints and a backlog of around 200.	**Non-Obstetric Ultrasound** Agency Sonographers are being utilised, with associated costs offset through Community Diagnostic Centre (CDC) funding, alongside substantive staff undertaking additional bank shifts beyond their contracted hours. Mitigating actions continue to focus on active recruitment, review of retention incentives, optimising the use of bank and agency staffing, exploring additional capacity solutions including insourcing, mutual aid arrangements, and referral management initiatives. **Respiratory Sleep Studies –** funding authorised and sleep study slots will be increased to 80 patients per week which has been actioned with immediate effect. **Echocardiography** Recovery is now underway, supported by additional clinic capacity delivered throughout June and July, with backlog levels beginning to reduce. While demand remains high, the additional clinics are improving throughput and helping to restore capacity. Recruitment to Band 7 and Band 6 vacancies is also continuing to support service recovery.	TBC dependant on US capacity

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 is not validated	• July 2026 4-hour performance improved achieving 79.37%, however below MTP plan of 81% • On average 29 patients per day waited >12 hours before discharge in ED, an improvement from previous month • July 2026 saw 2,762 ambulance conveyances, with 74% offloaded within 15 minutes (78% previous month) • Patients awaiting admission from ED waited an average of 11 hours 42 minutes, an improvement of 96 minutes from the previous month. • Performance pressures are in line with other SWL acute providers. • A high volume of mental health patients are attending ED, with long waits for mental health beds. • STG are ranked 2nd regionally and 13th Nationally for 4 hour performance over 6 weeks.	• Review of full capacity protocol to better support ED when in challenged position. • The Emergency care delivery board ensures assurance and accountability on ED performance. • Roll out of Ambient voice technology rolling out across department in August • NEL workstream eradicating corridor care commenced • Productivity alignment of resident doctors. • ED manager of the day to support team • Working group with Paediatric team over summer bed closures and prolonged waits in ED for Paediatric patients, aim to improve paediatric 4 hour performance. • Reviewing feedback from resident doctor local survey to improve flow within ED.	August 2026

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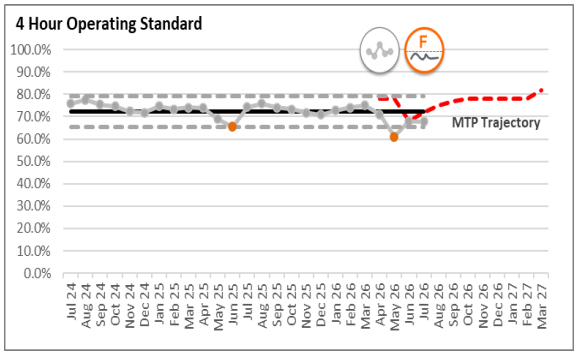
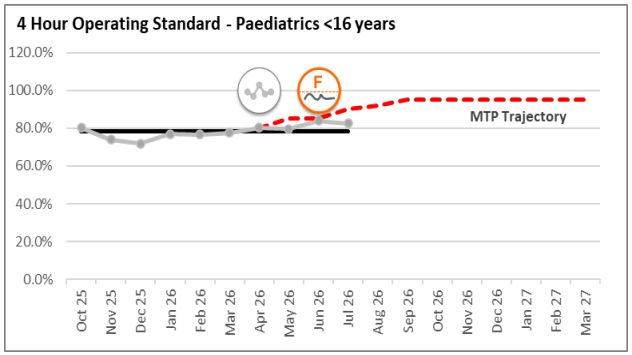
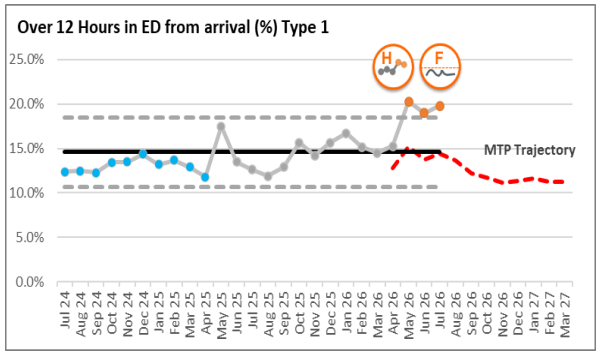
Operational Performance

Key Metrics| ESTH A&E Waits and Ambulance Handovers



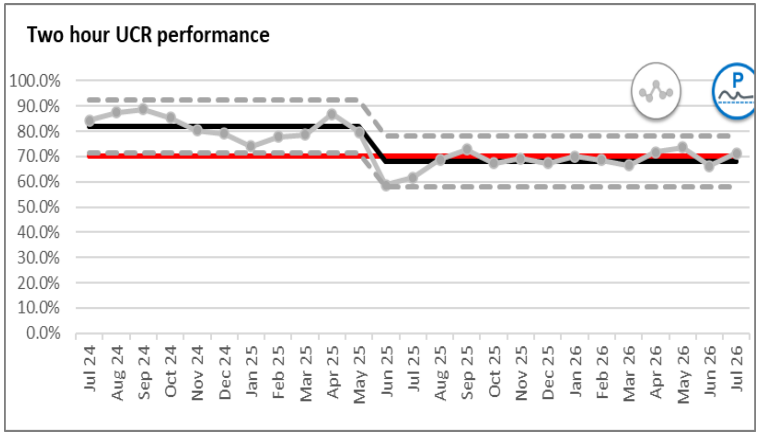




Site & Metric	Cause of variance/ non-compliance	Actions: Completed since last update, New, and Ongoing	Recovery Date
ESTH 4 Hr performance - normal variation below MTP ED Type 1 LOS>12 Hours Not meeting MTP **Data Quality:** Sufficient for assurance	• 4-hour performance remained at 67.8% in July 2026, below revised trajectory target of 72%. Performance has been impacted by the decommissioning of ED SDEC and the transition to a UTC-first model. • 12-hour waits for Type 1 attendances remain above the planned level. Internal data indicates recent improvement; however, this has not yet been reflected in ECDS submissions and is subject to ongoing review and validation • Ambulance handovers exceeding 45 minutes fell to 2.5% in July 2026, improving from 4.1% in June 2026, outperforming the 6% target. This was also complemented by a further reduction in average handover times, which decreased by 2 minutes to 20 minutes during July 2026.	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 and ongoing during the last month include: • Following the Trust-wide launch of UTC First and ED Medical Ambulatory pathways on 22 April 2026, increasing numbers of appropriate patients are being streamed to alternative pathways, supported by ring-fenced SDEC capacity. A UEC recovery plan is in place to mitigate the impact and support a return to the planned trajectory by the end of Q2. • Earlier specialty assessment continues to improve ED flow and patient experience, supported by effective collaboration between Medical SDEC and ED teams. A review of the Trust's Internal Professional Standards, including real-time data collection is underway to support further improvements. • A frailty-attuned ED front door pilot was delivered at the Epsom site between 19 June and 5 July 2026. Initial findings are encouraging, with detailed analysis and impact evaluation underway. • Ring-fencing 1 bed in the St Helier 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.	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	• July 2026 2-hour Urgent Community Response performance improved above target achieving 71.2% however continues to show normal variation. • 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 and has therefore shown instability in performance.	• 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 and changing hours of practice are underway to align demand with capacity, since the increase in activity and time of activity has shifted since conception of the ICC, particularly at weekends and out of hours.	September 2026

Section 2.2:
Operational Productivity

Operational Productivity

Overview Dashboard

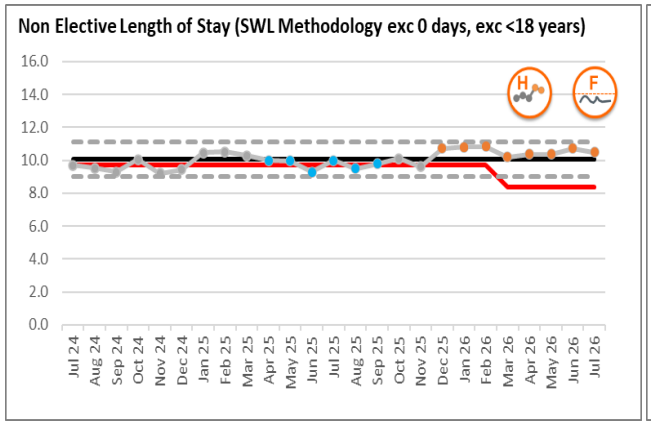
KPI Operational Productivity	St George's Latest month	St George's Previous month measure	St George's Lastest month measure	St George's Target	St George's Variation	St George's Assurance	St George's Benchmark	Epsom & St Helier Latest month	Epsom & St Helier Previous month measure	Epsom & St Helier Lastest month measure	Epsom & St Helier Target	Epsom & St Helier Variation	Epsom & St Helier Assurance	Epsom & St Helier Benchmark
Implied Productivity Growth YTD	Mar 26	-1.1%	-0.2%	-	N/A	N/A	Lowest Quartile	Mar 26	0.6%	-1.1%	-	N/A	N/A	Lowest Quartile
Cost Weighted Activity Growth YTD	Mar 26	-1.0%	-1.1%	-	N/A	N/A	Lowest Quartile	Mar 26	-0.5%	-0.2%	-	N/A	N/A	Lowest Quartile
Real Terms Resource Use Growth YTD	Mar 26	0.1%	-0.8%	-	N/A	N/A	2nd Quartile	Mar 26	-1.1%	0.9%	-	N/A	N/A	3rd Quartile
Non Elective Length of Stay (SWL Methodology exc 0 days, exc <18 years)	Jul 26	10.7	10.5	8.4	H	F	N/A	Jul 26	11.0	10.5	10.9		?	N/A
Average days from Discharge Ready Date to date of discharge (inc 0 day delays)	Jun 26	0.8	0.7	0.7		?	2nd Quartile	Jun 26	1.1	1.3	0.5		F	3rd Quartile
Theatre Utilisation (Capped)	Jul 26	83.7%	84.4%	85.0%		?	Top Quartile	Jul 26	81.2%	82.3%	85.0%		F	2nd Quartile
BADS All Daycase & Outpatient Procedures % of total procedures	Apr 26	76.8%	79.7%	87.0%		F	Lowest Quartile	Apr 26	68.1%	69.6%	87.0%		F	Lowest Quartile
Outpatients Patient Initiatied Follow Up Rate (PIFU)	Jul 26	2.3%	2.4%	3.9%		F	Lowest Quartile	Jul 26	5.6%	6.2%	4.1%		P	2nd Quartile
Outpatients Missed Appointments (DNA Rate)	Jul 26	9.4%	9.9%	8.0%		F	Lowest Quartile	Jul 26	5.7%	5.7%	6.0%		?	2nd Quartile
First and Procedure Attendances as a proportion of Total Outpatients	Jul 26	53.2%	52.3%	49.0%		P	Lowest Quartile	Jun 26	43.6%	42.9%	49.0%		?	Lowest Quartile

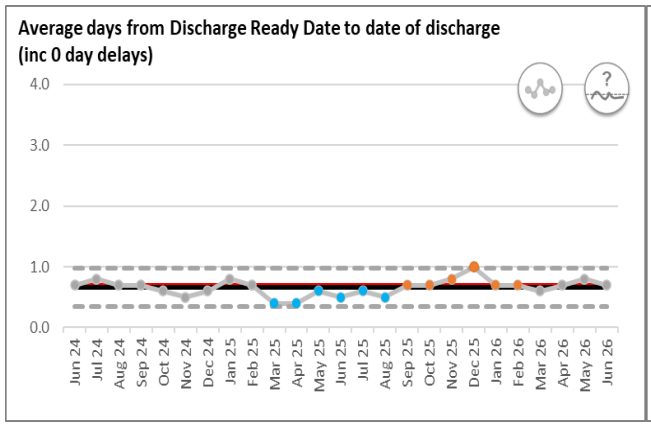
Notes for Implied Productivity - The final 2025/26 productivity metrics publication, include revisions to monthly data that reflect ESTH's data quality improvements and reduce the impact of central estimation. As a result, ESTH is now shown to have returned to positive productivity growth from October 2025, rather than February 2026 as previously reported. March 2026 was significantly affected by a one-off cost relating to the Soft FM pension liability, backdated to 2018. Excluding this impact, productivity growth would have continued to improve.

Operational Productivity

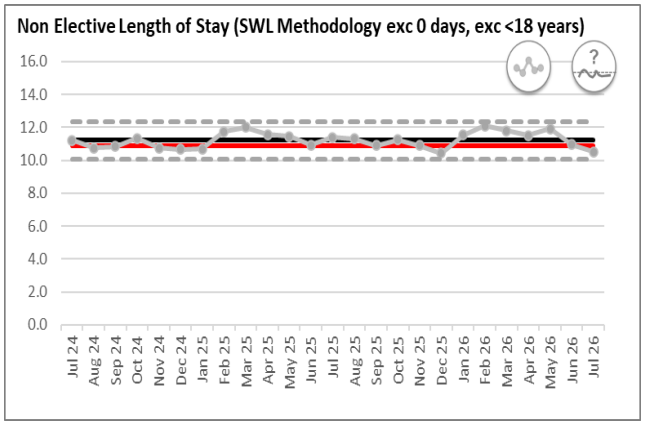
Bed utilisation

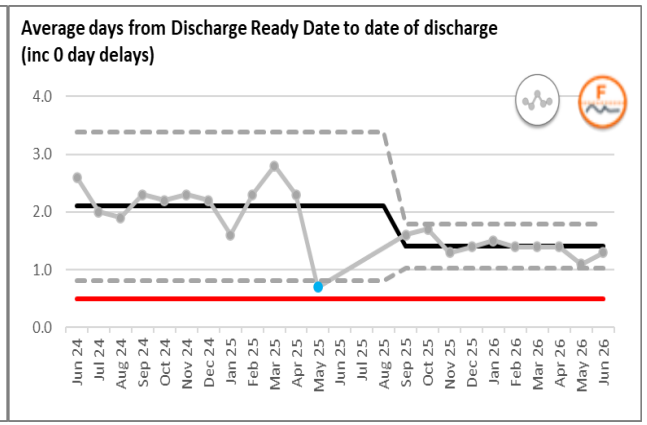
St George's





Epsom & St Helier





Analyses & Key actions

SGUH

Three transformation programmes have been aligned to support winter readiness:

1. NEL Programme: Expand virtual wards with geriatrician support and Home First same-day discharge pathways
2. Eradicating corridor programme (Increase re-direction and streaming from ED, increase SDEC (Frailty, medical, surgery) utilisation, standardise board rounds (GIRFT framework), increase departure lounge usage, improve corridor care oversight.
3. Winter schemes - Implement direct booking for M&W primary care slots and employ SGUH therapists to the UCR team.

- The new Full Capacity Protocol is under development
- Collaborative work with local authority colleagues focused on improving discharge pathways and reducing delays
- The Emergency department is meeting with NHSE around the funding for direct booking from 111 in to ED, UTC, SDEC.
- South West London partner meetings are underway, with the aim of co-producing a business case for a Mental Health ED.

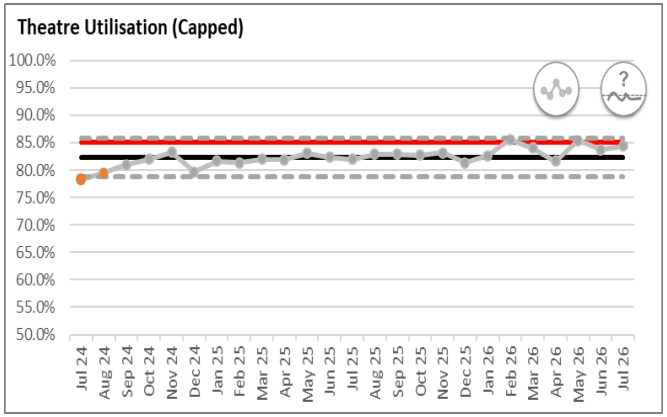
ESTH

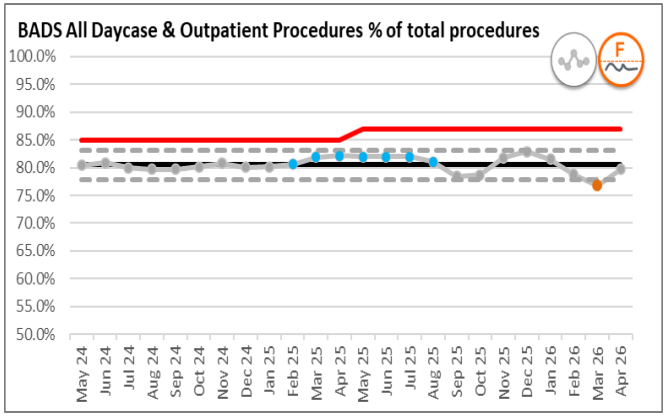
- Non-elective length of stay fell by a further 0.5 days in July 2026 to 10.5 days, surpassing the annual target by 0.4 days
- Phase 2 of the SWIFT and AMU relocation programme is complete, with SWIFT Ward moved to its interim location and AMU to its permanent site. Phase 3 refurbishment works are underway to establish SWIFT Ward in its permanent location and remain on track for completion by 14 September 2026. These changes will improve non-elective patient flow while increasing elective capacity
- Single-Site CCU Development: The phased programme also supports the development of a single-site CCU, with scoping work and revised models of care currently underway.
- A review of ESTH and Transfer of Care Hub performance has identified opportunities to reduce variation and improve discharge timeliness

Operational Productivity

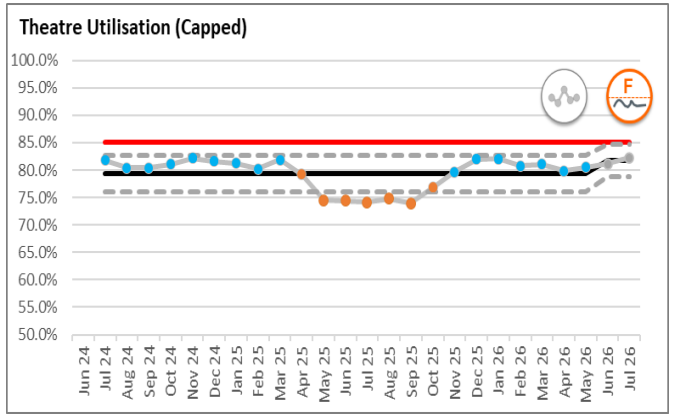
Theatre Utilisation

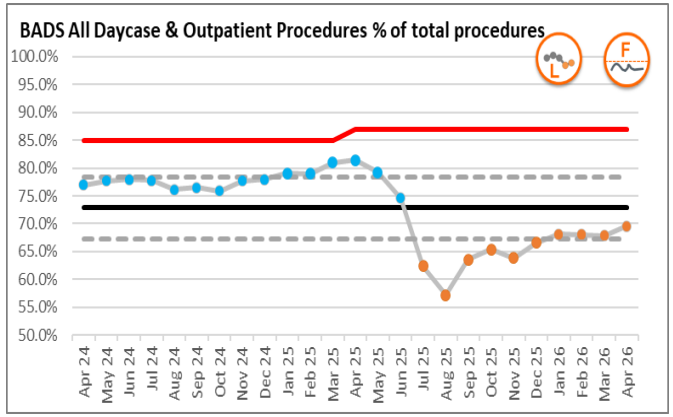
St George's





Epsom & St Helier





Analyses & Key actions

Group-wide - Progress continues on the gesh electronic Pre-Operative Assessment programme, supporting earlier digital pre-screening, risk identification and optimisation. Go-live dates for the patient questionnaire, issued through the patient portal, and the Cerner clinical management dashboard are awaiting confirmation

SGUH

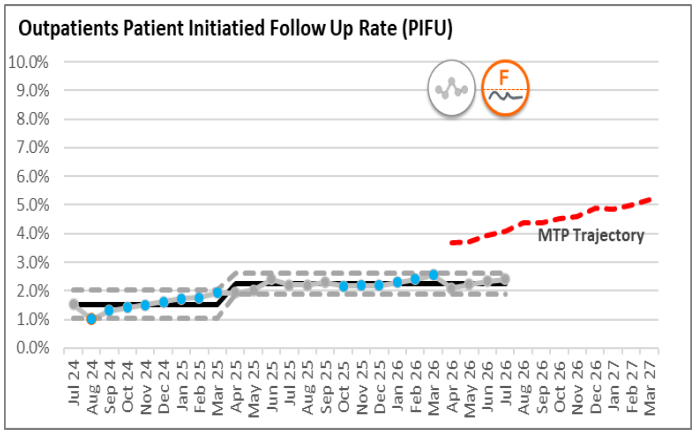
- Utilisation remained consistently above 80% in July 2026.
- Work is underway to reinvigorate list planning and the 6-4-2 process, with focuses on increasing productivity and speciality compliance.
- Work continues to strengthen case selection and theatre list planning to support BADS compliance, optimise patient flow and maximise the use of capacity.
- The current focus is on reducing variation in theatre performance across specialities through regular reviews, with the aim of improving consistency, resilience and utilisation.

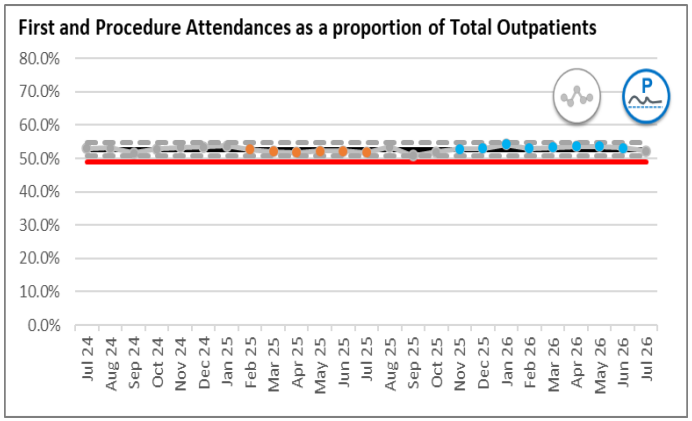
- ESTH
- July utilisation reached 82%, six percentage points above July 2025 and marking nine consecutive months at 80% or above. This was the strongest result since January and one percentage point below December's recent peak.
- A standardised Cerner process for recording late-start reasons was introduced in July to support targeted improvement.
- OTDC reporting is being reviewed with SGUH to improve rescheduled-cancellation data accuracy.
- The Standby Patient SOP is in development, with Gynaecology proposed as the pilot.
- Specialty-level BADS performance is under review, focusing on T&O and outpatient procedure opportunities.

Operational Productivity

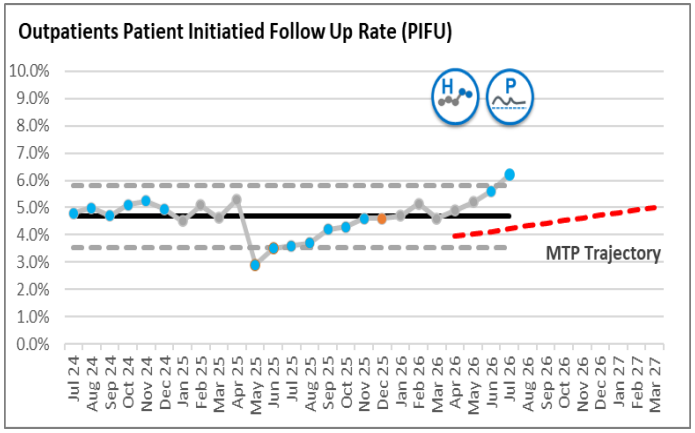
Outpatient Follow-ups

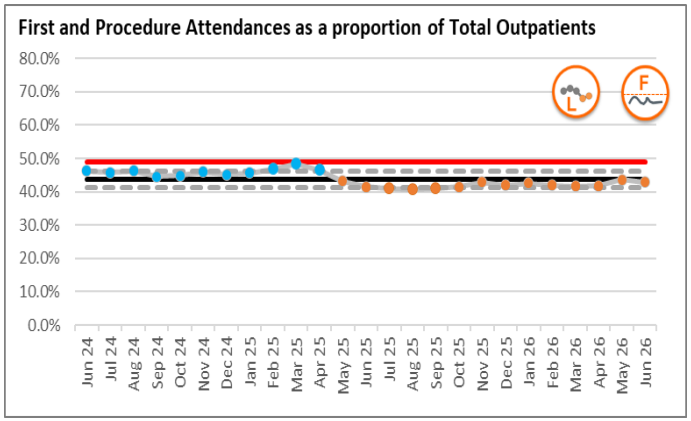
St George's





Epsom & St Helier





Analyses & Key actions

Group-wide

- Both sites are working collaboratively on increasing PIFU uptake using a standard model.

SGUH

- Recruitment of new OP Transformation Project Manager complete
- PIFU improvement programme to commence once Project Manager in post.
- Work underway to pilot Clinical Validation project to commence in Urology and ENT with expansion once pilot complete.
- Non RTT PTL tableau report developed to support review of potential non value add activity
- DNA rebooking plan to be presented to clinical leads Sept 26 for approval

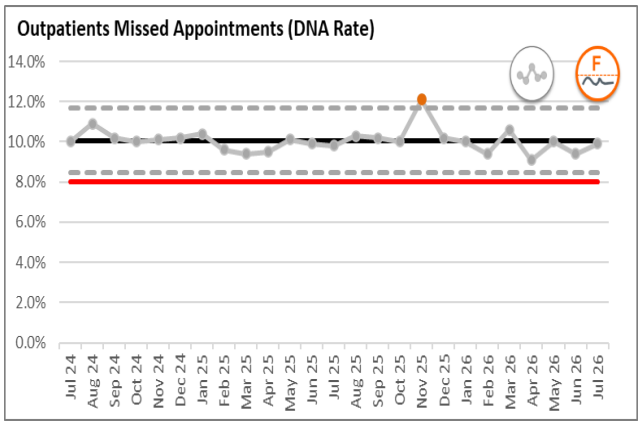
ESTH

- The proportion of first and procedure attendances remained stable in July 2026, the PIFU state has increased to 6.1%, well above target and we continue to work on this with a target of top-quartile performance.
- We continue to focus on the 6 key specialty areas highlighted at ESTH. The project managers continue to work on different schemes and projects to try and support this further.
- Identified a number of PIFU patients that haven't had an order placed (Teething issue from iClip roll over) we are also working on this to increase the PIFU %.

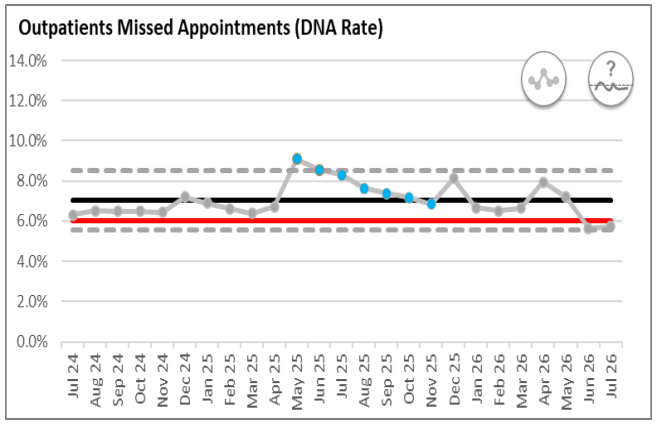
Operational Productivity

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.

Piloting four DNA reduction initiatives:

- DNA rebooking pathway (Plastics & Urology)
- Two-way appointment management via Netcall
- Day 28 reminder pilot and patient portal User Acceptance Testing
- Targeted RPA intervention for high-risk non-attenders

Next steps

- Gain agreement from clinical leads and SLT for DNA rebooking pathway
- Agree standardised approach to DNA calculation across the Group.
- Launch pilots, track benefits and evaluate outcomes to prioritise rollout
- Complete testing and implementation of two way communication functionality in Netcall.
- Implement Day 28 reminder pilot and evaluate impact
- Resolve remaining technical and operational dependencies for RPA deployment.
- Establish DNA performance dashboards and benefits realisation reporting.

ESTH

- DNA text reminders resolved, and we continue to see an stable DNA rate of approximately 5.7%. Summer tends to have a slight increase, so this was expected.
- We are looking to Pilot DNA automated calling in Cardiology, this is being scoped at the moment.
- An updated process for onboarding new clinics has started: A revised New Clinic Request Form has been implemented, including an option to request text reminder activation + any new build automatically feeds into appointment reminder system

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	Jul 26	4.9%	5.1%	4.3%		
MAST	Jul 26	91.5%	91.2%	85.0%		
Vacancy Rate	Jul 26	6.3%	6.2%	10.0%		
Appraisal Rate Medical	Jul 26	81.9%	81.1%	90.0%		
Appraisal Rate Non Medical	Jul 26	76.9%	76.5%	90.0%		
Turnover (12-month)	Jul 26	8.9%	8.7%	13.0%		
Percentage BAME staff band 8a and above	Jul 26	32.0%	32.4%	-		-
Workforce WTE All Staff Total	Jul 26	10888	10943	10986	-43	-
Substantive Total	Jul 26	10125	10125	10209	-84	-
Bank Total	Jul 26	704	763	753	10	-
Agency Total	Jul 26	58	54	24	30	-

Epsom & St Helier

KPI	Latest month	Previous month measure	Lastest month measure	Target	Variation	Assuranc
Staff Sickness Absence rate	Jul 26	5.5%	5.7%	4.5%		
MAST	Jul 26	88.3%	87.9%	85.0%		
Vacancy Rate	Jul 26	10.9%	11.8%	10.0%		
Appraisal Rate Medical	Jun 26	91.2%	88.0%	90.0%		
Appraisal Rate Non Medical	Jul 26	79.0%	77.4%	90.0%		
Turnover (12-month)	Jul 26	8.3%	8.1%	12.0%		
Percentage BAME staff band 8a and above	Jul 26	30.0%	30.3%	-		-
Workforce WTE All Staff Total	Jul 26	7359	7352	7222	130	-
Substantive Total	Jul 26	6406	6388	6413	-25	-
Bank Total	Jul 26	900	923	756	167	-
Agency Total	Jul 26	53	41	53	-12	-

Sutton Healthcare

KPI	Latest month	Previous Month Measure	Latest Month Measure	Target	Variation	Assurance
Sickness Absence Rate	Jul 26	5.4%	6.3%	4.5%		
MAST	Jul 26	92.5%	92.1%	85.0%		
Vacancy Rate	Jul 26	11.7%	11.2%	10.0%		
Appraisal Rate Medical	May 26	100.0%	100.0%	90.0%		
Appraisal Rate Non Medical	Jul 26	82.7%	97.0%	90.0%		
Turnover (12-Month)	Jul 26	9.5%	9.4%	12.0%		
Percentage BAME staff band 8a and above	Jul 26	27.7%	28.3%	-		-

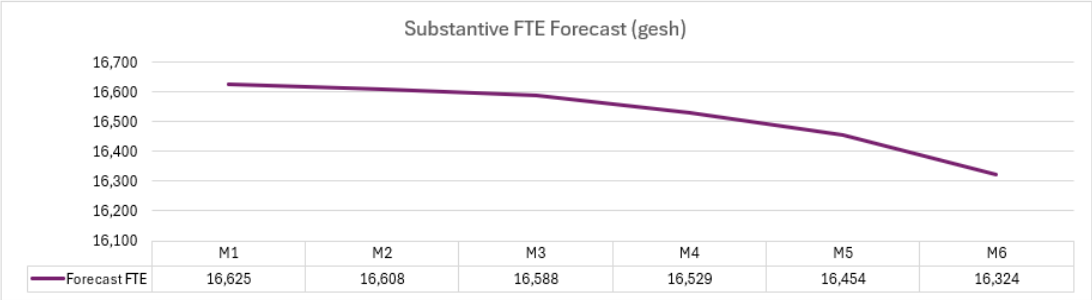
Surrey Downs

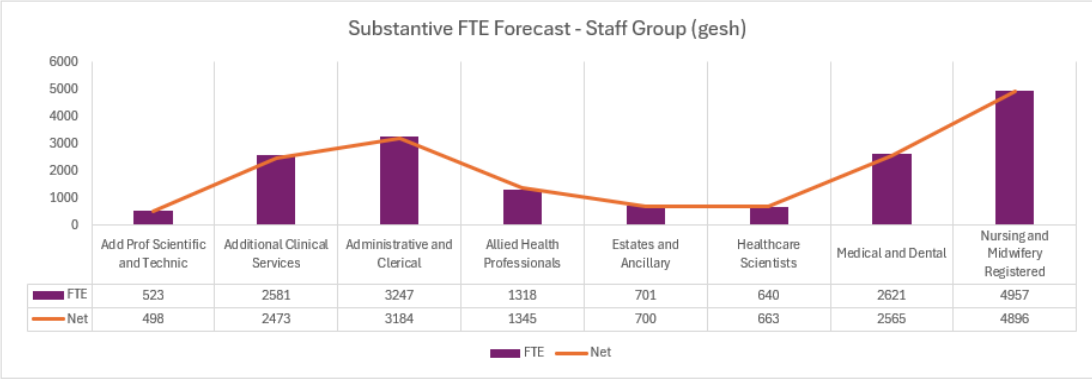
Latest month	Previous Month Measure	Measure	Target	Variation	Assurance
Jul 26	4.9%	5.4%	4.5%		
Jul 26	92.1%	92.1%	85.0%		
Jul 26	6.8%	11.7%	10.0%		
May 26	100.0%	100.0%	90.0%		
Jul 26	80.8%	82.4%	90.0%		
Jul 26	9.8%	9.7%	12.0%		
Jul 26	10.3%	12.3%	-		-

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.

Workforce Forecast

Recruitment pipeline and three-month workforce forecasting





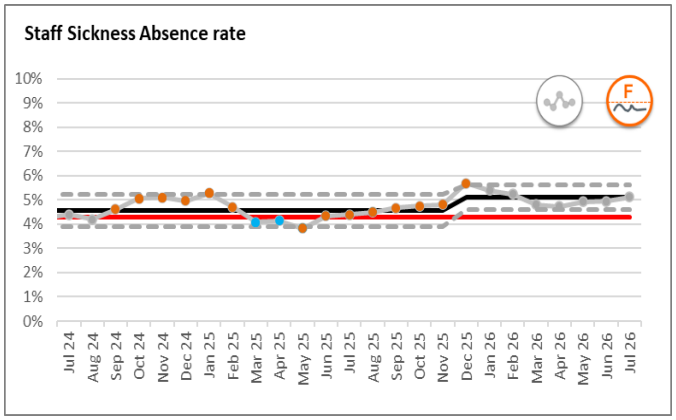
Forecasted FTE - Candidates in Unconditional Offer State with Confirmed Trust Start Date

	Substantive Forecast (FTE)	M1	M2	M3	M4	M5	M6
STG	Permanent	10,171	10,141	10,151	10,151	10,129	10,072
	Average Leavers in Month	-	-	-	100	128	120
	Recruitment Pipeline	-	-	-	78	71	52
	Forecast	10,171	10,141	10,151	**10,129**	**10,072**	**10,004**
	Net Change	-	-	-	*-22*	*-57*	*-68*
ESTH	Substantive Forecast (FTE)	M1	M2	M3	M4	M5	M6
	Permanent	6,454	6,467	6,437	6,437	6,400	6,382
	Average Leavers in Month	-	-	-	70	59	80
	Recruitment Pipeline	-	-	-	33	41	18
	Forecast	6,454	6,467	6,437	**6,400**	**6,382**	**6,320**
	Net Change	-	-	-	*-37*	*-18*	*-62*
GESH	Substantive Forecast (FTE)	M1	M2	M3	M4	M5	M6
	Permanent	16,625	16,608	16,588	16,588	-59	16,454
	Average Leavers in Month	-	-	-	170	187	200
	Recruitment Pipeline	-	-	-	111	112	70
	Forecast	16,625	16,608	16,588	**16,529**	**16,454**	**16,324**
	Net Change	-	-	-	*-59*	*-75*	*-130*

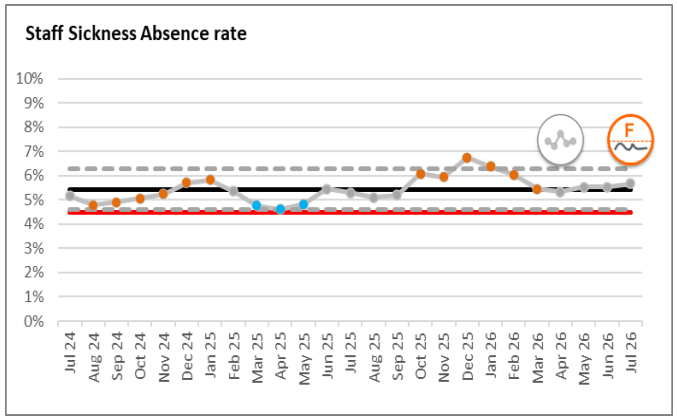
Our People

Exception Report| Sickness Absence Rate

St George's



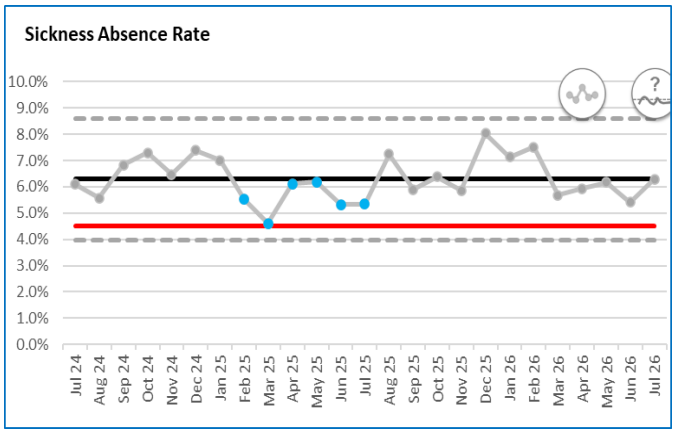
Epsom & St Helier



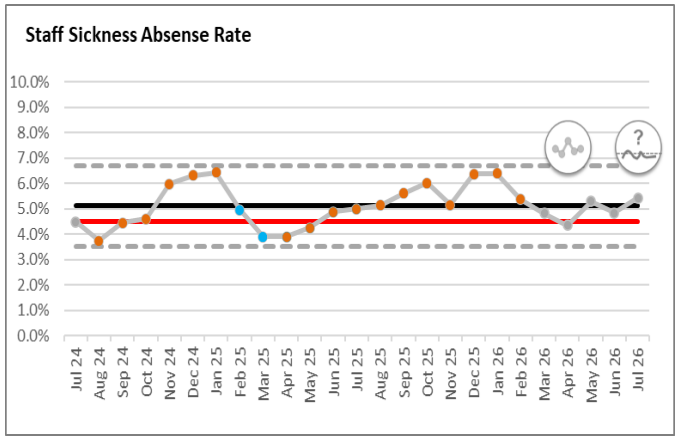
Analyses & Key actions

- Sickness absence levels remain high across gesh, adversely affecting performance, quality and operational efficiency. In response, the Clinical Workforce Transformation Programme is prioritising the reduction of sickness absence as a key workstream for mobilisation, with a focus on identifying the underlying drivers and delivering targeted interventions to improve workforce resilience and attendance.
- Progress has been made during mobilisation, with the majority of programme posts recruited, governance arrangements established, and the Operational Delivery Group established. Priority remains the management of long-term sickness absence, with targeted interventions focused on reducing the number of open cases, particularly those exceeding 18 months

Sutton Healthcare



Surrey Downs



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	Assurance	Benchmark
Mixed Sex Accommodation Breaches	Jul 26	114	125	0			Lowest Quartile
Number of Complaints Received	Jul 26	131	159	-		-	N/A
Number of re-opened complaints in month	Jul 26	8	5	-		-	N/A
Parliamentary and Health Service Ombudsman (PHSO) Received	Jul 26	6	1	-		-	N/A
Parliamentary and Health Service Ombudsman (PHSO) Closed	Jul 26	1	1	-		-	N/A
RTT - Total Size Incomplete Waiting List	Jun 26	69355	69329	68199			N/A
On the Day Cancellations not re-booked within 28 days	Jul 26	4	1	0			2nd Quartile
Outpatient Advice & Guidance Rate per 100 First OPA	Apr 26	22.6	21.6	16.0			3rd Quartile
Emergency Department Attendances per day	Jul 26	451	447	-		-	N/A
Mental health delays 4 Hour Breaches	Jul 26	127	128	-		-	N/A
Length of stay > 21 days (super stranded)	Jul 26	184	174	-		-	3rd Quartile
Overnight G&A beds occupancy - Adults	Jul 26	96.3%	96.2%	96.0%			N/A
Number of patients not meeting criteria to reside (Daily Avg)	Jul 26	117	106	-		-	2nd Quartile

Epsom & St Helier

Latest month	Previous month measure	Lastest month measure	Target	Variation	Assurance	Benchmark
Jul 26	42	37	0			Lowest Quartile
Jul 26	77	86	-		-	N/A
Jul 26	4	3	-		-	N/A
Jul 26	1	0	-		-	N/A
Jul 26	1	0	-		-	N/A
Jun 26	57374	57011	57100			N/A
Jun 26	2	0	0			2nd Quartile
Apr 26	64.8	59.5	16.0			Top Quartile
Jul 26	462	450	-		-	N/A
Jul 26	227	206	-		-	N/A
Jul 26	140	154	-		-	Lowest Quartile
Jul 26	96.2%	95.3%	88.0%			N/A
Jul 26	192	199	-		-	TBC

Sutton Healthcare

KPI	Latest month	Previous Month Measure	Latest Month Measure	Target	Variation	Assurance
Urgent Community Response (UCR) Referrals	Jul 26	396	416	-		-
Virtual ward - Admissions	Jul 26	303	306	-		-
Discharge to Assess- Pathway 0-3 Delays (Median Days)	Jul 26	3	0	-		-
Total number of adult patients on the waiting list	Jul 26	3328	3396	-		-
Total number of children patients on the waiting list	Jul 26	1199	1168	-		-
Total Number of Compliants Received	Jul 26	5	2	-		-

Surrey Downs

Latest month	Previous month measure	Latest month measure	Target	Variation	Assurance
Jul 26	587	605	441		
Jul 26	297	288	-		-
Jul 26	3	2	-		-
Jul 26	5580	5764			-
Jul 26	1	0			-

Appendix 3 - Cancer Performance by Tumour Type

Overview Dashboard

28 Day Faster Diagnosis Standard

St George's

KPI	Latest month	Previous Month Measure	Latest Month Measure	National Average	Variation
Suspected brain/central nervous system tumours	Jun 26	N/A	N/A	100.0%	-
Suspected head & neck cancer	Jun 26	74.4%	77.7%	77.4%	
Suspected breast cancer	Jun 26	93.9%	95.0%	92.8%	
Exhibited (non-cancer) breast symptoms - cancer not initially suspected	Jun 26	92.2%	90.5%	94.5%	
Suspected lung cancer	Jun 26	79.5%	77.8%	82.9%	
Suspected upper gastrointestinal cancer	Jun 26	64.2%	56.5%	77.9%	
Suspected lower gastrointestinal cancer	Jun 26	68.8%	76.9%	72.9%	
Suspected gynaecological cancer	Jun 26	86.5%	91.3%	76.4%	
Suspected testicular cancer	Jun 26	87.5%	100.0%	100.0%	
Suspected urological malignancies (excluding testicular)	Jun 26	62.9%	80.2%	75.9%	
Suspected haematological malignancies (excluding acute leukaemia)	Jun 26	44.4%	69.2%	75.0%	
Suspected skin cancer	Jun 26	91.1%	90.0%	92.9%	
Suspected sarcoma	Jun 26	N/A	N/A	58.3%	-
Suspected children's cancer	Jun 26	100.0%	60.0%	100.0%	
Suspected cancer - non-specific symptoms	Jun 26	60.6%	66.0%	60.2%	

Epsom & St Helier

Latest month	Previous Month Measure	Latest Month Measure	National Average	Variation
Jun 26	33.3%	92.3%	100.0%	
Jun 26	88.3%	94.5%	77.4%	
Jun 26	N/A	N/A	92.8%	-
Jun 26	N/A	N/A	94.5%	-
Jun 26	76.3%	80.0%	82.9%	
Jun 26	94.4%	86.1%	77.9%	
Jun 26	81.1%	76.0%	72.9%	
Jun 26	86.6%	93.1%	76.4%	
Jun 26	N/A	N/A	100.0%	-
Jun 26	95.3%	98.0%	75.9%	
Jun 26	77.8%	75.0%	75.0%	
Jun 26	99.6%	99.0%	92.9%	
Jun 26	N/A	N/A	58.3%	-
Jun 26	N/A	100.0%	100.0%	
Jun 26	77.4%	89.7%	60.2%	

Cancer 62 Day Referral to Treatment Standard

KPI	Latest month	Previous Month Measure	Latest Month Measure	National Average	Variation
Gynaecological	Jun 26	100.0%	0.0%	63.5%	
Skin	Jun 26	84.2%	90.0%	94.1%	
Lung	Jun 26	55.0%	61.1%	65.2%	
Other (a)	Jun 26	100.0%	100.0%	91.5%	
Lower Gastrointestinal	Jun 26	57.1%	91.9%	73.4%	
Head & Neck	Jun 26	52.0%	68.6%	62.7%	
Breast	Jun 26	75.9%	93.8%	73.8%	
Upper Gastrointestinal - Oesophagus & Stomach	Jun 26	66.7%	50.0%	71.7%	
Haematological - Lymphoma	Jun 26	71.4%	87.5%	71.4%	
Upper Gastrointestinal - Hepatobiliary	Jun 26	80.0%	100.0%	76.8%	
Urological - Prostate	Jun 26	100.0%	100.0%	83.2%	
Urological - Other (a)	Jun 26	63.4%	51.5%	75.0%	
Haematological - Other (a)	Jun 26	66.7%	75.0%	100.0%	

Latest month	Previous Month Measure	Latest Month Measure	National Average	Variation
Jun 26	58.3%	62.5%	63.5%	
Jun 26	96.1%	97.8%	94.1%	
Jun 26	69.0%	64.3%	65.2%	
Jun 26	100.0%	100.0%	91.5%	
Jun 26	80.0%	87.5%	73.4%	
Jun 26	100.0%	100.0%	62.7%	
Jun 26	66.7%	100.0%	73.8%	
Jun 26	50.0%	77.8%	71.7%	
Jun 26	50.0%	71.4%	71.4%	
Jun 26	89.5%	81.0%	76.8%	
Jun 26	100.0%	100.0%	83.2%	
Jun 26	75.0%	100.0%	75.0%	
Jun 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 (Public)

Meeting on Friday, 11 September 2026

Agenda Item	5.1	
Report Title	**People Committees Report to Group Board**	
Non-Executive Lead	Yin Jones, People Committees Chair, SGUH & ESTH NED	
Report Author(s)	Yin Jones, People Committees Chair, SGUH & ESTH NED	
Previously considered by	n/a	
Purpose	**For Assurance**	

Executive Summary

This report sets out the key issues considered by the People Committees at its meeting in August 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:

- Mutually Agreed Resignation Scheme (MARS): The MARS was formally launched on 10 August 2026 for a six-week exploratory window, and had received strong initial interest. The Committee also discussed the potential impact on staff not opting into the scheme, including the risk of demoralisation given the broader economic context.

- Sexual Safety: Sexual safety remains a significant issue across the NHS and a priority within the group, and the organisation has further to go to meet the standard set by the incoming Employment Rights Act 2025. The Committees received a limited level of assurance regarding Sexual Safety.

- NHS 10 Point Plan for Improving Resident Doctors' Working Lives (IRDWL): The Committees received a detailed update on actions being taken to improve the working environment for resident doctors. Tracked actions have increased to 97 total actions across gesh, with 10 items complete. A direct executive reporting line has been established to ensure momentum. Progress at ESTH has been slower due to competing priorities, and there is a noted need for larger systemic improvements rather than focusing on small wins.

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 August 2026.

Committee Assurance	
Committee	People 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

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, 11 September 2026

1.0 Purpose of paper

1.1 This report sets out the key issues considered by the People Committees at its meeting in August 2026 and includes the matters the Committees specifically wish to bring to the attention of the Group Board.

1.2 The role of the Committees, as set out in its terms of reference, is to provide assurance on the development and delivery of a sustainable, engaged and empowered workforce that supports the provision of safe, high quality, patient-centred care.

2.0 Items considered by the Committees

2.1 At its meeting on 20 August 2026, the Committees considered the following items of business:

20 August 2026
• Group Chief People Officer Report • Sexual Safety • Violence & Aggression Assurance • Sickness Absence Reduction Programme Briefing • Flexible Working • Equality, Diversity & Inclusion (EDI) • Guardian of Safe Working, Q1 2026/27 • Freedom To Speak Up Report – Q1 2026/27 • Workforce KPI Performance Report • Staff Survey – NSS 2026 planning

2.2 The Committees meet every two months as agreed by the Group Board. An informal meeting between the Chair and GCPO takes place in the month between Committee meetings. The meeting on 20 August 2026 was quorate.

3.0 Key issues for escalation to the Group Board

3.1 No new risks or issues were raised for escalation to the Board.

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:

- Sexual Safety at Work: The Committee considered that it had received a limited level of assurance regarding sexual safety based on the update received and the further work required to ensure compliance with the new Employment Rights Act. The Committees an update on the work being undertaken across the Group to prepare the organisation for the tightening legislation under the new Employment Rights Act 2025, which sets a very high bar that the Trusts have further to go to meet. Extensive cultural work had improved the balance in historically problematic areas such as ESTH theatres, although under-reporting of inappropriate behaviour likely persists. The Committee heard that the GCPO chaired a dedicated steering group which provides targeted oversight to drive positive action in this area.

- Violence & Aggression: The Committees received a reasonable level of assurance regarding Violence & Aggression. There had been a 24% increase in reported incidents, which is interpreted partly as a positive indicator of improved reporting culture and staff empowerment.

- Sickness Absence Reduction Programme Briefing: The Committees received a reasonable level of assurance for the newly established sickness intervention programme, which targets areas with high temporary staffing backfill costs (£3m at SGUH, £5.5m at ESTH). Feedback was noted from experienced leaders and consultants regarding grievances with both the sickness policy's design and the lack of management support in applying it, which makes early intervention difficult.

- Flexible Working: The Committees received reasonable assurance for the flexible working policy framework, but limited assurance regarding data and information, pending upcoming internal audit findings. A disparity in formal flexible working appeals between sites (21 at ESTH vs 5 at SGUH) may stem from a lack of manager confidence to explore alternative arrangements at the informal stage.

- Guardians of Safe Working (GOSW), Q1 2026/27: The Committees received a reasonable level of assurance regarding the statutory GOSW reports. At SGUH, exception reporting more than doubled across medical and surgical specialties due to additional hours, late finishes, and missed breaks, alongside noted concerns regarding the lack of e-rostering rollout. At ESTH, exception reports doubled to 219 following the removal of clinical supervisor narrative requirements, which the Committees viewed positively as evidence of a more accessible, barrier-free reporting system. Concerns were highlighted regarding the lack of e-rostering in many departments and immediate safety concerns being routed directly to Clinical Directors, removing vital independent GOSW oversight. Additional resources have been hired to roll out e-rostering at SGUH.

- Freedom To Speak Up (FTSU) Report – Q1 2026/27: The Committees received a reasonable level of assurance for the FTSU function, but limited assurance regarding the wider speaking-up culture across the Group, given the issues identified in the previous NHS staff survey at both Trusts. Perceived unfair conduct by line managers and lack of process support remained the leading themes raised by staff. Measurable operational changes were taking place via the employee relations service redesign and the gesh people management programme.

- Workforce KPI Performance Report: The Committees received a reasonable level of assurance for the Workforce KPIs. A positive reduction of 71 WTE compared to April 2026 was noted. The strategic workforce plan triangulates WTE reductions with financial forecasts, natural attrition, and the recruitment pipeline.

5.0 Other issues considered by the Committees

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

- Equality, Diversity & Inclusion (EDI): The Committees endorsed the WRES and WDES reports for presentation to the Board in September 2026, ahead of publication. The Committee also endorsed the continuation of the Inclusion Board and fully supported a second cohort. It was stressed that future reports require deeper analysis explaining

the drivers behind the data and linking outcomes to specific action efficacy. The updated EDI Action Plan will be presented to the Committees in October 2026.

- NHS Staff Survey (NSS) – 2026 planning: The Committees approved the NSS 2026 planning approach, which pivots to focus on rebuilding trust and increasing the overall response rate to capture the views of the broader workforce. The Committee supported localised, team-based incentives to drive response rates, particularly amongst lower-banded and frontline clinical staff.

- NHS 10 Point Plan for Improving Resident Doctors' Working Lives (IRDWL): At the beginning of the meeting, the Committees received a detailed update on actions being taken to improve the working environment for resident doctors. The Deputy Group Director of Facilities reported an increase in targeted tasks from 39 to 55, with 97 total actions currently being tracked across the group. Of these, 10 items are now complete and 39 remain in progress. A direct executive reporting line has been established to maintain momentum for these improvements. Progress at ESTH has reportedly been slower due to other competing priorities; however, a dedicated meeting with the PGMC (postgraduate medical centre) lead is underway to address this delay. The Resident Doctor Peer Lead for SGUH emphasised the need to focus on larger systemic improvements, such as providing dedicated rest spaces, rather than solely delivering small wins like new chairs and IT equipment. A further update is scheduled for the October Committee meeting to demonstrate tangible improvements across both sites. The Committees also noted that the IRDWL Steering Group (chaired by the GCMO) will be meeting later this year to track progress.

6.0 Recommendations

6.1 The Group Board is asked to note the issues escalated to the Group Board and the wider issues on which the People Committees received assurance on 20 August 2026.

Group Board (Public)

Meeting on Friday, 11 September 2026

Agenda Item	5.2	
Report Title	**Equality, Diversity and Inclusion (EDI) Overview, including approval of 2026 WRES and WDES reports**	
Executive Lead(s)	Victoria Smith, Group Chief People Officer	
Report Author(s)	Joseph Pavett-Downer, Head of EDI (Workforce)	
Previously considered by	People Committee-in-Common	
Purpose	**For Approval / Decision**	

Executive Summary

The 2026 EDI position demonstrates overall steady progress in strengthening workforce diversity, representation and inclusion across the Group. Workforce representation remains broadly reflective of the communities we serve, disability declaration rates continue to increase, and progress has been made in delivering the commitments set out within the Group EDI Action Plan. The majority of planned actions are now either completed or embedded into business-as-usual activity, reflecting a sustained organisational commitment to creating a more inclusive working environment.

At the same time, the latest evidence confirms that structural inequalities remain evident across several aspects of workforce experience. Persistent disparities in recruitment outcomes, career progression, disciplinary and capability processes, experiences of bullying and harassment, and confidence in reporting concerns continue to affect colleagues from ethnic minority backgrounds and colleagues with disabilities. Whilst progress has been made in some areas, improvement remains inconsistent across the Group and the pace of change is not yet sufficient to eliminate long-standing inequities.

Taken together, the findings from the WRES, WDES, Inclusion Board Evaluation and EDI Action Plan provide a consistent picture. The priority is now translating existing commitments into sustained cultural, behavioural and operational change, with stronger local ownership and accountability across divisions, services and leadership teams.

Action required by Group Board

The Board is asked to:

a. Approve the publication of the 2026 WRES and WDES reports.
b. Note the progress in delivering the EDI Action Plan.
c. Support our work to develop strengthened accountability, ensuring divisions and services are actively engaged in understanding their local data, identifying priorities and leading improvement activity within their areas of responsibility – accessing support via the EDI Team and their respective HRBP.

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

Appendices	
Appendix No.	**Appendix Name**
Appendix 1	Group WRES 2026 Report
Appendix 2	Group WDES 2026 Report
Appendix 3	EDI Action Plan Update
Appendix 4	Inclusion Board mid-point evaluation 050826

Implications

Group Strategic Objectives

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

Risks

Workforce Sustainability: Failure to improve WRES and WDES outcomes may lead to reduced staff engagement, higher turnover, increased sickness absence and greater challenges in recruiting and retaining a diverse workforce.

Quality of Care: Persistent inequalities in staff experience may undermine inclusion, psychological safety and teamwork, potentially impacting the quality, safety and experience of patient care.

Legal and Regulatory Compliance: Lack of progress may increase the risk of discrimination claims and make it more difficult for the Trust to demonstrate compliance with the Equality Act 2010, the Public Sector Equality Duty and NHS England's EDI expectations.

Reputation and Stakeholder Confidence: Poor equality outcomes may damage the Trust's reputation and reduce confidence amongst staff, patients, partners and regulators in the organisation's commitment to fairness and inclusion.

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

If we decide to run a further cohort of the Inclusion Board we will need to seek Executive support to fund the external facilitation.

Legal and / or Regulatory implications

Equality, diversity and inclusion are fundamental responsibilities for NHS organisations, supported by both the Equality Act 2010 and the Public Sector Equality Duty. NHS trusts must work to eliminate discrimination, advance equality of opportunity and foster good relations for staff, patients and communities.

Equality, diversity and inclusion implications
This paper focuses on our EDI progress and areas for improvement. The Workforce Race Equality Standard (WRES) and Workforce Disability Equality Standard (WDES) provide mandated frameworks for monitoring and addressing inequalities in the workforce. NHS England has also strengthened expectations through its EDI Improvement Plan, placing greater emphasis on board-level accountability and measurable improvement. Delivering EDI effectively helps organisations meet their legal and regulatory duties while improving staff experience, patient care, patient safety and organisational performance.
Environmental sustainability implications
N/A

Equality, Diversity and Inclusion (EDI) Overview

Group Board, 11 September 2026

1.0 Purpose of paper

1.1 This paper provides an overview update of progress against the Group's Equality, Diversity and Inclusion (EDI) agenda. It also meets the organisation's compliance in preparation for publishing the Workforce Race Equality Standard (WRES) and the Workforce Disability Equality Standard (WDES) for 2026. This paper should be read alongside the detailed reports on the Workforce Race Equality Standard (WRES), Workforce Disability Equality Standard (WDES), the 2025-27 EDI Action Plan, and the Inclusion Board Evaluation reports, which provide further analysis and supporting evidence.

2.0 Background

2.1 The NHS Workforce Race Equality Standard (WRES), introduced in 2015, and the Workforce Disability Equality Standard (WDES), introduced in 2019, are mandated by NHS England and form part of the NHS Standard Contract. They provide a consistent framework for NHS organisations to measure, monitor and address inequalities in the experience, opportunities and treatment of staff from Black and minority ethnic backgrounds and disabled staff. Through a series of nationally defined indicators, WRES and WDES support organisations to identify areas for improvement, strengthen accountability and promote an inclusive workplace.

2.2 We recognise that equality, diversity and inclusion are critical to creating a culture of belonging, improving staff experience and ensuring fair access to opportunities. Evidence cited by NHS England demonstrates that a motivated, included and valued workforce contributes to higher quality patient care, improved patient satisfaction and better patient safety outcomes.

3.0 Key issues for consideration

3.1 **WRES Summary**

The 2026 WRES data demonstrates continued progress in workforce diversity across both Trusts, with BME representation increasing to 55.4% at St George's and 50.0% at Epsom and St Helier, ensuring the workforce remains broadly reflective of the communities served. Positive progress was also seen in Voting Board representation at both Trusts, alongside small improvements in staff experience at St George's, where reports of harassment, bullying and abuse from colleagues declined. Access to non-mandatory training and CPD remains broadly equitable across both organisations, indicating continued progress towards fair access to development opportunities.

However, the report also highlights several persistent inequalities. Both Trusts continue to report disparities in recruitment outcomes, with White applicants more likely to be appointed from shortlisting than BME applicants, and BME staff remaining more likely to enter formal disciplinary processes. Whilst Executive Board representation remains below workforce representation at both organisations, the most significant challenges are evident within staff experience measures at ESTH, where reports of harassment, bullying and abuse have increased and confidence in career progression opportunities has declined. These findings

reinforce the importance of continuing delivery of the Group EDI Action Plan and Talent Management Plan, using the latest WRES data to target interventions, monitor impact and focus effort on the areas where inequalities remain greatest.

3.2 WDES Summary

The 2026 WDES data shows continued progress in disability representation across the Group, with the proportion of staff declaring a disability increasing to 4.7% at St George's, 5.6% at ESTH and 5.1% across gesh overall. Positive improvements were also seen in several staff experience indicators, including reduced reports of harassment from patients, the public and colleagues at St George's, alongside a reduction in pressure to attend work whilst unwell at ESTH. Recruitment outcomes remained broadly equitable across both Trusts, staff engagement scores remained stable, and the proportion of staff reporting that workplace adjustments had been implemented continued to be maintained at around two-thirds of staff with a disability.

Despite these positive developments, the report highlights ongoing challenges in the workplace experience of staff with disabilities. Both Trusts reported declines in perceptions of career progression opportunities, increased disparity in formal capability processes, and a reduction in disabled representation at Voting Board level. Challenges relating to harassment from managers, reporting confidence, how work is valued and access to effective workplace adjustments also remain evident. These findings demonstrate the importance of continuing delivery of the Group EDI Action Plan and Talent Management Plan, using the latest WDES data to target interventions, monitor progress and maintain focus on the areas where inequalities continue to have the greatest impact on staff experience.

3.3 EDI Action Plan progress summary

The 2025-27 gesh EDI Action Plan continues to provide the strategic framework for improving workforce equality, inclusion and opportunity across the group. Since Board approval, substantial progress has been made, with 46 of 58 actions completed or embedded into business as usual activity, including the implementation of the Talent Management Plan, expansion of inclusive recruitment initiatives, strengthened leadership expectations, enhanced disability support resources, and continued investment in staff networks, awareness raising and inclusive leadership development. These actions align directly to many of the themes identified within the 2026 WRES and WDES reports, including recruitment, career progression, representation, workplace wellbeing and staff experience.

Whilst progress against the Action Plan has been positive, it is important to recognise that many of the outcomes measured through WRES and WDES reflect long-term cultural and behavioural change. As a result, there is not always a direct or immediate correlation between the completion of an action and measurable improvements within workforce equality indicators. The 2026 WRES and WDES findings show that several of the priority areas identified when the action plan was developed, including career progression, staff experience, harassment and bullying, and fairness within people processes, remain ongoing challenges across both Trusts.

The findings reinforce the need to continue delivery of the existing EDI Action Plan whilst strengthening divisional engagement and local accountability for outcomes. Sustainable improvement will require continued commitment from operational, clinical and corporate leaders across gesh, supported by the EDI team, rather than delivery through a central function alone. The latest WRES and WDES data will therefore be used to further refine priorities, target interventions and measure impact, ensuring resources remain focused on the

areas where inequalities persist and where the greatest improvements for staff experience and opportunity can be achieved.

Alongside the update on the EDI Action Plan, we have included an overview of the Inclusion Board programme midpoint, where evaluation findings demonstrate strong progress against the programme's intended objectives. The People Committee have expressed a desire to continue to have an Inclusion Board and have made suggestions for improvements.

3.4 Key Challenges

Despite encouraging progress, the latest evidence highlights several areas requiring sustained attention.

Across both organisations, ethnic minority staff continue to experience less favourable outcomes in recruitment processes, with White applicants more likely to be appointed following shortlisting. Similarly, ethnic minority colleagues remain disproportionately represented within formal disciplinary processes. These findings indicate that inequities within workforce processes remain embedded and require ongoing scrutiny.

For disabled staff, while recruitment outcomes remain broadly equitable, disparities are evident in relation to formal capability processes, perceptions of career progression opportunities, workplace valuation and confidence that concerns will be acted upon. The reduction in disability representation at Voting Board level also highlights the need to maintain focus on leadership representation and visibility.

Career progression emerges as a particularly significant issue across both the WRES and WDES findings. Staff from underrepresented groups continue to report lower confidence in opportunities for advancement and development. This suggests that although access to development activity may be improving, the lived experience of progression and advancement has not yet improved at the same rate.

Staff experience indicators continue to present a mixed picture. While St George's has seen improvements in some measures of harassment, bullying and abuse, concerns remain across the Group, particularly within Epsom and St Helier where negative experiences have increased. These findings underline the importance of creating psychologically safe working environments where all colleagues feel respected, valued and able to raise concerns without fear of negative consequences.

3.5 Strategic Response

The collective findings from the WRES, WDES, EDI Action Plan and Inclusion Board Evaluation reinforce the need for a coordinated and strategic approach to inclusion across the Group.

The Group's focus over the next phase should be on three interconnected priorities:

1. *Strengthening Fairness in People Processes*
   Continue to address inequalities within recruitment, disciplinary and capability processes through robust data analysis, enhanced assurance, manager capability development and greater accountability for outcomes owned within divisional/management teams.

2. *Improving Career Development and Representation*

Accelerate delivery of the Talent Management Plan, strengthen succession planning and leadership pathways, and ensure equitable access to progression opportunities for underrepresented groups at all levels of the organisation.

3. *Embedding Inclusive Culture and Leadership*
Move beyond programme delivery towards deeper cultural change by strengthening divisional ownership, leadership accountability and everyday inclusive behaviours. This includes creating psychologically safe environments where bullying, harassment and discrimination are actively challenged and addressed.

4.0 Recommendations

4.1 The Board is asked to:

a. Approve the publication of the 2026 WRES and WDES reports.
b. Note the progress in delivering the EDI Action Plan.
c. Support our work to develop strengthened accountability, ensuring divisions and services are actively engaged in understanding their local data, identifying priorities and leading improvement activity within their areas of responsibility – accessing support via the EDI Team and their respective HRBP.

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Workforce Race Equality Standard (WRES) 2026 Report

Features: 2025 Staff Survey Data and workforce information on 31/03/2026
Published: 00/00/2026

Workforce Race Equality Standard Report 2026

Purpose, background and definitions

Purpose

- This paper provides an overview of the 2026 Workforce Race Equality Standard (WRES) findings.
- This report will be published on the Trust websites.
- The Board is asked to receive this report for information and approve for publication.

Background

- In April 2015, NHS England introduced the WRES in response to consistent findings that BME applicants and staff consistently fared worse in employment outcomes and satisfaction surveys. The WRES was designed to enable NHS organisations to demonstrate progress against a number of key indicators of workforce equality, including a specific indicator to address the low levels of BME Board representation.
- Since April 2015, the WRES has been included in the full-length NHS Standard Contract and requires all providers of NHS services to address the issue of workforce race inequality by implementing and using the WRES.
- There are nine WRES indicators. Four of the indicators focus on workforce data, four are based on data from national NHS Staff Survey questions, and one indicator focuses upon BME board representation. The WRES highlights differences between the experience and treatment of White staff and BME staff in the NHS with a view to organisations closing those gaps through the development and implementation of action plans focused upon continuous improvement over time.
- The WRES is produced in line with Technical Guidance issued by NHS England.
- Indicators 1-3 and 9 are produced via the Electronic Staff Record (ESR) from a snapshot of data taken on 31st March 2026. All other indicators are from the 2025 staff survey.

Definitions of ethnicity: people covered by the WRES

- In line with NHSE's WRES Guidance, the term 'BME' and 'white' are used to describe the two groups of staff referred to in this report.
- 'White' staff include white British, Irish, Eastern European and any other white. The 'Black and Minority Ethnic' staff category includes all others except 'unknown' and 'not stated.'
- Further information can be found in *appendix A: Definitions of ethnicity: people covered by the WRES.*

Overview of Workforce Numbers

STG	2021	2022	2023	2024	2025	**2026**
Total number of staff in organisation	9,154	9,608	9,915	10,345	10,831	**10,868**
% of BME Staff	47.7%	50.1%	51.9%	53.6%	54.7%	**55.4%**
% of staff who self-reported ethnicity	96%	97%	97%	97%	97%	**97%**

ESTH	2021	2022	2023	2024	2025	**2026**
Total number of staff in organisation	6,150	7,092	7,190	7,410	7,326	**7,284**
% of BME Staff	38.1%	38.2%	42.0%	44.2%	47.8%	**49.9%**
% of staff who self-reported ethnicity	95%	91%	92%	94%	97%	**97%**

Workforce Race Equality Standard Report 2026

Indicator Overview

Note: '*Compared to White Staff*': A green cell indicates BME staff report a more positive experience (compared to white staff).
Indicators are classified as Improved, Static or Declined based on the significance of year-on-year change

	WRES Indicator	STG							ESTH						
		2022	2023	2024	2025	2026	vs. LY	Compared to White Staff	2022	2023	2024	2025	2026	vs. LY	Compared to White Staff
1	% of BME staff in organisation	50.1%	51.9%	53.6%	54.7%	**55.4%**	**Increased**		38%	41%	44.2%	47.8%	**50%**	**Increased**	
2	Relative likelihood of White applicants being appointed from shortlisting compared BME applicants	1.26	1.50	2.2	1.77	**1.76**	**Static**		1.04	1.30	0.74	1.56	**1.65**	**Static**	
3	Relative likelihood of BME staff entering the formal disciplinary process, compared to that of White staff	1.65	1.67	1.48	1.17	**1.98**	**Declined**		1.20	1.45	1.04	1.36	**1.48**	**Declined**	
4	Relative likelihood of White staff accessing non-mandatory training and CPD compared to BME staff	0.98	0.95	0.87	0.93	**0.96**	**Static**		1.07	0.52	1.01	1.09	**1.06**	**Static**	
5	% of BME staff experiencing harassment, bullying or abuse *from patients, relatives or the public* in the last 12 months.	23.3%	27.0%	25.7%	25.2%	**25.3%**	**Static**		27.5%	28.3%	25.5%	24.8%	**29.2%**	**Declined**	
6	% of BME staff experiencing harassment bullying or abuse *from staff* in the last 12 months	25.9%	27.3%	26.9%	28.0%	**25.8%**	**Improved**		26.2%	25.5%	23.2%	21.6%	**24.4%**	**Declined**	
7	% of BME staff believing that organisation provides equal opportunities for career progression or promotion	42.1%	43.8%	44.0%	45.2%	**45.1%**	**Static**		44.7%	45.9%	51.6%	51.0%	**48.3%**	**Declined**	
8	% of BME staff personally experiencing discrimination at work from *manager/leader/ or other colleagues*.	16.6%	16.9%	15.9%	16.4%	**15.8%**	**Static**		15.8%	15.8%	14.7%	13.4%	**14.1%**	**Static**	
9	% difference between the board voting membership and its overall BME workforce	-32%	-43%	-35%	-25%	**-22%**	**Improved**		-10%	-16%	-26%	-26%	**-17%**	**Improved**	
	% difference between the board executive membership and its overall BME workforce	-36%	-41%	-41%	-42%	**-55%**	**Declined**		0	-10	-33%	-35%	**-50%**	**Declined**	

Workforce Race Equality Standard 2026
EDI Action Plan

Our 2025-27 EDI Action Plan and Talent Management Plans continue to provide the framework through which we address workforce race inequalities. The 2026 WRES findings reinforce the priority themes including recruitment, career progression, staff experience, representation and leadership diversity. The six workstreams below, from our 2025-2027 EDI Action Plan, align directly to these recent findings and will continue to be the focus of delivery during 2026/27.

Progress against each of the high-impact actions outlined below continues to be monitored and reported to our Board for ongoing assurance.

- **Leadership Commitment (Action 1):** Supports Board representation gaps of -22% (STG) and-17% (ESTH) at Voting Board level.
- **Inclusive Recruitment & Talent Management (Action 2):** Supports recruitment inequalities (1.76 STG / 1.65 ESTH) and career progression outcomes (45.1% STG / 48.3% ESTH).
- **Eliminating Pay Gaps (Action 3):** Supports ongoing under-representation of BME staff in senior pay bands and leadership roles.
- **Improving Health & Wellbeing (Action 4):** Supports reducing discrimination (15.8% STG / 14.1% ESTH) and improving workforce experience.
- **Supporting Internationally Recruited Staff (Action 5):** Supports inclusion, development and progression of internationally recruited colleagues.
- **Safeguarding our Workforce (Action 6):** Supports reducing harassment, bullying and abuse from colleagues (25.8% STG / 24.4% ESTH) and patients/public (25.3% STG / 29.2% ESTH).

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Site Report: St George's University Hospitals NHS Foundation Trust

Workforce Race Equality Standard 2026

Features: 2025 Staff Survey Data and workforce information on 31/03/2026
Published: 00/00/2026

Workforce Race Equality Standard Report 2026

Trust: STG

Executive summary

All NHS providers are required to complete an annual Workforce Race Equality Standard (WRES) report. The report is based on a snapshot of data from 31st March each year and aims to highlight progress against a number of key indicators of workforce equality, including a specific indicator to address the low numbers of Black, Asian and Minority Ethnic board members across NHS organisations. Data for WRES indicators 5 to 8 are drawn from questions in the NHS staff survey.

In line with national requirements, this report and any associated action plans should be reviewed internally and approved at Board before being published on the organisation's website. The deadline for publication is 31st October 2026.

The key findings and metrics for this report submission are outlined below. Unless indicated, each point is compared to the previous reporting period:

Improved indicators

- Three of the ten indicators improved.
- BME workforce representation increased from 54.7% to 55.4%.
- BME staff experiencing harassment, bullying or abuse from colleagues reduced from 28.0% to 25.8%.
- The gap between Voting Board membership and workforce BME representation improved from -25% to -22%.

Static indicators

- Five of the ten indicators remained static.
- The likelihood of White applicants being appointed from shortlisting remained unchanged at 1.76.
- Access to non-mandatory training and CPD remained favourable for BME staff (0.93 to 0.96).
- Harassment, bullying or abuse from patients, relatives or the public remained broadly unchanged at 25.3%.
- Staff confidence in equal opportunities for career progression remained broadly unchanged at 45.1%.
- Discrimination from managers, team leaders or colleagues remained broadly unchanged at 15.8%.

Declined indicators

- Two of the ten indicators declined.
- BME staff remain over-represented in lower pay bands.
- The likelihood of BME staff entering the formal disciplinary process increased from 1.17 to 1.98.
- The gap between Executive Board membership and workforce BME representation widened from -42% to -55%.

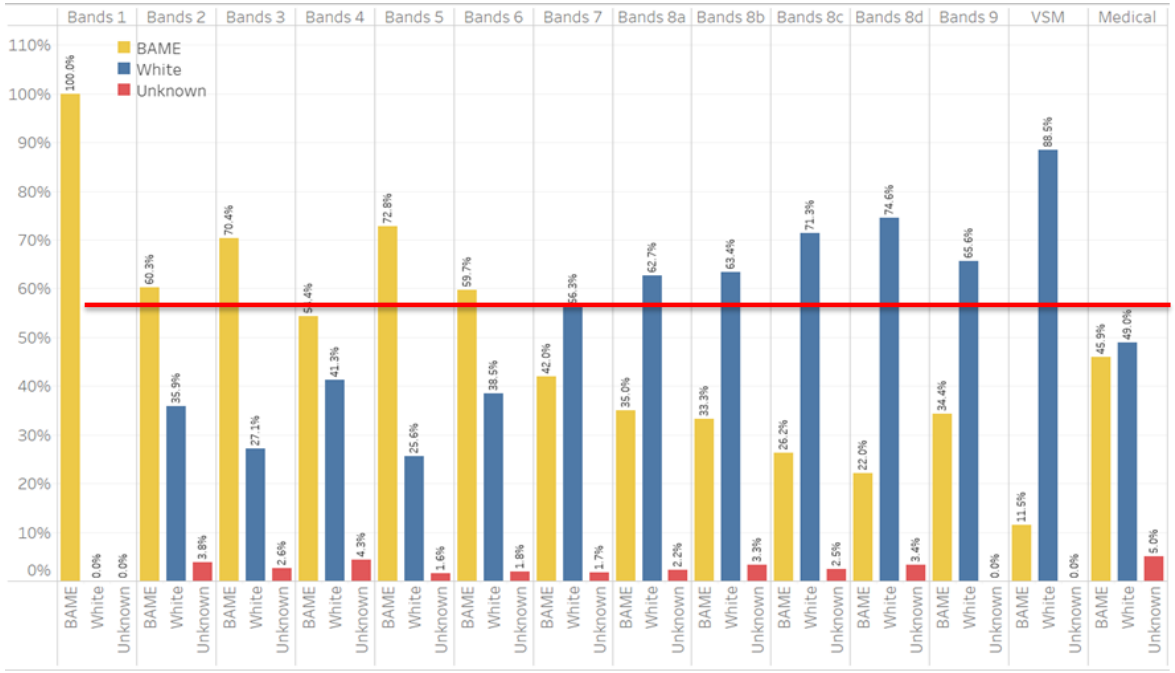
While progress has been made in workforce representation, colleague experience and Voting Board representation, the 2026 WRES data highlights ongoing challenges in recruitment, disciplinary processes and Executive Board representation. These findings will be used to further refine and target delivery of our group EDI Action Plan and Talent Management Plan, ensuring efforts remain focused on the areas of greatest inequality

Workforce Race Equality Standard Report 2026

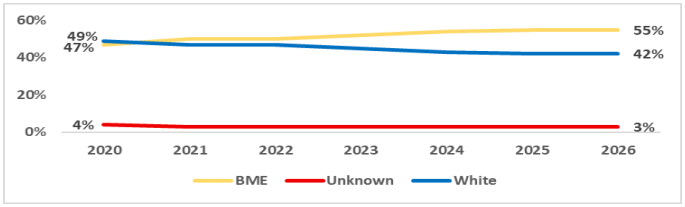
Trust: STG

Indicator 1 *% of staff by AfC pay band and ethnicity*

Table A: % of Staff in each AFC Band by Ethnicity at St Georges

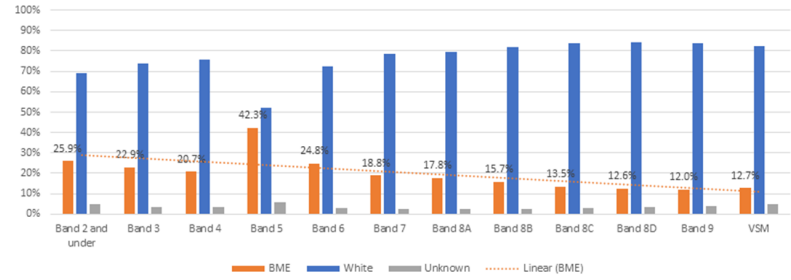


Note: The solid red line indicates the target for St George's to be representative across all AFC pay bands.



- We continue to see an annual increase in our Black, Asian and Minority Ethnic workforce, increasing by 0.7 percentage points from 2025 (54.7%) to 2026 (55.4%).
- Our BME workforce continues to be representative of the local communities we serve.
- BME staff continue to be underrepresented across all mid-senior bands, both in clinical and non-clinical groups.
- This is not unique to St George's and mirrors what we see across NHS trusts nationally (see table A and B).

Table B: % of Staff in each AFC Band by Ethnicity (National 2024)



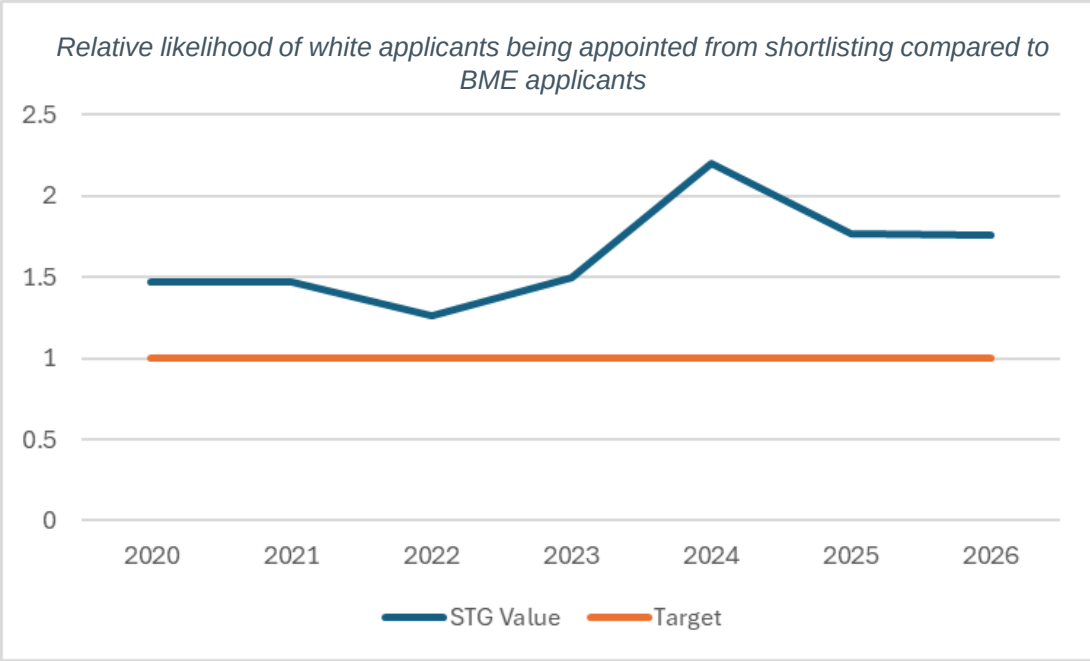
Workforce Race Equality Standard Report 2026

Trust: STG

Indicator 2

Relative likelihood of white applicants being appointed from shortlisting compared to BME applicants

- Our 2026 figures show that white applicants at St George's are 1.76 times more likely to be appointed from shortlisting compared Black, Asian and Minority Ethnic (BME) applicants.
- Whilst this remains static from 2025, there is a notable reduction in overall numbers from all communities, this is likely due in part to a reduction in recruitment across the organisation in 2026.
- There were 5166 shortlisted BME candidates, this compares to 2540 white candidates. This means BME candidates made up 64% of our 2026 shortlisted applicants.
- The appointment rate for shortlisted BME candidates experienced a slight decline to 9.8% (506 out of 5166), down from 10.1% (658 out of 6,498) in 2025.
- Within the Medical and Dental, White shortlisted candidates had a 38.1% success rate compared to 10.4% for BME candidates, meaning White applicants were 3.65 times more likely to be appointed.
- If we remove Medical and Dental recruitment, the organisational relative likelihood drops from 1.76 to 1.60



Note: The solid orange line indicates the target relative likelihood of 1.0

2020	2021	2022	2023	2024	2025	2026
1.47	1.47	1.26	1.50	2.2	1.77	**1.76**

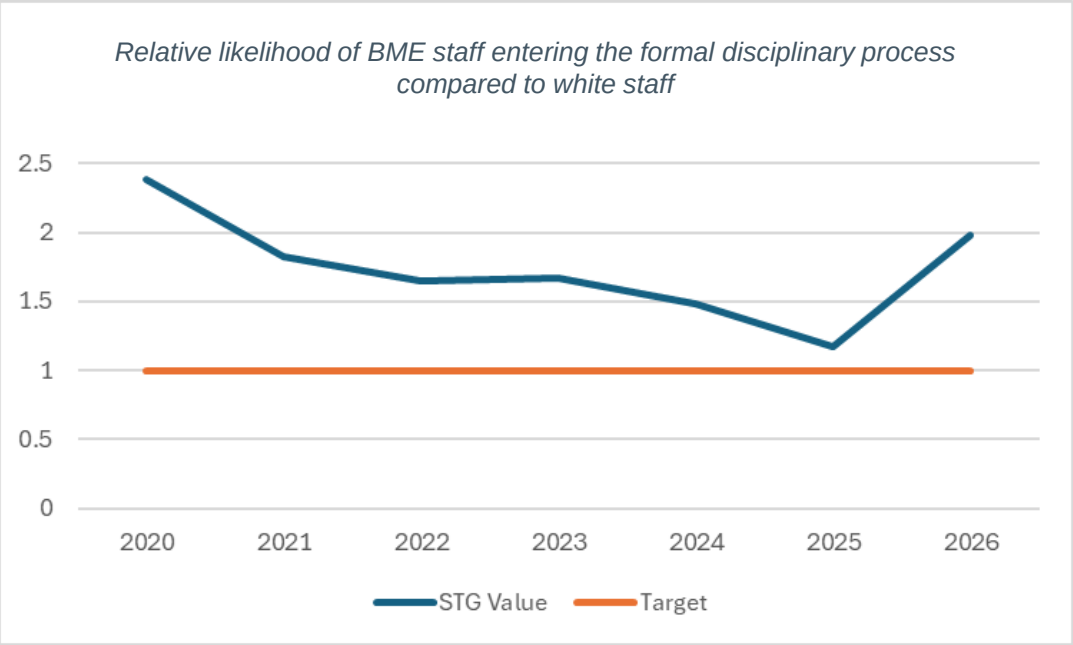
Workforce Race Equality Standard Report 2026

Trust: STG

Indicator 3

Relative likelihood of BME staff entering the formal disciplinary process compared to white staff

- Our 2026 figures show that BME staff at St George's were 1.98 times more likely than White staff to enter the formal disciplinary process.
- The relative likelihood of BME staff entering the formal disciplinary process increased from 1.17 in 2025 to 1.98 in 2026, indicating a widening disparity between BME and White staff during the reporting period.
- During 2025/26, 42 BME staff members entered the formal disciplinary process compared to 16 White staff members. This is a notable increased from 26 BME staff members in the previous year – white staff remains broadly static compared to the previous year.
- Whilst the overall number of staff entering the disciplinary process remains relatively low in relation to the size of the workforce, the increase in relative likelihood highlights the need for continued monitoring and further analysis to understand the factors contributing to this disparity.



Note: The solid orange line indicates the target relative likelihood of 1.0

2020	2021	2022	2023	2024	2025	2026
2.38	1.82	1.65	1.67	1.48	1.17	**1.98**

Workforce Race Equality Standard Report 2026

Trust: STG

Indicator 4

Relative likelihood of White staff accessing non-mandatory training and CPD compared to BME staff

Access to non-mandatory training and continuing professional development (CPD) remains broadly equitable across ethnic groups at St George's.

In 2026, 32% of BME staff accessed non-mandatory training and CPD, compared to 33% of White staff. The relative likelihood of White staff accessing non-mandatory training and CPD compared to BME staff was 0.96, compared to 0.93 in 2025, and is therefore considered static.

Following the larger disparity observed in 2024, the difference in access between White and BME staff has remained low for the second consecutive year, with only a 1 percentage point difference between groups reported in 2026.

BME staff continue to show slightly higher levels of access to non-mandatory training and CPD than White staff.

	2022			2023			2024			2025			2026		
	White	BME	Unknown	White	BME	Unknown	White	BME	Unknown	White	BME	Unknown	White	BME	Unknown
Number of staff in workforce	4495	4817	296	4486	5141	288	4495	5542	308	4570	5929	322	4549	6016	303
Number of staff accessing non-mandatory training and CPD	1324	1444	62	1222	1478	63	1300	1863	81	1577	2181	80	1475	2034	75
Likelihood of staff accessing non-mandatory training and CPD	29%	30%	21%	27%	29%	22%	29%	34%	26%	35%	37%	24%	33%	32%	24%
Relative likelihood of white staff accessing compared to BME staff	**0.98**			**0.95**			**0.87**			**0.93**			**0.96**		

Workforce Race Equality Standard Report 2026

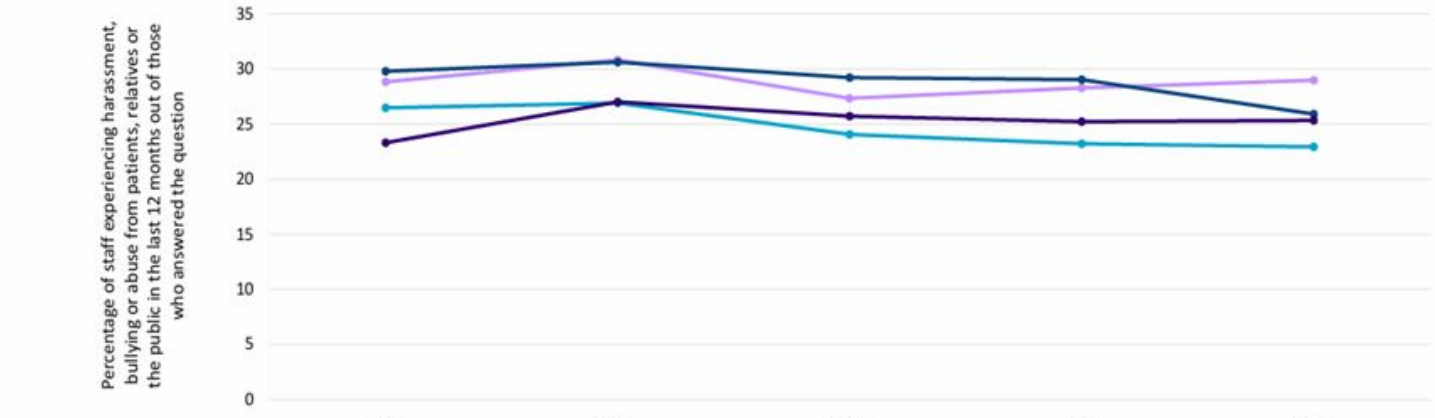
Trust: STG 11

Indicator 5

% of staff experiencing harassment, bullying or abuse from patients, relatives or the public in the last 12 months

- In our 2025 Staff Survey, 25.3% of BME staff reported experiencing harassment, bullying or abuse from patients, relatives or members of the public, compared with 25.9% of White staff.
- The percentage of BME staff reporting harassment, bullying or abuse from patients, relatives or the public has remained broadly static compared to the previous year (25.2% to 25.3%).
- The percentage of White staff reporting harassment, bullying or abuse from patients, relatives or the public reduced from 29.0% in 2024 to 25.9% in 2025.
- The gap between White and BME staff reduced from 3.8 percentage points in 2024 to 0.6 percentage points in 2025, representing the smallest disparity reported over the last five years.

% of staff experiencing harassment, bullying or abuse from patients/relatives or the public



	2021	2022	2023	2024	2025
White staff: Your org	29.79%	30.62%	29.22%	29.03%	25.90%
All other ethnic groups*: Your org	23.30%	27.01%	25.72%	25.22%	25.32%
White staff: Average	26.47%	26.91%	24.05%	23.21%	22.93%
All other ethnic groups*: Average	28.84%	30.82%	27.34%	28.27%	28.98%
White staff: Responses	2484	2296	1832	2329	2185
All other ethnic groups*: Responses	2034	2025	1552	2343	2176

*Staff from all other ethnic groups combined

Note: The staff survey data featured in this report is the most recently published data – the 2025 Staff Survey.

Workforce Race Equality Standard Report 2026

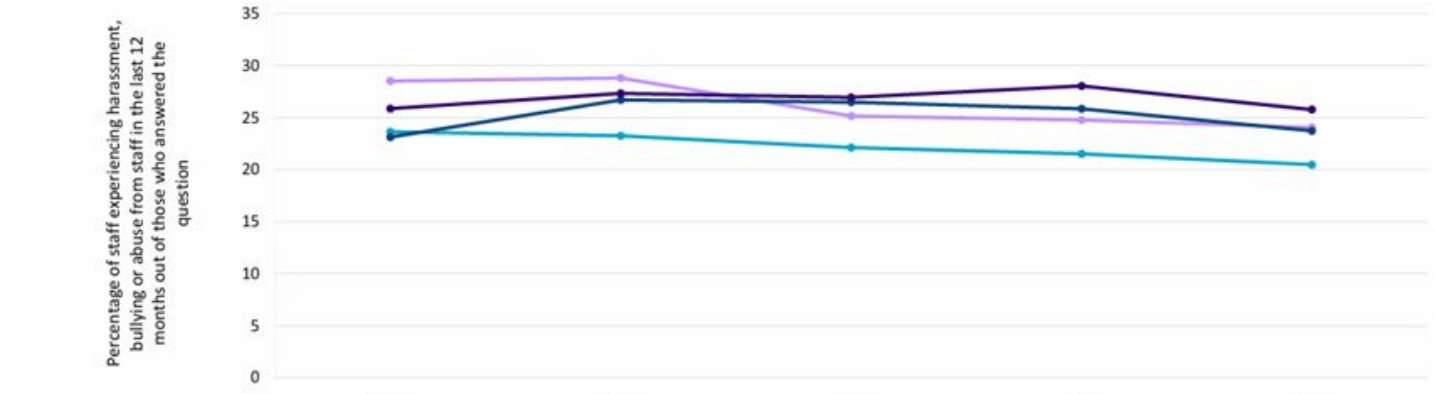
Trust: STG

Indicator 6

% of staff experiencing harassment, bullying or abuse from staff in the last 12 months

- In 2025, 25.78% of BME staff reported experiencing harassment, bullying or abuse from staff, compared with 23.7% of White staff.
- The percentage of BME staff reporting harassment, bullying or abuse from staff reduced from 28.1% in 2024 to 25.78% in 2025, representing a reduction of 2.3 percentage points.
- The percentage of White staff reporting harassment, bullying or abuse from staff also reduced from 25.9% in 2024 to 23.7% in 2025, representing a reduction of 2.1 percentage points.
- The Trust's result for BME staff (25.8%) remains above the national average for staff from all other ethnic groups (24.1%).

% of staff experiencing harassment, bullying or abuse from staff



	2021	2022	2023	2024	2025
White staff: Your org	23.14%	26.71%	26.49%	25.85%	23.73%
All other ethnic groups*: Your org	25.87%	27.34%	26.94%	28.05%	25.78%
White staff: Average	23.65%	23.25%	22.12%	21.53%	20.48%
All other ethnic groups*: Average	28.53%	28.81%	25.16%	24.78%	24.06%
White staff: Responses	2494	2295	1832	2329	2187
All other ethnic groups*: Responses	2041	2030	1546	2328	2161

*Staff from all other ethnic groups combined

Note: The staff survey data featured in this report is the most recently published data – the 2025 Staff Survey.

Workforce Race Equality Standard 2026

Trust: STG

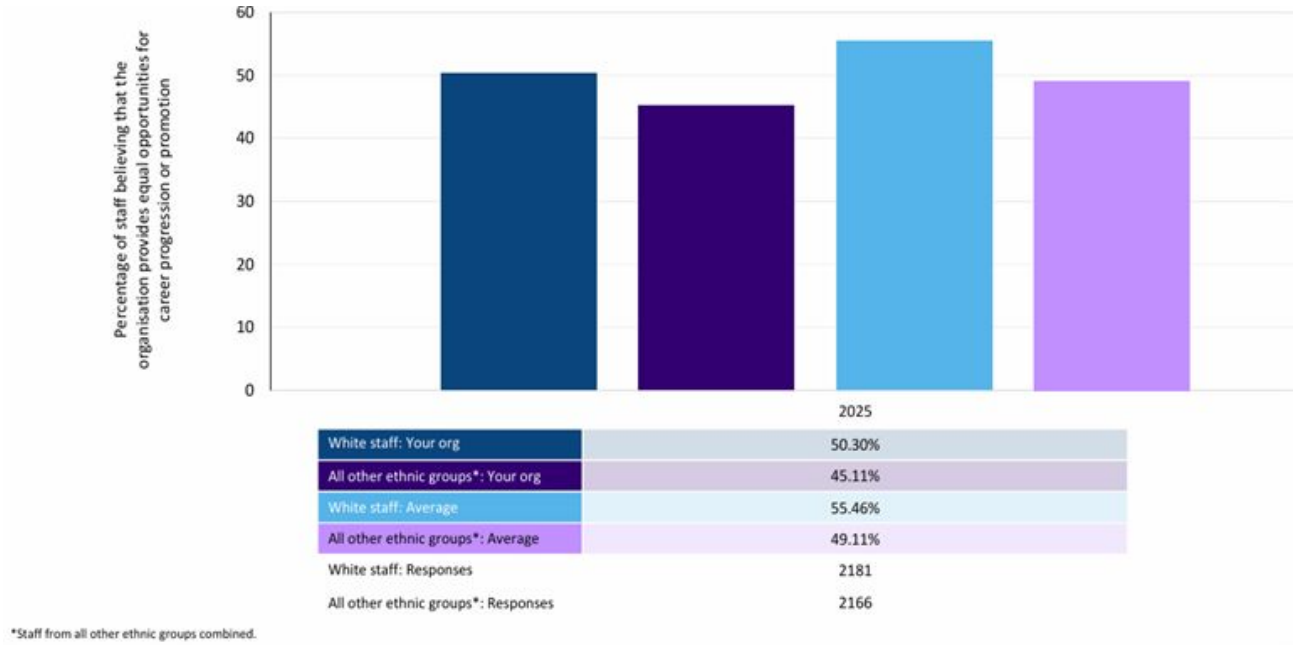
Indicator 7

% of staff believing that trust provides equal opportunities for career progression or promotion

- In 2025, 45.1% of BME staff reported that they believe the organisation provides equal opportunities for career progression or promotion.
- The percentage of BME staff reporting positively on equal opportunities for career progression has remained broadly static* compared to the previous year (45.2% in 2024 compared to 45.1% in 2025).
- Among White staff, 50.3% reported that they believe the organisation provides equal opportunities for career progression or promotion.
- White staff continue to report a more positive experience of career progression opportunities than BME staff, with a gap of approximately 5.2 percentage points between the two groups.
- Both White and BME staff at St George's continue to report lower levels of confidence in career progression opportunities than the national benchmark for their respective groups (55.5% for White staff and 49.1% for BME staff).

*Due to changes in the question wording in 2025, previous years' results as not directly comparable.

% of staff believing that trust provides equal opportunities for career progression or promotion



Note: The staff survey data featured in this report is the most recently published data – the 2025 Staff Survey.

Workforce Race Equality Standard Report 2026

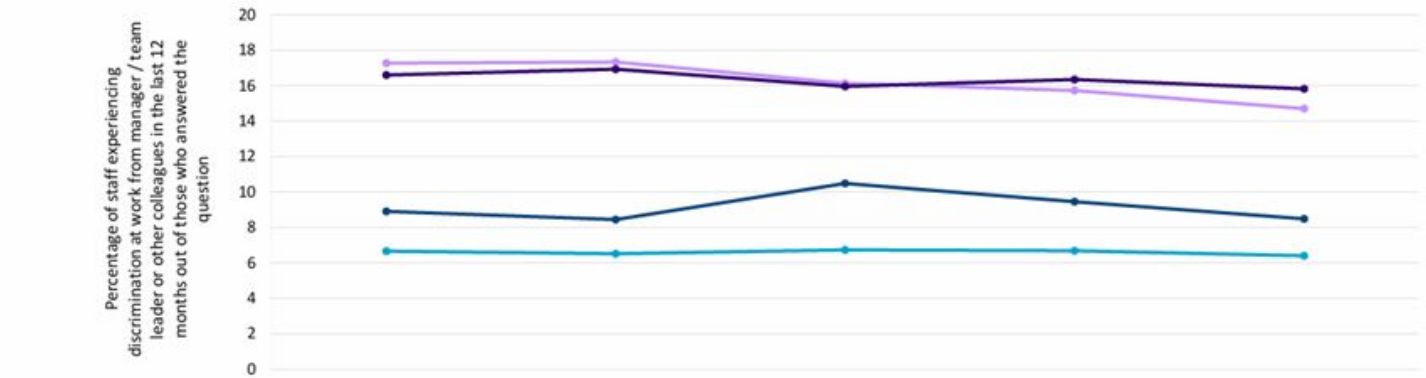
Trust: STG

Indicator 8

% of staff that personally experienced discrimination at work from a manager or colleagues

- In 2025, 15.8% of BME staff reported experiencing discrimination at work from a manager, team leader or colleague, compared to 8.5% of White staff.
- The percentage of BME staff reporting discrimination decreased from 16.3% in 2024 to 15.8% in 2025.
- For White staff, the percentage reporting discrimination reduced from 9.4% in 2024 to 8.5% in 2025, continuing the downward trend seen over recent years.
- Both White and BME staff at St George's report higher levels of discrimination than the national benchmark for their respective groups.

% of staff that personally experienced discrimination at work from a manager or colleagues



	2021	2022	2023	2024	2025
White staff: Your org	8.91%	8.45%	10.48%	9.45%	8.49%
All other ethnic groups*: Your org	16.60%	16.93%	15.96%	16.35%	15.82%
White staff: Average	6.67%	6.52%	6.73%	6.69%	6.40%
All other ethnic groups*: Average	17.28%	17.33%	16.14%	15.72%	14.70%
White staff: Responses	2560	2297	1898	2306	2179
All other ethnic groups*: Responses	2102	2020	1654	2330	2149

*Staff from all other ethnic groups combined

Note: The staff survey data featured in this report is the most recently published data – the 2025 Staff Survey.

Workforce Race Equality Standard Report 2026

Trust: STG

Indicator 9

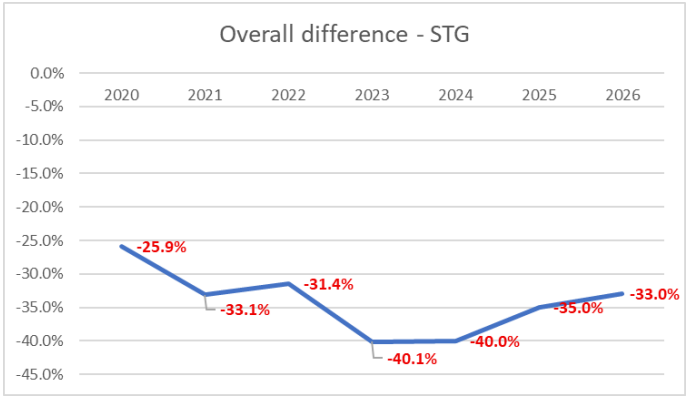
% of board members by ethnicity compared to BME workforce

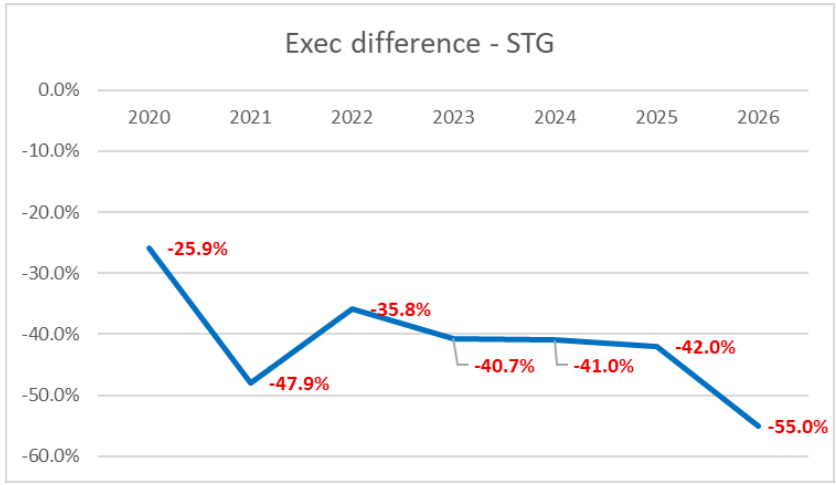
As at 31 March 2026, the Trust Board comprised 18 members, four of whom identify as Black, Asian and Minority Ethnic (BME).

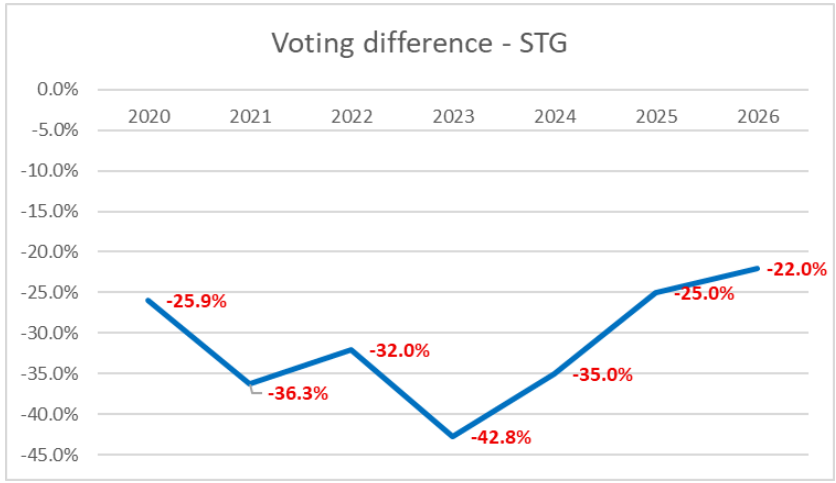
All four BME Board members were Non-Executive Directors. The Voting Board comprised nine members, including six Non-Executive Directors and three Executive Directors. Three Voting Board members identify as BME, resulting in a difference of -33% between overall Board representation and the Trust's BME workforce, -22% at Voting Board level and -55% at Executive Board level.

Whilst BME representation at Voting Board level has improved compared to 2025, Executive Board representation remains disproportionately low relative to the workforce profile.

Since the 31 March 2026 reporting snapshot, further progress has been made to increase Board diversity across the Group. The impact of these changes will be reflected in future WRES reports.







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

gesh

Site Report: Epsom and St Helier University Hospitals NHS Trust

Workforce Race Equality Standard 2026

Features: 2025 Staff Survey Data and workforce information on 31/03/2026
Published: 00/00/2026

Workforce Race Equality Standard Report 2026

Trust: ESTH

Executive summary

All NHS providers are required to complete an annual Workforce Race Equality Standard (WRES) report. The report is based on a snapshot of data from 31st March each year and aims to highlight progress against a number of key indicators of workforce equality, including a specific indicator to address the low numbers of Black, Asian and Minority Ethnic board members across NHS organisations. Data for WRES indicators 5 to 8 are drawn from questions in the NHS staff survey.

In line with national requirements, this report and any associated action plans should be reviewed internally and approved at Board before being published on the organisation's website. The deadline for publication is 31st October 2026.

The key findings and metrics for this report submission are outlined below. Unless indicated, each point is compared to the previous reporting period:

Improved indicators

- We saw an improvement in one of our ten indicators.
- BME workforce representation increased from 47.8% to 50.0%.
- The gap between Voting Board membership and workforce BME representation improved from -26% to -17%.

Static indicators

- Three of the ten indicators remained broadly static.
- The likelihood of White applicants being appointed from shortlisting remained broadly unchanged at 1.65.
- Access to non-mandatory training and CPD remained broadly unchanged at 1.06.
- Discrimination from managers, team leaders or colleagues remained broadly unchanged at 14.1%.

Declined indicators

- We saw a declined in six of the ten indicators.
- BME staff remain over-represented in lower pay bands.
- The likelihood of BME staff entering the formal disciplinary process increased from 1.36 to 1.48.
- Harassment, bullying or abuse from patients, relatives or the public increased from 24.8% to 29.2%.
- Harassment, bullying or abuse from colleagues increased from 21.6% to 24.4%.
- Staff confidence in equal opportunities for career progression reduced from 51.0% to 48.3%.
- The gap between Executive Board membership and workforce BME representation widened from -35% to -50%.

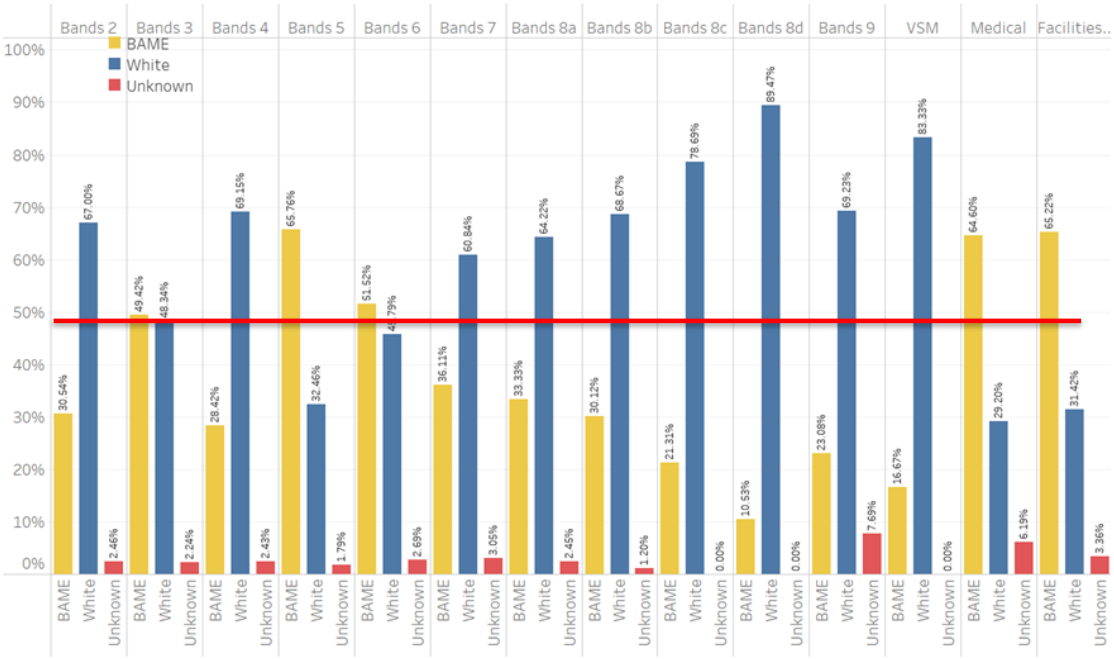
Whilst workforce diversity and Voting Board representation have improved, the 2026 WRES data indicates continuing inequalities across recruitment, staff experience, career progression and Executive Board representation. These findings will help shape the ongoing delivery of the Trust's existing EDI Action Plan and Talent Management Plan, ensuring actions remain focused on the areas where the greatest improvements are needed

Workforce Race Equality Standard Report 2026

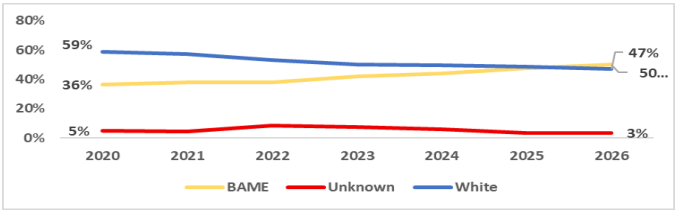
Indicator 1 *% of staff by AfC pay band and ethnicity*

Trust: ESTH

Table A: % of Staff in each AFC Band by Ethnicity

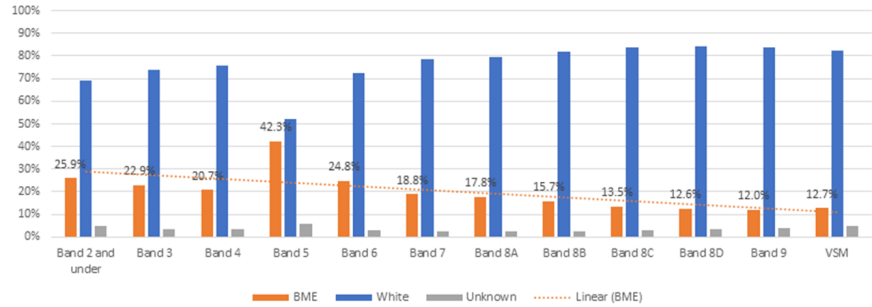


Note: The solid red line indicates the target for the Trust to be representative across all AFC pay bands.



- Our Black, Asian and Minority Ethnic (BME) workforce has increased year on year since 2020 and continues to be representative of the local communities we serve.
- For this reporting year, we see an increase of +2.2 percentage points in indicator 1. This is approximately an increase of 139 BME members of staff compared to the previous year.
- For the second consecutive year, our BME workforce remains lower than the London average. Whilst we see a continued annual increase across the workforce, our workforce data still highlights that Black, Asian and Minority Ethnic staff are over-represented in lower bands and under-represented in higher bands
- This is not unique to ESTH and mirrors what we see across NHS trusts nationally (see table A and B).

Table B: % of Staff in each AFC Band by Ethnicity (National 2024)



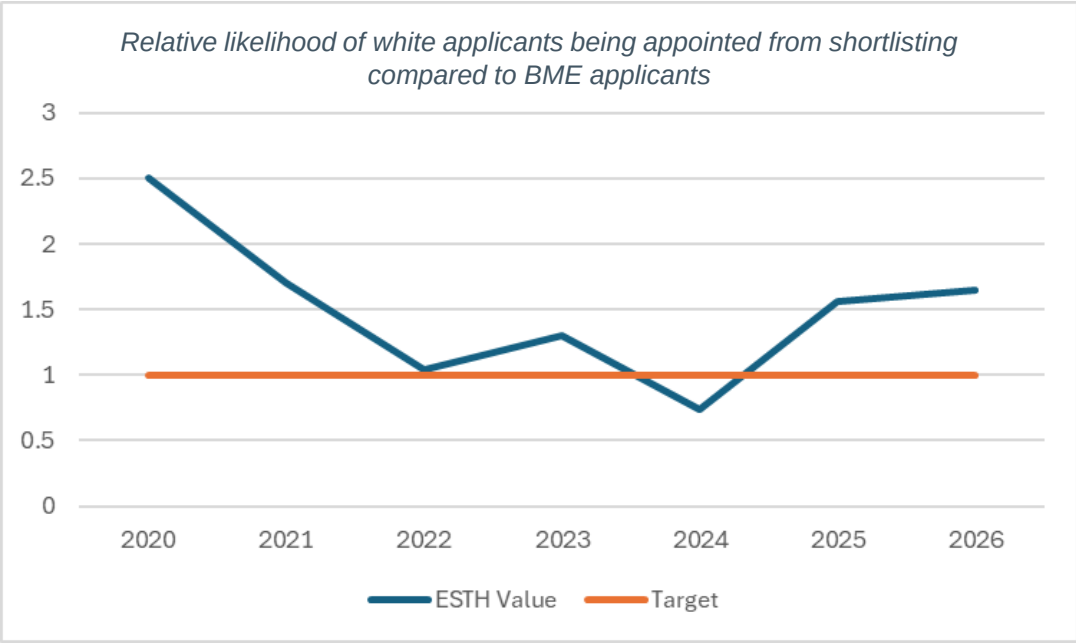
Workforce Race Equality Standard Report 2026

Trust: ESTH

Indicator 2

Relative likelihood of white applicants being appointed from shortlisting compared to BME applicants

- Our 2026 figures show that White applicants at ESTH were 1.65 times more likely to be appointed from shortlisting than Black, Asian and Minority Ethnic (BME) applicants. This is a slight increase compared to 2025 (1.56).
- Of the 4,006 shortlisted BME applicants, 380 were appointed, representing an appointment rate of 9.5%.
- Of the 1,818 shortlisted White applicants, 286 were appointed, representing an appointment rate of 15.7%.
- For applicants who did not disclose their ethnicity, 34 of 255 shortlisted applicants were appointed, representing an appointment rate of 13.3%.
- Whilst appointment rates remain higher for White applicants than BME applicants, the relative likelihood has remained broadly unchanged compared to the previous reporting period.
- Within the Medical and Dental, there is a more equitable relative likelihood – with White applicants 0.98 times more likely to be appointed.
- If we remove Medical and Dental recruitment, the organisational relative likelihood increased from 1.65 to 1.71



Note: The solid orange line indicates the target relative likelihood of 1.0

2020	2021	2022	2023	2024	2025	2026
2.50	1.70	1.04	1.30	0.74	1.56	**1.65**

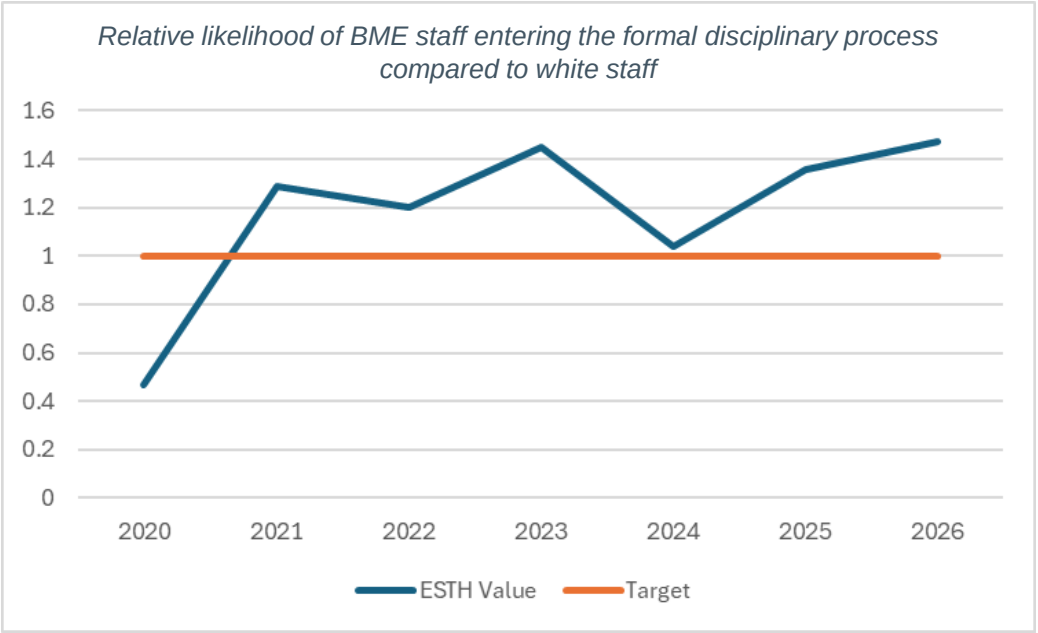
Workforce Race Equality Standard Report 2026

Trust: ESTH

Indicator 3

Relative likelihood of BME staff entering the formal disciplinary process compared to white staff

- Our 2026 figures show that BME staff at Epsom and St Helier were 1.47 times more likely than White staff to enter the formal disciplinary process.
- The relative likelihood of BME staff entering the formal disciplinary process increased from 1.36 in 2025 to 1.47 in 2026, indicating a widening disparity between BME and White staff during the reporting period.
- During 2025/26, 33 BME staff members entered the formal disciplinary process compared with 21 White staff members. This is a notable increase from 16 BME staff members, and 12 White staff in the previous year.
- Whilst the overall number of staff entering the disciplinary process remains relatively low in relation to the size of the workforce, the increase in relative likelihood highlights the need for continued monitoring and further analysis to understand the factors contributing to this disparity.



Note: The solid orange line indicates the target relative likelihood of 1.0

2020	2021	2022	2023	2024	2025	2026
0.47	1.29	1.20	1.45	1.04	1.36	**1.47**

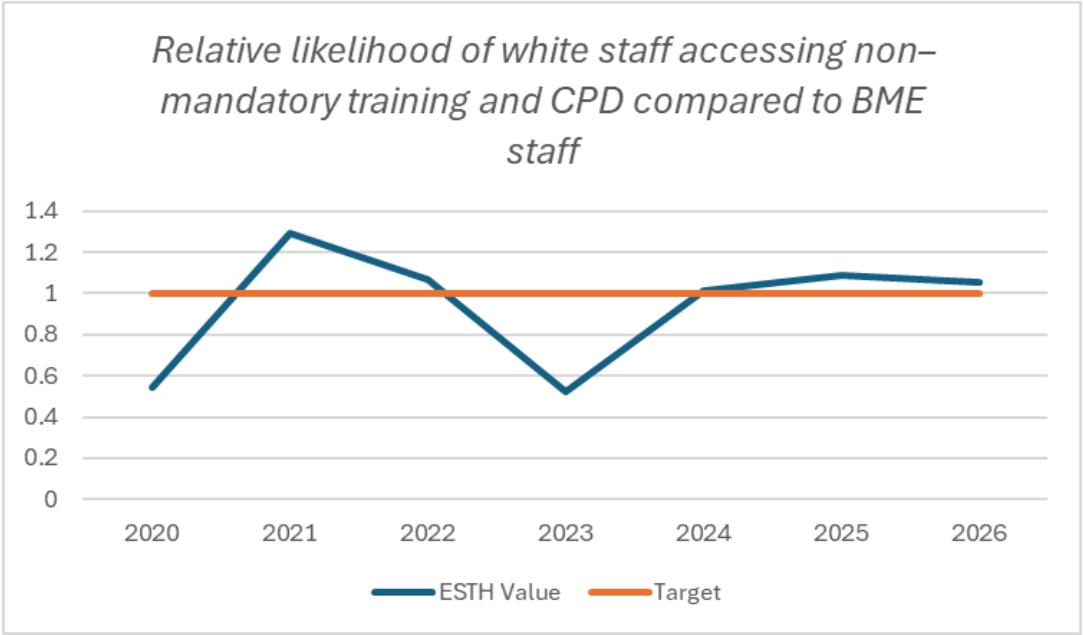
Workforce Race Equality Standard Report 2026

Trust: ESTH

Indicator 4

Relative likelihood of white staff accessing non–mandatory training and CPD compared to BME staff

- In 2026, the relative likelihood of White staff accessing non-mandatory training and continuing professional development (CPD), compared to BME staff, was 1.06. This is a slight decreased from 1.09 in the previous year.
- During 2025/26, 175 BME staff and 174 White staff accessed non-mandatory training and CPD.
- The likelihood of BME staff accessing non-mandatory training and CPD was 4.8%, compared with 5.1% for White staff.
- The disparity in access to non-mandatory training and CPD remains small, with a difference of approximately 0.3 percentage points between White and BME staff.
- Overall, access to non-mandatory training and CPD remains broadly equitable across both groups.



Note: The solid green line indicates the target relative likelihood of 1.0

2020	2021	2022	2023	2024	2025	2026
0.54	1.29	1.07	0.52	1.01	1.09	**1.06**

Workforce Race Equality Standard Report 2026

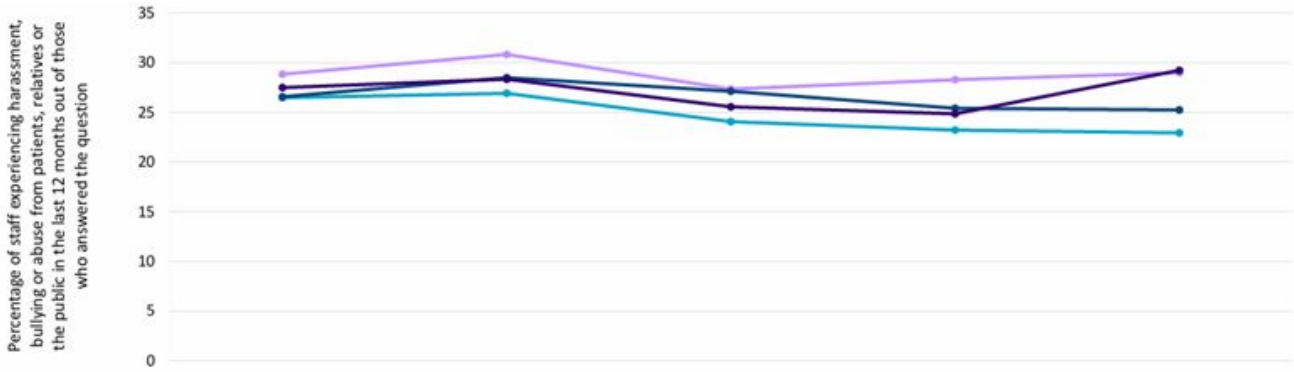
Trust: ESTH

Indicator 5

% of staff experiencing harassment, bullying or abuse from patients, relatives or the public in the last 12 months

- In 2025, 29.2% of BME staff reported experiencing harassment, bullying or abuse from patients, relatives or members of the public, compared with 25.2% of White staff.
- The percentage of BME staff reporting harassment, bullying or abuse increased from 24.9% in 2024 to 29.2% in 2025, representing an increase of 4.4 percentage points.
- The percentage of White staff reporting harassment, bullying or abuse remained broadly static, reducing slightly from 25.4% in 2024 to 25.2% in 2025.
- This represents a reversal of the position reported in 2024, with BME staff now reporting higher levels of harassment, bullying or abuse from patients, relatives or members of the public than White staff.
- The Trust's result for BME staff (29.2%) is broadly in line with the national average for staff from all other ethnic groups (29.0%).

% of staff experiencing harassment, bullying or abuse from patients/relatives or the public



	2021	2022	2023	2024	2025
White staff: Your org	26.57%	28.48%	27.12%	25.41%	25.24%
All other ethnic groups*: Your org	27.49%	28.33%	25.55%	24.85%	29.22%
White staff: Average	26.47%	26.91%	24.05%	23.21%	22.93%
All other ethnic groups*: Average	28.84%	30.82%	27.34%	28.27%	28.98%
White staff: Responses	2401	2117	1965	2125	1858
All other ethnic groups*: Responses	1197	1253	1237	1638	1492

*Staff from all other ethnic groups combined

Note: The staff survey data featured in this report is the most recently published data – the 2025 Staff Survey.

Workforce Race Equality Standard Report 2026

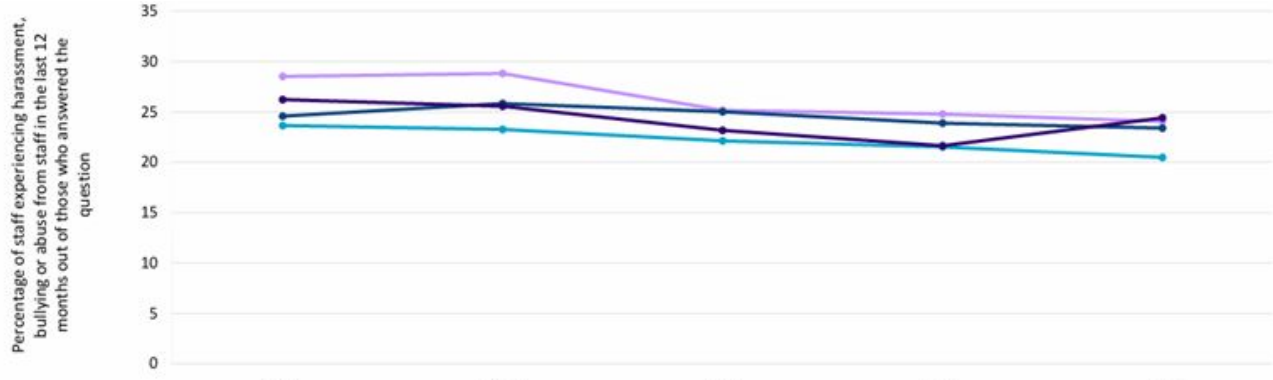
Trust: ESTH

Indicator 6

% of staff experiencing harassment, bullying or abuse from staff in the last 12 months

- In 2025, 24.4% of BME staff reported experiencing harassment, bullying or abuse from staff, compared with 23.4% of White staff.
- The percentage of BME staff experiencing harassment, bullying or abuse from staff increased from 21.6% in 2024 to 24.4% in 2025, representing an increase of 2.8 percentage points.
- The percentage of White staff experiencing harassment, bullying or abuse from staff reduced slightly from 23.9% in 2024 to 23.4% in 2025.
- This represents a reversal of the position reported in 2024, with BME staff now reporting higher levels of harassment, bullying or abuse from staff than White staff.
- The Trust's result for BME staff (24.4%) is slightly above the national average for staff from all other ethnic groups (24.1%).

% of staff experiencing harassment, bullying or abuse from staff



	2021	2022	2023	2024	2025
White staff: Your org	24.58%	25.83%	25.02%	23.89%	23.39%
All other ethnic groups*: Your org	26.22%	25.56%	23.16%	21.64%	24.40%
White staff: Average	23.65%	23.25%	22.12%	21.53%	20.48%
All other ethnic groups*: Average	28.53%	28.81%	25.16%	24.78%	24.06%
White staff: Responses	2396	2110	1964	2110	1851
All other ethnic groups*: Responses	1186	1244	1232	1622	1467

*Staff from all other ethnic groups combined

Note: The staff survey data featured in this report is the most recently published data – the 2025 Staff Survey.

Workforce Race Equality Standard 2026

Trust: ESTH

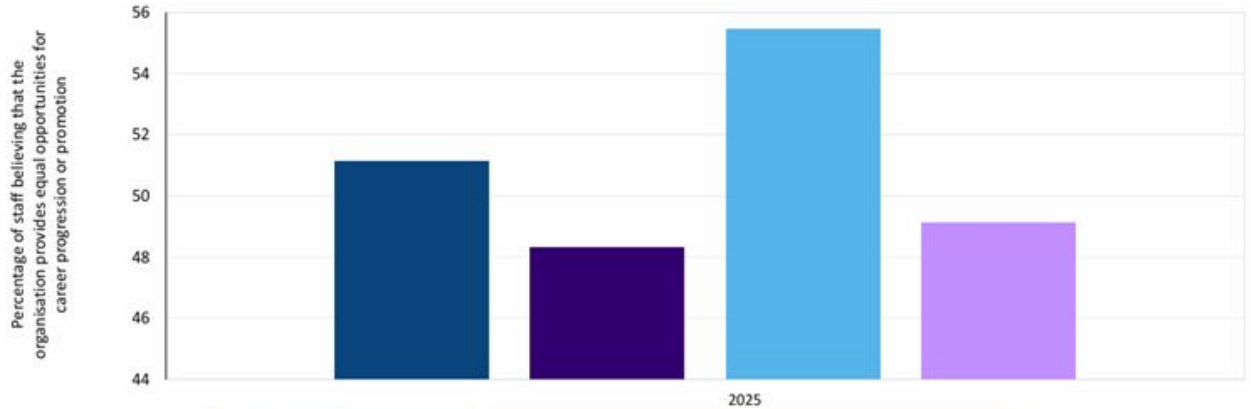
Indicator 7

% of staff believing that trust provides equal opportunities for career progression or promotion

- In 2025, 48.3% of BME staff reported that they believe the organisation provides equal opportunities for career progression or promotion.
- The percentage of BME staff reporting positively on equal opportunities for career progression reduced from 51.0% in 2024* to 48.3% in 2025.
- Among White staff, 51.1% reported that they believe the organisation provides equal opportunities for career progression or promotion.
- White staff continue to report a more positive experience of career progression opportunities than BME staff, with a gap of approximately 2.8 percentage points between the two groups.
- Both White and BME staff at Epsom and St Helier report lower levels of confidence in career progression opportunities than the national benchmark for their respective groups (55.5% for White staff and 49.1% for staff from all other ethnic groups).

*Due to changes in the question wording in 2025, previous years' results as not directly comparable

% of staff believing that trust provides equal opportunities for career progression or promotion



White staff: Your org	51.14%
All other ethnic groups*: Your org	48.31%
White staff: Average	55.46%
All other ethnic groups*: Average	49.11%
White staff: Responses	1846
All other ethnic groups*: Responses	1476

*Staff from all other ethnic groups combined.

Note: The staff survey data featured in this report is the most recently published data – the 2025 Staff Survey.

Workforce Race Equality Standard Report 2026

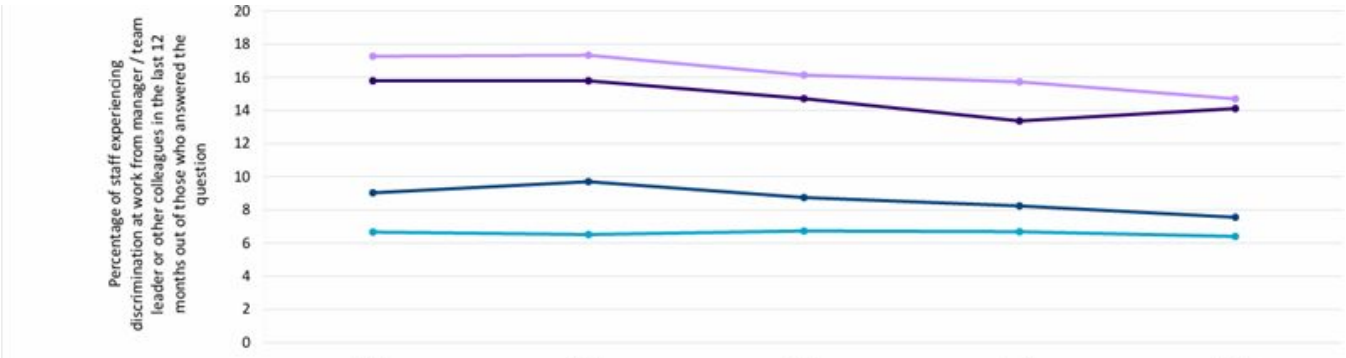
Trust: ESTH

Indicator 8

% of staff that personally experienced discrimination at work from a manager or colleagues

- In 2025, 14.1% of BME staff completing the Staff Survey reported experiencing discrimination at work from a manager, team leader or colleague.
- This represents an increase from 13.4% in 2024 to 14.1% in 2025. The Trust's result remains slightly below the national average for BME staff (14.7%).
- For White staff, the percentage reporting discrimination reduced from 8.3% in 2024 to 7.6% in 2025, continuing the downward trend observed in recent years, and it slightly higher than the national average.
- Whilst BME staff continue to report higher levels of discrimination than White staff, the gap between the two groups widened from approximately 5.1 percentage points in 2024 to 6.6 percentage points in 2025.

% of staff that personally experienced discrimination at work from a manager or colleagues



	2021	2022	2023	2024	2025
White staff: Your org	9.04%	9.71%	8.75%	8.25%	7.56%
All other ethnic groups*: Your org	15.79%	15.79%	14.72%	13.37%	14.12%
White staff: Average	6.67%	6.52%	6.73%	6.69%	6.40%
All other ethnic groups*: Average	17.28%	17.33%	16.14%	15.72%	14.70%
White staff: Responses	2479	2112	2057	2097	1839
All other ethnic groups*: Responses	1235	1235	1352	1623	1466

*Staff from all other ethnic groups combined

Note: The staff survey data featured in this report is the most recently published data – the 2025 Staff Survey.

Workforce Race Equality Standard Report 2026

Trust: ESTH

Indicator 9

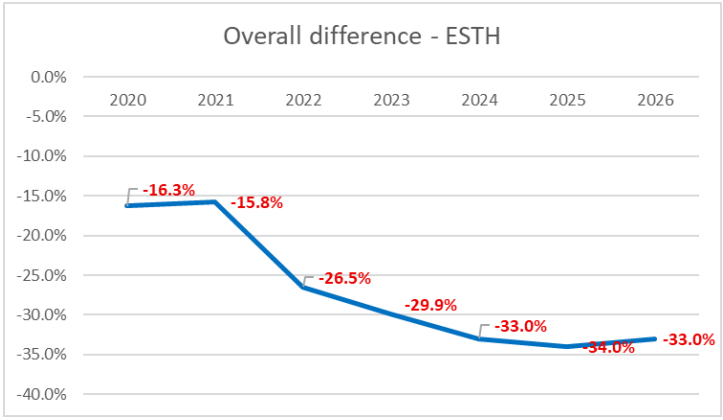
% of board members by ethnicity compared to BME workforce

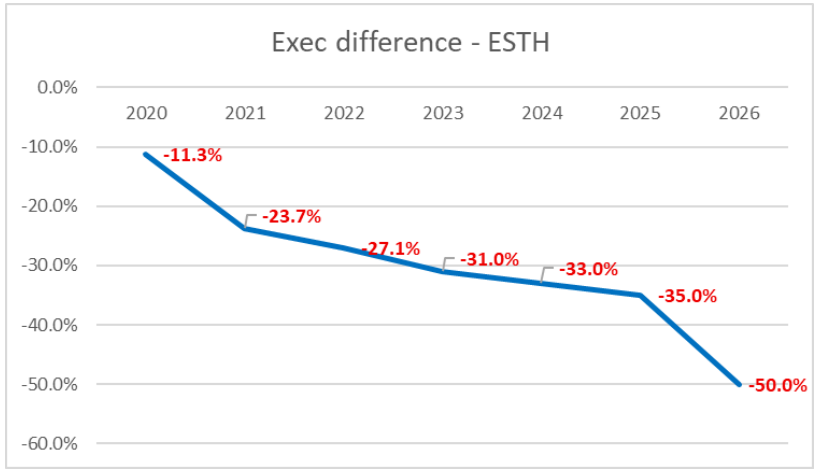
As at 31 March 2026, the Trust Board comprised 18 members, three of whom identify as Black, Asian and Minority Ethnic (BME).

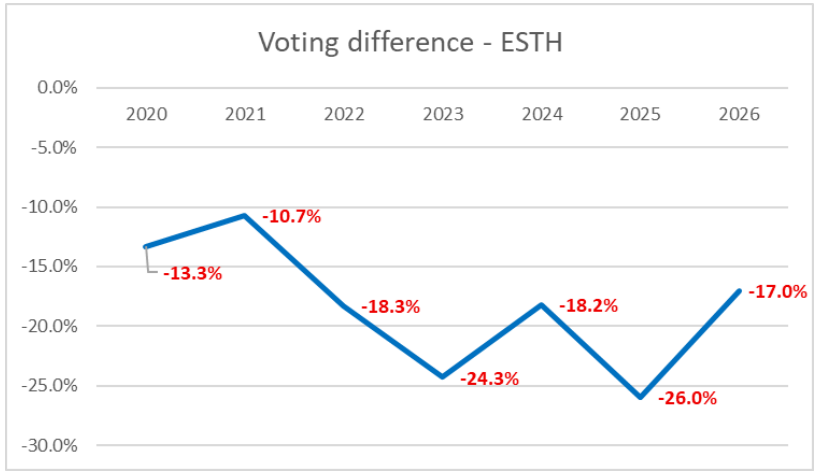
All three BME Board members were Non-Executive Directors. The Voting Board comprised nine members, including six Non-Executive Directors and three Executive Directors. Three Voting Board members identify as BME, resulting in a difference of -33% between overall Board representation and the Trust's BME workforce, -17% at Voting Board level and -50% at Executive Board level.

Whilst BME representation at Voting Board level has improved compared to 2025, Executive Board representation remains disproportionately low relative to the workforce profile.

Since the 31 March 2026 reporting snapshot, further progress has been made to increase Board diversity across the Group. The impact of these changes will be reflected in future WRES reports







Workforce Race Equality Standard (WRES)

Appendix A: Definitions of ethnicity: people covered by the WRES

- **In line with Health Education England's WRES guidance and national WRES reporting metrics, the term 'BME' and 'white' are used to describe the two groups of staff referred to in this report**.
- The definitions of 'black and minority ethnic' and 'white' used in Health Education England's (HEE) WRES guidance 2024 have followed the national reporting requirements of ethnic category in the NHS data model and dictionary and are as used in NHS Digital data. At the time of publication these definitions were based upon the 2001 ONS Census categories for ethnicity. These are presented in Annex B.
- 'White' staff include white British, Irish, Eastern European and any other white i.e. categories 1–4 in the table in.
- The 'black and minority ethnic' staff category includes all others except 'unknown' and 'not stated.'
- To aggregate data for BME staff, organisations should include categories 5-18 from current values and exclude 'not stated' and any 'NULL' values.
- The treatment of staff from ethic categories [2 – white Irish] or [3 – Gypsy or Irish Traveler] or [4 – Any other white background] i.e. eastern European who may, in some organisations, be a significant minority group and experience considerable discrimination, is considered in the WRES FAQs document. Where this is the case, organisations should also explore such discrimination using workforce and staff survey data and take appropriate action.
- Source: WRES Additional Information 2024 for NHS Trusts and Foundation Trusts (30/04/2024)

Ethnicity refers to: ONS definitions found here: Ethnic group, national identity and religion - Office for National Statistics (ons.gov.uk)

Ethnic Categories 2021

WHITE
1 – White –British / Welsh / Scottish / Northern Irish / British
2 – White –Irish
3 - Gypsy or Irish Traveller
4 – Any other white background please describe

MIXED / MULTIPLE ETHNIC GROUPS
5 – White and Black Caribbean
6 – White and Black African
7 – White and Asian
8 – Any other mixed / multiple ethnic background please describe

ASIAN / ASIAN BRITISH
9– Asian or Asian British –Indian
10 – Asian or Asian British –Pakistani
11 – Asian or Asian British – Bangladeshi
12 - Asian or Asian British – Chinese
13 – Any other Asian background please describe

BLACK / AFRICAN / CARIBBEAN / BLACK BRITISH
14 – Black or black British – African
15 – Black or black British – Caribbean
16 – Any other black background please describe

ANY OTHER ETHNIC GROUP
17 – Arab
18 – Any other ethnic group please describe

Workforce Race Equality Standard (WRES)

Appendix B: High impact action plan framework

This plan prioritises the following six high impact actions to address the widely-known intersectional impacts of discrimination and bias.

Measurable objectives on EDI for Chairs Chief Executives and Board members.

Success metric

1a. Annual Chair/CEO appraisals on EDI objectives via Board Assurance Framework (BAF).

Overhaul recruitment processes and embed talent management processes.

Success metric

2a. Relative likelihood of staff being appointed from shortlisting across all posts

2b. NSS Q on access to career progression and training and development opportunities

2c. Improvement in race and disability representation leading to parity

2d. Improvement in representation senior leadership (Band 8C upwards) leading to parity

2e. Diversity in shortlisted candidates

2f. NETS Combined Indicator Score metric on quality of training

Eliminate total pay gaps with respect to race, disability and gender.

Success metric

3a. Improvement in gender, race, and disability pay gap

Address Health Inequalities within their workforce.

Success metric

4a. NSS Q on organisation action on health and wellbeing concerns

4b. National Education & Training Survey (NETS) Combined Indicator Score metric on quality of training

4c. To be developed in Year 2

Comprehensive Induction and onboarding programme for International recruited staff.

Success metric

5a. NSS Q on belonging for IR staff

5b. NSS Q on bullying, harassment from team/line manager for IR staff

5c. NETS Combined Indicator Score metric on quality of training IR staff

Eliminate conditions and environment in which bullying, harassment and physical harassment occurs.

Success metric

6a. Improvement in staff survey results on bullying / harassment from line managers/teams (ALL Staff)

6b. Improvement in staff survey results on discrimination from line managers/teams (ALL Staff)

6c. NETS Bullying & Harassment score metric (NHS professional groups)

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Workforce Disability Equality Standard (WDES) 2026 Report

Features: 2025 Staff Survey Data and workforce information on 31/03/2026
Published: 00/00/2026

Workforce Disability Equality Standard (WDES)

Background

The WDES was introduced in 2019 and is designed to improve the experiences of people with a disability working in or seeking employment within the NHS. This mandated collection of evidence-based metrics helps an organisation understand more about the experiences of its staff. The 10 metrics on which we report against each year are included in the table opposite.

The WDES report compares data between staff that have a *disability* and staff that do not have a disability in order to identify disparities and barriers in the workplace. These findings inform the organisation's EDI Action Plan, which aims to directly address inequalities faced by staff with protected characteristics.

We are pleased that the NHS, our parent organisation, is currently the only UK employer that mandates its member organisations to report annually on its representation and inclusion of staff with disabilities. However, our ambition is to go far beyond what is mandated, and to become a truly great employer of people with disabilities, and an exemplar for other NHS trusts.

Metric	Indicator Description
Metric 1	% Disabled staff in AfC pay-bands (or medical and dental subgroups and VSMs) compared with the percentage of staff in the overall workforce (for both clinical and non-clinical groups)
Metric 2	Relative likelihood of non-disabled staff compared to Disabled staff being appointed from shortlisting across all posts
Metric 3	Relative likelihood of Disabled staff compared to non-disabled staff entering the formal capability process, as measured by entry into the formal capability procedure
Metric 4	Staff Survey: % Disabled staff compared to non-disabled staff: a-c) experiencing harassment, bullying or abuse from different groups d) saying that the last time they experienced harassment, bullying or abuse at work, they or a colleague reported it
Metric 5	Staff Survey: % Disabled staff compared to non-disabled staff believing that the Trust provides equal opportunities for career progression or promotion
Metric 6	Staff Survey: % Disabled staff compared to non-disabled staff saying that they have felt pressure from their manager to come to work, despite not feeling well enough to perform their duties
Metric 7	Staff Survey: % Disabled staff compared to non-disabled staff saying that they are satisfied with the extent to which their organisation values their work
Metric 8	Staff Survey: % Disabled staff saying that their employer has made adequate adjustment(s) to enable them to carry out their work
Metric 9	a) The staff engagement score for Disabled staff, compared to non-disabled staff
Metric 10	% difference between the organisation's Board voting membership and its organisation's overall workforce

Workforce Disability Equality Standard (WDES)

Our ambition

Serving a diverse population of over 1.5 million and with over 17,000 employees, gesh is the largest healthcare provider in south west London. It is crucial that the diversity of our workforce reflects the diversity of the communities we serve, and we are proud that in 2026 the number of Electronic Staff Record (ESR) declarations for people with a disability has increased. We will continue to reinforce the importance of declaring one's disability on ESR to ensure adequate representation, resource allocation and support and importantly, reduce stigma by building inclusion.

Gesh is committed to building a workforce in which each employee can enjoy a strong sense of belonging and where diversity, difference and uniqueness are truly valued. As well as being well-represented across all levels, we must ensure that people from marginalised groups, including people with a disability, are actively and always included, and that this inclusion is felt authentically at a personal level. Lip-service will not suffice.

Achieving strong diversity and inclusion of people with a disability will offer significant benefits for our organisation:

- Delivery of better patient care, because:
  - Staff who feel included, engaged, and supported have greater personal resources and resilience to offer thorough and compassionate care
  - Staff who are differently abled may offer enhanced empathy and support to patients due to their lived-experience of disability
  - Patients with disabilities may be more able to identify with and relate to our staff with a disability
- Stronger team performance by maximising our blend of skills, talents, knowledge, and professional experience
- Stronger individual performance by enabling staff with a disability to use their disability at work as advantage instead of a disadvantage
- Improved retention of our staff, especially our staff with a disability (including staff who may later become affected by a disability)
- A reduction in bullying, harassment, discrimination and other forms of exclusion by building greater understanding, appreciation and respect for people with disabilities
- Supporting our organisational journey towards adopting a more compassionate and inclusive culture.

"Our ambition is to create an organisation - and a reinforcing culture - that not only offers equality and a positive experience for all our colleagues with a disability, but one that actively nurtures and celebrates our physical and mental differences in ability. We strive for this in the certainty that our rich diversity and a universal sense of belonging will be integral to our success as a healthcare organisation"

Workforce Disability Equality Standard 2026
Purpose and Terminology

Purpose

- This paper provides an overview of the 2026 Workforce Disability Equality Standard (WDES) findings.
- This report will be published on the Trust websites.
- The Board is asked to receive this report and associated action plan for information and approve for publication.

Terminology: people covered by the WDES

For the purposes of this report and in line with national WDES metrics, the term 'disabled staff' and 'non-disabled staff' are used to describe the two groups of staff referred to in this report. Gesh and its staff encourages the use of 'staff with a disability' and 'staff without a disability' respectively as preferred terminology to foster better inclusion, reduce disability associated stigma and recognise the disability is not one's identity but rather something people live with.

Overview of Workforce Numbers

STG	2022	2023	2024	2025	2026
Total number of staff in organisation	9,608	9,915	10,345	10,815	**10,868**
% of staff with a declared Disability on ESR	2.9%	3.5%	3.7%	4.3%	**4.7%**
% of staff which indicated a disability via Staff Survey	7.5%	6.8%	5.9%	7.5%	**7.8%**

ESTH	2022	2023	2024	2025	2026
Total number of staff in organisation	7,092	7,190	7,410	7,326	**7,284**
% of staff with a declared Disability on ESR	4.3%	4.4%	4.3%	5.0%	**5.6%**
% of staff which indicated a disability via Staff Survey	9.1%	8.5%	8.0%	9.4%	**8.6%**

Gesh	2022	2023	2024	2025	2026
Total number of staff in organisation	16,700	17,105	17,755	18,141	**18,152**
% of staff with a declared Disability on ESR	3.4%	3.9%	3.9%	4.6%	**5.1%**

Workforce Disability Equality Standard 2026

Indicator Overview

Note: '*Compared to Colleagues':* A green cell indicates staff with a disability report a more positive experience than colleagues that do not have a disability.
Indicators are classified as Improved, Static or Declined based on the significance of year-on-year change.

WDES Indicator		STG							ESTH						
		2022	2023	2024	2025	2026	vs. LY	Compared to colleagues	2022	2023	2024	2025	2026	vs. LY	Compared to colleagues
1	% of Disabled staff in organisation	2.9%	3.5%	3.7%	4.3%	**4.7%**	**Increased**		4.0%	4.4%	4.3%	5.0%	**5.6%**	**Increased**	
2	Relative likelihood of non-Disabled candidates compared to Disabled candidates being appointed from shortlisting across all posts.	1.21	1.15	1.26	0.97	**1.04**	**Static**		23.2	1.20	1.52	0.92	**0.94**	**Static**	
3	Relative likelihood of Disabled staff compared to non-disabled staff entering the formal capability process, as measured by entry into the formal capability procedure	4.78	4.26	4.08	0.00	**1.59**	**Declined**		4.95	7.99	0.00	0.00	**2.59**	**Declined**	
4a	% of staff experiencing harassment, bullying or abuse from patients/ service users	34.8%	37.1%	35.1%	30.9%	**29.5%**	**Improved**		32.0%	34.5%	31.7%	31.2%	**32.9%**	**Declined**	
4b	% of staff experiencing harassment, bullying or abuse from managers in the last 12 months	21.1%	20.1%	21.1%	17.6%	**20.7%**	**Declined**		20.9%	19.5%	18.4%	19.6%	**19.3%**	**Static**	
4c	% of staff experiencing harassment, bullying or abuse from other colleagues	31.6%	32.1%	29.3%	31.2%	**27.7%**	**Improved**		25.7%	26.1%	26.1%	24.9%	**26.2%**	**Declined**	
4d	% of staff saying that the last time they experienced harassment, bullying or abuse at work, they or a colleague reported it	47.9%	44.3%	50.7%	52.9%	**47.7%**	**Declined**		49.3%	48.9%	52.8%	55.2%	**53.7%**	**Declined**	
5	% of staff believing that the Trust provides equal opportunities for career progression or promotion	40.1%	44.1%	41.5%	45.9%	**37.3%**	**Declined**		46.3%	45.9%	46.4%	47.6%	**43.1%**	**Declined**	
6	% of staff saying that they have felt pressure from their manager to come to work, despite not feeling well enough to perform their duties	35.2%	32.0%	29.0%	29.6%	**30.6%**	**Static**		31.1%	33.5%	30.4%	31.9%	**30.2%**	**Improved**	
7	% of staff saying that they are satisfied with the extent to which their organisation values their work	31.0%	29.9%	31.3%	34.1%	**30.3%**	**Declined**		31.5%	32.7%	37.6%	34.5%	**33.4%**	**Declined**	
8	% of staff saying that their employer has made reasonable adjustment(s) to enable them to carry out their work	-	61.7%	68.9%	67.1%	**67.6%**	**Static**		-	66.2%	70.9%	68.7%	**68.1%**	**Static**	
9	Staff Engagement score (0-10)	6.25	6.33	6.26	6.34	**6.28**	**Static**		6.47	6.35	6.46	6.35	**6.32**	**Static**	
10	% difference between the organisation's Board voting membership and its organisation's overall workforce	-3.0%	5.6%	14.0%	16.0%	**-5%**	**Declined**		12.5%	5.6%	23.0%	17.0%	**-6%**	**Declined**	

Workforce Disability Equality Standard (WDES) 2026

EDI Action Plan

Our 2025-27 EDI Action Plan and Talent Management Plans continue to provide the framework through which we address workforce disability inequalities across gesh. The 2026 WDES findings highlight ongoing priorities relating to career progression, staff experience, workplace adjustments, health and wellbeing, harassment and bullying, and senior representation. The six existing workstreams below, from our EDI Action Plan, align directly to these findings and will continue to be the focus of delivery during 2026/27.

Progress against each of the high-impact actions outlined below continues to be monitored and reported to our Board for ongoing assurance.

- **Leadership Commitment (Action 1):** Supports Voting Board representation gaps of -5% (STG) and-6% (ESTH).
- **Inclusive Recruitment & Talent Management (Action 2):** Supports career progression outcomes of 37.3% (STG) and 43.1% (ESTH) and continued equity in recruitment processes.
- **Eliminating Pay Gaps (Action 3):** Supports equitable progression and representation of staff with disabilities across all pay bands and senior roles.
- **Improving Health & Wellbeing (Action 4):** Supports reducing pressure to work when unwell (30.6% STG / 30.2% ESTH) and improving workplace adjustment outcomes (67.6% STG / 68.1% ESTH).
- **Supporting Internationally Recruited Staff (Action 5):** Supports inclusion, belonging and equitable access to development opportunities for all staff groups.
- **Safeguarding our Workforce (Action 6)**: Supports reducing harassment, bullying and abuse from patients/public (29.5% STG / 32.9% ESTH) and from managers and colleagues.

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Site Report: St George's University Hospitals NHS Foundation Trust

Workforce Disability Equality Standard 2026

Features: 2025 Staff Survey Data and workforce information on 31/03/2026
Published: 00/00/2026

Workforce Disability Equality Standard 2026

Trust: STG

Executive summary

All NHS providers are required to complete an annual Workforce Disability Equality Standard (WDES) report. The report is based on a snapshot of data from 31st March each year and aims to highlight progress against a number of key indicators of workforce equality. Data for WDES indicators 4 to 9a are drawn from questions in the most recent NHS staff survey.

In line with national requirements this report and any associated action plans should be reviewed internally and approved at Board before being published on the organisation's website. The deadline for publication is 31st October 2026. The key findings are outlined below. Unless indicated, each point is compared to the previous reporting period:

Improved indicators

- Metric Success: Out of 13 monitored indicators, we see a measured improvement (compared to the previous year) in 4 metrics.
- Overall Declaration: The percentage of declared disabled staff across the organisation has continued its steady multi-year climb, increasing to 4.7%.
- Public Harassment: Staff report lower rates of harassment, bullying, or abuse (HBA) from patients and the public, dropping down to a five-year low of 29.5%.
- Colleague Harassment: Staff report lower rates of harassment from other colleagues, with a clear positive reduction down to 27.7%.

Reduced / static indicators

- Metric Challenges: Out of 13 monitored indicators, we see a decline in 5 metrics, while 4 remained static.
- Manager Harassment: Reported harassment from managers increased back up to 20.7%.
- Reporting Culture: The proportion of staff reporting their experiences of abuse fell to 47.7%, reversing last year's progress.
- Work Valuation & Support: Satisfaction with how work is valued dipped to 30.3%, while manager pressure to work when unwell (30.6%) and reasonable adjustments (67.6%) held static.
- Career Progression: Only 37.3% of staff feel equal opportunities are provided under the new survey baseline question.
- Capability & Voting: Entry into formal capability rose to 1.59, recruitment likelihood held static, and a drop in voting board members created a temporary deficit of -5%

While long-term trends show some positive progress in public and colleague-facing areas, the 2026 data highlights critical challenges in manager behaviours, reporting confidence, and career progression. These key areas are directly tied to our group-wide EDI workstreams, with targeted interventions detailed on the Next Steps slide.

Workforce Disability Equality Standard 2026

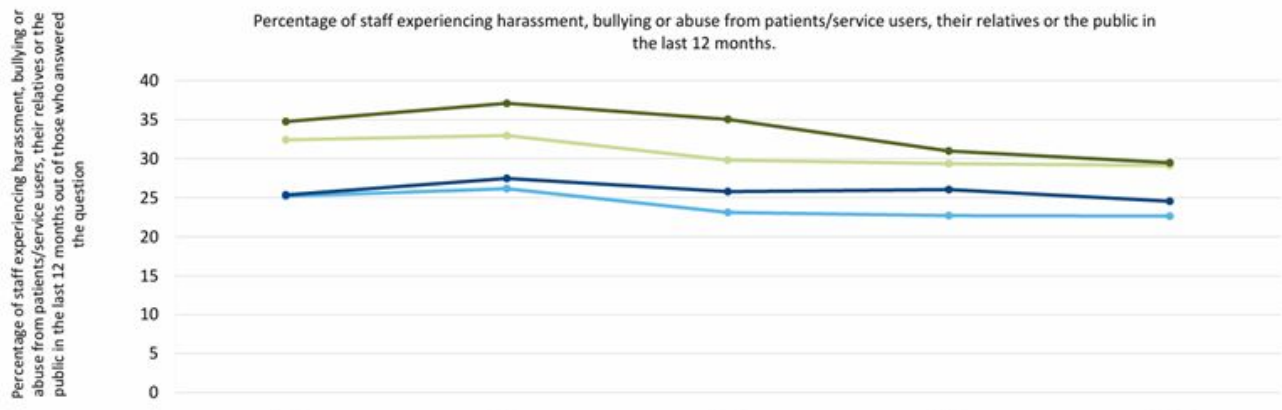
Trust: STG

Indicator 4a

% of staff experiencing harassment, bullying or abuse from patients, relatives or the public in the last 12 months

- 29.49% of staff with a long-term condition (LTC) or illness reported experiencing HBA from patients, relatives, or the public in 2025, compared to 24.55% of staff without.
- Encouragingly, the equity gap between these two cohorts has narrowed to a five-year low of 4.94 percentage points.
- This improvement is primarily driven by a sustained downward trend among staff with an LTC, whose reported incidents fell from a peak of 35.06% in 2023 to 29.49% in 2025.
- However, St George's rates for both groups remain above the national average (29.14% and 22.64% respectively), indicating a persistent exposure to public-facing behavioural challenges.

% of staff experiencing harassment, bullying or abuse from patients/relatives or the public



	2021	2022	2023	2024	2025
Staff with a LTC or illness: Your org	34.76%	37.11%	35.06%	30.99%	29.49%
Staff without a LTC or illness: Your org	25.35%	27.47%	25.79%	26.04%	24.55%
Staff with a LTC or illness: Average	32.43%	32.98%	29.83%	29.37%	29.14%
Staff without a LTC or illness: Average	25.19%	26.16%	23.11%	22.71%	22.64%
Staff with a LTC or illness: Responses	722	679	607	810	841
Staff without a LTC or illness: Responses	3889	3669	2724	3832	3499

Note: The staff survey data featured in this report is the most recently published data – the 2025 Staff Survey.

Workforce Disability Equality Standard 2026

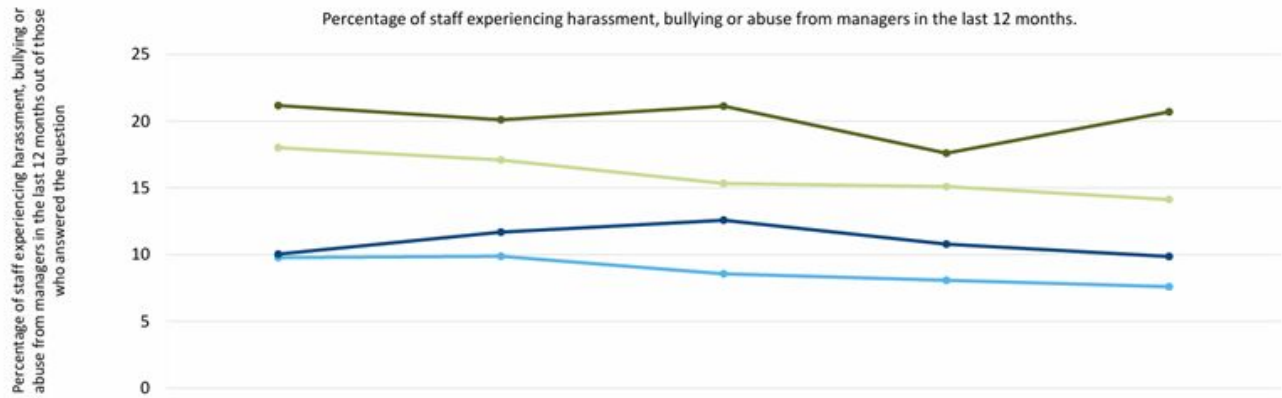
Trust: STG

Indicator 4b

% of staff experiencing harassment, bullying or abuse from managers in the last 12 months

- Staff with a long-term condition or illness continue to report higher levels of harassment from managers, affecting 20.69% of this group in 2025 compared to 9.86% of staff without - marking the widest gap in the last three years.
- While reported harassment, bullying, and abuse (HBA) from managers dropped notably to 17.60% in 2024, it has risen again this year to 20.69%, returning to the higher levels seen in 2022–23.
- St George's figures remain above the national average for both groups in 2025, with this disparity at a three-year high.

% of staff experiencing harassment, bullying or abuse from managers in the last 12 months



	2021	2022	2023	2024	2025
Staff with a LTC or illness: Your org	21.16%	20.09%	21.12%	17.60%	20.69%
Staff without a LTC or illness: Your org	10.05%	11.68%	12.57%	10.79%	9.86%
Staff with a LTC or illness: Average	18.00%	17.09%	15.33%	15.10%	14.12%
Staff without a LTC or illness: Average	9.77%	9.88%	8.56%	8.08%	7.60%
Staff with a LTC or illness: Responses	723	677	602	807	836
Staff without a LTC or illness: Responses	3872	3646	2692	3790	3459

Note: The staff survey data featured in this report is the most recently published data – the 2025 Staff Survey.

Workforce Disability Equality Standard 2026

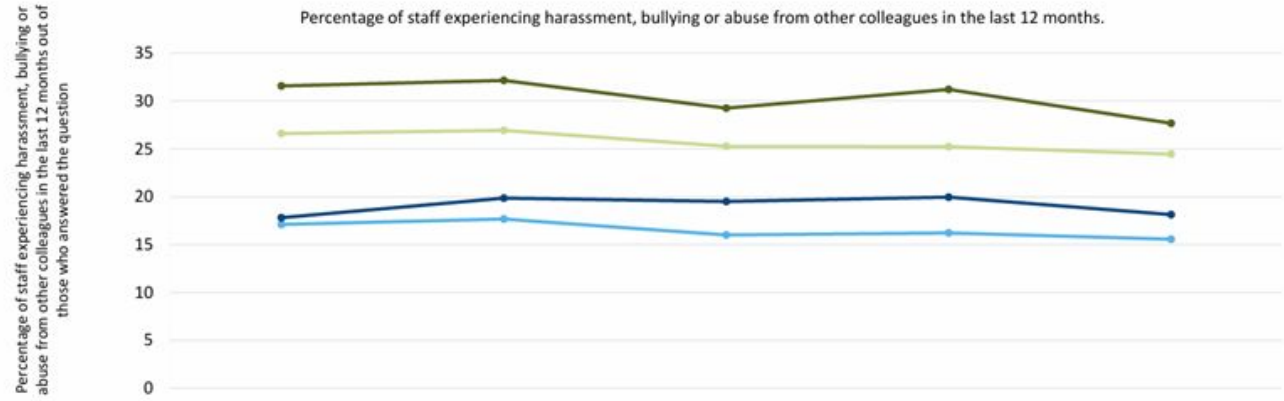
Trust: STG

Indicator 4c

% of staff experiencing harassment, bullying or abuse from other colleagues in the last 12 month

- In 2025, reported harassment from colleagues affected 27.68% of staff with a long-term condition (LTC) or illness, compared to 18.14% of staff without.
- While both demographics achieved a year-on-year reduction in colleague-led HBA, this 9.54 percentage point disparity represents the narrowest equity gap in the last five years.
- Despite these local improvements, figures for both cohorts remain consistently above the national peer average, highlighting an ongoing systemic cultural challenge with peer-to-peer behaviours.

%of staff experiencing harassment, bullying or abuse from other colleagues in the last 12 month



	2021	2022	2023	2024	2025
Staff with a LTC or illness: Your org	31.58%	32.15%	29.26%	31.21%	27.68%
Staff without a LTC or illness: Your org	17.82%	19.86%	19.51%	19.96%	18.14%
Staff with a LTC or illness: Average	26.60%	26.93%	25.26%	25.24%	24.45%
Staff without a LTC or illness: Average	17.11%	17.67%	16.01%	16.22%	15.57%
Staff with a LTC or illness: Responses	722	675	596	801	831
Staff without a LTC or illness: Responses	3873	3630	2678	3762	3457

Note: The staff survey data featured in this report is the most recently published data – the 2025 Staff Survey.

Workforce Disability Equality Standard 2026

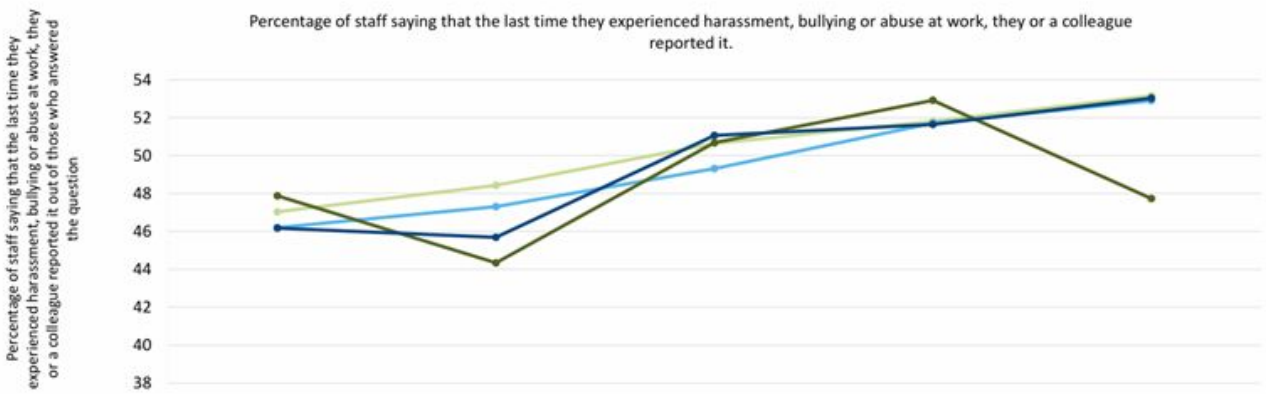
Trust: STG

Indicator 4d

% of staff saying that the last time they experienced harassment, bullying or abuse at work, they or a colleague reported it

- For organisational reporting culture, the proportion of staff with a long-term condition (LTC) or illness who reported their last experience of HBA fell significantly to 47.73% in 2025, down from a five-year peak of 52.91% in 2024.
- Conversely, the reporting rate among staff without an LTC continued its steady upward trajectory, climbing to a record high of 53.03%.
- This divergent performance has created a 5.30 percentage point internal equity gap, reversing a trend where staff with an LTC were previously more likely to report incidents than their peers.
- Notably, while our staff without an LTC report incidents in line with the national average (52.89%), St George's reporting rate for staff with an LTC has dropped 5.43 percentage points below the national peer benchmark (53.16%),

% of staff saying that the last time they experienced harassment, bullying or abuse at work, they or a colleague reported it.



	2021	2022	2023	2024	2025
Staff with a LTC or illness: Your org	47.88%	44.34%	50.68%	52.91%	47.73%
Staff without a LTC or illness: Your org	46.17%	45.69%	51.06%	51.64%	53.03%
Staff with a LTC or illness: Average	47.03%	48.43%	50.64%	51.82%	53.16%
Staff without a LTC or illness: Average	46.20%	47.30%	49.31%	51.71%	52.89%
Staff with a LTC or illness: Responses	353	327	302	378	375
Staff without a LTC or illness: Responses	1280	1287	916	1338	1156

Note: The staff survey data featured in this report is the most recently published data – the 2025 Staff Survey.

Workforce Disability Equality Standard 2026

Trust: STG

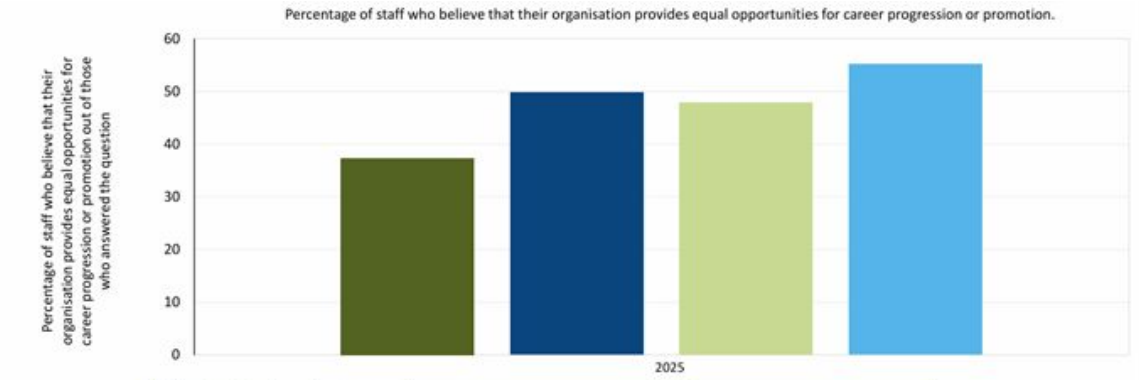
Indicator 5

% of staff who believe that their organisation provides equal opportunities for career progression or promotion

- Prior to the 2025 survey framework revision, favorable perception among staff with a long-term condition (LTC) or illness stagnated below national averages, peaking at just 45.92% in 2024.
- Under the revised 2025 baseline question, this internal equity gap has widened significantly: only 37.32% of staff with an LTC believe the organisation provides equal opportunities, compared to 49.77% of staff without – this is a stark 12.45 percentage point disparity.
- Crucially, this leaves the organisation tracking a substantial 10.47 percentage points below the current national average for staff with conditions (47.79%), marking promotion pathways as a high-priority area for urgent strategic intervention.

	2020	2021	2022	2023	2024
Staff with a LTC or illness: Your org	42.71%	40.11%	44.08%	41.51%	45.92%
Staff without a LTC or illness: Your org	50.06%	48.42%	50.36%	50.02%	50.82%
Staff with a LTC or illness: Average	51.61%	51.41%	51.39%	51.54%	51.30%
Staff without a LTC or illness: Average	57.45%	56.84%	57.25%	57.52%	57.57%
Staff with a LTC or illness: Responses	597	748	676	624	808
Staff without a LTC or illness: Responses	4155	3992	3638	2887	3821

%of staff who believe that their organisation provides equal opportunities for career progression or promotion



Staff with a LTC or illness: Your org	37.32%
Staff without a LTC or illness: Your org	49.77%
Staff with a LTC or illness: Average	47.79%
Staff without a LTC or illness: Average	55.09%
Staff with a LTC or illness: Responses	844
Staff without a LTC or illness: Responses	3478

Note: The staff survey data featured in this report is the most recently published data – the 2025 Staff Survey.

Methodological Note: Due to an update in the NHS Staff Survey core framework question regarding career development, the historical data set (2020–2024) cannot be mathematically compared to the 2025 results. The 2025 data must be interpreted as a reset benchmark. The long-term trends are shown left.

Workforce Disability Equality Standard 2026

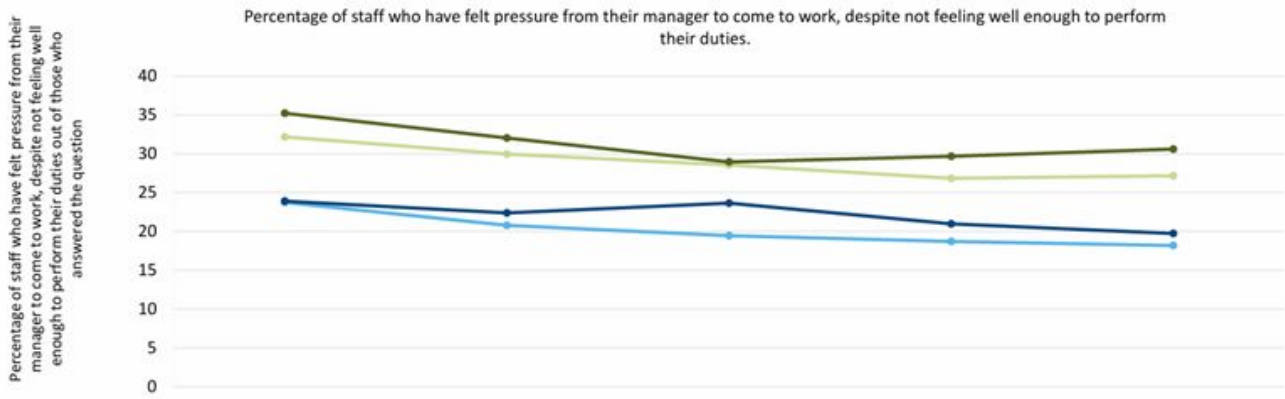
Trust: STG

Indicator 6

% of staff who have felt pressure from their manager to come to work, despite not feeling well enough to perform their duties

- Regarding presenteeism, the 2025 data shows a concerning trend as the proportion of staff with a long-term condition (LTC) or illness who felt pressure from managers to work while unwell rose for the second consecutive year to 30.61%.
- Conversely, staff without an LTC saw a positive reduction to 19.74%, widening the internal equity gap to 10.87 percentage points.
- While the trust has successfully reduced pressure on staff with conditions from a 2021 peak of 35.22%, this recent upward trajectory leaves the organisation tracking 3.42 percentage points above the national average (27.19%), flagging manager behaviours around sickness absence as a potential cultural focus area.

% of staff who have felt pressure from their manager to come to work, despite not feeling well enough to perform their duties



	2021	2022	2023	2024	2025
Staff with a LTC or illness: Your org	35.22%	32.04%	28.95%	29.68%	30.61%
Staff without a LTC or illness: Your org	23.91%	22.40%	23.66%	20.97%	19.74%
Staff with a LTC or illness: Average	32.18%	29.97%	28.55%	26.85%	27.19%
Staff without a LTC or illness: Average	23.74%	20.80%	19.46%	18.71%	18.19%
Staff with a LTC or illness: Responses	565	515	449	566	611
Staff without a LTC or illness: Responses	2083	1902	1403	1993	1788

Note: The staff survey data featured in this report is the most recently published data – the 2025 Staff Survey.

Workforce Disability Equality Standard 2026

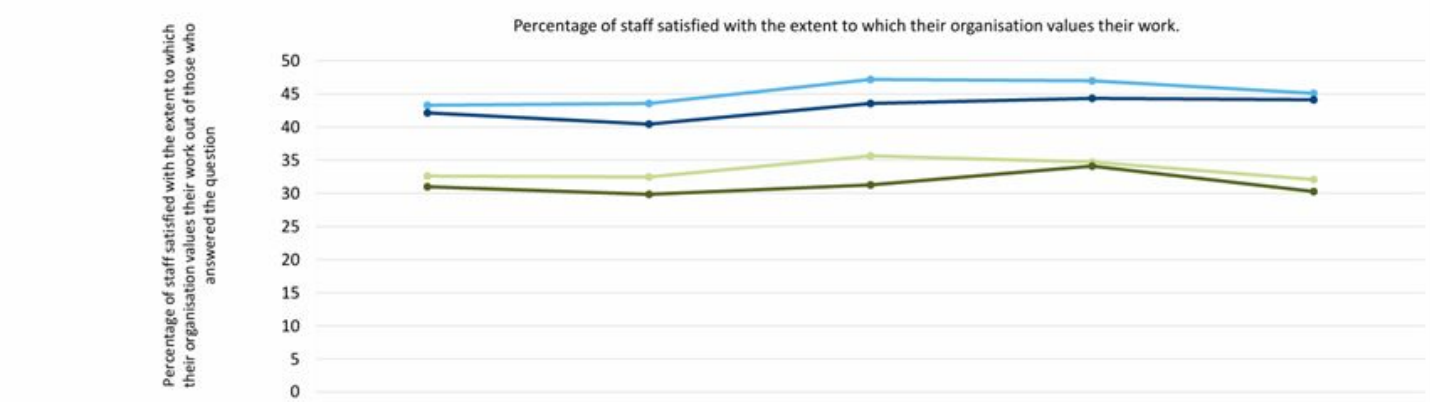
Trust: STG

Indicator 7

% of staff satisfied with the extent to which their organisation values their work.

- Regarding recognition and valuation of work, 2025 saw a decline in satisfaction among staff with a long-term condition (LTC) or illness, falling to 30.29% from a 2024 peak of 34.11%.
- Meanwhile, satisfaction among staff without an LTC remained stable at 44.13%, which has widened the internal equity gap to a notable 13.84 percentage points.
- While the trust has historically fluctuated around the 30% mark for staff with conditions since 2021, this recent drop leaves the organisation tracking 1.80 percentage points below the national average (32.09%), highlighting a clear deficit in how staff with health conditions experience workplace appreciation.

% of staff satisfied with the extent to which their organisation values their work.



	2021	2022	2023	2024	2025
Staff with a LTC or illness: Your org	30.99%	29.85%	31.27%	34.11%	30.29%
Staff without a LTC or illness: Your org	42.14%	40.45%	43.57%	44.34%	44.13%
Staff with a LTC or illness: Average	32.62%	32.46%	35.66%	34.73%	32.09%
Staff without a LTC or illness: Average	43.30%	43.56%	47.19%	46.98%	45.10%
Staff with a LTC or illness: Responses	755	680	630	815	842
Staff without a LTC or illness: Responses	4022	3676	2906	3843	3503

Note: The staff survey data featured in this report is the most recently published data – the 2025 Staff Survey.

Workforce Disability Equality Standard 2026

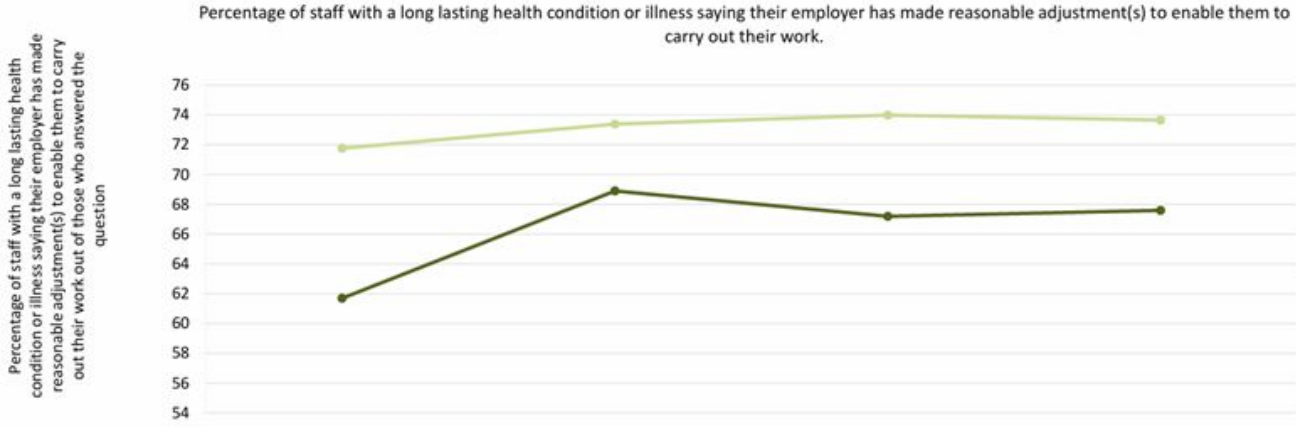
Trust: STG

Indicator 8

% of staff with a long lasting health condition or illness saying their employer has made reasonable adjustment(s) to enable them to carry out their work.

- In terms of workplace support, the trust achieved a modest stabilisation in 2025, with the proportion of staff reporting successful reasonable adjustments rising slightly to 67.59%.
- Crucially, this maintains a strong long-term positive trajectory, representing a 5.90 percentage point improvement over the 2022 baseline (61.69%).
- Furthermore, a steady annual increase in survey respondents (climbing from 402 to 543 over the same period) indicates growing staff engagement and confidence in disclosing adjustments.
- However, despite these foundational gains, local performance has plateaued below the 2023 peak (68.89%) and continues to track 6.06 percentage points below the national average (73.65%), underscoring the need to further accelerate and streamline the trust's delivery processes.

% of staff with a condition or illness saying their employer has made reasonable adjustment(s) to enable them to carry out their work.



	2022	2023	2024	2025
Staff with a LTC or illness: Your org	61.69%	68.89%	67.19%	67.59%
Staff with a LTC or illness: Average	71.76%	73.38%	73.98%	73.65%
Staff with a LTC or illness: Responses	402	389	512	543

Note: The staff survey data featured in this report is the most recently published data – the 2025 Staff Survey.

Workforce Disability Equality Standard 2026

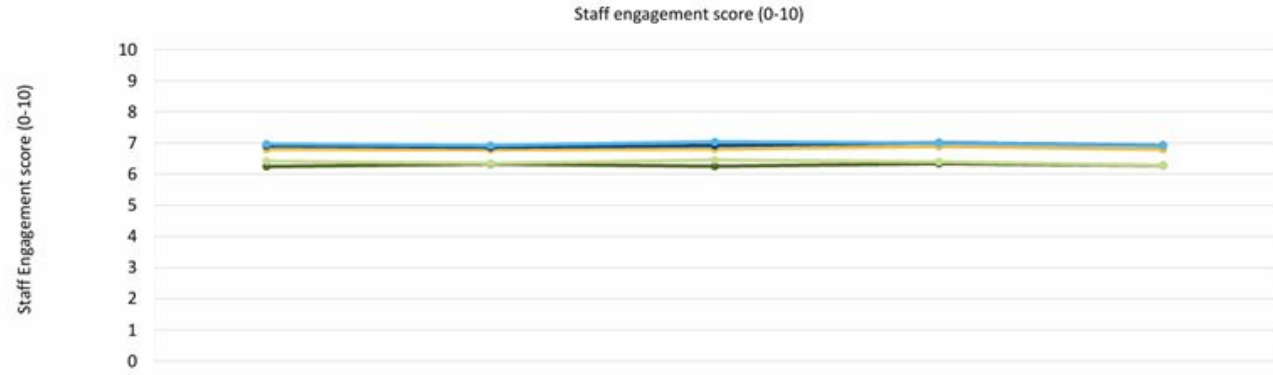
Trust: STG

Indicator 9

Staff engagement score (0-10)

- Regarding overall staff engagement, the 2025 data points to sustained stability, with the trust's staff engagement score holding at 6.80 out of 10.
- For staff with a long-term condition (LTC) or illness, the engagement score saw a marginal contraction to 6.28, down from 6.34 in 2024.
- While this slightly widens the internal equity gap with peers without conditions (6.93) to 0.65 points, a key positive is that the trust remains highly competitive against the national landscape.
- Specifically, local engagement for staff with an LTC tracks virtually in line with the national average of 6.29, and our staff without an LTC outperform their national peer average (6.93 locally vs. 6.91 nationally).

Staff engagement score (0-10)



	2021	2022	2023	2024	2025
Organisation average	6.80	6.78	6.80	6.89	6.80
Staff with a LTC or illness: Your org	6.25	6.33	6.26	6.34	6.28
Staff without a LTC or illness: Your org	6.91	6.87	6.92	7.01	6.93
Staff with a LTC or illness: Average	6.42	6.35	6.46	6.40	6.29
Staff without a LTC or illness: Average	6.97	6.92	7.04	7.00	6.91
Staff with a LTC or illness: Responses	757	685	631	816	849
Staff without a LTC or illness: Responses	4032	3682	2913	3856	3515

Note: Data shown in this chart are unweighted therefore will not match weighted staff engagement scores in other outputs.

Note: The staff survey data featured in this report is the most recently published data – the 2025 Staff Survey.

Workforce Disability Equality Standard 2026

Trust: STG / ESTH

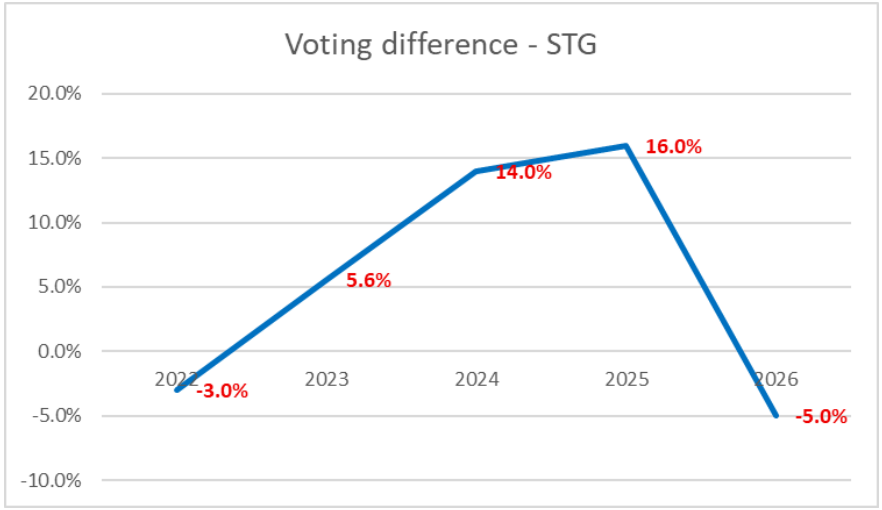
Indicator 10

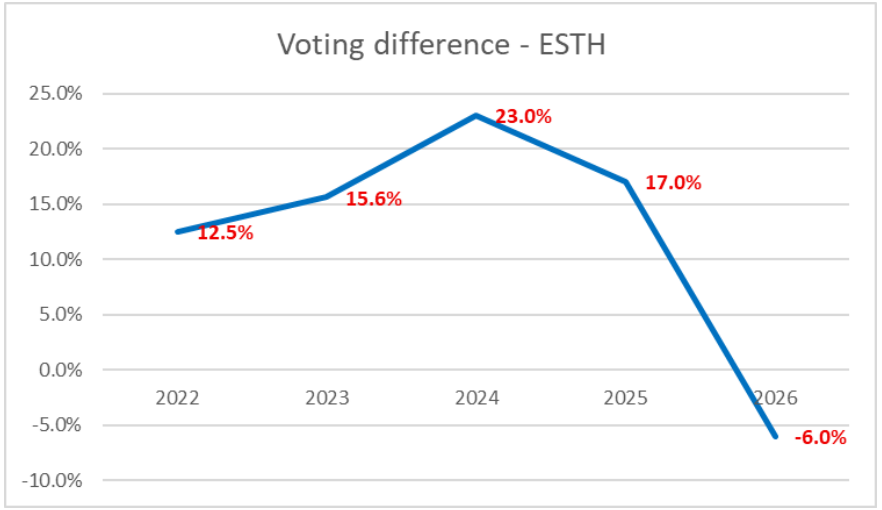
% difference between the organisation's Board voting membership and its organisation's overall workforce

As of 31 March 2026, the Trust Board of Directors comprised 18 members, split equally between 9 voting and 9 non-voting members. Within this cohort, no voting members have declared a disability, while two non-voting members have a declared disability. This shift is entirely due to recent changes in Board composition and voting allocations over the last 12 months. Given the small overall sample size, minor adjustments or leavers can cause mathematically significant swings in this indicator.

Consequently, for the first time since 2022, staff with a disability are underrepresented at the Voting Board level, standing at -5.0% for STG and -6.0% for ESTH. Despite this decline in voting representation, staff with disabilities remain positively represented across the wider governance structures, with overall Board representation tracking positively at 6.0% for STG and 15.0% for ESTH. Executive Board representation remains positive at 18.0% for STG and 17.0% for ESTH.

To address these recent shifts, we continue to work closely with the Council of Governors to ensure that attracting a diverse pool of candidates is a central focus for all future Board appointments. We will continue to focus on inclusive recruitment practices, working with our recruitment partners to actively welcome and seek out candidates from all diverse backgrounds.





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

gesh

Site Report: Epsom and St Helier University Hospitals NHS Trust

Workforce Disability Equality Standard 2026

Features: 2025 Staff Survey Data and workforce information on 31/03/2026
Published: 00/00/2026

Workforce Disability Equality Standard 2026

Executive summary

Trust: ESTH

All NHS providers are required to complete an annual Workforce Disability Equality Standard (WDES) report. The report is based on a snapshot of data from 31st March each year and aims to highlight progress against a number of key indicators of workforce equality. Data for WDES indicators 4 to 9a are drawn from questions in the most recent NHS staff survey.

In line with national requirements this report and any associated action plans should be reviewed internally and approved at Board before being published on the organisation's website. The deadline for publication is 31st October 2026. The key findings are outlined below. Unless indicated, each point is compared to the previous reporting period:

Improved indicators

- Metric Success: Out of 13 monitored indicators, we see a measured improvement (compared to the previous year) in two metrics.
- Overall Declaration: The percentage of declared disabled staff across the organisation has continued to expand positively, rising to 5.6%.
- Pressure to Work: Staff report a positive downward trend in manager pressure to work when unwell, dropping to its lowest five-year level at 30.2%

Reduced / static indicators

- Metric Challenges: Out of 13 monitored indicators, we see a decline in 7 metrics, while 4 remained static.
- Public & Colleague Harassment: Public-facing harassment rose to 32.9% and peer-on-peer colleague harassment increased to 26.2%.
- Manager Harassment: Reported harassment from managers held completely static at 19.3%.
- Reporting Culture: The percentage of staff reporting incidents experienced a downward trajectory, dipping to 53.7%.
- Work Valuation & Support: Satisfaction with how work is valued decreased to 33.4%, while staff engagement (6.32) and reasonable adjustments (68.1%) held static.
- Career Progression & Voting: Career fairness perception stands at 43.1% under the new baseline, formal capability rose to 2.59, recruitment held static, and a shift in membership moved voting board representation to -6%.

Despite maintaining strong reporting cultures and resilient staff engagement scores, ESTH faces distinct challenges regarding public harassment and career progression equity. These focus areas continue to be actively managed through our six high-impact group workstreams, as detailed on the Next Steps slide.

Workforce Disability Equality Standard 2026

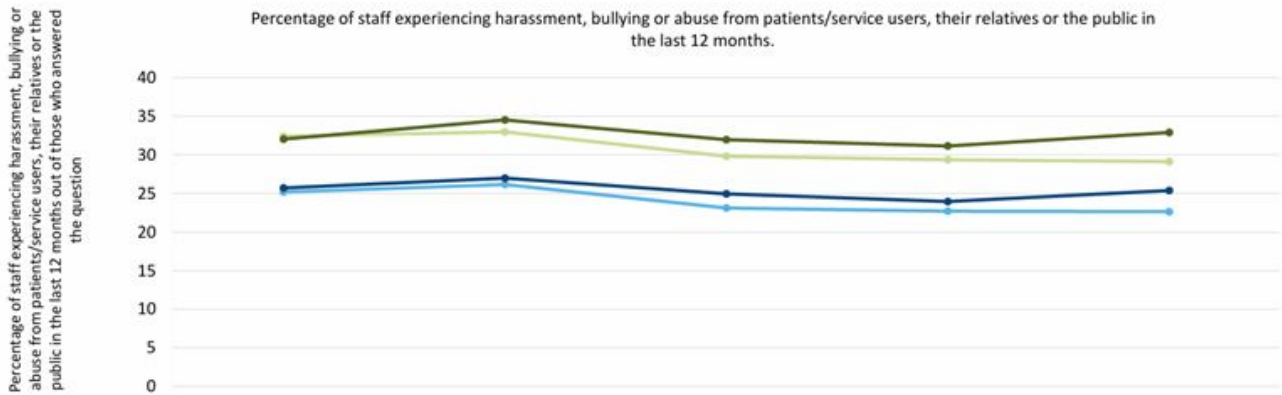
Trust: ESTH

Indicator 4a

% of staff experiencing harassment, bullying or abuse from patients, relatives or the public in the last 12 months

- The 2025 survey data reveals an upward trajectory in public-facing harassment for both staff groups, following a two-year period of steady decline.
- Reported incidents involving staff with a long-term condition (LTC) or illness rose by 1.76 percentage points to 32.91%, while rates for staff without an LTC increased by 1.42 percentage points to 25.38%, leaving the internal equity gap relatively stable at 7.53 points.
- Current rates for staff with conditions remain lower than the 2022 peak of 34.53%. However, ESTH figures continue to track above the national averages for both cohorts - with staff with an LTC sitting 3.77 percentage points higher than the national peer average (29.14%).

% of staff experiencing harassment, bullying or abuse from patients/relatives or the public



	2021	2022	2023	2024	2025
Staff with a LTC or illness: Your org	32.04%	34.53%	31.97%	31.15%	32.91%
Staff without a LTC or illness: Your org	25.71%	26.99%	24.94%	23.96%	25.38%
Staff with a LTC or illness: Average	32.43%	32.98%	29.83%	29.37%	29.14%
Staff without a LTC or illness: Average	25.19%	26.16%	23.11%	22.71%	22.64%
Staff with a LTC or illness: Responses	646	614	594	687	626
Staff without a LTC or illness: Responses	3030	2779	2577	3089	2730

Note: The staff survey data featured in this report is the most recently published data – the 2025 Staff Survey.

Workforce Disability Equality Standard 2026

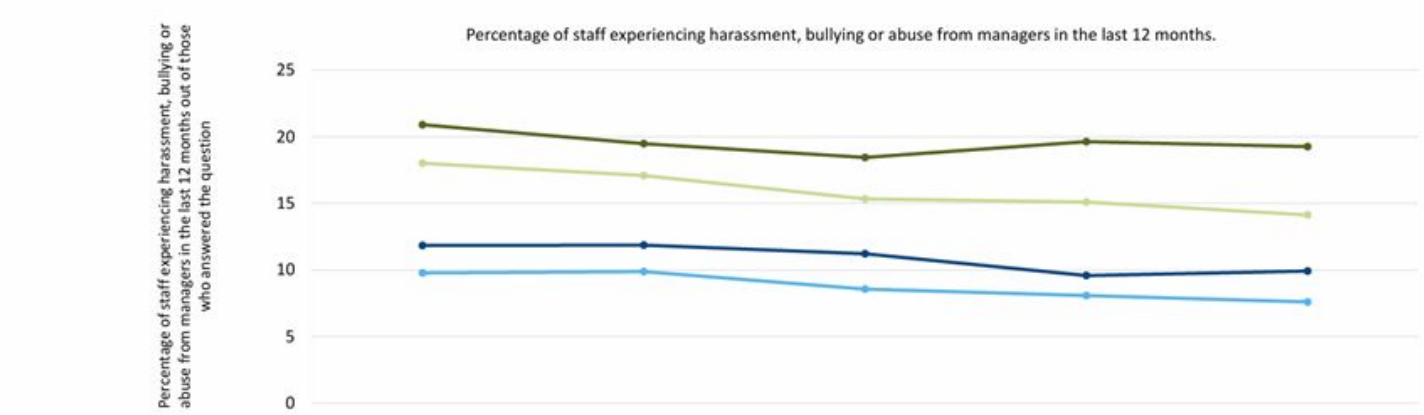
Trust: ESTH

Indicator 4b

% of staff experiencing harassment, bullying or abuse from managers in the last 12 months

- The 2025 survey data demonstrates a stable year-on-year position across the organisation, though it maintains a marginal positive trajectory.
- Reported harassment from managers dipped slightly by 0.37 percentage points to 19.25% for staff with a long-term condition (LTC) or illness, while staff without an LTC saw a nominal increase of 0.33 percentage points to 9.91%. Because these movements were minimal, the internal equity gap remains virtually flat at 9.34 percentage points.
- While it is encouraging that the rate for staff with conditions has stabilised below its 2021 peak (20.90%), ESTH figures remain consistently above national averages. Notably, staff with an LTC face a 5.13 percentage point deficit compared to their national peers (14.12%).

% of staff experiencing harassment, bullying or abuse from managers in the last 12 months



	2021	2022	2023	2024	2025
Staff with a LTC or illness: Your org	20.90%	19.48%	18.44%	19.62%	19.25%
Staff without a LTC or illness: Your org	11.84%	11.86%	11.21%	9.58%	9.91%
Staff with a LTC or illness: Average	18.00%	17.09%	15.33%	15.10%	14.12%
Staff without a LTC or illness: Average	9.77%	9.88%	8.56%	8.08%	7.60%
Staff with a LTC or illness: Responses	646	611	589	683	613
Staff without a LTC or illness: Responses	2981	2748	2547	3038	2694

Note: The staff survey data featured in this report is the most recently published data – the 2025 Staff Survey.

Workforce Disability Equality Standard 2026

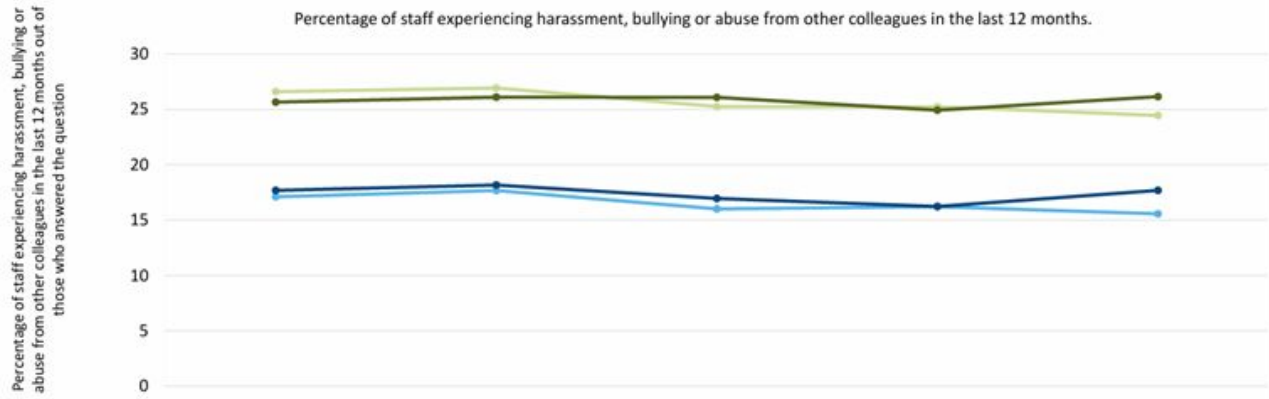
Trust: ESTH

Indicator 4c

% of staff experiencing harassment, bullying or abuse from other colleagues in the last 12 month

- The 2025 survey data reflects a negative year-on-year trajectory, with peer-on-peer harassment increasing across both cohorts.
- Reported incidents involving staff with a long-term condition (LTC) or illness rose by 1.22 percentage points to 26.15%, while staff without an LTC saw a similar increase of 1.46 percentage points to 17.69%.
- Both cohorts experienced parallel increases therefore the internal equity gap remained stable, narrowing slightly.
- Over a longer-term perspective, current figures remain closely aligned with the trust's historical 2021–2022 levels.
- ESTH rates continue to track above the national averages for both groups, sitting 1.70 percentage points higher for staff with an LTC (24.45% nationally) and 2.12 percentage points higher for staff without.

%of staff experiencing harassment, bullying or abuse from other colleagues in the last 12 month



	2021	2022	2023	2024	2025
Staff with a LTC or illness: Your org	25.66%	26.11%	26.09%	24.93%	26.15%
Staff without a LTC or illness: Your org	17.68%	18.17%	16.96%	16.23%	17.69%
Staff with a LTC or illness: Average	26.60%	26.93%	25.26%	25.24%	24.45%
Staff without a LTC or illness: Average	17.11%	17.67%	16.01%	16.22%	15.57%
Staff with a LTC or illness: Responses	647	609	586	678	608
Staff without a LTC or illness: Responses	2986	2736	2542	3032	2680

Note: The staff survey data featured in this report is the most recently published data – the 2025 Staff Survey.

Workforce Disability Equality Standard 2026

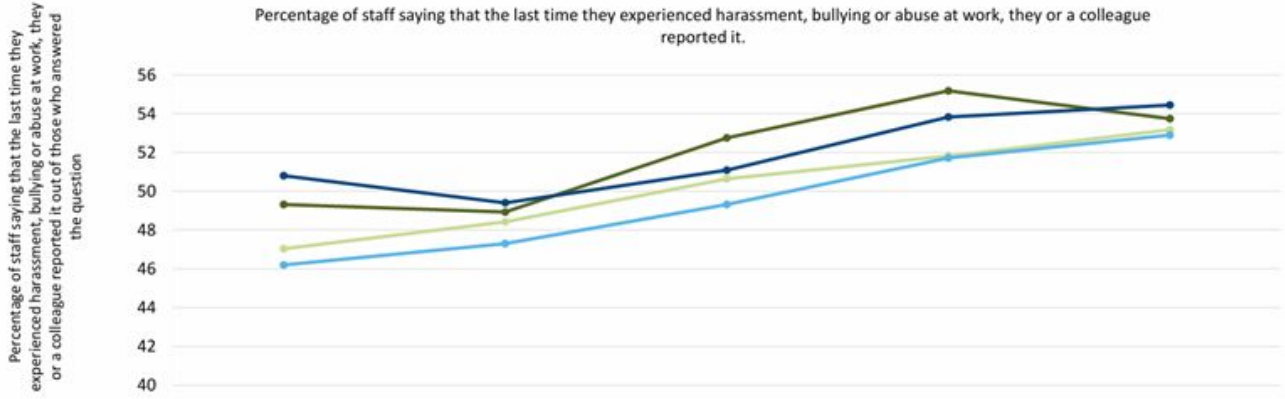
Trust: ESTH

Indicator 4d

% of staff saying that the last time they experienced harassment, bullying or abuse at work, they or a colleague reported it

- The 2025 survey data shows mixed results for how often staff report bullying, harassment, or abuse.
- For staff with a long-term condition (LTC) or illness, the reporting rate saw a downward trajectory, decreasing by 1.43 percentage points to 53.74% from its 2024 peak.
- Conversely, the reporting rate for staff without an LTC maintained a stable, upward path, climbing slightly by 0.62 percentage points to reach a five-year high of 54.44%.
- This has created a narrow internal equity gap of 0.70 percentage points
- On a very positive note, ESTH continues to perform well nationally, outperforming the peer average for both staff with an LTC (53.16% nationally) and those without (52.89% nationally).

% of staff saying that the last time they experienced harassment, bullying or abuse at work, they or a colleague reported it.



	2021	2022	2023	2024	2025
Staff with a LTC or illness: Your org	49.32%	48.93%	52.75%	55.17%	53.74%
Staff without a LTC or illness: Your org	50.80%	49.40%	51.08%	53.82%	54.44%
Staff with a LTC or illness: Average	47.03%	48.43%	50.64%	51.82%	53.16%
Staff without a LTC or illness: Average	46.20%	47.30%	49.31%	51.71%	52.89%
Staff with a LTC or illness: Responses	294	280	260	290	281
Staff without a LTC or illness: Responses	996	915	787	929	845

Note: The staff survey data featured in this report is the most recently published data – the 2025 Staff Survey.

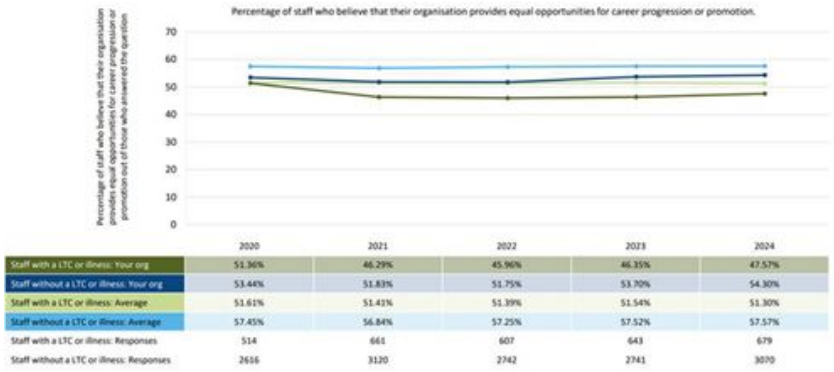
Workforce Disability Equality Standard 2026

Trust: ESTH

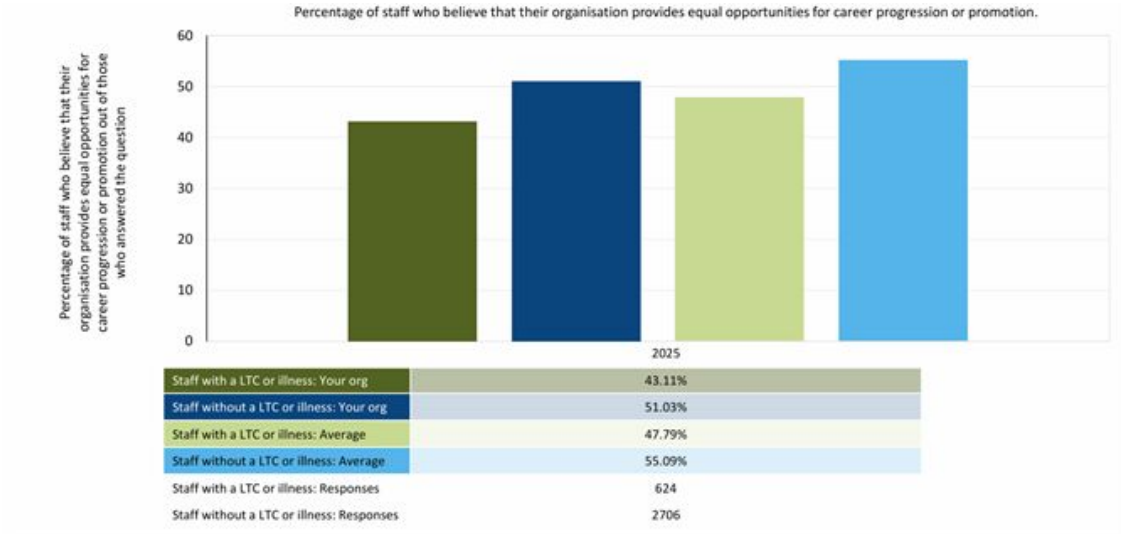
Indicator 5

% of staff who believe that their organisation provides equal opportunities for career progression or promotion

- Prior to the 2025 survey framework revision, favourable perception among staff with a long-term condition (LTC) or illness stagnated below national averages, peaking at 51.36% in 2020 and finishing at 47.57% in 2024.
- Under the revised 2025 baseline question, an internal equity gap remains: only 43.11% of staff with an LTC believe the organisation provides equal opportunities, compared to 51.03% of staff without - this is a 7.92 percentage point disparity.
- Crucially, this leaves the organisation tracking 4.68 percentage points below the current national average for staff with conditions (47.79%), marking promotion pathways as a priority area for supportive intervention.



%of staff who believe that their organisation provides equal opportunities for career progression or promotion



Note: The staff survey data featured in this report is the most recently published data – the 2025 Staff Survey.

Methodological Note: Due to an update in the NHS Staff Survey core framework question regarding career development, the historical data set (2020–2024) cannot be mathematically compared to the 2025 results. The 2025 data must be interpreted as a reset benchmark. The long-term trends are shown left.

Workforce Disability Equality Standard 2026

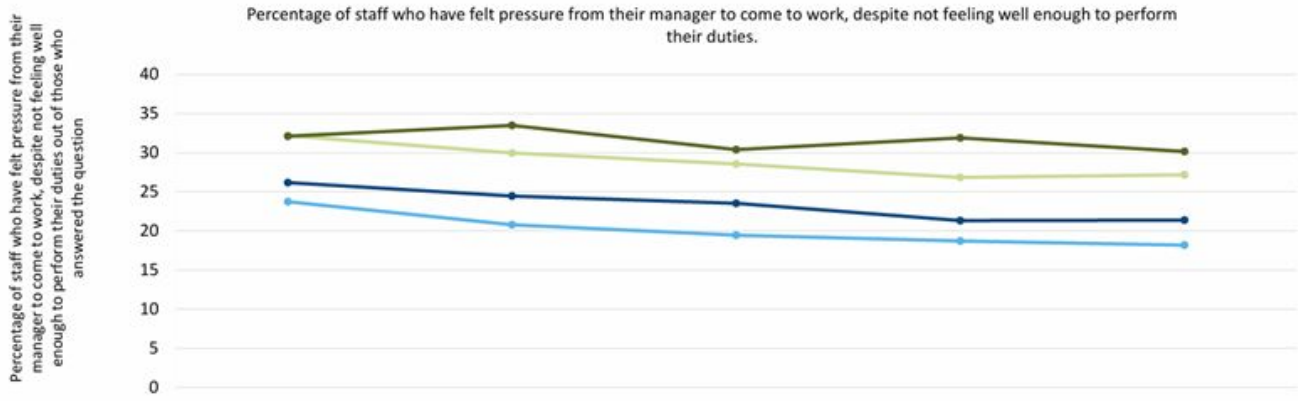
Trust: ESTH

Indicator 6

% of staff who have felt pressure from their manager to come to work, despite not feeling well enough to perform their duties

- Regarding presenteeism, the 2025 data shows a positive downward trend as the proportion of staff with a long-term condition (LTC) or illness who felt pressure from managers to work while unwell fell by 1.72 percentage points to 30.16%.
- Conversely, staff without an LTC remained stable with a marginal increase of 0.07 percentage points to 21.40%, slightly narrowing the internal equity gap to 8.76 percentage points.
- While it is encouraging that the trust has reduced pressure on staff with conditions down to its lowest level across the five-year period, the organisation still tracks 2.97 percentage points above the current national average (27.19%).

% of staff who have felt pressure from their manager to come to work, despite not feeling well enough to perform their duties



	2021	2022	2023	2024	2025
Staff with a LTC or illness: Your org	32.10%	33.49%	30.40%	31.88%	30.16%
Staff without a LTC or illness: Your org	26.18%	24.46%	23.52%	21.33%	21.40%
Staff with a LTC or illness: Average	32.18%	29.97%	28.55%	26.85%	27.19%
Staff without a LTC or illness: Average	23.74%	20.80%	19.46%	18.71%	18.19%
Staff with a LTC or illness: Responses	461	433	421	483	451
Staff without a LTC or illness: Responses	1524	1378	1271	1416	1285

Note: The staff survey data featured in this report is the most recently published data – the 2025 Staff Survey.

Workforce Disability Equality Standard 2026

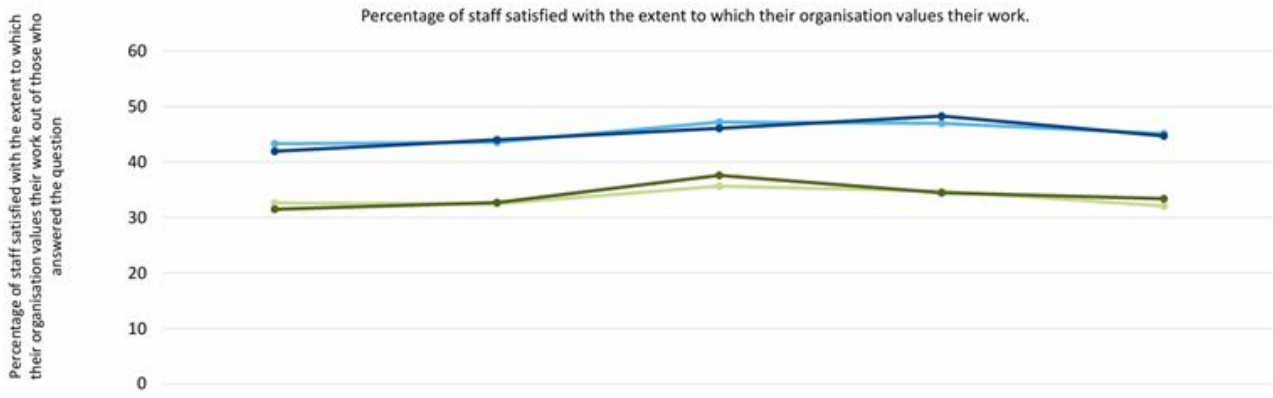
Trust: ESTH

Indicator 7

% of staff satisfied with the extent to which their organisation values their work.

- Regarding recognition and valuation of work, the 2025 data shows a downward trajectory in satisfaction levels across both staff cohorts.
- For staff with a long-term condition (LTC) or illness, satisfaction dipped slightly by 1.06 percentage points to 33.39% from 34.45% last year.
- Meanwhile, staff without an LTC saw a larger decrease of 3.58 percentage points to 44.70%, which narrowed the internal equity gap to 11.31 percentage points.
- On a positive note, despite this year's slight decline, ESTH continues to perform well against the national landscape for staff with health conditions, tracking 1.30 percentage points above the current national average (32.09%).

% of staff satisfied with the extent to which their organisation values their work.



	2021	2022	2023	2024	2025
Staff with a LTC or illness: Your org	31.48%	32.68%	37.60%	34.45%	33.39%
Staff without a LTC or illness: Your org	41.94%	44.02%	46.08%	48.28%	44.70%
Staff with a LTC or illness: Average	32.62%	32.46%	35.66%	34.73%	32.09%
Staff without a LTC or illness: Average	43.30%	43.56%	47.19%	46.98%	45.10%
Staff with a LTC or illness: Responses	667	612	641	685	626
Staff without a LTC or illness: Responses	3138	2783	2754	3088	2727

Note: The staff survey data featured in this report is the most recently published data – the 2025 Staff Survey.

Workforce Disability Equality Standard 2026

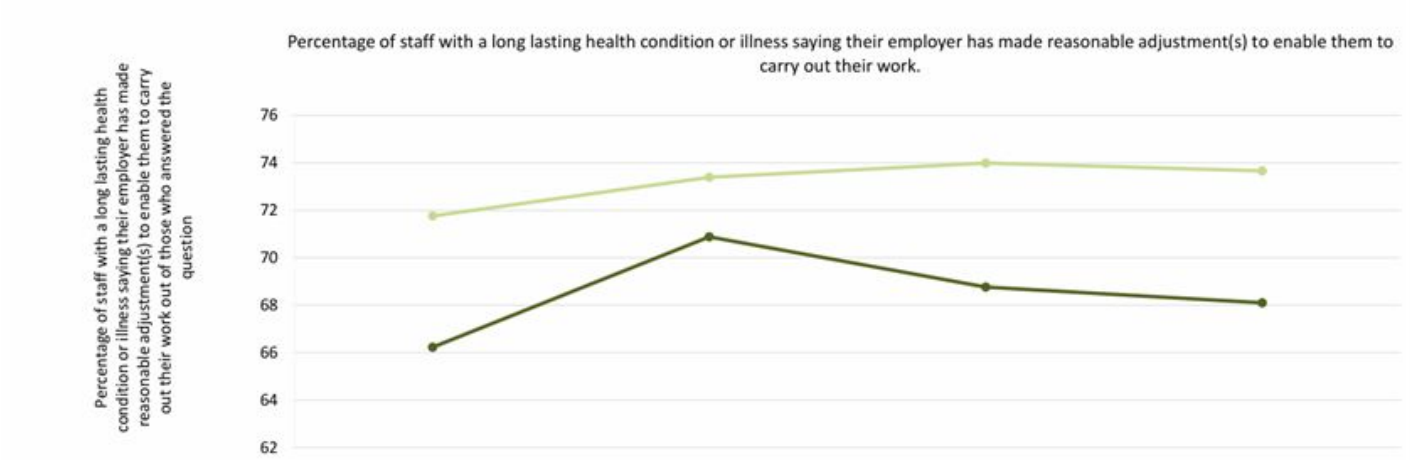
Trust: ESTH

Indicator 8

% of staff with a long lasting health condition or illness saying their employer has made reasonable adjustment(s) to enable them to carry out their work.

- In terms of workplace support, the trust maintained a stable position in 2025, with the proportion of staff reporting successful reasonable adjustments dipping marginally by 0.66 percentage points to 68.10%.
- Looking at the long-term trend, this represents a positive trajectory, marking a 1.87 percentage point improvement over the 2022 baseline (66.23%).
- However, local performance has continued to plateau below the 2023 peak (70.88%) and tracks 5.55 percentage points below the national peer average (73.65%).
- This highlights a clear opportunity to further streamline and improve how the trust delivers reasonable adjustments to our teams.

% of staff with a condition or illness saying their employer has made reasonable adjustment(s) to enable them to carry out their work.



	2022	2023	2024	2025
Staff with a LTC or illness: Your org	66.23%	70.88%	68.76%	68.10%
Staff with a LTC or illness: Average	71.76%	73.38%	73.98%	73.65%
Staff with a LTC or illness: Responses	379	388	429	395

Note: The staff survey data featured in this report is the most recently published data – the 2025 Staff Survey.

Workforce Disability Equality Standard 2026

Trust: ESTH

Indicator 9

Staff engagement score (0-10)

- Regarding overall staff engagement, the 2025 data shows a stable year-on-year position across the organisation, though it maintains a marginal downward trajectory.
- The engagement score for staff with a long-term condition (LTC) or illness held relatively flat, dipping slightly by 0.03 points to 6.32, while the score for staff without an LTC decreased by 0.10 points to 6.96 -leaving the internal equity gap at 0.64 points.
- From a benchmark perspective, ESTH continues to perform well against the national landscape. Engagement score for staff with conditions outpaces the national peer average of 6.29, while staff without conditions also track ahead of their national benchmark (6.91).

Staff engagement score (0-10)

	2021	2022	2023	2024	2025
Organisation average	6.86	6.84	6.93	6.93	6.84
Staff with a LTC or illness: Your org	6.47	6.35	6.46	6.35	6.32
Staff without a LTC or illness: Your org	6.96	6.95	7.04	7.06	6.96
Staff with a LTC or illness: Average	6.42	6.35	6.46	6.40	6.29
Staff without a LTC or illness: Average	6.97	6.92	7.04	7.00	6.91
Staff with a LTC or illness: Responses	668	614	645	692	630
Staff without a LTC or illness: Responses	3153	2788	2773	3091	2739

Note: The staff survey data featured in this report is the most recently published data – the 2025 Staff Survey.

Workforce Disability Equality Standard 2026

Trust: STG / ESTH

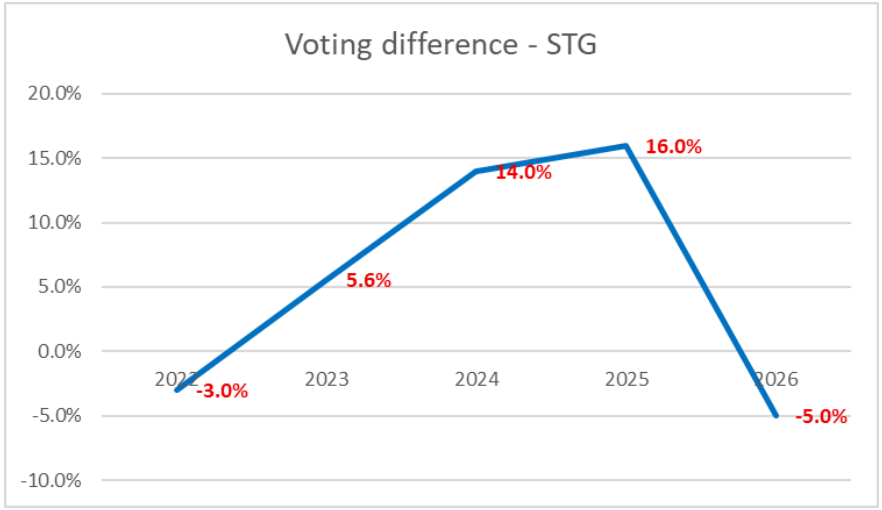
Indicator 10

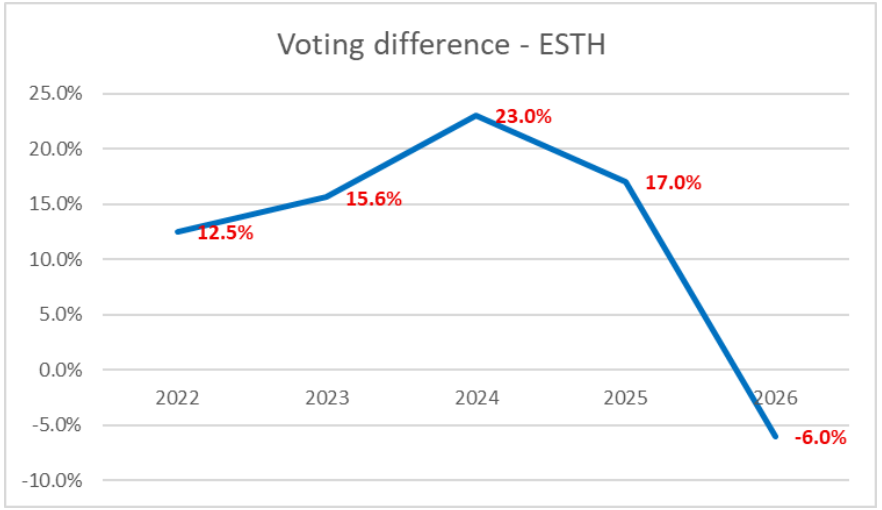
% difference between the organisation's Board voting membership and its organisation's overall workforce

As of 31 March 2026, the Trust Board of Directors comprised 18 members, split equally between 9 voting and 9 non-voting members. Within this cohort, no voting members have declared a disability, while two non-voting members have a declared disability. This shift is entirely due to recent changes in Board composition and voting allocations over the last 12 months. Given the small overall sample size, minor adjustments or leavers can cause mathematically significant swings in this indicator.

Consequently, for the first time since 2022, staff with a disability are underrepresented at the Voting Board level, standing at -5.0% for STG and -6.0% for ESTH. Despite this decline in voting representation, staff with disabilities remain positively represented across the wider governance structures, with overall Board representation tracking positively at 6.0% for STG and 15.0% for ESTH. Executive Board representation remains positive at 18.0% for STG and 17.0% for ESTH.

To address these recent shifts, we continue to work closely with the Council of Governors to ensure that attracting a diverse pool of candidates is a central focus for all future Board appointments. We will continue to focus on inclusive recruitment practices, working with our recruitment partners to actively welcome and seek out candidates from all diverse backgrounds.





Workforce Disability Equality Standard (WDES)

Appendix A: Legal Obligations and Disability

Legal Obligations of Employers and Workplace Adjustments (formerly Reasonable Adjustments)

Protection against disability-based discrimination is enshrined in the Equality Act 2010. Due to the additional barriers faced by people with a disability, it is permitted to treat applicants with a disability more favourably than their colleagues without a disability. Understanding this, and the reasons for it, is crucial to removing the barriers that continue to deny people with a disability equality of outcome in work and more broadly.

The Equality Act 2010 protects employees, and covers areas including recruitment, assessment and selection, terms of employment, promotion and training opportunities, dismissal or redundancy, and discipline and grievances. The Equality Act 2010 also requires that reasonable adjustments (now 'workplace adjustments' are made to working conditions, policies and practices that put a staff member with a disability at a disadvantage. A workplace adjustment could include any of the following:

- making adjustments to premises or acquiring/modifying equipment
- providing a reader or interpreter, or employing a support worker
- reallocating an employee with a disability's duties to another person
- providing supervision, training, mentoring or other support
- transferring a person to fill an existing suitable vacancy without competitive interview
- altering working hours or the place of work
- allowing someone to be absent during working hours for rehabilitation, assessment or treatment
- modifying procedures for testing or assessment

Useful checklists and further detail on the legal obligations can be found in the Guidance relating to disability for the NHS document, published by NHS Employers. This guidance document also sets out examples of good practice (when not legally obligated), particularly around the supporting carers and disability related absence from work.

What is 'disability'?

Defining 'disability' is not always straightforward. The Equality Act 2010 defines a person with a disability as:

"someone who has a mental or physical impairment that has a substantial and long-term adverse effect on the person's ability to carry out normal day-to-day activities."

Some of the terms in this definition are open to interpretation, and further guidance is found in Appendix C. However, instead of trying to judge whether a person falls within the statutory definition of disability, we should focus on meeting the needs of the worker (or job applicant). In supporting a staff with a disability, it is almost always more important to understand and support the effects of a disability rather than the cause.

It is important to note that the definition of disability regards the person as they are without aids, support or medication (the exception being visual impairment where it can be addressed by use of wearing prescription spectacles). This is particularly relevant for those with mental health conditions who are able to control their condition with medication, and also for those with conditions such as epilepsy and diabetes that are otherwise controlled by medication.

Additional information on the definition of disability is attached in Appendix C, taken directly from guidance produced and published by NHS Employers. This guidance was published in 2014. We will continue to closely monitor best practice and guidance and communicates updates as necessary.

Workforce Disability Equality Standard (WDES)

Appendix B: High impact action plan framework

This plan prioritises the following six high impact actions to address the widely-known intersectional impacts of discrimination and bias.

Measurable objectives on EDI for Chairs Chief Executives and Board members.

Success metric

1a. Annual Chair/CEO appraisals on EDI objectives via Board Assurance Framework (BAF).

Overhaul recruitment processes and embed talent management processes.

Success metric

2a. Relative likelihood of staff being appointed from shortlisting across all posts

2b. NSS Q on access to career progression and training and development opportunities

2c. Improvement in race and disability representation leading to parity

2d. Improvement in representation senior leadership (Band 8C upwards) leading to parity

2e. Diversity in shortlisted candidates

2f. NETS Combined Indicator Score metric on quality of training

Eliminate total pay gaps with respect to race, disability and gender.

Success metric

3a. Improvement in gender, race, and disability pay gap

Address Health Inequalities within their workforce.

Success metric

4a. NSS Q on organisation action on health and wellbeing concerns

4b. National Education & Training Survey (NETS) Combined Indicator Score metric on quality of training

4c. To be developed in Year 2

Comprehensive Induction and onboarding programme for International recruited staff.

Success metric

5a. NSS Q on belonging for IR staff

5b. NSS Q on bullying, harassment from team/line manager for IR staff

5c. NETS Combined Indicator Score metric on quality of training IR staff

Eliminate conditions and environment in which bullying, harassment and physical harassment occurs.

Success metric

6a. Improvement in staff survey results on bullying / harassment from line managers/teams (ALL Staff)

6b. Improvement in staff survey results on discrimination from line managers/teams (ALL Staff)

6c. NETS Bullying & Harassment score metric (NHS professional groups)

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EDI Action Plan Update

Joseph Pavett-Downer
Group Head of EDI (Workforce)

Date 28/07/2026

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EDI Action Plan Update

Our Equality, Diversity & Inclusion (EDI) Action Plan was formally approved, by the Board, in 2025. Since then, we have focused on building understanding, engagement and support across teams. This has included attending team meetings to present the plan, explain key actions, and begin embedding the work into day-to-day activity. These engagement efforts are ongoing and in conjunction with other approaches which will support communicate the plan more widely and at speed, for example website and comms stories.

It's worth noting that several action deadlines were set close to the plan's approval date and coincided with a significant and complex consultation and restructure within the People function leadership team. This overlap has diverted some attention and contributed to delays in a few areas. However, overall progress is strong and delivery is underway across several key actions. We have reviewed actions that are likely to be delayed or are already overdue and will be taking the necessary steps to prioritise progress in these areas.

Of the 58 actions, 46 are complete / moved to business as usual (BAU). Of the remaining 11 actions, 1 is track for delivery, 4 are paused and 7 overdue:

Key Successes

- Network Executive Sponsorship
- Talent Management Plan Approved
- Introduce effective Communications Training
- Launch Flexible Working Policy
- Launch Menopause training and guidance
- Wellbeing Toolkits to guide managers in supporting staff wellbeing
- Launch Disability in the Workplace Policy
- Reasonable Adjustment advice/resources are readily accessible
- D&I presence at all inductions, including Corporate, Medical and International.
- Embed Ask Aunty initiative across the group, including App launch.
- ERAF/EQIA for Talent Management Pilots
- RIS Process embedded at ESTH
- Stakeholder engagement (Talent and Career Development)
- Improved VSM and Board level JDs and expectations
- Culture / EDI questions (incl. on all VSM interviews)

Paused

- Integrate CARE objectives in the PDR Process
- Launch Neurodiversity in the Workplace module
- Gender Reassignment and Sexual Orientation topics (MAST)
- Launch LGBTQ+ Awareness Module (ESTH)

All actions above are paused due to national MAST review and the change in our OLM platform across the group.

Overdue

- Embed Coaching Culture
- Consider Mend the gap recommendations
- Develop and Implement Health Passport for Staff
- Introduce Cultural Intelligence Training Offer
- Bullying, Harassment and Abuse reduction targets Launch 'Just Culture' to ensure restorative approach to ER processes
- Roles and responsibilities of those involved in ER cases

As these actions were established over 12 months ago, subsequent changes in priorities, business context and delivery approaches have impacted progress and, in some cases, require reassessment of the original scope and intended outcomes.

2

See appendix A for a full overview of our EDI action plan actions

Inclusive Recruitment

How we will make recruitment more inclusive and drive improved outcomes

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Inclusive Recruitment is a one of six programmes of work in our gesh Talent Management Strategy. There are 8 initiatives within this programme (see overview), initiatives in green indicated those that are complete, those in amber are on track and in progress.

What has been actioned?

- RIS Process embedded at ESTH.
- Introduced a pre allocation process group wide to improve compliance.
- This has seen compliance at STG increase from 39% (April) to 78% (June). For ESTH this increased from 0% (April) to 58% (June).
- Updated scoring criteria and guidance launched.
- Clear guidance for Executives and SLT to support inclusive practice at senior recruitment.
- New Recruitment Toolkit launched (see appendix C).
- Updated Recruitment and Selection Training live.
- Inclusive Recruitment Practice included in our core Leadership and Management Development programmes.
- Gesh Inclusive Recruitment Session offered group wide as part of our Dive-In to Diversity series.
- Golden Ticket Live at STG, with 3 interns successfully securing permanent paid employment (under the scheme) since it's launch.

Launching soon:

- Initially we proposed the introduction of an Independent chair model, however following stakeholder feedback, we are exploring an alternative option which is likely more operationally sustainable and better received/supported by leaders.
- Standardised job descriptions is now part of the SWL Recruitment review. The EDI team will continue to support the hub and anticipate this launching later in 2026.

Overview of Inclusive Recruitment Programme

1. Embed Recruitment Inclusion Specialist (RIS) Across All Sites
- Provides impartiality and challenge to ensure fairer hiring decisions
- Drives consistency in EDI practice across divisions
- Strengthens accountability recruitment processes

2. Standardise Job Descriptions for Target Roles
- Removes unnecessary criteria to widen access
- Uses clear, inclusive language to improve accessibility and attraction
- Supports equitable banding and role clarity across the organisation

3. Implement Consistent, Structured Interview Scoring
- Reduces bias and subjectivity through standardised evaluation criteria
- Enables fair comparison of candidates across panels and sites
- Improves transparency and auditability of hiring decisions

4. Clarify Recruitment Roles, Responsibilities and Process
- Defines clear accountability at each stage of recruitment and selection
- Reduces variation and improves process consistency across teams
- Empowers staff to challenge and uphold inclusive practices

5. Introduce Independent Chairing of Interview Panels
- Minimises conflicts of interest and informal hiring practices
- Promotes balanced, objective decision-making within panels
- Reinforces fairness and organisational integrity in recruitment

6. Deliver Comprehensive Inclusive Recruitment Training
- Builds capability and confidence in inclusive hiring practices
- Aligns behaviours with NHS EDI priorities and legal requirements

7. Create a Supported Pathway from Internship to Employment
- Establishes a sustainable pipeline of neurodivergent talent into permanent roles (Golden Ticket Scheme)
- Reduces barriers associated with traditional recruitment processes

8. Strengthen Inclusive Recruitment for Senior Roles
- Expands diverse talent pipelines beyond traditional networks
- Embeds fair and transparent hiring practices
- Improves representation at senior levels, supporting inclusive leadership

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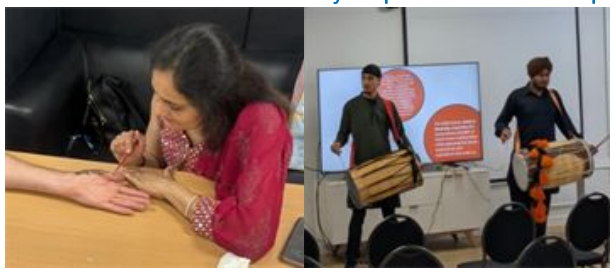
EDI Engagement Update

- Elected new leadership team for REACH (STG)
- Facilitated coffee mornings to support collaborative working across the networks
- Set up stalls at ESTH to promote the networks and encourage staff to become members
- Celebrated Staff Networks Day with an online session which highlighted the vital role our networks play in shaping an inclusive and representative workplace culture.
- International Women's Day at STG welcomed guests including the D. Mayor of Wandsworth.
- July marked Pride month, the LGBTQ+ Network and EDI team recognised this via:
  - Pride Flag raising at all site
  - Network vice chair took part in ESTH Charity abseil.
  - Around 40 staff, including some Exec/SLT sponsors, marched in London Pride and Trans Pride.
  - Weekly emails and comms campaigns focused on LGBTQ+ inclusion.
- Monthly Dive In to Diversity Awareness Sessions for all staff.
- South Asian Heritage Month – celebrated with a range of activities across the group including face to face events at St Georges and an online event held by ESTH Women's and Allies network welcoming Mumbai based author Rageshri Dhairyawan.
- LGBTQ+ Network held a safe space for trans and non-binary colleagues in light on Equality Act legislation
- ESTH Women's and Allies network held a series of talks with the focus of 'Give to Gain' – the theme for international women's day, welcoming a range of internal speakers.
- Our DaWN Network supported the implementation of our organisational Wellness Action Plan.



Appendix A: EDI Action Plan Overview

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Action Plan RAG Tracker															
1	**WORKSTREAM ONE: Leadership Commitment (including Board development and Executive Sponsorship)**	**Description**	VSM and Board level JDs Review/ Guidance	Culture / EDI questions (VSM Int.)	Board EDI dash board to drive accountability and monitor progress	EDI Objective (Board)	EDI Objective (Individual)	EDI Updates routinely taken to Board / Exec	EDI Compliance updates to Board / Exec	Network Executive Sponsorship	Quarterly Meetings Chair, CEO and Network Chairs	Board approval of all mandatory EDI reporting	Report routinely on current/new legislation and best practice	Execs actively promote the benefits of allyship	
		Action No.	1.4.1	1.4.2	1.7.1	1.1.1	1.1.2	1.2.1	1.2.2	1.2.3	1.2.4	1.3	1.5	1.6	
		Due	Jul-25	Jul-25	Mar-26	Jul-25	Jul-25	Apr-25	Apr-25	Apr-25	BAU	BAU	BAU	BAU	
2	**WORKSTREAM TWO: Inclusive Recruitment and Talent Management**	**Description**	Pilot Talent Management Plan	Widen Recruitment opportunities across SWL (via hub)	Inclusive Recruitment Projects (gesh wide)	Integrate CARE objectives in the PDR Process	Embed Coaching Culture	Embed Neuro-diversity in the workplace training	Review recruitment practices to ensure they are fully inclusive of all ages and removing bias	Talent Management Plan Approved	Diversifying our Leadership (Options Appraisal)	Introduce effective Communications Training	ERAF/EQIA for Talent Management and Career Development Programmes	Stakeholder engagement (Talent and Career Development)	Launch group wide Flexible Working Policy
		Action No.	2.1.2	2.2.1	2.2.2	2.3.1	2.3.2	2.4.3	2.5	2.1.1	2.1.3	2.3.3	2.4.1	2.4.2	2.6.1
		RAG	Dec-25	BAU	Oct-26	Pending Appraisal review	Dec-25	Pending national MAST review	See action 2.2.1	Dec-24	Dec-24	Jul-25	Sep-25	Sep-25	Mar-25
		Description	Launch My Health Matters Too Campaign (ESTH)	Explore recommendations from the Inclusive Recruitment Programme	Ensure FW Policy includes advice in relation to flexible retirement	Promote Flexible Working Policy	Collaborate and engage with SWL recruitment initiatives	Explore Propel Train the Trainer offer							
		Action No.	2.9.1	2. 10	2.6.2	2.7.1	2.8	2.9.2							
		RAG	Jul-26	Dec-25	Mar-25	Mar-25	BAU	Apr-25							
3	**WORKSTREAM THREE: Eliminating pay gaps**	**Description**	Consider Mend the Gap review recommendations	Introduce Annual Pay Gap Report	Implement an effective flexible working policy	Use the EDI dashboard to scrutinise progress	Focus on closing the gender pay gap and improving the experiences of the lowest paid people								
		Action No.	3.1.1	3.2.1	3.3	3.4	3.5								
		RAG	Jul-25	Jul-25	See action 2.6.1	See action 1.7	See actions 3.1-4								

Complete / BAU	
On track	
Potential delay	
Delayed / behind plan	

5

Appendix A: EDI Action Plan Overview

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Action Plan RAG Tracker															
4	**WORKSTREAM FOUR: Improving Health and Wellbeing**	**Description**	Embed Wellness Action Plan into appraisal process	Develop and implement Health Passport for Staff	Gender Reassignment and Sexual Orientation topics to be covered in mandatory training	Launch our LGBTQ+ awareness module at ESTH.	Launch Menopause training and guidance	Develop a series of Wellbeing Toolkits to guide managers in supporting staff wellbeing	Continue collaborative approach with SWL ICB	Launch Disability in the Workplace Policy across the group.	Ensure Reasonable Adjustment advice and resources are promoted and readily accessible across the group intranet.				
		Action No.	4.1.1	4.1.2	4.3.1	4.3.2	4.1.3	4.1.4	4.2	4.4.1	4.4.2				
		RAG	Dec-25	Dec-25	Pending national MAST review	Pending move to ESR OLM	Jul-25	Jul-25	BAU	Apr-25	Apr-25		**Complete / BAU**		
5	**WORKSTREAM FIVE: Supporting internationally recruited staff**	**Description**	Introduce robust Cultural Intelligence Training offer	Clear and comprehensive pre employment information for all international staff	Bespoke onboarding programme is in place for all international recruited nursing and midwifery staff.	Ensure continued D&I presence at all inductions, including Corporate, Medical and International.	Continue to embed Ask Aunty initiative across the group, including App launch.	International recruits will have equitable access to training and CPD available across the group					**On track**		
		Action No.	5.3.3	5.1	5.2	5.3.1	5.3.2	5.4					**Potential delay**		
		RAG	Dec-25	BAU	BAU	Dec-25	Dec-25	BAU					**Delayed / behind plan**		
6	**WORKSTREAM SIX: Safeguarding our Workforce**	**Description**	Reduction targets to be considered by Group Executive, SLT and relevant service leads.	Launch 'Just Culture' to ensure a restorative approach to ER processes	Explore ER Inclusion Specialist (ERIS) to support ER cases for employees from BME communities or those with a Disability.	Review roles and responsibilities of those involved in supporting or offering guidance and advice in relation to ER cases	As part of our Policy Review, review and launch a group wide disciplinary policy	Complete gesh DASV launch and commitment	Launch Sexual Misconduct Policy	Finalise assurance reporting structure	Introduce training on speaking up and raising concerns	Provide comprehensive psychological support for all staff	Have mechanisms to ensure staff who raise concerns are protected by their organisation.		
		Action No.	6.1.1	6.2.1	6.2.2	6.2.3	6.2.4	6.3.1	6.3.2	6.3.3	6.4	6.5	6.6		
		RAG	Jul-25	Dec-25	Dec-25	Dec-25	Dec-25	Apr-25	Apr-25	Apr-25	BAU	BAU	BAU		

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Appendix B:

Diversity and Inclusion

Equality, Diversity and Inclusion (EDI) Action Plan

As part of our ongoing commitment to inclusion, and in response to staff survey results and staff network feedback, we have launched our 2025 EDI Action Plan. This plan is structured into six workstreams, each aligning with NHSE's EDI Improvement Plan.

1. Leadership Commitment

Chief executives, chairs and board members must have specific and measurable EDI objectives to which they will be individually and collectively accountable.

2. Inclusive Recruitment and Talent Management

Embed fair and inclusive recruitment processes and talent management strategies that target under-representation, particularly at leadership levels.

3. Reducing pay gaps

Develop and implement an improvement plan to reduce pay gaps.

4. Improving Health and Wellbeing

Develop and implement an improvement plan to address health inequalities within the workforce.

5. Supporting Internationally Recruited Staff

Implement comprehensive induction, onboarding and development programme for internationally- recruited staff.

6. Safeguarding our Workforce

Create an environment that eliminates the conditions in which bullying, discrimination, harassment and physical violence at work occur.

Search **"EDI Action Plan"** on the intranet to find out more, or contact: diversity.inclusion@stgeorges.nhs.uk

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Appendix C: Snapshot of SWL Recruitment Toolkit

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Thank you.

For any other information, please see:

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Inclusion Board Mid-Programme Evaluation Report

Executive Summary

The Inclusion Board Programme was launched in April 2026 as a strategic leadership and inclusion initiative designed to amplify diverse voices within Group decision-making, build understanding of Board behaviours and governance, and create a future pipeline of diverse senior leaders.

This is a six-month programme with 16 participants running alongside 6 Group Board meetings, simulations covering key topics in parallel to Board papers and mentoring.

At the programme midpoint, evaluation findings demonstrate strong progress against the programme's intended objectives. Attendance and engagement have remained consistently high, with attendance exceeding 87.5% throughout the programme.

Feedback from participants, Board members and The King's Fund as co-partners in delivery, indicates that the programme is increasing confidence, strategic thinking, leadership capability and understanding of Board behaviours and processes. Participants also report feeling more connected to the wider organisation and more confident in contributing within senior leadership environments.

Evaluation feedback has included:

- *"The programme is a soft landing to being a Board member"*
- *"Amazing opportunity and pivotal to leadership growth*"
- *"I am finding value in this and am at a different place from when I applied"*
- *"Phenomenal experience"*

The programme has also demonstrated value for the Group Board. Inclusion Board members have contributed diverse perspectives informed by lived and professional experiences, helping strengthen discussions on strategic priorities and providing valuable insight from frontline services and communities.

As expected at the midpoint stage, opportunities remain to further strengthen participants' understanding of governance and assurance processes, alongside providing clearer feedback on how Inclusion Board contributions have influenced Board discussions and decision-making.

Whilst it remains too early to assess the long-term impact on the talent pipeline and Board representation, there is compelling evidence that the programme is successfully developing leadership capability and creating greater inclusion within organisational decision-making.

Original Purpose and Objectives

The Inclusion Board was designed to create a step change in how participants and the executive leadership of the organisation embark on a talent programme that harnesses future and under-represented leaders by building on real-world experience, capability and leadership confidence.

gesh is a collaboration between St George's University Hospitals NHS Foundation Trust and Epsom and St Helier University Hospitals NHS Trust.

The programme was established around three strategic objectives:

1. To amplify diverse voices and ensure lived experience informs strategic decision-making at the highest level.
2. To build leadership capability through exposure to Board-level governance, strategy and inclusive leadership practices.
3. To create a diverse talent pipeline for future senior and executive leadership roles across the Group.

Although outcomes relating to future Board appointments and career progression will require longer-term evaluation, the programme is already demonstrating strong progress against the first two objectives.

Key Learning and Insights

Building Confidence and Leadership Capability

A consistent finding across all evaluation data is the significant increase in participants' confidence. Participants reported greater confidence speaking in senior forums, engaging with colleagues outside their professional disciplines and contributing to strategic discussions. Many describe a shift in how they perceive themselves as leaders, coupled with greater ambition and confidence about future career opportunities.
Participant feedback has included:

"Recognising the social construct of power has helped me position myself on an equal footing in senior leadership meetings and allowed more courage to speak up and challenge."

"It has helped with how I present at work, confidence building and networking. It has also helped broaden and shape my strategic thinking."

Understanding Governance and Board Dynamics

Board simulations continue to be the most highly valued element of the programme. Participants consistently identify these sessions as helping them understand governance processes, assurance, accountability and strategic decision-making in practical and meaningful ways.

Participants reported increasing confidence in contributing strategic perspectives, moving beyond operational questions towards broader organisational considerations and solutions.

Those who have attended Group Board meetings described the experience as *"enlightening", "insightful" and "the best learning experience",* citing greater understanding of Board dynamics, governance and leadership accountability.

Inclusion Through Lived Experience

A key insight emerging from the programme is the value of creating structured opportunities for diverse voices to influence strategic discussions.

Participants have consistently demonstrated an ability to challenge assumptions, offer alternative perspectives and bring frontline experience into conversations about organisational priorities. This has strengthened both participant learning and Board insight. Feedback comments have included:

"I feel more engaged as I've got a sense of the bigger picture and some influence."

"It made me ask what I could do as an individual to influence the wider world of the organisation and do my part to make it a fairer environment for all."

The Importance of Mentoring and Sponsorship

Executive mentoring relationships continue to be viewed as one of the programme's most valuable features.

Participants described mentoring as supporting personal growth, career planning, increased confidence and understanding of senior leadership roles. Several participants specifically highlighted the openness and generosity of senior leaders and Board members in sharing knowledge and experience.

Feedback themes from Participants

Consistent strengths emerge from participant feedback:

- Board simulation exercises.
- Attendance at Group Board meetings.
- Mentoring and networking opportunities.
- Access to Executive and Non-Executive Directors.
- Safe and inclusive learning environment.
- High quality facilitation from the OD Team and The King's Fund.

Opportunities for Improvement

Participants would welcome:

- More time for discussion and reflection.
- Additional feedback following simulations and Board attendance.
- Greater understanding of governance, assurance and Board roles.
- Increased opportunities to meet with Executive and Non-Executive Directors.
- Further support around career planning and Board readiness.
- More visibility on how Inclusion Board recommendations have influenced Board discussions and decisions.

Feedback from The King's Fund

The King's Fund has highlighted the programme as a significant organisational development and culture change intervention. Participants have consistently reported

increased confidence, greater self-awareness and growing competence as future Board members.

The King's Fund identified several strengths:

- Strong participant engagement and commitment.
- High-quality mentoring relationships.
- Responsive and adaptive programme design.
- Effective balance between governance learning and adaptive leadership development.
- Attention to power, privilege, inclusion and self-awareness alongside technical Board knowledge.

The King's Fund views the programme as a longer-term cultural intervention that extends beyond leadership development alone and has the potential to influence organisational inclusion and decision-making more broadly.

Feedback from Board Chairs

Yin Jones, Non-Executive Director highlighted the significant value that Inclusion Board participants have brought to Board discussions through diverse perspectives and lived experience.
"The insights and perspectives of participants have not only helped to inform Board discussions but have also enabled the Board to hear directly from the frontline, including during strategic discussions relating to the merger."

It was also observed that participants have become noticeably more confident and settled in their roles as the programme has progressed. Yin Jones has suggested that future cohorts could benefit from exposure to a wider range of Board Chairs to experience different leadership and chairing styles and noted that some less vocal participants may benefit from additional support to maximise their contribution.

Mark Lowcock, Chairman echoed the positive impact of the programme and highlighted an opportunity for future programmes to have a strengthened selection process by identifying individuals with both strong aspirations and realistic prospects for future Board-level roles. He suggested greater involvement of Executive Directors within the recruitment and selection process to support this ambition.

Recommendations and Next Steps

To maximise impact during the final phase of the programme, the following actions are recommended:

- Increase structured developmental feedback for participants.
- Create additional opportunities for engagement with Executive and Non-Executive Directors.
- Further develop participants' understanding of governance, assurance and Board roles.
- Provide clearer feedback loops demonstrating how Inclusion Board observations, insights and recommendations have informed Board discussions and decision-making.

Looking beyond the pilot, the evaluation supports continuation of the Inclusion Board model as both a leadership development intervention and a mechanism for bringing diverse perspectives into strategic decision-making. Two specific actions are recommended:

1. Continue engagement with the current pilot cohort beyond programme completion in December by establishing the group as an advisory forum to the Board.

2. A second cohort to be commissioned for 2027, incorporating learning from the pilot and involving current participants in future programme design and delivery. It’s strongly recommended to maintain a continued partnership with The King's Fund to support the quality, credibility and impact of the next cohort. This will require investment in an additional programme cycle to build on and amplify the progress made so far.

Group Board Meeting (Public)

Meeting on Friday, 11 September 2026

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

Executive Summary

This report sets out the key issues considered by the Infrastructure Committees at their meeting on 24 July 2026. The key issues the Committees wished to highlight to the Board are:

1. **Group Chief Officer - Facilities, Infrastructure & Environment (GCOFIE) Update**
   The Committees received updates on mitigating extreme heat impacts across the estate. The Vanguard ITU project faced delays with no formal completion date provided, though patient treatment was estimated for early January 2027. The HSE issued an enforcement notice containing procedural items regarding formaldehyde and infrastructure points. A Group Estate Strategy is in development.

2. **ESTH and SGUH Estate and Facilities Update**
   Fire safety works continue, with Surrey Fire and Rescue standing down 4 of 5 articles at Epsom. An update on E-Block water safety was reviewed including the mitigating actions to ensure safety. The Committee supported progressing a paper to the Finance Committee for £4m to upgrade St Helier water supply resilience. At SGUH, significant engineering vacancies are impacting reactive maintenance, though mitigation plans are active. Ventilation ductwork in the neonatal units has been successfully completed.

3. **Digital Priorities and Strategy**
   The Committees endorsed a new Digital Performance Dashboard as the standard reporting framework. The £25.25m digital capital programme is underway, with £1.41m committed to date. In reviewing bi-monthly digital extreme risks, the Committees raised concerns over Business Continuity and Disaster Recovery (BC/DR) timelines, requesting that fixes be accelerated to an 18-month timeline rather than three years.

Action required by Infrastructure Committees

The Group Board is asked to note the issues escalated by Infrastructure Committees to the Group Board and the wider issues on which the Committees received assurance in July 2026.

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				
See section 4.5 - Digital Risk Management Update				
CQC Theme				
☐ Safe	☐ Effective	☐ Caring	☐ Responsive	☒ Well Led
NHS system oversight framework				
☐ Quality of care, access and outcomes			☒ People	
☐ Preventing ill health and reducing inequalities			☒ Leadership and capability	
☒ Finance and use of resources			☐ Local strategic priorities	
Financial implications				
Set out in the paper.				
Legal and / or Regulatory implications				
Set out in the paper.				
Equality, diversity and inclusion implications				
N/A				
Environmental sustainability implications				
N/A				

Infrastructure Committees Report
Group Board, 11 September 2026

1.0 Purpose of paper

1.1 The report sets out the key issues considered by the Infrastructure Committees' meetings on 24 July 2026 and includes matters the Committees specifically wish to bring to the attention of the Group Board. There was no meeting in August 2026.

2.0 Items considered by the Committees

2.1 At its meeting on 24 July 2026, the Committees considered the following items of business:

24 July 2026 (Both Estates & IT focus)
• Group Chief Officer - Facilities, Infrastructure & Environment Update • Epsom St Helier Estate and Facilities Update • SGUH Estate and Facilities Update • Proposed Digital KPIs • Digital Capital Report • Bi-monthly Digital Risk Review • Combined Forward Plan for 2026/27

2.2 The Committees were not quorate on 24 July 2026. As usual, 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

3.1 The Committees wish to highlight the following key matters for the attention of the Group Board:

3.2 **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:

- An update on the Vanguard ITU project. The contractor has not provided a completion date, but it was estimated to be 12 weeks away, pushing the likely start of patient treatment to early January 2027. The Committees stressed the need for a debrief and lessons-learned review regarding this contract.
- The HSE issued an enforcement notice regarding formaldehyde management and ventilation, which the Trust is actively managing.
- The extreme heat of recent months caused difficulties in all of our hospitals and the teams have been working hard to mitigate this as far as they reasonably can. However, the basic design and condition of the existing plant and equipment means that we will not be able to give assurance that the hospital will be able to fully mitigate the foreseeable high temperatures going forwards.

3.3 **Epsom & St Helier Estate and Facilities Update**

The Committees noted recent progress on water safety and emphasised that communications should clearly reflect that the mitigating actions being taken, including point of use filters, meant that E-Block water remained safe at present, though the Committee also noted that these measures could not provide a long-term solution or assurance on safety in the longer-term. The Committee noted that the Board was actively reviewing the position and would be considering options for the future, including potential temporary relocation beyond the St Helier site, in order to enable decant and refurbishment of E Block.

3.4 Separately, the Committees supported progressing a paper to the Finance and Investment Committee for an upgrade to the potable water supply at St Helier. The funding is both an enabler to the St Helier Emergency Department works and will contribute to help to address issues on the rest of the Site, although the Committee recognised that this did not address the specific issues with E Block.

3.5 **Bi-monthly Digital Risk Review**

The Committees reviewed three extreme risks that are managed jointly across the group: Core network infrastructure failure, cyber terrorism, and data centre failure. Due to concerns regarding the current Business Continuity and Disaster Recovery (BC/DR) capabilities and the risk of prolonged clinical system paralysis in the event of failure, the Committees requested accelerating the BC/DR fixes to an 18-month timeline instead of the previously planned three years.

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 **SGUH Estates and Facilities (E&F)**

The Committees received a reasonable level of assurance for the update on SGUH E&F. It was noted that ventilation ductwork in the neonatal and special care baby units is now complete with no further infection control issues. The team is proactively managing a nearly 20% vacancy rate in engineering through bank staff and graduate recruitment while strictly regulating overtime to prevent staff burnout.

4.3 **Digital Key Performance Indicators (KPIs)**

The dashboard has been developed to establish a consistent and standardised approach to reporting digital performance, risk and delivery across the Group. The proposed framework brings together key measures across digital operations, cyber security, information governance, digital adoption, programme delivery, workforce and financial performance into a single executive reporting view. Its intention is to provide clearer visibility of performance, strengthen accountability and support executive assurance across digital services. The Committees reviewed and endorsed the new Digital Performance Dashboard as the routine mechanism for digital reporting.

Subject to feedback from GEC, the dashboard will become the standard reporting mechanism for digital performance and will be reported routinely through both the Infrastructure Committees and the Digital Governance Group. This will provide a consistent line of sight from operational oversight through to executive assurance.

4.4 **Digital Capital Report**

The Committees received an update on the development of the Digital Capital Programme and the Five Year Digital Capital Roadmap and reviewed the 2026/27 digital capital envelope of £25.25m, noting that foundational spend is heavily dependent on a pending architectural review. The Committees received assurance that IT and Estates capital governance have been integrated to prevent cross-domain issues, such as IT cabling compromising fire stopping.

5.0 Other issues considered by the Committees

5.1 **Combined Forward Plan**

The Committees updated their combined forward plan to include biannual progress reports on the developing Group Estate Strategy. The agenda for September 2026 was adjusted to primarily focus on infrastructure, while maintaining capacity for urgent digital items to avoid extended reporting gaps.

6.0 Recommendations

6.1 The Group Board is asked to note the issues escalated by the Infrastructure Committees to the Group Board and the wider issues on which assurance was received in July 2026. There was no meeting in August 2026.