Group Board

Agenda

Meeting in Public on Friday, 06 November 2026, 12:30 – 16:00

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

Board visits					
Time	**Item**	**Title**	**Presenter**	**Purpose**	**Format**
12:30	-	Feedback from visits across the hospital site	All	Discuss	Verbal

Introductory items					
Time	**Item**	**Title**	**Presenter**	**Purpose**	**Format**
13:00	1.1	Welcome and Apologies	Chair	Note	Verbal
	1.2	Declarations of Interest	All	Note	Verbal
	1.3	Minutes of previous meetings	Chair	Approve	Report
	1.4	Action Log and Matters Arising	Chair	Review	Report
13:05	1.5	Feedback from the Inclusion Board	Inclusion Board Members	Review	Report

Group Leadership, Strategy and Risk					
Time	**Item**	**Title**	**Presenter**	**Purpose**	**Format**
13:15	2.1	Group Chief Executive Officer's Report (inc. Initial Group-wide CQC Well Led Action Plan)	GCEO	Review	Report
13:35	2.2	Group Research and Innovation Strategy	GCMO	Approve	Report
13:45	2.3	Group Board Assurance Framework	GCCAO	Approve	Report

Quality and Safety					
Time	**Item**	**Title**	**Presenter**	**Purpose**	**Format**
13:55	3.1	Quality Committees Report	Committee Chair	Assure	Report
14:05	3.2	Perinatal Sub-Committee Report	GCMidO	Review	Report
14:15	3.3	Thirlwall Assurance Report	SCNO-SGUH / SCNO-ESTH	Review	Report
14:25	-	*Break*			

Infrastructure					
Time	**Item**	**Title**	**Presenter**	**Purpose**	**Format**
14:40	4.1	Infrastructure Committee Report	Committee Chair	Assure	Report

Finance and Performance					
Time	**Item**	**Title**	**Presenter**	**Purpose**	**Format**
14:50	5.1	Finance and Performance Committees Report	Committee Chair	Assure	Report
	5.2	Integrated Finance Report – Month 6	GCFO	Review	Report
15:05	5.3	Integrated Quality and Performance Report	GDCEO	Review	Report
15:15	5.4	Audit and Risk Committee Report	Committee Chair	Assure	Report

People and Culture					
Time	**Item**	**Title**	**Presenter**	**Purpose**	**Format**
15:25	6.1	People Committees Report	Committee Chair	Assure	Report
15:35	6.2	Freedom to Speak Up Report	GFTSUG / GCCAO	Assure	Report

Closing items					
Time	**Item**	**Title**	**Presenter**	**Purpose**	**Format**
15:50	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
16:00	-	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
Pankaj Davé	Non-Executive Director – ESTH and SGUH	PD
Jenni Doman*^	Acting Group Chief Facilities, Infrastructure and Environment Officer	AGCFIEO
Richard Jennings	Group Chief Medical Officer	GCMO
Stephen Jones*^	Group Chief Corporate Affairs Officer	GCCAO
Yin Jones	Non-Executive Director – ESTH and SGUH	YJ
Tracey Luckett	Group Chief Nursing Officer	GCNO
Anna Macarthur^*	Group Chief Communications Officer	GCCO
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
Leonie Penna*	Non-Executive Director SGUH and ESTH (Associate)	LP
Bidesh Sarkar	Non-Executive Director – ESTH and SGUH	BS
Kate Slemeck^	Site Chief Executive Officer – SGUH	SCEO-SGUH
Victoria Smith*^	Group Chief People Officer	GCPO
Phil Wilbraham*	Associate Non-Executive Director – ESTH	PW
In Attendance		
Kelly Brown	Senior Corporate Governance Manager	SCGM
Michelle Cudjoe	Group Chief Midwifery Officer	GCMidO
Theresa Matthews*	Site Chief Nursing Officer – ESTH	SCNO-ESTH
Nicola Shopland^	Site Chief Nursing Officer – SGUH	SCNO-SGUH
Rebecca Suckling	Site Chief Medical Officer – ESTH *(deputising for Site CEO – ESTH)*	SCMO-ESTH
Steve Walters	Group Deputy Director of Governance, Risk and Assurance	GDDGRA
Apologies		
Mark Bagnall*^	Group Chief Facilities, Infrastructure and Environment Officer	GCFIEO
Chinyama Okunuga*	Site Chief Executive Officer – ESTH	SCEO-ESTH
Claire Sunderland Hay^	Associate Non-Executive Director – SGUH	CSH
Observers		
TBC	Inclusion Board Member	
TBC	Inclusion Board Member	

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

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

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

Minutes of Group Board Meeting

Meeting in Public on Friday, 11 September 2026, 12:40 – 16.50

Tooting and Balham Rooms, Wandsworth Professional Development Centre, Building 1, Burntwood School, Burntwood Lane, SW17 0AQ

PRESENT		
Mark Lowcock	Group Chair	Chair
Mat Shaw	Group Chief Executive Officer	GCEO
Natalie Armstrong	Non-Executive Director – ESTH & SGUH	NA
Mark Bagnall*^	Group Chief Facilities, Infrastructure and Environment Officer	GCFIEO
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
Theresa Matthews	Site Chief Nursing Officer – ESTH	CNO-ESTH
Khadir Meer^	Associate Non-Executive Director – SGUH	KM
Andrew Murray	Non-Executive Director – ESTH & SGUH	AM
Michael Pantlin*^	Group Deputy Chief Executive Officer	GDCEO
Thirza Sawtell*	Managing Director – Integrated Care	MD-IC
Nicola Shopland	Site Chief Nursing Officer – SGUH	CNO-SGUH
Kate Slemeck^	Site Chief Executive Officer – SGUH	SCEO-SGUH
Victoria Smith*^	Group Chief People Officer	GCPO
Rebecca Suckling	Interim Site Chief Executive – 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 Director of Midwifery	GCMidO
Steve Walters	Group Deputy Director - Governance, Risk and Assurance	GDDGRA
APOLOGIES		
Anna Macarthur	Group Chief Communications Officer	GCCO
Leonie Penna	Non-Executive Director – SGUH & ESTH (Associate)	LP
Bidesh Sarkar	Non-Executive Director – ESTH & SGUH	BS
Phil Wilbraham^	Associate Non-Executive Director – ESTH	PW
OBSERVERS		
Zahra Abbas	Inclusion Board Member, Strategy and Planning Manager	ZA
Sunil Dasan	Consultant in Emergency Medicine, SGUH	SD
Michelle Ellis	Appointed Governor, City St George's University	ME
Elyscia Howell	Inclusion Board Member, Group Head of Complaints and PALS	EH
John Hallmark	SGUH Public Governor, Wandsworth	JH
Jackie Parker	SGUH Public Governor, Wandsworth	JP
Hugh Taylor	Lead, external governance review	HT

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

1.0	INTRODUCTORY ITEMS
1.1	**Welcome, introductions and apologies**
	The Chair welcomed Board members, colleagues, Inclusion Board representatives, St George's Governors and members of the public. He particularly welcomed Azara Mukhtar to her first public Board meeting as Group Chief Finance Officer; Michelle Cudjoe, Group Chief Midwifery Officer; Rebecca Suckling, providing interim leadership at ESTH; Nicola Shopland and Theresa Matthews, jointly covering the Group Chief Nursing Officer responsibilities; and Steve Walters, who had joined as Group Deputy Director of Governance, Risk and Assurance. Hugh Taylor was welcomed as an observer at the start of the external governance review. Apologies were recorded as set out above. The Board noted that the role of Non-Executive Lead for Freedom to Speak Up (FTSU)would transition from Yin Jones to Leonie Penna; there were no changes to the Executive Lead for FTSU which remained the GCCAO. The Chair explained that ward visits had not taken place because the meeting was being held away from the hospital sites. During the meeting, the order of business was varied to accommodate attendees. These minutes follow the published agenda.
1.2	**Declarations of Interests**
	The Board noted the standing declarations relating to shared Group roles across the two Trusts. No new declarations of interest were made.
1.3	**Minutes of the Previous Meeting**
	The minutes of the Group Board meeting held in public on 9 July 2026 were **APPROVED** as a true and accurate record.
1.4	**Action Log and Matters Arising**
	Action Log The Board reviewed the action log and received the following update on the open action: • PUBLIC20250901.1: Mandatory and Statutory Training: The GCPO advised that revised national guidance remained outstanding. Most mandatory training requirements were now aligned across the Group, with remaining differences generally relating to delivery methods or frequency and reflecting specific operational requirements. A written summary would set out the areas of alignment, remaining differences and the reasons for them. This would be prepared by the end of September, taken through governance during October and would be presented to the People Committee for review in October. Any subsequent changes arising from national guidance would be considered separately through the Group Executive Committee, with assurance provided to the People Committee. The existing action would remain open pending the report on alignment of MAST across the Trusts being considered by the Committee. **Matters arising** The Chair sought an update on delivery of the commitments made following the Board's July discussion of the Royal College of Physicians' review of care provided by a former consultant to patients with Interstitial Lung Disease (ILD). The GCMO advised that 231 patients treated for ILD between 2019 and 2023 had been identified. The RCP had reviewed 28 cases, and the remaining 203 patients or their families had been contacted about the further internal review using the RCP methodology.

	Three additional cases had been reviewed. The GCMO explained that substantial preparatory work had now been completed: consultant reviewers had been identified, a standardised review tool developed, locum backfill arranged to provide protected clinical time, and a second-stage multidisciplinary review established to ensure consistency between reviewers. Patients and families had previously been advised that the programme could take up to two years. The GCMO was confident that it could be completed sooner and hoped to achieve completion within one year, while cautioning that this was not an absolute commitment. Progress against the defined trajectory would be reported monthly through the Group Executive Committee and the Quality Committees, with updates provided to the Board through Quality Committee reporting. The outcome of the further review would be presented to the Board once completed. The Chair also asked about patients treated by the former consultant for conditions other than ILD. The GCMO confirmed that work was continuing to develop appropriate review methods for samples from other cohorts, including asthma and chronic obstructive pulmonary disease. This would also be reported through the Group Executive Committee and the Quality Committee. The Board **NOTED** the update on the further ILD review and the arrangements for continued oversight.
1.5	**Feedback from the Inclusion Board**
	Zahra Abbas and Elyscia Howell presented feedback from the Inclusion Board's consideration of the Workforce Race Equality Standard (WRES) and Workforce Disability Equality Standard (WDES) reports. They described a difficult and emotionally demanding discussion at the Inclusion Board and emphasised the importance of conveying colleagues' experiences honestly. The Inclusion Board recognised improvements in workforce representation and some indicators but questioned whether incremental changes were translating into sustained improvements in staff experience. Persistent concerns included inequalities in recruitment, career progression and disciplinary processes for ethnic minority colleagues; disproportionate involvement of disabled colleagues in capability processes; inconsistent implementation of reasonable adjustments; and bullying, harassment and psychological safety. The representatives called for greater curiosity about the causes of these differences. They suggested analysing information by staff group, band, profession and service, alongside the experience of staff networks and colleagues, rather than relying on aggregate trends. They also sought greater clarity about ownership of improvement priorities and how staff would know that their feedback had influenced action. Psychological safety was a particular concern. Some colleagues found it difficult to describe their lived experiences even within the Inclusion Board, having experienced or feared repercussions from speaking openly. Zahara and Elyscia highlighted the need for safe spaces, appropriate support for leaders from marginalised communities and opportunities to discuss wider events affecting staff. They also asked how the Inclusion Board's contribution was informing decisions and whether earlier involvement in relevant discussions would strengthen its impact. Andrew Murray asked what would enable a move from incremental to significant and sustained change. The representatives identified safe opportunities to share experiences, coupled with a deeper understanding of where inequalities arose, as essential starting points. Pankaj Davé emphasised the value of understanding the different barriers colleagues faced, while the GCFO highlighted the distinction between equality and equity and the need to become more comfortable with difficult conversations. The GCMO invited suggestions for Board members' own learning and development in anti-racism. Zahara and Elyscia offered to consider this further and suggested that peer relationships, mentoring and structured listening could provide useful approaches. Khadir Meer cautioned that asking colleagues to share vulnerable experiences created an obligation to be clear about what

	could change and to demonstrate meaningful follow-through. Claire Sunderland Hay stressed the importance of listening and reflecting before moving immediately to solutions. The GCEO acknowledged that considerable effort over many years had not produced sufficient change in how colleagues experienced the organisation. He emphasised the need for evidence-informed interventions, co-development with staff networks and stronger engagement of senior leaders with the Group's own data and lived experience. This would need to connect with the wider work on organisational culture, values and behaviours. The Chair thanked the representatives and their colleagues for their courage, honesty and challenge. The Board **NOTED** the feedback, which informed the subsequent discussion under item 5.2.
1.6	**Chief Executive Officers Report**
	The GCEO presented his report and highlighted forthcoming leadership changes. Chinyama Okunuga would join as Site Chief Executive Officer for ESTH on 1 October, and Tracy Luckett as Group Chief Nursing Officer on 2 November. He thanked Rebecca Suckling, Theresa Matthews and Nicola Shopland for providing interim leadership. Recruitment and interim arrangements were being developed ahead of the GCPO's departure in early November. The change from Site Managing Director to Site Chief Executive Officer titles reflected the breadth of those roles and aligned terminology with other NHS groups. The underlying responsibilities and reporting arrangements were unchanged. The GCEO highlighted the development of a single Group-wide values and behaviours framework, with staff involvement, and the importance of connecting this with the wider culture and inclusion agenda. The GCEO provide an update on the proposed Mental Health Emergency Department at St George's. The scheme remained under development but offered significant potential given the need for a more appropriate environment for people experiencing mental health crises, who were spending excessive periods in acute emergency departments. In response to a question about timing, the SCEO-SGUH explained that the shared service specification, location, capacity and capital requirements were still being worked through with partners. The initial £1.9m funding proposition was unlikely to be sufficient, and a requirement closer to £5m was being discussed. March 2028 remained an indicative timescale rather than a confirmed opening commitment. The draft Epsom & ST Helier CQC Well-Led report was expected shortly and would be circulated to Board members when received. The GCEO also recognised the contribution of the communications teams and hospital charities to the Big Thank You, held in July, long-service recognition and forthcoming staff CARE Awards. He reported that the Big Thank You had reached approximately 10,000 colleagues and emphasised the importance of staff feeling valued. The Board **NOTED** the GCEO's report.
2.0	**Priority Matters for the Board**
2.1	**Water Safety, E block, St Helier Hospital**
	The ISCEO-ESTH presented the update on water safety and the development of options for addressing the underlying infrastructure problems in St Helier E Block, which accommodated maternity, neonatal, gynaecology and assisted conception services. Services remained safe to operate at present with the extensive mitigations in place. These were temporary controls, however, and did not remove the need for a sustainable solution. Independent work was assessing the feasibility, risks, costs and operational implications of

undertaking the works with services in situ, fully decanting the building temporarily, or adopting a hybrid approach involving phased relocation.

The independent reviews, clinical risk assessments and estates work would inform a smaller number of credible options for Board consideration in October or November. No preferred option had been identified. Further assessment would be required of clinical quality, workforce, capacity, patient access and equality impacts before decisions could be reached.

The ISCEO-ESTH and GCMidO described continuing engagement with staff, the Maternity and Neonatal Voices Partnership, patients and other stakeholders. Clinical colleagues' expertise was informing the risk assessments. A patient helpline and social media communications were providing reassurance and opportunities to raise questions.

Andrew Murray reported on a recent maternity safety champion visit with Leonie Penna. Staff had highlighted patients' concerns about both current safety and the future location of services, including whether patients could continue to book their care at St Helier. He welcomed the clearer communication and the structured approach to the appraisal.

Natalie Armstrong emphasised that the viable options were likely to involve difficult trade-offs. The criteria and principles used to appraise them would therefore need to be clearly articulated.

The Chair stressed the need to progress the work as quickly as could responsibly be achieved. Although services were currently safe, the organisation could not predict when deterioration might require an emergency response. A planned approach was preferable to an unplanned decant. He also recognised that some enabling decisions would depend on other NHS bodies and that stakeholder perspectives would be important.

The Board **NOTED** the update, the current safety position with mitigations in place and the continuing options-appraisal work. Further reports would return as the independent assessments were completed.

3.0 QUALITY AND SAFETY

3.1 Quality Committees Report

Andrew Murray, Chair of the Quality Committee, presented the report covering the Committees' meetings in July and August and highlighted three matters:

- First, delivery against the Group's quality priorities was not yet where the Committees would have expected at this stage of the year. In particular, the fundamentals of care programme had not demonstrated the anticipated improvement trajectory. The Quarter 2 review would provide a clearer assessment of performance, the effectiveness of mitigations and the assurance that could be taken on delivery.
- Second, the initial investigation into the St Helier Frailty Unit incident had not identified evidence of further widespread severe patient harm. This did not resolve the wider questions about culture, behaviours, leadership, escalation or whether comparable concerns might exist elsewhere. A further report had been requested to bring together the cultural review, clinical learning, wider organisational implications and measures to prevent recurrence and improve detection.
- Third, the Perinatal Subcommittee had been established to provide sufficient dedicated time for detailed scrutiny of maternity and neonatal services. Its terms of reference had been approved by the Quality Committees and were included for the Board's information.

In response to a question about external benchmarking, Andrew Murray explained that its use varied by measure and that national, regional and internal comparisons were considered where available. For the fundamentals of care priorities, the immediate concern was to demonstrate sustained improvement against the Group's own trajectories.

	The Board **NOTED** the report, the matters escalated and the further work required before assurance could be concluded on the outstanding quality-priority and Frailty Unit issues.
3.2	**Perinatal Subcommittee Report**
	The GCMidO presented the report from the inaugural Perinatal Subcommittee meeting on 27 July. She highlighted organisational culture at St George's, the Maternity and Newborn Safety Investigations (MNSI) escalation concerning foetal monitoring, and delivery risks associated with the Maternity Incentive Scheme Year 8 requirements. The MNSI escalation concerned recurring recommendations about cardiotocography interpretation and historical delays in implementing agreed actions. The GCMidO acknowledged previous gaps in leadership and governance oversight. Following a review of the outstanding actions and strengthened arrangements, all but two actions had been completed. A subsequent meeting with MNSI and regional colleagues had resulted in verbal confirmation that MNSI was satisfied to close the escalation; written confirmation was awaited. Completion and sustained implementation would continue to be monitored through the Subcommittee. The GCMidO explained that multiple national, regional and local requirements had overlapping timescales and created significant delivery-capacity challenges. Some required work across maternity, emergency care and primary care. The intention was to deliver meaningful quality improvements rather than treat implementation solely as a compliance exercise. The financial implications of the Maternity Incentive Scheme were also recognised. Claire Sunderland Hay sought clarification of the Subcommittee's coverage of perinatal mental health. The GCMidO confirmed that its remit extended beyond maternity physical health and included mental health, anaesthetics, neonatal care and other relevant specialties. The GCEO confirmed that the GCMidO now reported directly to him and was a member of the Executive Team. He emphasised the connection between organisational culture and patient safety, and the need for strong medical leadership alongside strengthened midwifery leadership. In response to the GCFO, the GCMidO confirmed that the Subcommittee's meeting frequency had been increased from bi-monthly to monthly because of the volume of oversight required. The Board **NOTED** the report and **AGREED REASONABLE ASSURANCE** regarding maternity governance, workforce and safety oversight arrangements, subject to the continuing work on culture, completion and sustainability of MNSI actions, and delivery of the national improvement requirements.
3.3	**NHS 10-Point Plan for Maternity and Neonatal Services: Baseline Benchmarking Review**
	The GCMidO presented the separate baseline assessments for the two Trusts, which had been considered by the Perinatal Subcommittee on 7 September. Board approval was sought for submission to NHS England, with supporting evidence, by 24 September. A progress return would follow in December. The assessments identified strengths in governance, Board accountability, safety learning and completion of the national mortuary assurance requirements. Several newer improvement requirements were not yet fully embedded. Three shared priorities were proposed: strengthening listening to women and families; reducing inequalities; and improving maternity triage assurance. Implementation of Martha's Rule was underway, with a St George's maternity pilot expected to begin shortly. Work included enabling the patient wellbeing question to be captured electronically. Yin Jones questioned whether the compliance ratings reflected the latest implementation position, and the SCEO-SGUH highlighted the need to distinguish clearly between the two Trusts' assessments. The GCMidO confirmed that the returns would be updated before submission.

	Work on maternity inequalities would build on the improvement programmes already established. For triage, additional metrics would be developed to support regular Board oversight of performance and safety. Andrew Murray welcomed the clear synthesis of strengths and priorities and considered it reassuring that the main areas for improvement were already recognised locally. Claire Sunderland Hay asked whether the exercise had revealed new concerns or insufficient progress on existing issues. The GCMidO explained that the principal themes were familiar, but recent national publications introduced additional requirements. These were being brought together with incident, complaint and claims intelligence to maintain a manageable set of priorities. Escalation and clinical decision-making had also emerged as a further theme for development. The Board: • **NOTED** the baseline findings and the assurance provided on the governance and oversight arrangements, recognising the areas not yet fully implemented; • **ENDORSED** the three Group-wide improvement priorities; and • **APPROVED** submission of the benchmarking returns and supporting evidence to NHS England, incorporating the updates discussed. Progress would continue to be monitored through site governance and the Perinatal Subcommittee, with further Board reporting following the December return.
4.0	**Finance and Performance**
4.1	**Finance Committees Report**
	In the absence of Bidesh Sarkar, Chair of the Finance and Performance Committee, the Chair invited questions on the report, which was taken as read. The report highlighted the continuing reliance on non-recurrent financial mitigations, pressure on recurrent savings delivery and the year-end forecast, and delays in capital expenditure. The Committees' assessment remained limited assurance in relation to delivery of the financial plan. The Board **NOTED** the report and the issues escalated. No additional questions were raised under this item.
4.2	**Finance Month 4 Report**
	The GCFO presented the Month 4 position. Both Trusts were reporting in line with plan, but this required higher levels of non-recurrent mitigation than originally anticipated. The reported position therefore did not remove the material pressure on delivery of the full-year plan. Recurrent Cost Improvement Plan (CIP) delivery remained behind plan, with non-recurrent savings and other adjustments supporting the reported financial position. Approximately 42% of the total savings requirement was now supported by fully developed schemes. The GCFO highlighted differences between the two Trusts' treatment of year-to-date savings variances within their forecast reporting. The approach would be standardised from Month 5 to improve consistency and transparency. Capital expenditure remained behind plan. The capital programme would be reforecast for the second half of the year, with proposals taken through the Group Executive Committee and the Finance and Performance Committee to support delivery and full use of the available allocation. The Chair acknowledged the scale of the financial challenge and confirmed that only limited assurance could be taken.

	The Board **NOTED** the Month 4 position, the reliance on non-recurrent measures and the risks to the full-year plan, and **AGREED LIMITED ASSURANCE** in relation to the financial position and delivery outlook.
4.3	**Integrated Quality and Performance Report (IQPR)**
	The GDCEO introduced the IQPR, highlighting improvements in several core access measures alongside continuing challenges in urgent and emergency care at ESTH, diagnostic waits and sickness absence. He reported the newly published Quarter 1 NHS Oversight Framework results. Before application of the financial override, St George's was assessed in Segment 2 and ESTH in Segment 3; the financial override resulted in both Trusts being placed in Segment 3 overall. The framework and measures had changed, limiting direct comparison with previous rankings. A fuller analysis would be presented to the Finance and Performance Committees. ESTH remained subject to enhanced regional oversight for urgent and emergency care. The following Site-specific updates were provided: **St George's** The SCEO-SGUH reported continued delivery against the planned referral-to-treatment trajectory, with fewer than 1% of patients waiting over 52 weeks. Cancer performance had improved, with the three principal standards meeting the agreed trajectories in June. Four-hour Emergency Department performance was just below 80% in July, and corridor care was reducing. Sustaining these improvements through winter remained a priority. Diagnostic waits were more challenging, particularly in non-obstetric ultrasound because of sonographer recruitment and retention difficulties. Recovery was progressing in other diagnostic services. In response to the Chair, the SCEO-SGUH explained that recruitment and retention payments offered elsewhere had affected the Trust's ability to retain and recruit staff, and that the position was being addressed. **Epsom and St Helier** The ISCEO-ESTH reported sustained theatre utilisation above 80% for nine months, strong cancer performance and progress in planned care, including patient-initiated follow-up. Urgent and emergency care remained the principal operational concern. Four-hour performance had deteriorated following the changes to Emergency Department same-day emergency care and the introduction of the UTC-first model. Senior clinical and operational leaders were reviewing the pathways and strengthening the recovery response. Corridor care had reduced but remained a significant concern. Replacement of the lift in the paediatric building had necessitated ward moves and reduced available adult bed capacity. The GCEO highlighted the resulting impact on flow and the need to avoid unsafe arrangements for moving children when the lift was unavailable. **Integrated care** The MD-IC described work to strengthen Sutton virtual ward and urgent community response services. Review of the longer bed stays at St Helier had reinforced the importance of improving the community response. The proposed approach involved closer integration with Surrey Downs, greater consistency in service delivery and deployment of staff across the services without detriment to the Surrey system. Additional investment and operational changes were expected to improve activity and impact before winter. The Chair asked why closer integration was now becoming possible. The MD-IC explained that different commissioners, funding arrangements and service specifications had previously inhibited

	a common approach. More recent scrutiny had also challenged assumptions about whether the existing Sutton model was achieving its full potential. The MD-IC also reported a detailed review of children's speech and language therapy pathways. Alongside demand and workforce pressures, the review had identified opportunities to redesign the model of care. Proposals would be brought to the Finance and Performance Committees, including short-term investment to address the backlog and changes intended to sustain waiting times below 18 weeks thereafter. Improvement was already evident in the dysphagia pathway, although successful implementation of the wider changes would require sustained attention. The Chair invited comments and questions from Board members, and the following were raised and noted in discussion: • Pankaj Davé questioned the difference in 30-day emergency readmission rates between the Trusts and whether the figures indicated premature discharge. The ISCEO-ESTH explained that some readmissions were expected and that the Medicine Division was auditing cases to identify avoidable readmissions and common themes. The SCEO-SGUH confirmed that St George's was also examining its position. Both emphasised the need to balance timely discharge with the risk of patients returning, with findings to be reported through the quality reporting arrangements. • Khadir Meer highlighted the increase in ESTH's Summary Hospital-level Mortality Indicator. The ISCEO-ESTH explained that the measure had moved into the higher-than-expected range. Changes in coding depth and comorbidity capture following the electronic patient record implementation might have reduced the calculated expected death rate; further analysis was required rather than assuming that coding explained the position. The GCMO cautioned that potential data effects should not obscure the clinical significance of overcrowded emergency departments and delayed transfer from them. He emphasised the relationship between those pressures and excess mortality and the importance of the work on corridor care, flow and timely emergency treatment. The Board **NOTED** the IQPR, welcoming progress in cancer and elective access while recognising the continuing risks in urgent and emergency care, diagnostics, sickness absence, readmissions and mortality. The planned reviews and recovery work would continue through the established reporting arrangements.
5.0	**People and Culture**
5.1	**People Committees Report**
	Yin Jones, Chair of the People Committee, presented the report from the August meeting and highlighted sexual safety, sickness absence and progress against the NHS 10-Point Plan for Improving Resident Doctors' Working Lives. The Committees had received limited assurance on sexual safety, recognising the further work required to strengthen prevention, reporting and organisational readiness for enhanced requirements. A dedicated steering group chaired by the GCPO would provide focused oversight. The sickness absence programme would target areas with high temporary-staffing backfill costs. Feedback indicated that aspects of the existing policy and support available to managers could inhibit early intervention. The GCPO's team would review these issues and report back to the People Committees. Yin Jones reported concerns from the resident doctor peer lead that improvements to working conditions had progressed too slowly. The GCMO acknowledged that the organisation had been slow to address some of the most visible concerns and that residents' frustration was justified. Progress had been made on payroll accuracy, advance provision of rotas and work schedules, annual leave and recognition of previous mandatory training, although performance reporting

	needed to become more systematic. The more difficult issues concerned the physical working environment, functioning equipment and suitable rest, mess, education and flexible working spaces. Work with resident doctor representatives was now clarifying priorities and strengthening delivery. A further report would be considered by the People Committees in October. The Chair confirmed the need to sustain attention to these matters. He also highlighted the Committees' limited assurance regarding flexible-working data and the wider speaking-up culture, distinguishing these from the assurance available on the policy framework and the Freedom to Speak Up Guardian Service function. The Board **NOTED** the report, the areas of limited assurance and the planned follow-up on resident doctors' working lives.
5.2	**Equality, Diversity and Inclusion Report**
	The GCPO presented the EDI overview, WRES and WDES reports, action-plan update and Inclusion Board evaluation. She acknowledged the challenge conveyed by the Inclusion Board and accepted that greater workforce diversity had not yet translated into sufficiently equitable staff experience. Forty-six of the 58 EDI actions had been completed or embedded into routine activity. Work included strengthened staff networks, dedicated support to implement reasonable adjustments, inclusive recruitment guidance and training, greater use of recruitment inclusion specialists, leadership development and targeted support for teams experiencing structural inequalities. The GCPO identified three immediate areas of focus: fairer employee-relations processes, including culturally competent consideration before formal proceedings; stronger staff voice and engagement; and the Group-wide values and behaviours programme. A successor three-year action plan would be developed with staff networks and other colleagues. Andrew Murray challenged whether the reports sufficiently explained the causes of the trends, rather than describing changes in the indicators. He sought a clearer connection between root causes, the interventions selected and the outcomes expected. Khadir Meer similarly welcomed completion of actions but questioned how this related to the continuing inequalities and what measurable difference had resulted. The GCPO explained that many actions arose from the national NHS EDI improvement requirements. Nevertheless, the refresh provided an opportunity to focus effort more clearly and strengthen the link between intervention and impact. The ISCEO-ESTH reported that discussion of the findings with site and divisional leaders had been powerful. Divisions would use their local information to develop more specific responses, recognising that the implications differed between services and staff groups. Yin Jones reported the positive mid-programme evaluation of the Inclusion Board and the People Committees' support for a second cohort. Future arrangements should draw on participants' experience, but it was premature to establish a permanent advisory group comprising successive cohorts. An alumni approach could be explored. The Chair asked the GCEO to consider the Inclusion Board's feedback, particularly opportunities to create safe spaces for colleagues to share lived experience. He also suggested a follow-up discussion with the current cohort, led by himself and Yin Jones approximately six months after completion, to understand its longer-term experience and whether participants could see how their feedback had influenced the organisation. The Board: • **APPROVED** publication of the 2026 WRES and WDES reports;

	• **NOTED** progress against the existing action plan and development of its successor; • **SUPPORTED** a second Inclusion Board cohort; and • **ENDORSED** stronger divisional accountability for addressing inequalities in people processes, career progression and staff experience. **ACTION:** A follow-up discussion to be arranged with the members of the first cohort of the Inclusion Board six months after completion to understand members' longer-term experience.
6.0	**Infrastructure**
6.1	**Infrastructure Committees Report**
	Claire Sunderland Hay, Co-Chair of the Infrastructure Committee, presented the report covering the July meeting. She highlighted work to mitigate extreme heat across the estate, continuing delays affecting the St George's Intensive Care Unit development and the introduction of a digital performance dashboard. Progress on fire safety at Epsom & St Helier was noted, including the closure of four of the five outstanding articles at Epsom. The Board also received confirmation of approval through the relevant Committee arrangements for investment in the wider St Helier water supply as part of the Emergency Department redevelopment enabling works. This was a separate infrastructure issue from the E Block contamination and remediation programme and should not be conflated with it. Pankaj Davé questioned the proposed timescale for improving business continuity and disaster recovery capabilities. Although the Committees had requested acceleration from three years to 18 months, he remained concerned about the duration given the potential consequences of digital infrastructure failure. Claire Sunderland Hay undertook to clarify the position, and the Chair confirmed that the matter would be followed up separately. The importance of accelerating mitigation of significant digital risks was recognised. The Board **NOTED** the report and the issues requiring continued oversight.
7.0	**CLOSING ITEMS**
7.1	**New Risks and Issues Identified**
	The Chair invited members to identify any additional risks or issues arising from the meeting. No new standalone risks were identified.
7.2	**Reflections on meeting**
	The MD-IC reflected on the meeting using the Inclusion Board's challenge as a framework: willingness to have uncomfortable conversations, curiosity, attention to lived experience, and a balance of encouragement and scrutiny. She considered that members had generally engaged openly and that participation reflected a more integrated Group Board, with contributions no longer visibly divided by Trust affiliation. Agreement and challenge had appeared genuine rather than predetermined. The depth of scrutiny had varied between items. The maternity discussion had demonstrated curiosity and challenge particularly well, while the public finance discussion had been more limited despite its significance for staff, services and the organisation. Andrew Murray agreed that important concerns and challenge should be visible in public, even where matters had already received scrutiny in other forums. The Chair supported that observation.

	The MD-IC emphasised the importance of retaining a partnership approach to shared problems, particularly as organisational pressures increased. The Chair thanked her for the thoughtful and candid feedback.
6.3	**Questions from Members of the Public**
	Part of this discussion was brought forward to enable Sonia Jeffers, a member of the public, to participate before she needed to leave. **Patient experience, dignity and privacy** Mrs Jeffers described her experience during a recent inpatient stay. She was positive about her clinical care but wished to raise concerns about the ward environment, privacy and the impact on patients sharing accommodation with someone experiencing significant distress and complex needs. Her intention had been to provide constructive feedback, but an initial response she considered dismissive had led to escalation as a complaint. She described disrupted rest and the difficulty of protecting the wellbeing and dignity of both the distressed patient and others in the bay. She also questioned the availability of private space for sensitive conversations, noting that curtains did not provide confidentiality. The Chair thanked Mrs Jeffers and apologised for her experience. The SCNO-SGUH acknowledged that the initial response had not helped and emphasised the value of direct conversation. She recognised the constraints created by the limited availability of side rooms and private spaces, but agreed that the service should consider what could be done differently. The SCNO-SGUH would reflect with matrons and ward managers on communication with patients sharing bays, the management of complex needs and access to appropriate specialist support. Mrs Jeffers had agreed to speak with nursing colleagues to support learning. Her concerns would be followed up locally. The Chair thanked her for presenting the issues constructively and confirmed that the Board took the experience seriously. **Picture Archiving and Communications System (PACS)** The GCEO responded to six written questions submitted by Marion Parks concerning the South West London enterprise PACS programme. On the contractual counterparty, he advised that the sale of the Optum UK EMIS business had not changed the relevant contractual relationship. The enterprise PACS contract remained with Change Healthcare UK Holdings Limited, operating within Optum and the UnitedHealth Group. Contract Change Notice discussions had been conducted with Optum in relation to that existing contract. Responding to the question about why the contract had not been terminated in April 2024, the GCEO stated that decisions had been taken through the governance arrangements in place, using the information and professional advice then available and what was considered to be in the participating Trusts' interests. He acknowledged that lessons needed to be learned from the programme's procurement, implementation and management. The GCEO clarified that November 2027 had been identified as a planning assumption for the first Trust deployment, rather than an unconditional or guaranteed go-live date. He explained that preparatory work—including standardisation of workflows, technical preparation and clinical engagement—could progress while detailed contractual changes were being developed. The GCEO rejected the suggestion that the Board had misled patients or the public, while acknowledging programme difficulties and changes to the proposed timetable. Primary copies of imaging data remained within the originating Trusts. Copies transferred during planned migration were held in secure Google Cloud storage and managed through the programme's information governance, cybersecurity and clinical risk arrangements.

	Following the February 2024 Change Healthcare cybersecurity incident, the assurance received and reported through governance was that South West London data had not been accessed or affected. The organisation therefore had no evidence that South West London patient data had been compromised. The responses would be provided in writing to Marion Parkes.
6.4	**Any Other Business**
	The Chair marked Thirza Sawtell's final public Board meeting and thanked her for her substantial contribution to the Group. He particularly recognised her expertise in community services, integration and national policy, and the distinctive insight she brought to Board discussions. Khadir Meer added his appreciation of her contribution to strategy and transformation across the wider London system. No further business was raised.
6.5	**Patient Story – St George's Neonatal Unit**
	The Board heard a presentation from the St George's Neonatal Unit following its achievement of UNICEF UK Baby Friendly Initiative Gold Accreditation. The team reported that St George's was the first neonatal unit in London and the fifth in the UK to achieve this recognition. The team described the programme's focus on close parent–baby relationships, breast milk and breastfeeding, and parents as partners in care. Gold Accreditation recognised that these standards were embedded and sustained in everyday practice, supported by leadership, staff knowledge, family feedback, audit and continuing improvement. The presentation centred on Ayat, born at 22 weeks and three days' gestation weighing 430 grams. She had required prolonged, complex neonatal care and had been discharged home in August after 164 days, with continuing specialist follow-up. Through recorded reflections, her parents described the uncertainty, fear and exhaustion of the admission, alongside the trust they developed in the team. Staff had supported them to participate progressively in care, including holding, feeding and caring for their daughter and preparing to manage her needs at home. They particularly valued clear explanations, consistent infant-feeding support and recognition of their emotional needs as parents. The unit had become a safe place and a second home. Discharge brought joy and relief, but also anxiety about leaving the team and environment on which they had relied. Andrew Murray asked which factors had been most important in achieving the evident cultural change. The team highlighted involving staff in designing improvements, sustained education, management support and shared ownership across the whole multidisciplinary team, rather than relying on instructions from a small number of leaders. The GCMO asked whether staff received sufficient support when outcomes were poor or families' expectations could not be met. The team described close multidisciplinary working, early conversations with families, support from the Baby Friendly Guardian and access to psychological support and immediate and subsequent debriefing for staff. They recognised that compassionate care and family involvement remained essential when a baby could not survive. Natalie Armstrong asked about sharing the learning with other services. The team described national and regional networks, collaboration with maternity and paediatric colleagues, and training opportunities for staff from Epsom and St Helier. The SCEO-SGUH and GCEO highlighted the relevance of the team's approach to culture, staff engagement and family partnership across the wider Group. The GCEO also emphasised that culture improvement needed to recognise the cumulative emotional impact of clinical work and the importance of supporting staff through difficult experiences. In discussing opportunities for research in extreme prematurity, the clinical team

	stressed the need to consider longer-term outcomes and quality of life alongside further innovation. The Board congratulated the team on Gold Accreditation and thanked the family and staff for sharing their experience. Members recognised the value of the learning for compassionate, family-centred care and organisational culture across the Group.
CLOSE	
The meeting closed at 16.50.	

DRAFT

Group Board (Public) - 6 November 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	**Group-wide alignment of Mandatory and Statutory Training:** 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~~ 6 November 2026	GCPO	Update on November 2026: The revised national guidance remains outstanding. However, most mandatory training requirements are now aligned across the Group, with remaining differences generally relating to delivery methods or frequency and reflecting specific operational requirements. A report setting out the areas of alignment, remaining differences and the reasons for them was presented to the Group Executive Committee and People Committee in October. Further work is required to work through the discretionary MAST training alignment across the Group, with the Executive adopting an approach of ensuring that the overall burden of MAST training does not increase. The Executive has agreed to review the position in 6 months. The FTSU training has been reviewed by the Mandatory Training Oversight Group which has endorsed making this part of mandatory training on a Group-wide basis (currently SGUH only), as soon as another item of MAST training is identified for removal. Any subsequent changes arising from national guidance will be considered separately through the Group Executive Committee, with assurance provided to the People Committee. On this basis, the action is proposed for closure.	**PROPOSED FOR CLOUSRE**
GB-2610/01	11-Sep-26	5.2	Equality, Diversity and Inclusion Report	**Inclusion Board Follow Up (Cohort 1):** A follow-up discussion to be arranged with members of the Inclusion Board (Cohort 1) six months after completion to understand Inclusion Board members' longer-term experience and whether participants could see how their feedback had influenced the organisation.	10-Jun-27	GCPO		**NOT YET DUE**

Group Board

Meeting in Public on Friday, 06 November 2026

Agenda Item	2.1	
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

he period since our September Board meeting has brought important leadership changes and a continued focus on the culture, capability and consistency we need across gesh. This report welcomes new colleagues, recognises those who have provided interim leadership and records our thanks to Victoria Smith as she leaves the Group.

Our second leadership forum focused on culture and the responsibility of leaders to shape colleagues' everyday experience. Work with Kaleidoscope Health will support shared values, behaviours and a Group compact, alongside targeted investment we have recently made in sickness absence management and employee relations support.

The CQC's Epsom and St Helier Well-Led report, published on 22 October, rated the Trust Requires Improvement. It recognised strengths in partnership working, learning and innovation, and environmental sustainability, while identifying further improvements in culture, inclusion, speaking up, governance and management. An initial Group-wide action plan is appended, reflecting common themes across both Trusts and our ambition to become a well-led, integrated organisation.

The report also highlights the gesh CARE Awards, wider staff recognition, Black History Month, the live Staff Survey and flu vaccination campaign. It updates the Board on national guidance on single-sex accommodation and staff facilities, our provider capability submissions and planned NHS England-supported Board development during the coming year.

Action required by Group Board

The Group Board is asked to:

a) note the leadership, workforce, organisational and regulatory developments set out in this report;
b) note the findings of the Epsom and St Helier CQC Well-Led assessment, the priorities for improvement; and
c) Review and comment on the initial Group-wide CQC Well Led action plan at Appendix 1, to inform its further development and implementation.

Appendices	
Appendix No.	**Appendix Name**
Appendix 1	Initial Group-wide CQC Well Led action plan

Implications				
Group Strategic Objectives				
☒ Collaboration & Partnerships			☒ Right care, right place, right time	
☒ Affordable Services, fit for the future			☒ Empowered, engaged staff	
Risks				
The report addresses risks relating to leadership capacity, organisational culture, staff experience, workforce inequalities and effective governance.				
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				
Targeted People-function investment has been considered through the Group Executive Committee. No additional funding approval is sought through this report.				
Legal and / or Regulatory implications				
The report covers our response to CQC findings, NHS oversight requirements and national guidance on single-sex accommodation and staff facilities.				
Equality, diversity and inclusion implications				
Inclusive leadership, fair workforce processes, staff networks and addressing inequalities in staff experience are central themes.				
Environmental sustainability implications				
The report recognises positive CQC findings on environmental sustainability. No additional direct implications arise from this report.				

Group Chief Executive Officer's Report

Group Board, 06 November 2026

1.0 Purpose of paper

1.1 This report provides an update on significant developments across the Group since the public Board meeting in September. It focuses particularly on leadership, organisational culture, support for our people and our response to the CQC's Well-Led findings, alongside staff engagement, recognition and relevant national developments.

2.0 Key Issues

Leadership changes

2.1 Since our last public Board meeting, we have welcomed Chinyama Okunuga as Site Chief Executive Officer for Epsom and St Helier, following her arrival on 1 October. This week, Tracy Luckett joined us as Group Chief Nursing Officer on 2 November. I am very pleased to welcome Chin and Tracy to their roles and look forward to working with them as we strengthen leadership, improve care and bring the Group closer together.

2.2 I would also like to recognise the colleagues who have provided interim leadership over recent months. Rebecca Suckling covered the Epsom and St Helier Site Chief Executive Officer role following Alex Shaw's departure in August until Chin's arrival. Theresa Matthews and Nicola Shopland jointly covered the Group Chief Nursing Officer responsibilities between Elaine Clancy's departure at the end of August and Tracy joining us. All three have taken on significant additional responsibilities alongside their substantive roles, and I am grateful for the continuity, commitment and leadership they have provided.

2.3 Victoria Smith leaves the Group today, 6 November, after more than two years as Group Chief People Officer. Vic has led the People function through a demanding period of organisational change and has made an important contribution to bringing our teams together and developing our approach to people and culture. I would like to thank her for her work and wish her well for the future.

2.4 Sheridan Flavin has been appointed as Interim Group Chief People Officer and will join us on 16 November, remaining with us until our new substantive postholder arrives. Interviews for the substantive role took place on Wednesday, 4 November, and we will communicate the outcome in due course.

Leadership development, culture, values and behaviours

2.5 Our second gesh Leadership Forum took place on 2 October, bringing together the Executive Team, site leadership teams and divisional leaders. The day focused on culture: how colleagues experience the organisation now, the culture we want to build and what it means for each of us to lead that change. It was a positive and constructive discussion, with a shared recognition that the way we lead, respond to challenge and support our teams has a direct influence on both staff experience and patient care. I found the willingness to reflect openly on our own leadership particularly encouraging. We need to build on that discussion by making our expectations of leaders clearer and supporting them to put those expectations into practice. Leadership development will remain an important part of this work, helping leaders across the Group develop the confidence, skills and relationships needed to lead well through change.

2.6 We will shortly begin the next phase of our values and behaviours work, supported by Kaleidoscope Health. This will involve colleagues in developing a common set of values across the Group and a Values and Behaviours Compact that we will ask all staff to sign up to. The compact should establish shared expectations of how we work together, how we lead and what colleagues can expect from the organisation. Its value will be demonstrated through everyday behaviour, including how we listen, make decisions, recognise contributions and respond when something has gone wrong.

Strengthening support for our people

2.7 We know that some of the support available to managers and staff is not yet as strong or responsive as they need to be. We have therefore made targeted investment in sickness absence management, providing additional HR capacity to support earlier intervention, more consistent case management and appropriate support for colleagues to return to work. This complements the work of Occupational Health, staff wellbeing services and managers across our sites.

2.8 Alongside this, the Group Executive Committee has also approved targeted investment in strengthening our employee relations support to staff. This will strengthen specialist leadership and advisory capacity to staff, improve support for managers and help concerns and cases reach earlier resolution. Prolonged processes can have a significant effect on the wellbeing of the individuals involved and on their wider teams; improving the timeliness and quality of our response is therefore an important part of our cultural improvement work.

2.9 Additional capacity needs to be accompanied by stronger management practice. We want managers to have the advice and confidence to address issues early, listen carefully and resolve concerns fairly. Where formal processes are necessary, they must be handled promptly, consistently and with appropriate support for everyone involved.

CQC Well-Led Inspection – Epsom and St Helier

2.10 The CQC published its Well-Led report for Epsom and St Helier on 22 October, following the inspection in May. The assessment resulted in a Requires Improvement rating for Well-Led. Having undertaken our own self-assessment, the findings were broadly consistent with our understanding of the organisation. We accept them and recognise the work required to improve.

2.11 The report identified strengths in partnerships and communities, learning and innovation, and environmental sustainability. These included effective collaboration with health and care partners, established approaches to continuous improvement and research, and a structured approach to delivering our Green Plan. These are important foundations on which to build.

2.12 The CQC also recognised developments in governance and management. This is encouraging in the context of the weaknesses identified at St George's in February 2025. However, the report makes clear that our arrangements need to work more consistently across sites and divisions.

2.13 There are strong parallels between the CQC's Well Led findings at Epsom & St Helier and St George's. These include translating strategy into local delivery, embedding values and behaviours, strengthening leadership, addressing workforce inequalities and improving staff confidence that speaking up will lead to a timely and constructive response. Our task is to make improvement visible in colleagues' everyday experience.

2.14 An initial Group-wide CQC Well-Led action plan is attached at Appendix 1. Developed through a review of both assessments and an Executive workshop, it brings together existing work and proposed further improvements under three themes:

- **Strategy into everyday delivery:** making our direction clear and connecting Group priorities with the work of sites, divisions, teams and individuals.
- **People, culture and speaking up:** strengthening leadership, fair treatment, development opportunities and confidence that concerns will be heard and acted upon.
- **Group model, governance and accountability:** clarifying responsibilities and decision-making, improving consistency and strengthening oversight of quality, people and risk.

2.15 As we work towards becoming a single integrated legal entity, we need a shared approach to becoming a well-led Group. The common themes require collective action, alongside site plans that respond to particular findings and local staff experience. This first draft provides the basis for that work. As it develops, the emphasis must be on clear ownership, practical delivery and evidence that the changes are making a difference for patients and colleagues.

Provider Capability Assessments

2.16 We submitted our latest provider capability assessments to NHS England on 2 October. This is an opportunity to take stock of our leadership and organisational capability, recognise progress and identify where further development is needed.

2.17 Following the original assessments, we will begin a programme of Board development supported by NHS England early in the new year. This will provide an opportunity to strengthen our effectiveness as a Board, including how we lead culture, exercise oversight and hold ourselves collectively accountable for improvement. It will complement our wider leadership development and the work arising from the CQC Well-Led assessments.

Celebrating our people: gesh CARE Awards and recognition

2.18 The gesh CARE Awards on 23 September brought over 400 colleagues together at the Kia Oval for a fantastic evening of celebration. More than 800 nominations were received across 13 award categories, reflecting the breadth of excellent work taking place in our hospitals and community services. Hearing patients and families describe the difference colleagues had made to their lives was particularly moving, and a powerful reminder of why that work matters.

2.19 I would like to congratulate our winners, finalists and highly commended colleagues, and thank everyone who nominated someone or helped make the evening possible, including our hospital charities and sponsors. The awards also recognised the contribution of the many colleagues whose work takes place behind the scenes and is essential to the care we provide.

2.20 Recognition is a wider priority for the Group. Last year's Staff Survey told us that we needed to do more to help colleagues feel valued and appreciated. The CARE Awards, gesh25 and the Big Thank You have been important parts of our response. Our developing recognition strategy will build on these events and help make appreciation a more consistent part of everyday working life.



Listening to colleagues: NHS Staff Survey

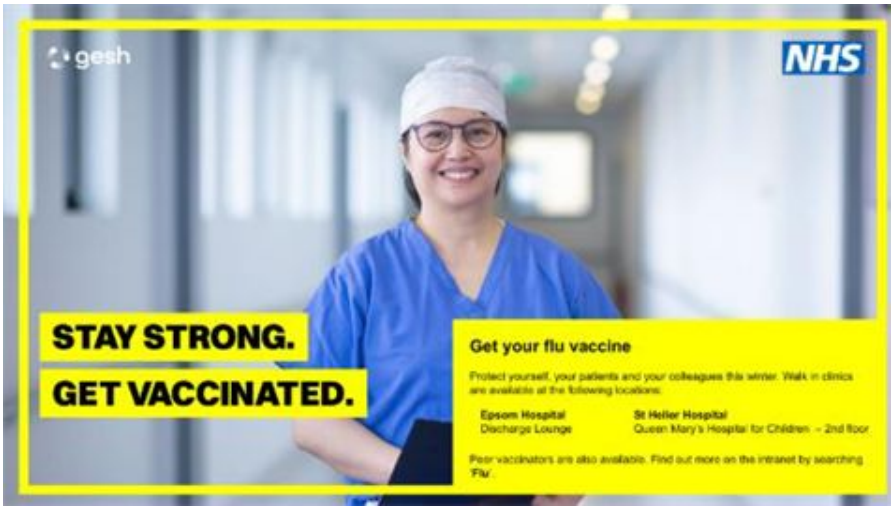
2.21 The 2026 NHS Staff Survey is now live and will remain open until Friday, 27 November. I encourage every colleague to take part. The survey provides an important opportunity to tell us what is working well, what makes working here more difficult and where change is most needed. Responses are confidential, and we want to hear from colleagues across all our services and staff groups.



2.22 We are encouraging leaders to support colleagues to complete the survey. The results will provide an important measure of staff experience and help us understand whether the changes we are making are being felt. Once the findings are available, we will use them with teams to identify specific priorities and actions, alongside the intelligence we receive through staff networks, speaking up and other engagement routes.

Protecting colleagues and patients this winter

2.23 Our staff flu vaccination campaign is underway, and we are encouraging as many colleagues as possible to take up the offer of vaccination. Protecting staff and patients also helps maintain the resilience of our services over winter. Clinics, peer vaccinators and roving vaccination support are helping colleagues access their vaccination around working commitments. I would like to thank everyone supporting the campaign and encourage colleagues to take the opportunity to protect themselves and those around them.



Black History Month

2.24 Throughout October, colleagues across the Group marked Black History Month, supported by our REACH – Race, Ethnicity and Cultural Heritage – Staff Network. Under the theme of "Honouring Our Communities", events provided opportunities to celebrate the contribution of Black colleagues and communities, share experiences and learn together. Activities included a launch at St Helier, online discussions on identity, belonging and allyship, and a closing celebration at St George's.

2.25 I am grateful to the network, speakers and colleagues who contributed to these events. Their work also reinforces the importance of sustained action on inclusion throughout the year.

Celebrating contribution must be accompanied by fair access to development and progression, a willingness to challenge discrimination and improvements in the experience of colleagues across the Group.

National guidance on single-sex accommodation and staff facilities

2.26 NHS England has published revised guidance on privacy, dignity and safety in hospital accommodation, alongside new guidance on NHS staff facilities. These documents provide an updated national framework for how organisations should approach accommodation and facilities for patients and staff.

2.27 We are working through the implications for gesh with our Equality, Diversity and Inclusion Team and staff networks. This requires careful consideration of our services, policies and physical environments, alongside clear communication and support for those affected. Throughout this work, our commitment is to provide safe and respectful care and workplaces that protect the privacy and dignity of patients and colleagues.

3.0 Recommendations

3.1 The Group Board is asked to:

a) note the leadership, workforce, organisational and regulatory developments set out in this report;
b) note the findings of the Epsom and St Helier CQC Well-Led assessment, the priorities for improvement; and
c) Review and comment on the initial Group-wide CQC Well Led action plan at Appendix 1, to inform its further development and implementation.

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

gesh

Initial Group-wide CQC Well-Led Action Plan:

Responding to the CQC's findings

6 November 2026

Initial Group-wide CQC Well-Led action plan

Responding to the CQC's Well-led findings

An initial Group-wide plan, supported by aligned site improvement plans

Findings and response

This pack summarises the CQC's Well-led reports for St George's (October 2025) and Epsom and St Helier (October 2026), highlighting common themes and each Trust's distinct points of emphasis.

It presents an initial Group-wide action plan developed by the executive team and representatives of site leadership teams. The plan focuses on Quality Statements 1–5 and largely brings together work already underway or planned.

Group and site delivery

Site Well-led plans will embed the Group-wide actions locally and address each site's particular findings and priorities.

St George's has developed its site plan following extensive staff listening, with close alignment to the Group plan.

Epsom and St Helier will now begin staff engagement to shape its site plan.

Delivery and impact

Over the coming weeks, we will refine the plan with clear delivery milestones and measures of impact for each action.

We will define how to check that changes are implemented and embedded in practice, and whether they improve staff experience, leadership and governance. The refined plan will set out how progress and sustained impact will be monitored.

The finalised Group-wide CQC Well Led action plan will be presented to the Group Board for approval at its next public meeting on 7 January 2027

CQC well-led findings across the gesh Group

CQC findings across the two trusts

Both rated Requires improvement for Well-led. St George's assessed in February 2025 and ESTH in May 2026.

This comparison covers all eight quality statements. The Group-wide action plan focuses on statements 1–5.

CQC quality-statement scores	St George's	Epsom & St Helier
1 Shared direction and culture	2	2
2 Capable, compassionate and inclusive leaders	2	2
3 Freedom to speak up	2	2
4 Workforce equality, diversity and inclusion	1	2
5 Governance, management and sustainability	1	2
6 Partnerships and communities	3	3
7 Learning, improvement and innovation	3	3
8 Environmental sustainability	3	3

St George's

Two Regulation 17 requirements: use staff feedback to improve culture and measure impact, and improve governance to protect people from avoidable harm.

Epsom and St Helier

No regulatory requirements arising from this Well-led assessment. Concerns about consistency and impact remained.

Shared strengths

Both scored 3 for partnerships, learning and innovation, and environmental sustainability. CQC recognised tangible benefits from collaboration and improvement.

A well-led Group

This draft Group-wide CQC Well-Led action plan has been developed through a review of the CQC findings for St George's and Epsom & St Helier and the subsequent Executive workshop. It focuses on Quality Statements 1-5, which scored 2 or 1 at both trusts. The proposed actions bring together work already underway and further improvements planned through that review. They are organised around the three themes below, reflecting where we believe collective Group-wide action can make the difference.

Each site also needs its own site-based Well-led action plan, aligned with and supporting these Group-wide actions. Site plans will translate the Group's commitments into local delivery and address the particular findings and staff priorities at each site. St George's, whose assessment took place first, has already developed a site plan informed by an extensive programme of staff listening events. Epsom & St Helier will now begin a similar process following the recent publication of the ESTH report.

1 Strategy into everyday delivery

Make the Group's direction clear and translate it into everyday decisions, from Board to ward. Align strategies and delivery plans, connect local and individual objectives through QMS, and use two-way communication so staff understand their contribution and help shape delivery.

2 People, culture and speaking up

Improve the experience of working across the Group, with fair treatment and opportunities to develop. Strengthen leadership and a culture where staff feel valued and safe to speak up, concerns lead to learning, and teams with poor experiences receive targeted support.

3 Group model, governance and accountability

Make the Group model work consistently, with clear responsibilities across Group, sites, divisions and corporate services. Strengthen oversight of quality, people, health equity and risk, and streamline governance so leaders can make clear decisions and demonstrate improvement.

Shared Group actions, embedded through executive, site and divisional plans

1

Shared direction. Local delivery.

Connect the Group's strategy to the decisions, priorities and objectives of every site, team and individual.

WHAT SHOULD CHANGE

Staff understand the direction and can see their contribution.

Initial Group-wide CQC Well-Led action plan

Strategy into everyday delivery

Action and delivery	Proposed executive lead(s)	Relationship to existing work
1.1 Strategy on a page and local delivery. Create an elevator pitch and one-page strategy. Link Group, site, division, team and individual objectives through QMS. Quality Statement (primary / secondary): 1 / 2, 5	Group Deputy CEO & Site CEOs, with Group Chief Communications Officer	**Under way / additional** H2 2026/27 Board-to-ward objectives agreed. QMS under way. Pitch and one-page strategy are new.
1.2 Communications cascade and staff involvement. Launch a consistent cascade, support local discussion and show how staff feedback changes decisions. Quality Statement (primary / secondary): 1 / 5	Group Chief Communications Officer & Site Chief Executive Officers	**Under way** Executive-agreed cascade, supported at the October Board development session.
1.3 Review the strategy architecture. Define core strategies and delivery plans. Identify gaps and simplify overlaps where appropriate. Quality Statement (primary / secondary): 1 / -	Group Deputy CEO	**Additional** Executive had already identified the need for a strategy-architecture review.
1.4 Overarching clinical strategy. Bring specialty strategies into a Group clinical strategy, aligned with the three NHS shifts. Quality Statement (primary / secondary): 1 / -	Group Chief Medical Officer and Group Chief Nursing Officer	**Additional** Workshop supported an overarching clinical strategy, distilling existing specialty strategies.

Under way = in delivery. Planned = committed. Additional = new or extended scope.

1

Shared direction. Local delivery.

Connect the Group's strategy to the decisions, priorities and objectives of every site, team and individual.

WHAT SHOULD CHANGE

Staff understand the direction and can see their contribution.

Initial Group-wide CQC Well-Led action plan

Strategy into everyday delivery

Action and delivery	Proposed executive lead(s)	Relationship to existing work
1.5 Nursing and midwifery strategy. Develop a Group strategy aligned with clinical direction and workforce priorities. Quality Statement (primary / secondary): 1 / -	Group Chief Nursing Officer	**Additional** Fills a recognised gap for the largest workforce, alongside the existing AHP strategy.
1.6 Education strategy. Develop a Group education strategy aligned with clinical, workforce and organisational priorities. Quality Statement (primary / secondary): 1 / 2	Group Chief Medical Officer, Group Chief Nursing Officer & Group Chief People Officer	**Additional** Already considered by the executive team and Executive–Site Development Forums.
1.7 Estates master plan. Progress the Group master plan alongside clinical strategy, capital and new-hospital requirements. Quality Statement (primary / secondary): 1 / 5	Group Chief Facilities, Infrastructure & Environment Officer	**Planned** Estates master plan already needed and planned.

Under way = in delivery. Planned = committed. Additional = new or extended scope.

2

A better experience of working here.

Build capable, inclusive leadership and a culture in which people feel valued, treated fairly and safe to speak up.

WHAT SHOULD CHANGE

Fairer outcomes, stronger leadership and confidence that concerns lead to action.

Initial Group-wide CQC Well-Led action plan

gesh

People, culture and speaking up

Action and delivery	Proposed executive lead(s)	Relationship to existing work
2.1 People Strategy and culture. Develop the next People Strategy with staff, using engagement and local delivery to build the desired culture. Quality Statement (primary / secondary): 1 / 2	Group Chief People Officer & Site CEOs	**Planned** Renewal already planned as the 2024–2026 People Strategy comes to an end.
2.2 Values, behaviours and compact. Embed Group values, the behavioural framework and compact in leadership and everyday working relationships. Quality Statement (primary / secondary): 1 / 2, 3	Group Chief People Officer & Site CEOs, with all executives	**Planned** Values, behaviours and compact work planned in response to Well-led and the staff survey.
2.3 Group recognition strategy and sharing great practice. Develop and implement the Group Recognition Strategy to celebrate contribution across staff groups, support consistent local recognition and share great practice. Quality Statement (primary / secondary): 2 / 1, 4	Group Chief Communications Officer with Site CEOs and Group Chief People Officer	**Under way** Group Recognition Strategy scheduled for GEC consideration in November 2026.
2.4 Meaningful appraisals and career conversations. Align Group appraisals and achievement reviews. Make conversations regular and useful, linking objectives, behaviours and career development. Quality Statement (primary / secondary): 2 / 1	Group Chief People Officer	**Under way** Group appraisal alignment already planned and now a priority for legal integration.
2.5 Site and divisional leadership development. Build on the King's Fund approach for site leadership teams. Agree targeted divisional support and assess changes in leadership practice. Quality Statement (primary / secondary): 2 / 1, 3	Group Chief People Officer & Site CEOs	**Under way / additional** Executive development in place. Additional scope: extension to sites and divisions.

Under way = in delivery. Planned = committed. Additional = new or extended scope.

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gesh

People, culture and speaking up

Action and delivery	Proposed executive lead(s)	Relationship to existing work
2.6 Talent management and succession. Identify future leaders and key succession needs. Create inclusive development pathways, including for staff outside formal management roles. Quality Statement (primary / secondary): 2 / 4	Group Chief People Officer (approach and framework) & Site CEOs, with all executives	**Under way / planned** Talent development in train, with strengthened succession already planned.
2.7 Next Inclusion Board cycle and progression. Continue the Inclusion Board, with credible development, internal movement, progression and succession opportunities. Quality Statement (primary / secondary): 4 / 2	Group Chief People Officer	**Planned** Next Inclusion Board cycle planned, with stronger progression and succession links.
2.8 Refresh the EDI plan and strengthen senior oversight. Refresh the Group EDI plan with staff and site SLTs. Agree local priorities, owners and outcomes, with regular divisional, site, executive and Board oversight. Quality Statement (primary / secondary): 4 / 1, 5	Group Chief People Officer and Site CEOs	**Under way / additional** Existing EDI plan in delivery. Refresh adds wider staff and local prioritisation.
2.9 Divisional ownership of people metrics and workforce inequalities. Embed key people metrics, including WRES/WDES indicators, in divisional IQPRs. Require local ownership of inequalities and link workforce, speaking-up and safety intelligence. Quality Statement (primary / secondary): 4 / 5	Site CEOs, with support from Site Directors of People	**Additional** Good-practice extension of people metrics, including WRES/WDES, into divisional IQPRs.
2.10 Staff networks' capacity and contribution. Set priorities and work plans. Provide protected time, support, wider participation and executive and site sponsorship. Quality Statement (primary / secondary): 4 / 1, 2	Group Chief People Officer, with executive and site sponsors	**Under way** Augments network work already in train, including priorities, time and support.

Under way = in delivery. Planned = committed. Additional = new or extended scope.

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Initial Group-wide CQC Well-Led action plan

People, culture and speaking up

Action and delivery	Proposed executive lead(s)	Relationship to existing work
2.11 Fair recruitment, development and progression. Address selection and progression barriers. Improve access to opportunities and track whether outcome gaps reduce. Quality Statement (primary / secondary): 4 / 2	Group Chief People Officer & Site CEOs	**Under way / planned** Inclusive recruitment and development work in train, with further fair-process work planned.
2.12 Fair disciplinary and capability processes. Strengthen relevant HR policies, triage and managers' capability to support fair, consistent and timely decisions. Quality Statement (primary / secondary): 4 / 3	Group Chief People Officer, Group Chief Medical Officer, Group Chief Nursing Officer & Site CEOs	**Planned** Fair disciplinary and capability processes planned through stronger ER arrangements.
2.13 Group speak-up strategy and priorities. Agree Board-overseen priorities, accessible routes and a resilient Guardian service. Identify and address barriers to speaking up across staff groups. Quality Statement (primary / secondary): 3 / 1, 4, 5	Group Chief Corporate Affairs Officer	**Under way / planned** Group FTSU strategy and improvement priorities already in development or planned.
2.14 Protection from detriment. Strengthen prevention, identification, support and escalation. Follow up with staff to test safety and whether protections work. Quality Statement (primary / secondary): 3 / 1, 4	Group Chief Corporate Affairs Officer, with Group Chief People Officer	**Under way** Work to strengthen identification of, protection from and response to detriment is in train.
2.15 Oversight, response standards and targeted action. Re-establish the Raising Concerns Group. Track all routes, set response standards and triangulate intelligence to target support and intervention. Quality Statement (primary / secondary): 3 / 1, 2, 5	Group Chief Corporate Affairs Officer, Group Chief Medical Officer, Group Chief Nursing Officer & Site CEOs	**Under way** Enhances existing triangulation and oversight through the Raising Concerns Group.

Under way = in delivery. Planned = committed. Additional = new or extended scope.

2

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WHAT SHOULD CHANGE

Fairer outcomes, stronger leadership and confidence that concerns lead to action.

Initial Group-wide CQC Well-Led action plan

People, culture and speaking up

Action and delivery	Proposed executive lead(s)	Relationship to existing work
2.16 Early, fair resolution through manager capability and ER support. Improve managers' access to ER support. Strengthen escalation processes so that investigators and decision-makers conclude processes fairly and promptly. Quality Statement (primary / secondary): 3 / 2, 4	Group Chief People Officer & Site CEOs	**Under way / additional** ER strengthening under way. Further work builds managers' early-resolution capability.
2.17 Systematic learning and communication of Freedom to Speak Up themes. Identify recurring Freedom to Speak Up themes. Implement and check improvements, then communicate learning and resulting changes while protecting confidentiality. Quality Statement (primary / secondary): 3 / 1, 5	Group Chief Corporate Affairs Officer, with Group Chief Communications Officer	**Under way / planned** FTSU themes, learning and communication already committed through internal audit work.
2.18 Map leadership strengths and target support. Use workforce intelligence and staff feedback to identify strong and struggling teams. Direct development to those who need it and review impact. Quality Statement (primary / secondary): 2 / 1, 3, 4	Site CEOs, with Group Chief People Officer	**Additional** Builds on existing local understanding. Adds systematic mapping and targeted support.
2.19 Racism, discrimination and bullying. Act with affected staff in teams with poor experiences. Combine leadership support, accountability and follow-up. Quality Statement (primary / secondary): 4 / 1, 2, 3	Site CEOs, with Group Chief People Officer	**Planned / additional** Values and compact work planned. Additional element: targeting teams with poor experiences.

Under way = in delivery. Planned = committed. Additional = new or extended scope.

3

A Group model that works in practice.

Make responsibilities and decision-making clear across the Group, with effective oversight of quality, people and delivery.

WHAT SHOULD CHANGE

Clearer decisions, consistent governance and stronger assurance.

Initial Group-wide CQC Well-Led action plan

Group model, governance and accountability

Action and delivery	Proposed executive lead(s)	Relationship to existing work
3.1 Group target operating model. Define Group, site and divisional working arrangements, linked to the future merged organisation. Quality Statement (primary / secondary): 5 / 1, 2	Group Deputy CEO, with all executives	**Under way / planned** Initial TOM workshop held. Main design and implementation work remains planned.
3.2 Group Accountability Framework. Refresh the Group Accountability Framework to clarify roles, decisions and escalation for the current Group and the future merged organisation. Quality Statement (primary / secondary): 5 / 1, 2	Group Chief Corporate Affairs Officer	**Under way** Group Accountability Framework refresh already in progress.
3.3 Quality Governance Improvement Plan. Fully implement the Board-agreed plan. Demonstrate effective quality oversight, escalation and improved outcomes. Quality Statement (primary / secondary): 5 / 3	Group Chief Medical Officer and Group Chief Nursing Officer	**Under way** Board-agreed Quality Governance Improvement Plan in implementation.
3.4 Health equity in governance. Use the health equity dashboard to embed access, experience and outcome inequalities systematically in governance, with priorities, owners and impact measures. Quality Statement (primary / secondary): 5 / 4	Group Chief Medical Officer & Site CEOs	**Under way / additional** Health equity dashboard in place. Adds more systematic use within governance.
3.5 People and culture in divisional governance. Embed people, WRES/WDES, recruitment fairness, formal-process and speaking-up metrics in divisional agendas. Quality Statement (primary / secondary): 5 / 2, 3, 4	Site CEOs, with support from Site Directors of People and FTSU Guardian	**Planned / additional** Governance standardisation under way. Explicit people and culture metrics add scope.

Under way = in delivery. Planned = committed. Additional = new or extended scope.

3

A Group model that works in practice.

Make responsibilities and decision-making clear across the Group, with effective oversight of quality, people and delivery.

WHAT SHOULD CHANGE

Clearer decisions, consistent governance and stronger assurance.

Initial Group-wide CQC Well-Led action plan

Group model, governance and accountability

Action and delivery	Proposed executive lead(s)	Relationship to existing work
3.6 Standardise and converge site governance. Align and streamline site governance, reporting and escalation through a distinct site-led programme alongside the TOM, reducing duplication. Quality Statement (primary / secondary): 5 / 1	Site CEOs, with support from Group Chief Corporate Affairs Officer	**Planned / additional** TOM-linked convergence. Streamlining should reduce duplication and release time.
3.7 Executive governance and hosted services. Embed executive and site forums and their oversight of all hosted services, explicitly including procurement. Quality Statement (primary / secondary): 5 / 1	Group Chief Corporate Affairs Officer and Site CEOs	**Under way** Embedding executive governance and oversight of hosted services, including procurement.
3.8 BAF routes to green. Use Risk and Compliance Focused GEC reviews to agree material actions, lower risk and strengthen assurance. Quality Statement (primary / secondary): 5 / -	Group Chief Corporate Affairs Officer and all strategic risk owners	**Under way / planned** Risk improvement and material BAF route-to-green actions are in train or planned.
3.9 Major projects and capital oversight. Major Projects Group: Group CEO chair. Capital Group: Group Deputy CEO chair. Both report to Group Executive Committee. Quality Statement (primary / secondary): 5 / -	Group CEO & Group Deputy CEO	**Under way / planned** Capital and Major Projects oversight arrangements are developing and not yet fully formed.

Under way = in delivery. Planned = committed. Additional = new or extended scope.

Appendix 1:
Overview of CQC Well Led Inspection Findings

Quality Statement 1: CQC findings

1. Shared direction and culture

Quality Statement 1: "We have a shared vision, strategy and culture. This is based on transparency, equity, equality and human rights, diversity and inclusion, engagement, and understanding challenges and the needs of people and our communities in order to meet these."

St George's 2 | ESTH 2

Group-wide synthesis – common findings

- **Established foundations:** A five-year CARE strategy, enabling strategies and formal Board, GEC, BAF and performance oversight are in place.
- **The main gap is deployment:** staff across both Trusts did not consistently understand the vision, values, strategic priorities or their role in delivery.
- **Group integration has been slower than intended:** the shared purpose, practical benefits and common ways of working are not yet consistently clear or experienced.
- **Legacy identities and silo working remain:** local values and Site/divisional cultures can displace the Group narrative and weaken collaboration and shared learning.
- **Board-to-ward alignment is variable:** strategy, local objectives, co-production, risk and improvement activity are not consistently connected at divisional and team level.
- **Activity is not yet impact:** CQC saw multiple culture and strategy initiatives, but limited evidence that they were embedded and changing behaviour consistently.

St George's – Distinct Emphasis

- **Extensive engagement did not secure embedding:** around 2,000 people shaped the strategy, yet staff still described a dual culture and the "St George's way".
- **Values were not consistently lived:** some teams used local values rather than the Trust's values, reinforcing variation in behaviour and identity.
- **CQC received serious cultural accounts:** anonymous contacts described blame, toxicity, unprofessional behaviour, weak accountability and reluctance to challenge.
- **Follow-through was not trusted:** several cultural-change actions and external-review recommendations remained early, ongoing or not yet evidenced.
- **Silo working affected learning:** CQC linked the lack of shared purpose to missed opportunities to collaborate and learn from patient-safety incidents.
- **Professional insight could be diluted:** limited direct engagement between the Chief Pharmacist and the Board was cited as weakening shared understanding and accountability.

Epsom & St Helier – Distinct Emphasis

- **Frontline understanding was weak:** many staff could not explain the strategy, how it affected their area or how they contributed to it.
- **CARE deployment was inconsistent:** CARE Boards, local ownership and translation of priorities into day-to-day practice varied across services and teams.
- **Co-production and line of sight were uneven:** staff involvement in divisional planning and alignment between strategy and improvement were not consistent.
- **Culture varied by Site and team:** staff continued to describe differences between Epsom and St Helier, with variable leadership visibility and local ownership.
- **Workforce insight was not used consistently:** divisional use of EDI and staff-experience data to shape improvement and accountability was variable.
- **Cultural concerns remained material:** staff contacts described discrimination, poor wellbeing, bullying and harassment and fear of reprisal, including in pharmacy and surgery.

Quality Statement 2: CQC findings

2. Capable, compassionate and inclusive leaders

Quality Statement 2: "We have inclusive leaders at all levels who understand the context in which we deliver care, treatment and support and embody the culture and values of their workforce and organisation. They have the skills, knowledge, experience and credibility to lead effectively. They do so with integrity, openness and honesty."

St George's 2 | ESTH 2

Group-wide synthesis – common findings

- **Core capability was generally present:** CQC found most leaders had the skills, knowledge and credibility required and understood quality and sustainability challenges.
- **Experience was inconsistent:** visibility, inclusive behaviour, communication, recognition and follow-through varied between services, divisions and Sites.
- **Capacity and bandwidth mattered:** leaders could identify what needed to change but did not always have the capacity or capability to implement and sustain it.
- **Leadership development was not enough on its own:** programmes existed, but access, uptake, embedding and evidence of impact were uneven.
- **Pipelines and role clarity were weak:** succession planning, talent development and clarity of Group, Site and operational roles needed strengthening.
- **Expected behaviour lacked consistent enforcement:** the reports point to the need for clear standards, measurable impact and timely intervention where leadership falls short.

St George's – Distinct Emphasis

- **Non-inclusive behaviour affected services:** CQC was told that some senior leaders' behaviour undermined culture and the delivery of quality care.
- **Strategic leadership capacity was questioned:** interviews raised concerns about capacity, bandwidth and the ability to lead effectively across the Group model.
- **Communication broke down in places:** service, divisional, Site and Group leadership did not always connect effectively or anchor decisions in strategy and values.
- **Professional voices were not reliably heard:** pharmacy was absent from some safety forums and the Caldicott Guardian lacked formal information routes and Board access.
- **Leadership interventions lacked measures:** coaching and development initiatives were not supported by sufficiently clear success measures or assurance.
- **The staff picture remained mixed:** compassionate leadership had improved over time but remained below the Picker comparator.

Epsom & St Helier – Distinct Emphasis

- **Leadership stability was a material context:** recent changes and interim Executive and Site appointments created discontinuity immediately before and during inspection.
- **Visibility and support varied:** staff experience of leadership, recognition and engagement differed across divisions and protected groups.
- **Operational pressure constrained development:** access to leadership programmes, coaching and staff-engagement capability was not consistent.
- **Succession and pipeline gaps remained:** leaders recognised weaknesses in succession planning, talent management and leadership diversity.
- **Role overlap created complexity:** unclear or inconsistent structures and operational roles reduced accountability and slowed decision-making and delivery.

Quality Statement 3: CQC findings

3. Freedom to speak up

Quality Statement 3: **"We foster a positive culture where people feel that they can speak up and that their voice will be heard."**

St George's 2

ESTH 2

Group-wide synthesis – common findings

- **Formal arrangements were established:** both Trusts had Guardian access, policy, reporting routes and Board/committee oversight.
- **The lived experience remained inconsistent:** staff did not always feel safe, believed, protected from detriment or confident that leaders would act.
- **Response quality was variable:** timeliness, confidentiality, fairness and leadership/HR handling were recurring concerns.
- **Themes were organisational, not just case-related:** management conduct, bullying, harassment, discrimination and inappropriate behaviour featured repeatedly.
- **Learning and feedback were not consistently visible:** staff could not always see how speaking up produced change and recurring themes were not fully gripped.
- **Stronger intelligence and accountability are needed:** FTSU, ER, workforce, patient-safety and external concerns need systematic triangulation, ownership and escalation.

St George's – Distinct Emphasis

- **Fear of retribution was explicit:** CQC received 23 contacts from staff afraid to raise safety concerns, with some reporting anonymously or externally.
- **Confidentiality and senior accountability were questioned:** staff described leaders as blocking issues or influencing decisions and feared not being believed.
- **Race and gender affected voice:** contacts described racism, bullying, harassment and barriers to being heard for BME staff and others.
- **The seriousness was initially underestimated:** CQC was concerned leaders focused on the small proportion raising externally rather than the underlying risk.
- **Structures had strengthened:** a Group Guardian and four deputies, training, an oversight/ triangulation group and regular reporting in place.
- **The evidence still showed limited cultural improvement:** bullying, inappropriate behaviour, worker safety and patient safety remained prominent concern themes.

Epsom & St Helier – Distinct Emphasis

- **A visible service was a strength:** CQC recognised an accessible Guardian, multiple routes, standard triage and clear Board oversight.
- **Concern themes were recurring:** 85 concerns in Q3/Q4 included management conduct, bullying and harassment, HR issues, confidentiality, delay and perceived unfairness.
- **Some concerns led to change:** water safety, interstitial lung disease and acute medicine generated mitigations, reviews or targeted programmes.
- **Response was not consistently timely or trusted:** the ILD response was initially slow and staff described variable HR investigations and missed policy timescales.
- **Confidence remained below benchmark:** divisional variation, concerns about detriment and low confidence that concerns would be acted on.
- **Service resilience was fragile:** CQC identified strong reliance on one individual and a potential single point of failure.

Quality Statement 4: CQC findings

4. Workforce equality, diversity and inclusion

Quality Statement 4: "We value diversity in our workforce. We work towards an inclusive and fair culture by improving equality and equity for people who work for us."

St George's 1 | ESTH 2

Group-wide synthesis – common findings

- **The infrastructure exists:** EDI plans, WRES/WDES reporting, training, networks, executive sponsorship and talent initiatives are in place.
- **Outcomes remain unequal:** both reports found persistent disparities in recruitment, progression, senior representation, discipline/capability and day-to-day experience.
- **Staff experience does not match stated ambition:** bullying, harassment, discrimination, racism and perceived structural unfairness remained evident.
- **Disability inequality is material:** disabled staff reported poorer progression, feeling valued, reasonable-adjustment and bullying/harassment experiences.
- **Interventions are not yet consistently effective:** activity is unevenly embedded and there is limited evidence of sustained improvement at Trust, division or hotspot level.
- **The safety connection is underdeveloped:** workforce inequality is not routinely triangulated with patient safety and service outcomes to target action and assurance.

St George's – Distinct Emphasis

- **CQC rated this inadequate and linked it to Regulation 17:** leaders had not fully recognised the impact of workforce inequality on service delivery and patient safety.
- **Structural disparities were extensive:** BME staff were over-represented in lower bands and under-represented in Band 8b+, VSM, Executive and Board roles.
- **Experience gaps were pronounced:** BME staff reported worse discrimination, bullying and career progression than white colleagues and national BME comparators.
- **Disabled staff faced multiple disadvantages:** recruitment, capability, bullying by managers, progression and feeling valued all showed significant gaps.
- **Mechanisms lacked impact:** anti-bullying actions and staff networks were not consistently effective; sponsor involvement and protected time varied.
- **There was progress but not transformation:** eight of ten WRES indicators improved and reasonable adjustments improved, yet major inequalities and a fragile ER function remained.

Epsom & St Helier – Distinct Emphasis

- **Representation remained weak at senior levels:** only a small proportion of non-clinical VSM posts were held by BME staff and Board composition did not reflect workforce or community.
- **Recruitment and formal-process disparities persisted:** white applicants were more likely to be appointed and BME staff were more likely to enter disciplinary processes.
- **BME experience remained poorer:** discrimination, career progression and workplace treatment continued to lag despite some improvement.
- **Disabled staff reported worse treatment:** harassment by managers, feeling valued, progression, pressure to work when unwell and reasonable-adjustment outcomes remained concerns.
- **Embedding varied:** maternity and other targeted areas showed positive practice, but divisional ownership, capacity and engagement were inconsistent.
- **Current initiatives had not yet shifted outcomes:** the EDI plan, networks and Inclusion Board were positive foundations but measurable organisation-wide impact was still limited.

Quality Statement 5: CQC findings

5. Governance, management and sustainability

Quality Statement 5: "We have clear responsibilities, roles, systems of accountability and good governance. We use these to manage and deliver good quality, sustainable care, treatment and support. We act on the best information about risk, performance and outcomes, and we share this securely with others when appropriate."

St George's 1

ESTH 2

Group-wide synthesis – common findings

- **The architecture exists:** Group Board and Committees-in-Common, GEC, Site leadership, GAF, BAF, IQPR, risk systems, audit and performance oversight are established.
- **The weakness is how the system operates:** Group, Site, divisional and service governance did not always interact effectively or provide clear decision rights and escalation.
- **Known quality risks did not always trigger timely action:** the reports identified delays between recognising safety concerns, agreeing mitigation and demonstrating that action reduced harm.
- **Assurance was not consistently reliable:** limited assurance, control gaps, off-track actions and weak evidence of effectiveness reduced confidence available to the Board.
- **Local application varied:** data use, escalation, risk articulation, process consistency and governance maturity differed between divisions and Sites.
- **The Group model remains unfinished in practice:** structural differences, overlapping roles and inconsistent interfaces create complexity, duplication and missed opportunities.

St George's – Distinct Emphasis

- **CQC issued a Regulation 17 requirement:** governance and management functionality had not reliably protected people from avoidable harm.
- **Known service risks were not addressed with sufficient pace:** maternity, surgery and emergency-care concerns had been visible through inspections, incidents and risk systems.
- **Group–Site disconnect weakened accountability:** unclear roles and escalation affected pace, Board assurance and the response to known risks.
- **The BAF showed substantial assurance gaps:** 11 of 14 strategic risks were rated limited assurance in January 2025.
- **Risk mitigation was sometimes late:** the full-capacity protocol for emergency overcrowding was only embedded after staff escalated externally.
- **Information and professional governance also failed in places:** CQC highlighted information-governance weaknesses and gaps in pharmacy and Caldicott involvement, despite strong finance, performance and EPRR arrangements.

Epsom & St Helier – Distinct Emphasis

- **Corporate systems were comparatively well defined:** IQPR, audit, financial controls, BAF, GAF and committee structures provided a sound formal framework.
- **Structures were not aligned across the Group:** different ESTH arrangements and overlapping roles reduced clarity of accountability and decision-making.
- **Group–Site interaction did not always secure timely mitigation:** previously identified maternity, surgery and emergency-care risks were not consistently addressed at pace.
- **Assurance remained limited in key areas:** patient safety, staff experience, inclusive culture and workforce development had control gaps and some off-track actions.
- **Divisional practice varied:** risk identification, articulation, escalation and use of data were not consistently applied at service and team level.
- **ESTH also carried material local dependencies:** estate condition, EPR/digital usability, community digital barriers and regulatory segment 3 required sustained management attention.

Quality Statement 6: CQC findings

6. Partnerships and communities

Quality Statement 6: "We understand our duty to collaborate and work in partnership, so our services work seamlessly for people. We share information and learning with partners and collaborate for improvement."

St George's 3

ESTH 3

Group-wide synthesis – common findings

- **This is a shared strength:** both Trusts were rated good and CQC found collaboration embedded in strategy and leadership practice.
- **Partnerships deliver measurable benefit:** examples included elective orthopaedics, theatres, urology, frailty, virtual wards, admission avoidance and mental-health pathways.
- **The Group model has begun to add value:** better use of capacity, selected pathway integration and corporate efficiencies were recognised.
- **External relationships are broad and mature:** acute, community, primary care, local authority, VCSE, academic and clinical-network partners were actively engaged.
- **The remaining issue is consistency and scale:** benefits of Group and system working are not yet realised evenly across services, Sites or places.
- **Partnership activity needs a clearer benefit framework:** outcomes, co-production, accountability and learning should be more consistently connected to Group priorities.

St George's – Distinct Emphasis

- **Patient partnership was visible:** the Patient Partnership and Experience Group had direct Executive access and influenced improvement.
- **Acute-provider collaboration was strong:** the elective orthopaedic centre delivered shorter lengths of stay and greater capacity.
- **Group collaboration showed early benefits:** CQC cited theatres, urology and administrative efficiencies.
- **Local partnerships supported community pathways:** work with Wandsworth, Merton, primary care, mental health and VCSE partners included frailty and mental-health care.
- **System information was shared openly:** leaders and staff worked with partners on challenges beyond the hospital's direct control.
- **The full Group benefit was not yet realised:** positive examples existed, but integration was not consistently scaled or visible.

Epsom & St Helier – Distinct Emphasis

- **Community partnerships were a particular strength:** Surrey Downs Health and Care and Sutton Health and Care supported integrated acute, community and primary-care delivery.
- **Outcomes were tangible:** virtual wards, frailty MDTs and neighbourhood working reduced discharge delay, emergency attendance, non-elective admission and waits.
- **The Trust was active in the Acute Provider Collaborative:** elective orthopaedics and joint pathways improved flow and capacity.
- **Clinical, operational and academic networks supported learning:** specialist knowledge, workforce development and pathway redesign were shared.
- **Integration was still uneven:** joint transformation in outpatients and non-elective care needed strengthening across acute, community and tertiary services.
- **Place relationships varied:** financial pressures and differing London/Surrey commissioning arrangements affected attention and maturity of some ICB relationships.

Quality Statement 7: CQC findings

7. Learning, improvement and innovation

Quality Statement 7: "We focus on continuous learning, innovation and improvement across our organisation and the local system. We encourage creative ways of delivering equality of experience, outcome and quality of life for people. We actively contribute to safe, effective practice and research."

St George's 3

ESTH 3

Group-wide synthesis – common findings

- **There is substantial strength and infrastructure:** both Trusts were rated good, with established learning systems, improvement capability, research and innovation.
- **Incident learning mechanisms are in place:** PSIRF, clinical audit, mortality review, DIRGs, simulation and human-factors approaches provide multiple routes to learn.
- **Improvement is increasingly structured:** QMS, High Performing Wards/Teams, CI pathways, huddles and capability programmes are connecting strategy and daily work.
- **Research and innovation are organisational assets:** academic partnerships, clinical trials, digital innovation and specialist networks support evidence-based care.
- **Embedding is inconsistent:** learning, feedback, data literacy and improvement capability vary across teams and areas with known safety concerns.
- **Operational pressure limits participation:** protected time, workforce capacity, co-production and alignment between improvement, research and innovation remain uneven.

St George's – Distinct Emphasis

- **Research and innovation were prominent strengths:** CQC cited more than 300 trials, research champions, multidisciplinary participation and academic relationships.
- **Visible innovations had impact:** SMART theatres and the Site control room improved efficiency, energy use, flow and access to information.
- **Accreditation and networks supported learning:** major trauma, ward accreditation, JAG, ACSA and other external schemes were positive.
- **DIRGs were open and multidisciplinary:** but CQC was not assured that learning was consistently embedded in maternity, surgery and emergency care.
- **Quality and improvement capacity had increased:** the Quality and Safety Strategy and High Performing Teams approach were developing.
- **A specific function was ineffective:** CQC received information that the Fundamentals of Care team was not achieving expected outcomes.

Epsom & St Helier – Distinct Emphasis

- **QMS and improvement routines were developing:** CI pathways, High Performing Wards, CARE Boards and daily huddles supported operational improvement.
- **Learning systems were established:** Datix, PSIRF, clinical audit, mortality review and monthly DIRGs generated themes and divisional safety plans.
- **Learning led to practical change:** simulation and human factors altered equipment, pathways and workforce models.
- **Research and academic partnerships were active:** national programmes and wider-system relationships supported evidence-based practice.
- **Visibility and maturity varied:** some teams could demonstrate change while others could not see feedback or use data confidently for improvement.
- **Capacity and alignment gaps remained:** research nursing, medical job planning, community participation, co-production and connection between research and improvement were uneven.

Quality Statement 8: CQC findings

8. Environmental sustainability

Quality Statement 8: "We understand any negative impact of our activities on the environment and we strive to make a positive contribution in reducing it and support people to do the same."

St George's 3

ESTH 3

Group-wide synthesis – common findings

- **This is a shared strength:** both Trusts were rated good and CQC found clear leadership commitment, strategy and practical delivery.
- **A common framework exists:** the Group Green Plan, Infrastructure Committee oversight, dedicated expertise and developing scorecards support delivery.
- **Operational change is visible:** SMART theatres, LED lighting, anaesthetic-gas reduction, waste, procurement and pathway initiatives were cited.
- **Sustainability is connecting to improvement:** SusQI, clinical workshops, transformation and quality-improvement approaches are increasingly used.
- **Embedding remains variable:** divisional engagement and integration into routine service planning and clinical decisions are not consistent.
- **Impact evidence needs strengthening:** carbon, cost, clinical outcomes and resilience are not yet measured consistently at service and divisional level.

St George's – Distinct Emphasis

- **There is a long-standing record of action:** CQC referenced external recognition, the Green Plan and decarbonisation strategy.
- **SMART theatres demonstrated tangible benefit:** the initiative reduced energy use and linked innovation with sustainability.
- **LED installation was a major delivery programme:** the Trust was progressing estate-wide energy-efficiency improvements.
- **A Net Zero roadmap was in place:** the estates decarbonisation strategy provided a strategic route to longer-term targets.
- **The remaining CQC emphasis was measurement:** a KPI scorecard was still being developed to improve data and assurance.

Epsom & St Helier – Distinct Emphasis

- **Governance and infrastructure were well developed:** a refreshed Green Plan, Infrastructure Committee, Green Plan team, champions, training and scorecard were in place.
- **Clinical and operational actions were broad:** high-carbon gases, pathways, energy, procurement and waste initiatives demonstrated delivery.
- **Sustainability was entering wider planning:** the Green Plan was linked to the MTP, transformation and a Climate Change Risk Assessment.
- **Clinical engagement varied:** workshops and sustainability initiatives were not consistently taken up across all divisions.
- **Operational pressure constrained participation:** staff capacity affected involvement in sustainability activity.
- **Measurement and strategic integration were incomplete:** carbon, cost and care impact, preventative healthcare and clinical-strategy integration remained early or inconsistent.

Group Board

Meeting in Public on Friday, 06 November 2026

Agenda Item	2.2	
Report Title	**Group Research and Innovation Strategy**	
Executive Lead(s)	Richard Jennings, Group Chief Medical Officer	
Report Author(s)	Heather Jarman, Group Director for Research and Innovation	
Previously considered by	Group Executive Committee Group Board Strategy and Development Session	29 September 2026 1 October 2026
Purpose	**For Approval / Decision**	

Executive Summary

The Research and Innovation Strategy 2026-2031 sets out how we will build on our existing strengths and increase the impact of research and innovation across the Group over the next five years.

Research and innovation are critical to improving outcomes for patients, reducing health inequalities, supporting service transformation and attracting and retaining research active staff. We already have a strong track record, with over 12,800 participants taking part in research during 2025/26 and more than £10.3m in research income. The strategy provides a clear direction for how we will grow this further, ensuring more patients have the opportunity to participate in research, more staff are supported to lead and deliver research, and research and innovation make a greater contribution to improving care and reducing health inequalities.

The strategy has been developed with input from patients, public contributors, staff and partners, including feedback from more than 600 colleagues. It aligns with the Group CARE Strategy and national priorities for research, innovation and NHS transformation.

The strategy is organised around six themes:

- Building on our areas of research strength
- Focusing research on the needs of our local population
- Developing the research and innovation workforce
- Strengthening partnerships across the NHS, academia and industry
- Making the most of digital opportunities
- Growing a sustainable and high-performing research portfolio

Subject to approval, a phased implementation and delivery plan will be developed and brought to Group Executive Committee for approval, with clear priorities, milestones and outcomes.

Action required by Group Board
The Board is asked to: a. Approve the Research and Innovation Strategy 2026-2031 b. Endorse the strategic direction set out in the strategy, including the commitment to expanding research and innovation across community services c. Support the development of a detailed implementation and delivery plan, including priorities, milestones, outcome measures and resource requirements d. Note that the implementation and delivery plan will be presented to Group Executive Committee for separate approval e. Champion the delivery of the strategy and promote research and innovation as a means of improving patient outcomes, reducing health inequalities and increasing opportunities for patients and staff to participate in research

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

Appendix No.	Appendix Name
Appendix 1	Group Research and Innovation Strategy

Implications

Group Strategic Objectives

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

Risks

Failure to maintain and grow research activity will impact our ability to attract and retain high-quality clinical, academic and research staff, reducing future research capacity and capability

Failure to deliver the strategy may reduce opportunities to improve patient outcomes, embed evidence-based practice and use research and innovation to support service transformation

There is a risk that research activity remains concentrated within a limited number of specialties and professions, resulting in unequal access to research opportunities for patients and staff across the Group

There is a financial risk that external research funding, commercial research income and investment in research infrastructure may reduce if the organisation does not continue to develop its research portfolio, partnerships and delivery capability

Failure to maintain a strong research environment will reduce opportunities to participate in commercial research and clinical trials, potentially resulting in a loss of income, investment and wider economic benefits to the organisation

Failure to deliver the strategy will limit our ability to strengthen partnerships with universities, industry and NHS organisations, reducing opportunities for collaboration, innovation and future growth

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 strategy will be delivered largely through existing research infrastructure funding, research grants and external income.

Some areas of delivery may require additional investment over the lifetime of the strategy. Where this is needed, this will be brought forward through separate business cases and existing approval routes.

Successful delivery of the strategy is expected to increase external funding opportunities, strengthen research infrastructure and support long-term sustainability of research activity.

Legal and / or Regulatory implications

All research activity will continue to be undertaken in line with relevant legislation, Health Research Authority requirements, research governance frameworks and national standards relating to research conduct, sponsorship and delivery.

The strategy supports compliance with national policy expectations regarding NHS participation in research and innovation.

Equality, diversity and inclusion implications

The strategy aims to increase access to research opportunities for patients and communities who have traditionally been underrepresented in research.

Delivery will include a focus on reducing inequalities in research participation, widening access across professions and ensuring that research opportunities are accessible across our diverse populations.

Environmental sustainability implications

The strategy is not expected to have any significant negative environmental impact.

The Group Research and Innovation Strategy
Group Board, 06 November 2026

1.0 Purpose of paper

1.1 To seek approval of the Research and Innovation Strategy 2026-2031.

1.2 The paper also seeks support for the development of a detailed implementation and delivery plan, which will be presented to Group Executive Committee for approval

2.0 Background

2.1 Research and innovation play an important role in improving patient outcomes and quality of care, supporting workforce development and enabling organisational transformation.

2.2 Research activity provides opportunities for patients to access new treatments and interventions, supports the generation of evidence to improve services and helps attract and retain high-quality staff.

2.3 The group has a strong track record of research delivery, supported by significant external funding, strong academic partnerships and increasing participation in research activity across a range of services and professions.

2.3 The formation of the gesh group has created opportunities to further strengthen our research and innovation capability by bringing together complementary research expertise, infrastructure and partnerships.

2.4 The strategy has been developed through extensive engagement with patients, public contributors, staff and partners and aligns with national and local priorities for research, innovation and improving population health.

2.5 The purpose of the Research and Innovation Strategy 2026-2031 is to provide a clear, shared direction for research and innovation across the Group, ensuring activity is focused on areas of greatest impact, supports delivery of organisational priorities and creates the foundations for sustainable growth over the next five years

3.0 Key issues for consideration

3.1 The strategy sets out a five-year framework for the development of research and innovation across the Group.

3.2 The strategy is organised around six strategic themes focused on research excellence, population need, workforce development, partnerships, digital innovation and sustainability.

3.3 Delivery of the strategy will integrate research and innovation into the clinical services and increase opportunities for patients to participate in research.

3.4 A key priority within the strategy is to increase research and innovation activity beyond traditional acute hospital settings and into community services. This reflects growing national expectations around prevention, population health and care closer to home.

3.5 Following approval of the strategy, a detailed implementation and delivery plan will be developed and presented to Group Executive Committee. This will include delivery priorities, milestones, outcome measures and investment needs for implementation.

4.0 Sources of assurance

4.1 The strategy has been informed by extensive stakeholder engagement, including patients, public contributors, staff and external partners overseen by a Steering Committee.

4.2 The strategy has been developed in line with national health and research policy, and organisational priorities.

5.0 Recommendations

5.1 The Committee is asked to:

f. Approve the Research and Innovation Strategy 2026-2031
g. Endorse the strategic direction set out in the strategy, including the commitment to expanding research and innovation across community services
h. Support the development of a detailed implementation and delivery plan, including priorities, milestones, outcome measures and resource requirements
i. Note that the implementation and delivery plan will be presented to Group Executive Committee for separate approval
j. Champion the delivery of the strategy and promote research and innovation as a means of improving patient outcomes, reducing health inequalities and increasing opportunities for patients and staff to participate in research

gesh

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

The Group Research and Innovation (R&I) strategy 2026 - 2031

"Making Research Everyone's Business"

Professor Heather Jarman | Group Director for Research and Innovation

Group Board | November 2026

Executive summary

Research and innovation are already significant organisational strengths. During 2025/26, more than 12,800 patients participated in research studies and research income exceeded £10.3 million. gesh has strong academic partnerships, an NIHR-funded Clinical Research Facility, the Translational and Clinical Research Institute (TACRI), and a growing clinical academic workforce. The NHS 'three shifts' need new evidence, innovation and evaluation with gesh being uniquely positioned to support this through clinical, academic and research strengths.

The merger, combined with the increasing emphasis on research, innovation, digital transformation and prevention within the NHS, provides a unique opportunity to strengthen the role that research and innovation play in improving patient outcomes, supporting transformation and attracting external investment. However, research activity is not yet consistently embedded across the organisation, participation remains variable between services and professions, and achieving future ambitions will require choices about organisational priorities and investment.

The strategy has been developed following extensive engagement with patients, partners and colleagues, including more than 600 staff responses, and aligns with the ambitions set out within the Group CARE Strategy and the NHS 10-Year Plan.

The strategy sets out an ambition that by 2031 gesh will be recognised as a leading centre for research and innovation, where research is visible, valued and embedded in everyday practice.

Six strategic themes underpin delivery of this ambition:

- Building on areas of clinical and academic strength;
- Leading research aligned to local population health needs;
- Developing a skilled and supported research and innovation workforce;
- Enhancing academic, commercial and system partnerships;
- Maximising digitally enabled research and innovation; and
- Creating a high-performing, financially sustainable research portfolio

Together, these priorities will support improved patient outcomes, reduced health inequalities, increased external funding and a stronger reputation for research excellence.

Questions for the Board:

- Approve the Research & Innovation Strategy.
- Endorse the proposed implementation priorities for Years 1-2
- Support research and innovation as a core pillar of organisational strategy and transformation
- Champion delivery of the strategy within their respective areas of responsibility

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Why research and innovation matters



Positive patient impact

Research-active trusts delivering clinical research trials and studies have better patient outcomes

Patients value the opportunity to participate in research studies and trials as part of their care

Greater access to research opportunities improves equity and inclusion



Stronger workforce

Research and innovation-active organisations attract and retain talented staff

Research and innovation opportunities improve job satisfaction, career development and leadership capability

Nationally, the clinical academic workforce is declining, creating a need for investment in capacity and capability



Organisational benefits

Research provides a route for evaluating and implementing innovative technologies, treatments and models of care

Research and innovation attracts external funding and infrastructure investment

Research and innovation strengthe
ns
organisational reputation and influence

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The Research and Innovation Directorate

The Research & Innovation Directorate is a group-wide function responsible for supporting research delivery, research governance, innovation development and external funding opportunities across the Group. It sits under the responsibility of the Group Chief Medical Officer and is led by the Group Director for Research and Innovation. Together, these functions enable patients to access research opportunities, support staff to develop as researchers, and generate the income and capability needed to grow research across the Group.

Joint Clinical Research Office (JCRO): providing integrated support for research funding, governance, study delivery, contracts, innovation support and research finance across the Group. There are JCRO offices at both St George's and St Helier with remote support available to all other sites.

Dedicated facilities for clinical research: St George's: a purpose-built NIHR-accredited Clinical Research Facility offering clinic room and a research laboratory supporting early-phase and complex studies.

St Helier: a dedicated Trials Unit supporting the delivery of commercial and non-commercial research studies.

Translational and Clinical Research Institute (TACRI): supports clinical academic development, research capacity building and collaboration across clinical and academic partners. TACRI provides fellowships, mentorship and research support to help staff develop as researchers.

Research skills support and development for health and care professions (HCPs): training, mentorship and supervision to increase research capability of nurses, midwives, AHPs, and pharmacists is led by a Group Director for Health and Care Professions. It includes bespoke department level training and HCP specific training schemes.

Research delivery workforce: our research delivery workforce is made up of nurses, midwives, practitioners and research assistants. They are responsible for the recruitment, care and monitoring of patients taking part in research.

Research Engagement and Inclusion: making research visible and accessible to patients, communities and colleagues, and widening participation among under-represented groups is key to our ambitions. This work is led by a Research Engagement and Inclusion Lead working across all sites.

Research funding * : research is funded through a mix of national research funding, grants and income from commercial studies. National funding helps maintain the staff and systems needed to run research, while commercial studies sponsored by healthcare and pharmaceutical companies provide additional income. This income is reinvested to support protected research capacity, including in TACRI, research staff and facilities.

*see appendix for further detail

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Across gesh Research and Innovation is a significant and growing organisational asset

Over 12,800 patients recruited into research studies across the Group in 2025/26 (George's recruited 10,541participants and ESTH 2,322)

Track record of funding for career development awards for research (Integrated academic training and NIHR fellowships)

Total research income of £10.3m in 25/26, with continued year-on-year growth

Strong examples of clinician innovation examples: Patientcheck.in, AVT, smartphone vital sign measurement study in ED

Our Clinical Research Facility (CRF) supports early-phase and experimental medicine including a growing number of complex commercial and academic trials

Established partnership working with City St George's University including joint Clinical Academic Groups

TACRI supports clinical staff to develop as independent researchers. During 2025/6 TACRI supported 15 multi-professional research fellows with awards totalling more than £270,000.

Shared EPR & strong Business Intelligence and data teams including experience in robotic process automation and agentic AI, developed Operations Command Centre at St George's

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Why now? A strategic opportunity for gesh

A unique opportunity for gesh	The formation of gesh brings together two research-active organisations, creating the scale, population reach, clinical breadth and academic partnerships needed to compete for major research funding, infrastructure and national leadership opportunities. With both organisations merging, we have the opportunity to achieve more than either organisation could individually.
National policy and system direction	At the same time, the NHS 10-Year Plan sets out a clear direction for the future of healthcare, with a shift: • From hospital to community-based care • From analogue to digital delivery • From treatment to prevention Greater use of data, AI, genomics and digital innovation to improve outcomes and productivity
Our operating environment	gesh is also entering a period of significant organisational transformation. To meet future challenges we will need to redesign services, improve productivity, adopt new technologies and deliver care differently. Research and innovation provide the mechanism to test, evaluate and implement these changes safely and effectively, ensuring transformation is evidence-based rather than assumption-led.
Our key partners	Following the merger of City and St George's universities, gesh now has an academic partner with significantly greater scale and capability. A jointly commissioned review identified opportunities for deeper collaboration across research, education and innovation, including the potential development of an Academic Health Science System. A joint partnership group has been established to take these opportunities forward and develop a shared programme of work.

Together these create an opportunity to:

- **Position gesh as the leading research and innovation organisation in Southwest London**
- **Embed research, innovation and evaluation within major transformation programmes**
- **Accelerate the adoption of digital technologies, AI and new models of care**
- **Strengthen partnerships with City St George's, industry and system partners**
- **Increase external funding and investment to support organisational priorities**
- **Improve outcomes, experience and equity for the populations we serve**

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What does good look like? A connected NHS / academic health sciences 'system'



Developing the strategy: themes in feedback from stakeholders

- Strategy developed in partnership with patients, public, staff and system partners
  - 600 staff completed survey and/or commented on drafts of the strategy and the importance of the priorities
  - Patient engagement events, newsletters and comments form

Theme 1: research is valued rhetorically but deprioritised operationally	Theme 2: time and workload are the biggest barriers	Theme 3: inequity of opportunities between sites, professions and role
• Colleagues consistently describe a gap between stated commitment to research and the operational reality of clinical services, job planning, and management priorities	• Lack of time and overwhelming workload emerge as the single most consistently reported barrier to engagement in research, cutting across profession, seniority, and setting • Colleagues describe this as the direct consequence of service pressure, staffing shortages, and competing priorities. • Research is 'crowded out' by clinical and operational demands	• Community and ESTH staff report lower visibility, fewer opportunities, and weaker research culture • Doctors generally have clearer, legitimised routes into research • Nurses, AHPs, scientists and pharmacists rely on goodwill or exceptional arrangements

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Strategy for 2031

Vision

We will be a leading centre for research and innovation, improving health and care through research, evidence and innovation

Our mission is:
To make gesh a place where research and innovation are visible, valued and embedded in everyday practice, and where colleagues have the time, skills and support to generate, apply and implement evidence that improves care

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Emerging strategy themes and objectives

Our mission

To make gesh a place where research and innovation are visible, valued and embedded in everyday practice, and where colleagues have the time, skills and support to generate, apply and implement evidence that improves care

Our objectives

- Create a culture where research is a visible and valued part of core gesh business
- Expand access to research for under-represented groups and communities
- Increase patient and public involvement in shaping and delivering research
- Grow external research funding and support new income streams
- Increase the number of clinical academics and research-active colleagues
- Reduce unwarranted variation in access to research opportunities for colleagues
- Expand access to research opportunities closer to home
- Strengthen digital, data and innovation capability

Our themes

Building on our areas of strength and reputation
Our clinical and academic strengths will help us focus investment, attract funding and reputation, and deliver greater impact through research and innovation

Enhancing academic, clinical and system partnerships
We will build strong partnerships with academic, industry and system partners to expand opportunities, capability and impact

Developing a skilled and supported research and innovation workforce
Every colleague will have the opportunity to engage with research or innovation at a level appropriate to their role, interests and career stage, with the right support and recognition

Maximising opportunities for digitally-enabled research and innovation
We will use data, digital technologies and innovation to improve research delivery, participation, evaluation and impact

Leading research aligned with local health needs
Research and innovation priorities will be shaped by what matters most to patients and communities, helping improve outcomes and reduce health inequalities

Building a high performing and financially sustainable research portfolio
We will develop a high-quality and sustainable research portfolio that supports growth

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Building on our areas of strength and reputation

The theme

What are we known for and where will we lead?

The key question this theme helps us to answer

Where we are now

Our current position, strengths and challenges

gesh has established strengths in a number of research areas, with a track record of attracting funding, delivering high-quality studies and developing strong academic partnerships. However, activity remains concentrated in a limited number of areas and we have an opportunity to build greater scale and impact from our existing strengths.

Our ambition

What we want to achieve by 2031

To be recognised for excellence in our priority research areas, developing nationally recognised programmes that improve patient care, attract investment, and create opportunities for staff and patients.

What this means strategically

What we need to do to achieve our ambition

- We will identify and invest in priority areas of research and innovation where we have established clinical, academic and translational strengths, and where there is the greatest opportunity to improve outcomes, attract funding and build international reputation
- We will pursue major research infrastructure opportunities, including NIHR funding and national research partnerships, to strengthen capability in our priority areas
- We will strengthen and expand Clinical Academic Groups and Research Groups as a mechanism for aligning clinical priorities, research activity and innovation adoption across gesh, ensuring participation from all professional groups

What success will look like

How will we know we have made progress

- Increased national recognition in our priority research areas
- Growth in major research grants and infrastructure funding
- More patients benefiting from research and innovation
- Stronger academic and industry partnerships

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Building on our areas of strength and reputation

What are we known for and where will we lead?

Where we are now

gesh has established strengths in a number of research areas, with a track record of attracting funding, delivering high-quality studies and developing strong academic partnerships. However, activity remains concentrated in a limited number of specialties and we have an opportunity to build greater scale and impact from our existing strengths.

Our ambition

To be recognised for excellence in our chosen priority research areas, developing nationally recognised programmes that improve patient care, attract investment, and create opportunities for staff and patients.

What this means strategically

- We will identify and invest in priority areas of research and innovation where we have established clinical, academic and translational strengths, and where there is the greatest opportunity to improve outcomes, attract funding and build international reputation
- We will pursue major research infrastructure opportunities, including NIHR funding and national research partnerships, to strengthen capability in our priority areas
- We will strengthen and expand Clinical Academic Groups and Research Groups as a mechanism for aligning clinical priorities, research activity and innovation adoption across gesh, ensuring participation from all professional groups

What success will look like

- Increased international and national recognition in our priority research areas
- Growth in major research grants and infrastructure funding
- More patients benefiting from research and innovation
- Stronger academic and industry partnerships

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Enhancing academic, industry and system partnerships

Who will we work with to achieve more than we can alone?

Where we are now

We have strong partnerships with City St George's, regional research organisations and other stakeholders, providing opportunities for collaboration. There is an opportunity to build on these relationships and develop a more coordinated and strategic approach.

Our ambition

To be the partner of choice for collaborative research and innovation, working across organisational boundaries to deliver greater impact for patients and communities.

What this means strategically

- We will working with other organisations to establish a hub for research governance, approvals and research support across Southwest London, providing shared expertise and streamlined processes for partners wishing to undertake research
- We will develop place-based research partnerships across acute, community, primary care and mental health settings to support research delivery
- Partnerships will be used to attract funding, build capability and increase research opportunities that could not be delivered by gesh alone
- We will strengthen collaboration with City St George's to align clinical priorities, research and education and support joint approaches to funding, workforce and infrastructure
- We will expand regional partnerships with academic institutions, industry, primary care, community organisations and system partners
- We will take a proactive approach to developing commercial and innovation partnerships that create mutual value

What success will look like

- Increased collaborative research programmes, infrastructure investment and funding applications
- Leading and delivering research and innovation across the wider system, including community settings
- Enhanced reputation as a trusted partner for academic, commercial and industry research and innovation

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Leading research aligned to local health need

What problems matter most to our population and how will research help address them?

Where we are now

We have a broad and growing research portfolio, with activity across a range of clinical specialties. However, there is an opportunity to strengthen the link between our research activity, population health needs and organisational priorities.

Our ambition

To lead a research portfolio that is closely aligned to local health need, supports improvements in outcomes and experience, and helps address health inequalities across our communities.

What this means strategically

- We will seek to establish a Community Research Hub as the focal point for research delivered in community, primary care and neighbourhood settings, bringing research closer to home and improving participation among underserved communities
- We will align research priorities with population health data, clinical outcomes and patient and community insight
- We will develop and evaluate innovative models of care, including remote monitoring, wearable technologies, virtual care and community-based approaches, helping to improve access, prevention and management of long-term conditions

What success will look like

- Establishment of a community research hub as the focal point for research delivered in community, primary care and neighbourhood settings
- Increased participation from underserved communities and evidence of research contributing to improved outcomes and reduced inequalities
- Stronger patient and public involvement in setting research priorities

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Developing a skilled and supported research and innovation workforce

Who will do research and how will we support them?

Where we are now

We have committed and talented colleagues involved in research across a range of professions, and established training and support mechanisms through the Translational and Clinical Research Institute . However, opportunities to engage in research are not always visible or accessible, and participation varies across professional groups and services.

Our ambition

To create an inclusive culture where colleagues can contribute to research and innovation, supported by clear development pathways, protected opportunities and strong leadership.

What this means strategically

- We will develop clear and inclusive research career pathways across professions and career stages, ensuring that opportunities to engage in research are accessible to all colleagues
- We will expand the capacity and reach of TACRI and strengthten clinical academic training in collaboration with City St George's
- We will increase the number and diversity of clinical academics across professions, building capacity and leadership across the organisation
- We will strengthen access to research training, mentorship and supervision, and create a more consistent approach to protected research time through job planning, appraisal and career development

What success will look like

- More staff actively participating in research and innovation and growth in clinical academic careers across all professions
- Increased fellowship, grant and award success
- Greater visibility of research and innovation opportunities
- Research and innovation recognised as a core part of professional development

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Maximising opportunities for digitally-enabled research and innovation

How will data, technology and innovation enable us to do research better?

Where we are now

Digital technologies, data and analytics already support some aspects of research delivery. However, there is significant opportunity to make better use of digital tools to improve participation, support data analytics and efficiency in study set-up.

Our ambition

To use digital technologies, data and innovation to make research more accessible, more efficient and more responsive to the needs of patients and services.

What this means strategically

- We will use digital systems to embed research within routine care through consent-to-contact approaches and other digitally enabled recruitment methods
- We will develop an interface to provide secure access to research-ready data, advanced analytics and linked datasets to support clinical and population health research
- We will introduce a research performance dashboard that provides real-time visibility of recruitment, study delivery, income and portfolio performance to support decision-making and accountability
- We will establish clearer pathways for the evaluation, adoption, spread and measurement of evidence-based innovations across the Group
- We will create more opportunities for our staff to develop and implement digital innovations and for external innovators to work with us

What success will look like

- Patients can access research opportunities more easily through digital, remote and community-based participation models
- Researchers can routinely access secure, research-ready data to support research and innovation
- Evidence-based innovations are adopted more consistently across services

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Building a high-performing and financially sustainable research portfolio

How will we build and sustain research activity over time?

Where we are now

Our research portfolio delivers significant benefits for patients, staff and the organisation, supported by external funding and successful partnerships. As competition for funding increases, there is a need to strengthen sustainability and maximise opportunities for future growth.

Our ambition

To develop a high-performing, diverse and financially sustainable research portfolio that delivers impact for patients while attracting investment and supporting long-term growth.

What this means strategically

- We will grow a balanced portfolio of commercial and non-commercial research, focusing on areas of clinical strength, population need and opportunities for external investment
- We will strengthen support for investigator-led research, and develop future chief investigators and research leaders
- We will strengthen business development capability to increase grant capture, commercial partnerships and strategic investment, and ensure income is reinvested to support future growth

What success will look like

- Sustained growth in external research income and infrastructure funding
- Increased studies commercial research and innovation activity, including that led by gesh researchers
- Greater reinvestment in research capability and capacity
- Long-term sustainability of research and innovation activity

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Strategy enablers

To realise the ambition of the strategy the following are **essential enablers**:

- **Research leadership:** strong executive sponsorship and accountable leadership for research and innovation across all Divisions and corporate functions
- **Strategic investment:** targeted investment in infrastructure opportunities that strengthen long-term sustainability
- **Academic partnerships:** strengthened strategic relationships with City St George's and other university partners, supported by joint appointments, shared infrastructure and coordinated research priorities
- **Research workforce:** clear training and development pathways, protected research time and enhanced support for clinical academic careers across all professions
- **Digital research infrastructure:** development of research-ready digital systems, integrated data platforms and Electronic Patient Record-enabled research recruitment
- **Community research:** strengthening capability and capacity to deliver research across community settings

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Research and Innovation infrastructure support delivery of our ambition

Infrastructure	Strategic value	Key considerations
NIHR Clinical Research Facility (CRF)	• We were awarded an NIHR grant to set up a CRF in 2022 to support early-phase, experimental medicine and complex commercial studies. • Has strengthened gesh's national reputation and attracted external funding	• Opportunity to bid for continuation of funding beyond 2028 from the NIHR
NIHR Biomedical Research Centre (BRC)	• BRCs are among the largest NIHR infrastructure awards available to NHS and university partnerships • Can act as a catalyst for further grant funding and industry investment • Strengthen reputation and influence - recognition as part of a BRC positions an organisation amongst the UK's leading research-active NHS providers • BRCs are designed to support rapid development, testing and adoption of new diagnostics, treatments, digital technologies and models of care	• The 2026 funding round has provided an opportunity to assess organisational readiness and identify building blocks required to develop a strong future BRC proposition • A phased approach will allow us to build capability and maximise the potential benefits of a future application • Given the highly competitive nature of NIHR BRC funding, early preparation and targeted development will be critical to strengthening our future position
Clinical Trials Unit (CTU)	• We currently rely largely on external CTUs for complex investigator-led studies. A CTU would enable us to design, sponsor and lead our own clinical trials rather than relying on external organisations. • Builds future clinical academic leadership and research capability • Increases competitiveness for major NIHR, charity & commercial research funding • Creates opportunities to generate additional income through grant recovery and trial management activity	• Long-term success dependent on strong and diverse portfolio of studies, creating a sustainable platform for future growth and impact • While full benefits will be realised over several years, the journey to NIHR licensing will strengthen research infrastructure, partnerships and organisational capability from the outset
Digital Innovation Centre	• Provides a coordinated approach to AI, data and digital innovation • Creates a structured route for adopting emerging technologies, including AI, data analytics and digital health tools, reducing the risk of fragmented or uncoordinated implementation • Supports delivery of key NHS priorities around productivity, prevention, personalised care and digital transformation. • Enables faster evaluation and implementation of new technologies, ensuring innovations are translated into real-world benefits rather than remaining pilot projects • Helps position the organisation as an attractive partner for regional, national and commercial digital innovation programmes	• A focus on adoption, implementation and benefits realisation will help ensure innovations deliver meaningful and measurable improvements for patients and services • Continued development of digital maturity, data quality and interoperability required to further enhance the value and impact of digital innovation initiatives

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What this strategy means for us



For gesh

Research is embedded into business as usual, not a separate process

Research is accessible, inclusive and representative of the populations we serve

Research income and infrastructure investment continue to grow

gesh is recognised as the major hub for research for Southwest London

Board decisions, service development and strategic planning is guided by research evidence, data and evaluation



For patients and communities

Every patient who wants to can participate in research

Research closer to home is the default

Patients and communities help shape research and innovation priorities

Evidence, innovation and partnerships drive better outcomes and reduce inequalities



For colleagues

Every colleague can contribute to improving care through research and innovation

Research and innovation are recognised, supported and enabled across all professions

Leaders create opportunities for staff development that build confidence in research awareness, evidence use and innovation

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Delivering the strategy

The Board previously considered the emerging Research and Innovation Strategy in October 2026 and the appropriate level of ambition for the Group. There was agreement that research is closely linked to quality of care, patient outcomes, workforce attraction and retention, and the Group's identity as a teaching organisation. The University partnership and the scale of the Group's population were recognised as significant opportunities.

We are developing a phased approach to implementation, with the majority of investment expected to be funded through existing Research Capacity Funding, NIHR and other external income. Any additional gesh investment will be subject to the development of detailed business cases and approval through the appropriate governance processes.

Year 1 priorities

- **Implement Cerner PowerTrials**, including consent-to-contact functionality embedded within the EPR
- **Scope the development of a community research hub** to support integrated, place-based research across acute, community and primary care
- Expand clinical academic training and launch a **Clinical Academic Training Office** with City St George's
- Establish the Centre for Digital Innovation
- **Increase visibility of research and innovation** opportunities for patients and colleagues
- Begin to **embed research as business as usual** in the Divisions through specific dedicated research leadership

Year 2 priorities

- Launch and **operationalise the community research hub** across neighbourhood and community services
- Develop a **Clinical Trials** Unit with City St George's
- Scope opportunities for a s**hared Research Governance function** across Southwest London
- **Realign Research and Innovation governance** structures to Divisions
- **Increase internal funding support** (pump priming) for researchers to develop grant applications

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Appendices

National research and innovation priorities

- Aligning with NHS health priorities there are several key research and innovation strategies that inform ongoing work in tackling health inequalities and streamlining bureaucracy in clinical trials set-up

Best Research for Best Health: The Next Chapter (2021)

Building capacity in public health, underserved regions, and underrepresented disciplines

Improving the lives of people with multiple long-term conditions through research

Embedding equality, diversity, and inclusion

Expanding partnerships with the life sciences industry

Transforming the UK Clinical Research System (2025)

Improving timely access to research for patients and clinicians

Accelerating trial setup (target: 150 days or less)

Reducing inequalities through inclusive research

Creating a world-leading research environment by streamlining processes and investing in infrastructure

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National research workforce priorities

Clinical academic workforce

The UK is facing a decline in the number of clinical academics. The Medical Schools Council 2024 census revealed that clinical academics now make up only 3.4% of consultants, down from 4.7% in 2009. The 2025 joint report by the Council of Deans of Health and the Association of Medical Research Charities (AMRC) highlights the critical role of nursing, midwifery and AHP (NMAHP) clinical academics in driving innovation and improving care with the ambition is to increase the number of NMAHP clinical academics by 50% over five years.

Research delivery workforce

The NHS research workforce strategy aims to build a sustainable, inclusive, and skilled pipeline of professionals who can deliver and lead research across all care settings. This includes strengthening careers for research delivery staff and underrepresented disciplines that removes barriers to career progression.

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What we said in the 2024-28 gesh strategy

- **Affordable Care:** use research and innovation to develop new, cost-effective treatments
- **Renal Service Excellence**: create one of the largest renal services in the country, improving patient care and advancing research
- New Specialist Emergency Care Hospital next to Cancer Research Institute
- **Expanding Research Leadership:** significantly increase research output through a thriving research community and an enabling environment
- **Cutting-Edge Innovation:** advance the use of innovations like 3D printing, robotics, AI, genomics, and cell-based therapies, in our tertiary services
- **Empowering Staff:** through expanding the Translational and Clinical Research Institute to Epsom & St Helier
- **Inclusive & Accessible Research:** ensure research opportunities are open to all, investing in staff training and support
- **Data-Driven Research:** develop a new data warehouse for integrated research insights (incorporating linked and searchable clinical, radiological and pathological datasets)
- **Strengthening Key Partnerships**: work closely with St George's, University of London
- **Leading in Tertiary Services:** maintain leadership in infection, neuroscience, genetics and cardiovascular and build on renal, paediatrics, major trauma and cancer.

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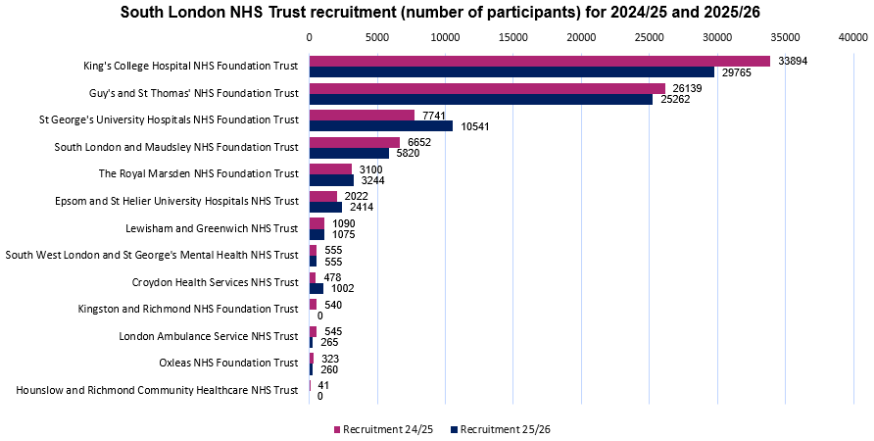
Research funding

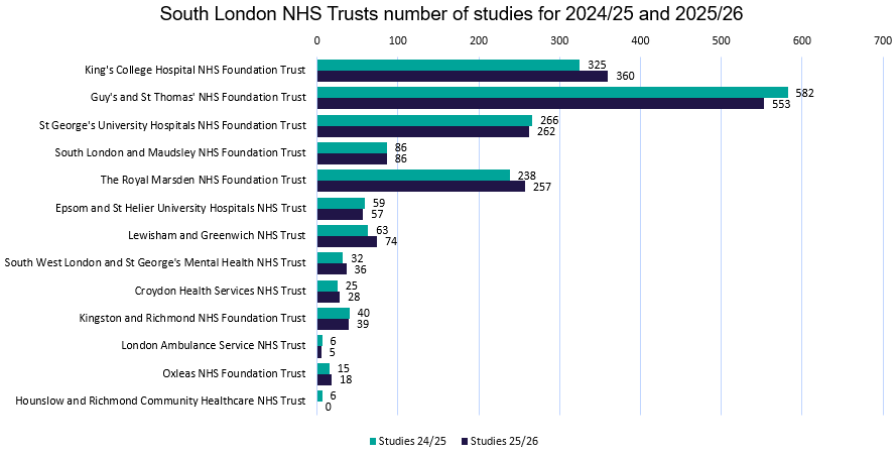
- Research income comprises core funding for delivering research studies and recruiting participants, infrastructure funding to support research staff, facilities and capability, and commercial income generated through studies sponsored by life sciences and pharmaceutical companies.
- The total amount across gesh in 2025/26 was £10.27M, representing an increase of £273k (2.7%) compared with £10.00M in 2024/25. This represents continued financial stability and modest growth despite increasing competition for external funding and changes to national research funding arrangements.
- Top sources of income:
  - NIHR delivery network (RRDN) funding is the largest source of income, contributing £5.1M (49.7%)
  - Non-commercial income also increased by £179k (17.0%) to £1.23M.
  - Commercial research income increased by £173k (7.0%) to £2.63M. Income from commercial studies is reinvested to recover study costs and support protected research capacity, including research staff, training and facilities that enable future research activity.
  - Study grant income, which fell from £755k to £610k
- *Core funding:* The NIHR awards core funding for Trusts to support the recruitment of patients into clinical trials. Core funding is allocated to spend in-year on research delivery, and funds most of our research delivery workforce and Joint Clinical Research Office (JCRO) staff. For 2025/26 a new NIHR Research Delivery Network funding model links a greater proportion of funding to research activity and delivery performance rather than previously. This provides opportunities to grow research income through strong performance but increases exposure to funding reductions if research activity declines.
- *NIHR Strategic Funding:* During the year, gesh secured more than £470,000 in NIHR strategic funding to support seven projects aimed at strengthening regional research capacity. These included developing community-based research pathways, expanding neuromuscular research activity, and implementing an electronic research file management system.

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Study recruitment 2025/26

Across gesh, more than 12,800 participants were recruited to NIHR portfolio studies during the year 2025/26 - St George's recruited 10,541 participants, ESTH recruited 2,322 participants. St George's is the third highest recruiting Trust in South London, while Epsom and St Helier (ESTH) study activity and participant recruitment is growing year on year and outperforming other smaller trusts in SW London.





Commercial trial setup time is an important metric as commercial trials represent an important source of research income and patient access to innovative treatments.

- Performance against national commercial study set-up metrics remains an area of focus across the Group. ESTH achieved stronger performance against both national measures (41% for set-up within 60days, 42% for time to 1st recruit). St George's maintains a larger and more complex research portfolio (33% and 29% for the respective measures).
- Although only a subset of studies are currently included within the national reporting methodology, performance against these metrics will become increasingly important as over the last few years UK commercial clinical trial activity has decreased and government and NIHR expectations continue to focus on performance and improving the UK's competitiveness for commercial research investment.

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Group Board

Meeting in Public on Friday, 06 November 2026

Agenda Item	2.2	
Report Title	**Group Board Assurance Framework**	
Executive Lead(s)	Stephen Jones, Group Chief Corporate Affairs Officer	
Report Author(s)	Stephen Jones, Group Chief Corporate Affairs Officer Steve Walters, Group Deputy Director, Governance, Risk and Assurance	
Previously considered by	People Committees Infrastructure Committees Quality Committees Finance & Performance Committees	22 October 2026 23 October 2026 27 October 2026 30 October 2026
Purpose	**For Approval / Decision**	

Executive Summary

This paper presents the updated Group Board Assurance Framework (BAF) for Board approval.

This is the first quarterly update since the BAF was fully refreshed in July 2026. As such, changes are minor and reflect improvements in controls for a range of the strategic risks. A summary of the changes is provided below:

STRATEGIC RISK		BASELINE + CURRENT		OCTOBER 2026 | UPDATE	MARCH 2028 TARGET	
		Risk score	Assurance rating	Risk score	Update	Risk score	Assurance rating
SR1	Financial Sustainability	**25**	**Limited**	**25**	Change in target date of cost structure and productivity action to July 2027	**15**	**Reasonable**
SR2	Transformation Delivery	**20**	**Partial**	**20**	No changes	**15**	**Reasonable**
SR3	Digital Transformation	**20**	**Partial**	**20**	Two further controls added, three actions now complete. Two related gaps in controls removed. No changes to score or outlook	**15**	**Reasonable**
SR4	Estates Modernisation and Infrastructure	**20**	**Limited**	**20**	Updated actions including expected timescales and current progress, and revised list of related risk to align with CRRs. No other changes	**20****	**Partial**

SR5	Research and Innovation	**12**	**Partial**	**12**	Improvement in control strength for the research strategy and governance framework. Due dates now included for all but one action.	**8**	**Reasonable**
SR6	Timely Access to Care	**20**	**Partial**	**20**	No changes	**15**	**Reasonable**
SR7	Patient Safety and Quality	**20**	**Partial**	**20**	Control strength improved for the Quality Governance and Assurance Framework. All actions are now on track.	**15**	**Reasonable**
SR8	Workforce Sustainability	**20**	**Partial**	**20**	Improvements in control strengths relating to temporary staffing reduction and workforce transformation. No other changes	**15**	**Reasonable**
SR9	Organisational Culture and Inclusion	**16**	**Partial**	**16**	Improvement to control strength relating to people strategy and delivery programme, the leadership OD and performance framework, and group health and wellbeing programme. Actions relating to EDI and staff survey improvements are considered “off track”. No other changes	**12**	**Reasonable**

The Group Executive Committee has agreed to propose to the Board an additional strategic risk related to the merger of the two Trusts. The GEC will develop this risk for consideration by the Board in January 2027. In addition, further work is being undertaken to define a strategic risk in relation to the left shift and neighbourhood health. The intention is to present this to the Board in the next BAF review.

In addition, the GEC is focusing on developing each strategic risk on the new BAF to ensure that there is a clear route to bring each strategic risk from its current risk score and current assurance rating to the defined target score and assurance rating, and within the Board’s risk appetite. This “route to green” is being developed by the relevant executive lead(s) for each BAF risk and is being considered through the GEC’s risk and compliance focused meetings. The intention is to ensure that each risk has a clear set of material actions that will, when completed, reduce the risk score and increase the assurance rating.

Action required by Group Board

The Board is asked to:

a. Note that the strategic risks delegated for oversight to Board Committees have been reviewed by the relevant Committees and no changes to risk scores or assurance ratings are proposed at this stage.
b. For the strategic risk reserved to the Board (SR2 Transformation Programme Delivery), note there is no proposed change to the risk score or assurance rating this month.
c. Approve the updates proposed to the Board Assurance Framework

Committee Assurance	
Committee	Group Board
Level of Assurance	Not Applicable

Appendices	
Appendix No.	**Appendix Name**
Appendix 1	Group Board Assurance Framework update report
Appendix 2	Group Board Assurance Framework

Implications

Group Strategic Objectives

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

Risks

The principal risk is that the refreshed Board Assurance Framework does not accurately reflect the Group's strategic risk profile, resulting in gaps in Board oversight and assurance. The purpose of the review process is to ensure that strategic risks, controls, assurances, gaps and mitigating actions are appropriately identified and aligned to the Group's strategic objectives.

CQC Theme

☒ Safe	☒ Effective	☒ Caring	☒ Responsive	☒ Well Led

NHS system oversight framework

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

Financial implications

The paper does not seek approval of any new expenditure or financial commitments. However, there is a strategic risk focused on financial sustainability.

Legal and / or Regulatory implications

The BAF is a key component of the Group's governance and risk management framework and supports the Board in discharging its responsibilities for oversight of strategic risk and internal control.

Equality, diversity and inclusion implications

One of the strategic risks presented (SR9 – Organisational Culture and Inclusion) specifically addresses inclusion, workforce equality and staff experience.

Environmental sustainability implications

There are no direct environmental sustainability implications arising from this paper.

Group Board Assurance Framework 2026/27

Strategic Risk	SR1	Financial Sustainability

Current Risk Score: 25

Assurance: Limited

Event	Caused by	Results in
The gesh Group fails to achieve financial sustainability	*Large unassured CIPs, stretching phasing of delivery, ability to manage underlying run rates with operational pressures and phased removal of Deficit support Funding*	*Widening underlying deficit, cash strain, reduced investment headroom, delayed delivery of strategic priorities, and regulatory intervention*

Strategic objective	Affordable Services Fit for the Future
Last review date	*23 October 2026*
Monitoring Committee	Finance & Performance Committees
Lead Executive	Group Chief Finance Officer
Risk appetite	Open (High)

Risk Score		Impact	Likelihood	Overall Risk Score	Assurance rating
Inherent	May-26	5	5	25	Limited
Current	**Jun-26**	**5**	**5**	**25**	**Limited**
Target	Mar-28	5	3	15	Reasonable

Change since last review: ⟺

Month	Jun-26	Oct-26	Dec-26	Mar-27	Jun-27	Oct-27	Dec-27	Mar-28	Jun-28	Oct-28	Dec-28	Mar-29
Risk Score	25	25										
Assurance	Limited	Limited										

	Key controls *What are we already doing to manage the risk?*	Assurances on controls *How do we have assurance that the controls are working?*	*Line of defence*	Control Strength
1	Maintaining a long term financial plan forward view.	Delivery of the financial plan and tracking through FPC.	2nd	Weak
2	Budget holder accountability for meeting approved delegated budgets, maintaining underlying run rates and delivering CIP.	Financial performance is in line with budget/plan.	1st	Weak
3	Ensuring there is an effective control environment.	Evidenced through finance reports, audit reports and against KPIs.	2nd	Weak-Moderate
4	BAU CIP, site responsibility for identifying and delivering actions to improve the financial position.	Project Management and meeting structure in place to identify, plan and deliver transformation CIPs in line with target.	1st	Weak-Moderate
5	Transformation CIP, SRO accountability for workstreams managed within a PMO governance structure.	Project Management and meeting structure in place to identify, plan and deliver transformation CIPs in line with target.	2nd	Weak-Moderate
6	Robust understanding of cost structure and productivity.	Costing systems systems and known areas of improvement in place.	2nd	Weak-Moderate
7	Robust process for deconstructing the block contract.	Clearly defined drivers for gaps in deconstructing the block contract.	2nd	Weak-Moderate
8	Robust process to forecast and manage cash.	Daily cashflows for 13 week and rolling 12 months in place. Scenario forecasts shared with FPC.	2nd	Moderate
9	Maintaining the capacity and capability of the finance team.	Clearly defined statement of how demands on dept are meet by available resources.	2nd	Moderate
10	External engagement with SWL, NHSE London and NHS national team.	Good engagement with SWL and London. NHE London attend FPC.	3rd	Moderate-Strong
11	Capital: clear view of future capital needs and how to meet them	Detail available of prioritised capital need together with available funding.	1st / 2nd	Weak-Moderate

Group Board Assurance Framework 2026/27

Gaps in controls *What do we need to do to control the risk that we are not yet doing?*		*Linked controls*
1	Enhance level of financial support and challenge, especially embed budget holder level.	2
2	Continue challenge and continued emphasis on identification and delivery of CIP.	4,5
3	Improve understanding and actions to address variances in benchmarking.	6
4	Improve understanding and actions to address productivity.	6
5	Compliance with existing control environment.	3
6	Review finance team capacity and capability in respect of current agenda and target operating model for corporate.	9
7	Developed plans to deliver Medium Term Financial Plan	1
8	Capital funding is insufficient to meet known investment needs; BAU and developmental.	11
9	Continue focus on cash flow forecasting and triangulation between historic cash flow and known future events.	8
10	Review bottom up work driving deconstructing the block contract.	7

Material actions to address gaps in controls and assurances *What are we going to do, by when, to further manage and mitigate the risk?*		Control Gaps	Executive Lead	Due date	Progress
1	Embed performance accountability framework and escalation of budgets that are materially overspent through site/divisional performance meetings and Exec/Site Development Forums.	1,2	MDs and GCFO	Dec 26	Off Track
2	BAU CIP identification and delivery ongoing through Site Financial Recovery Board.	2	MDs	Mar 27	Off Track
3	Transformation SRO/CEO monthly meetings to review progress and priorities within workstreams.	2	DCEO	Mar 29	Off Track
4	Review performance against productivity metrics to support identification of areas to address inefficiency.	3,4	MDs and GCFO	Mar 27	Off Track
5	Maintain up to date forecast, risks and mitigations to delivery of the medium term plan.	7	GCFO	Jul 26	On Track
6	Complete areas identified for Group Financial Structure.	6	GCFO	Jul 27	On Track
7	Assess compliance with existing control framework.	5	GCFO	Dec 26	On Track
8	Propose and embed revised Group and Site Capital Governance to support prioritisation and risk management.	8	GCFO	Dec 26	On Track
9	Continued focus on cash management, notably cashflow forecasting, debt recovery and creditor process management.	9	GCFO	Dec 26	On Track
10	Re-visit deconstructing the block contract to identify areas that require revising to close the gap.	10	GCFO	Dec 26	On Track

Related risks on Corporate Risk Registers

Trust	Datix ID	Score	Summary risk description
SGUH/ESTH	3124/2488	25	Delivery of sustainable income and expenditure
SGUH/ESTH	3125/2489	25	Cash availability
SGUH/ESTH	3126/2490	25	Impact of constrained capital

Emerging risks

What could materially affect this risk over the next 12-24 months?

- Clear message from NHSE that the Medium Term Plans submitted need to be delivered.
- Organisational engagement given activity, workforce and quality pressures.

Group Board Assurance Framework 2026/27

Strategic Risk	SR2	Transformation Delivery

Current Risk Score: 20

Assurance: Partial

Event	Caused by	Results in
The Group does not deliver the strategic change necessary, at the scale and pace required, to transform how it provides healthcare	*Caused by early maturity of transformation programmes, limited leadership and organisational capacity, competing operational pressures, and dependencies on workforce, digital, estates and system partners*	*Resulting in failure to realise planned financial, operational and quality benefits, deliver the Medium Term Plan, implement sustainable new models of care and ways of working, and secure the Group's long-term clinical and financial sustainability*

Strategic objective	Affordable Services Fit for the Future
Last review date	*22 October 2026*
Monitoring Committee	Group Board
Lead Executive	GDCEO
Risk appetite	Seek (Significant)

Risk Score		Impact	Likelihood	Overall Risk Score	Assurance rating
Inherent	Jun-26	5	5	25	Limited
Current	**Jun-26**	**5**	**4**	**20**	**Partial**
Target	Mar-28	5	3	15	Reasonable

Change since last review: ⟺

Month	Jun-26	Oct-26	Dec-26	Mar-27	Jun-27	Oct-27	Dec-27	Mar-28	Jun-28	Oct-28	Dec-28	Mar-29
Risk Score	20	20										
Assurance	Partial	Partial										

	Key controls *What are we already doing to manage the risk?*	Assurances on controls *How do we have assurance that the controls are working?*	*Line of defence*	Control Strength
1	Group Medium Tern Plan and Transformation Portfolio: Strategic portfolio of transformation programmes aligned to delivery of the CARE Strategy and Medium Term Plan.	Medium Term Plan reporting, Transformation Portfolio reporting, portfolio roadmap, Board Development Sessions.	1st / 2nd	Moderate
2	Programme governance through SROs, Steering Groups, PMO oversight and standard programme management arrangements.	Programme Highlight Reports, Steering Group reporting, SRO reviews, governance compliance reporting, PMO reporting.	1st / 2nd	Moderate
3	Delivery of the agreed transformation portfolio to realise planned strategic, operational and financial benefits.	Programme milestone reporting, delivery dashboards, programme status reports, programme risk reporting.	1st / 2nd	Weak-Moderate
4	Identification, tracking and assurance of programme benefits, productivity improvements and financial savings.	CIP maturity reporting, benefits realisation reporting, finance reporting, MTP Delivery Steering Group reporting.	1st / 2nd	Weak-Moderate
5	Deployment of transformation funding and resources to support programme delivery.	Transformation Fund reporting, business case approvals, investment monitoring, funding assurance reporting.	1st / 2nd	Moderate
6	Executive, Board and Committee oversight of portfolio delivery, risks, performance and strategic decisions.	Group Executive Committee, MTP Delivery Steering Group, Finance & Performance Committee, Board and Board Development Session reporting.	2nd	Moderate
7	Portfolio reporting, programme assurance, milestone monitoring, risk management and dependency oversight.	Portfolio dashboards, dependency reviews, programme maturity assessments, portfolio risk reporting.	2nd	Moderate

Group Board Assurance Framework 2026/27

Gaps in controls *What do we need to do to control the risk that we are not yet doing?*		*Linked controls*
1	Many transformation programmes remain in the early stages of delivery and have yet to demonstrate sustained delivery of planned outcomes and benefits.	3, 4
2	Financial, operational and quality benefits remain to be fully quantified, validated and realised, particularly cash-releasing savings required to deliver the Medium Term Plan.	4
3	The maturity of transformation programmes remains variable across the portfolio, with further work required to strengthen planning, delivery confidence and programme assurance.	2, 3, 7
4	Competing operational pressures and limited organisational capacity constrain delivery of transformation at the required scale and pace.	3, 6
5	Programme interdependencies and sequencing are not yet consistently embedded across the transformation portfolio.	2, 7
6	Successful delivery of the transformation portfolio remains dependent on wider enabling programmes, including workforce, digital, estates and system transformation.	1, 3

Material actions to address gaps in controls and assurances *What are we going to do, by when, to further manage and mitigate the risk?*		Control Gaps	Executive Lead	Due date	Progress
1	Deliver the agreed transformation portfolio and associated programme milestones in line with the Medium Term Plan.	1, 3	GDCEO	Mar-29	On Track
2	Strengthen programme benefits realisation, financial tracking and assurance to support delivery of planned transformation benefits and cash-releasing savings.	2	GDCEO / GCFO	Mar-27	On Track
3	Implement the Foundational Best Practice improvement actions to strengthen programme maturity, planning and delivery assurance across the transformation portfolio.	3	GDCEO	Mar-27	On Track
4	Align the transformation portfolio with organisational capacity through prioritisation and sequencing of programmes.	4, 5	GDCEO	Mar-27	On Track
5	Strengthen management of programme interdependencies and portfolio-level risks across the transformation portfolio.	5	GDCEO	Mar-27	On Track
6	Strengthen alignment between transformation programmes and enabling programmes across the portfolio.	6	GDCEO	Mar-27	On Track

Related risks on Corporate Risk Registers

Trust	Datix ID	Score	Summary risk description
No linked risks on the Corporate Risk Register			

Emerging risks

What could materially affect this risk over the next 12-24 months?

- National policy, planning guidance or regulatory expectations may require significant reprioritisation of the transformation portfolio.
- Financial pressures may reduce the investment available to support transformation delivery.
- Demand growth and operational pressures may reduce organisational capacity available for transformation.
- Changes arising from implementation of the NHS 10 Year Health Plan may require reprioritisation of the transformation portfolio.
- Delivery of major service reconfiguration programmes may affect the sequencing and pace of transformation across the wider portfolio.

Group Board Assurance Framework 2026/27

Strategic Risk	SR3	Digital Transformation

Current Risk Score: 20

Assurance: Partial

Event	Caused by	Results in
The gesh Group is unable to deliver a modern, interoperable and resilient digital environment that enables the digital transformation necessary to deliver the MTP and new models of care	*Legacy digital infrastructure, insufficient digital capacity, low digital adoption, fragmented data architecture, cybersecurity vulnerabilities, and inadequate capital relative to need*	*Reduced clinical productivity, poor user experience, inability to realise transformational benefits, increased cyber risk, and failure to meet national digital maturity standards*

Strategic objective	Affordable Services Fit for the Future
Last review date	*26 October 2026*
Monitoring Committee	Infrastructure Committees
Lead Executive	Group Deputy Chief Executive Officer
Risk appetite	Open (High)

Risk Score		Impact	Likelihood	Overall Risk Score	Assurance rating
Inherent	May-26	5	5	25	Limited
Current	**Jun-26**	**5**	**4**	**20**	**Partial**
Target	Mar-28	5	3	15	Reasonable

Change since last review

Month	Jun-26	Oct-26	Dec-26	Mar-27	Jun-27	Oct-27	Dec-27	Mar-28	Jun-28	Oct-28	Dec-28	Mar-29
Risk Score	20	20										
Assurance	Partial	Partial										

	Key controls *What are we already doing to manage the risk?*	Assurances on controls *How do we have assurance that the controls are working?*	*Line of defence*	Control Strength
1	Board-level governance of the digital agenda established through Infrastructure Committees.	The Infrastructure Committee focuses on digital on a bimonthly basis and the Audit & Risk Committee receives quarterly reports on cyber.	2nd	Moderate
2	Executive-level governance of the digital agenda across the Group established through the Digital Governance Group.	Control 10 indicates significant improvements in this area	2nd	Moderate-Strong
3	Board-level executive leadership of the digital agenda established through the Group Deputy Chief Executive Officer and Executive team sponsorship.	Executive sponsorship is in place for digital transformation, with oversight through Group governance and programme structures.	2nd	Moderate
4	Senior professional leadership of digital services established through the Group Chief Digital Information Officer and transformation leadership arrangements.	Substantive Group CDIO in post since April 2026	2nd	Moderate
5	Expertise and capacity within digital, ICT and transformation teams to deliver core programmes and service improvement.	Current team capability is strong, but remains under significant pressure from the scale of operational demand and transformation requirements. Further improvements are expected in this area. Third phase of digital restructure approved by the Group Executive Committee.	1st	Weak-Moderate
6	Agreed resourcing plans and capital investment processes in place supporting digital transformation and infrastructure priorities.	Resourcing remains under material pressure due to wider people resource constraints and competing workforce priorities across the Group.	2nd	Weak-Moderate
7	Shared Electronic Patient Record and enabling digital programmes in place to support Group transformation	EPR rollout has been delivered and post-go-live optimisation is ongoing to realise the benefits of shared systems and new ways of working.	2nd	Moderate
8	Arrangements in place for cybersecurity, resilience and disaster recovery, continuously developed and tested.	Internal audit and management reviews provide partial assurance; disaster recovery plans require further refinement and testing.	3rd	Weak-Moderate

Group Board Assurance Framework 2026/27

9	A group wide digital strategy aligned to the Medium Term Plan, known demand, affordability and available resources has been developed in July 2026.	The strategy was reviewed and signed off by Digital Governance Group, Group Exec Committee, Infrastructure Committee and Trust board. Progress against the strategy is and will continue to be monitored via the KPI dashboard and digital priorities update report.	3rd	Strong
10	Revised/refreshed digital governance group arrangements developed and signed off.	New governance structures approved by Group Exec Committee. New governance structure includes and Information Governance Steering Group and an AI ethics review group and a Digital Den for the review of new ideas. Sub group effectiveness will be evaluated by the new Digital Board. The Digital Board will report into Group Executive Committee and Infrastructure Committee who will also review effectiveness.	2nd	Moderate

Gaps in controls *What do we need to do to control the risk that we are not yet doing?*		*Linked controls*
1	~~Develop a Group-wide digital strategy aligned to the Medium Term Plan, known demand, affordability and available resources~~.	2,4,6
2	Complete integration of separate digital and ICT teams into a coherent Group-wide operating model with clear accountabilities.	4,5
3	Benefits realisation from digital investment and transformation programmes is not yet consistently evidenced and reported.	1,2,3
4	Maintain investment in cyber security, resilience and disaster recovery, including testing, remediation and horizon scanning.	8
5	~~Develop a clear Group-wide framework for artificial intelligence, data architecture and safe innovation.~~	7
6	The scale of digital ambition exceeds available capacity and resources, requiring clearer prioritisation and sequencing of delivery.	2,5,6,7

Material actions to address gaps in controls and assurances *What are we going to do, by when, to further manage and mitigate the risk?*		Control Gaps	**Executive Lead**	**Due date**	**Progress**
1	Develop and agree a Group Digital Strategy aligned to organisational priorities and available resources.	1	GDCEO	Jul-26	Complete
2	Complete integration of digital and ICT teams into a single Group-wide service and implement the agreed operating model.	2	GDCEO	Mar-27	On Track
3	Refresh Digital Governance Group arrangements and strengthen executive oversight of digital transformation priorities and benefits.	3	GDCEO	Oct-26	Complete
4	Develop and agree a prioritised digital transformation roadmap, including trade-offs, sequencing and benefits realisation.	6	GDCEO	Dec-26	On Track
5	Maintain focus on cybersecurity, resilience and disaster recovery, including enhanced testing, remediation and management reporting.	4	GDCEO	Jan-27	On Track
6	Develop a Group-wide framework for AI deployment, data governance and safe adoption of innovative digital tools.	5	GDCEO	Oct-26	Complete

Related risks on Corporate Risk Registers

Trust	Datix ID	Score	Summary risk description
SGUH/ESTH	3144/2514	20	Cybersecurity Attack
SGUH/ESTH	3143/2515	20	Core Network Failure
SGUH/ESTH	3142/2516	15	Data Centre Failure
SGUH	2700	16	Picture Archiving and Communication System

Emerging risks

What could materially affect this risk over the next 12-24 months?

- Mismatch between digital ambition, transformation demand and available revenue/capital resources.
- Delivery of key digital transformation programmes may take longer than planned due to operational pressures and interdependencies.
- Growing cybersecurity threats, legacy estate and resilience weaknesses could disrupt transformation and service delivery.
- National expectations for digital maturity, interoperability and data use may increase faster than local capacity to respond.

Group Board Assurance Framework 2026/27

Strategic Risk	SR4	Estates Modernisation and Infrastructure

Event	Caused by	Results in
The Group estate is unable to consistently support safe, effective and efficient care.	*Constrained capital funding, significant backlog maintenance, ageing infrastructure, and delays to SECH preventing consolidation of major acute services.*	*Safety and compliance risks, constrained capacity, service disruption, rising maintenance costs, diversion of capital from strategic priorities, and slower realisation of BYFH benefits.*

Current Risk Score: 20

Assurance: Limited

Strategic objective	Affordable Services Fit for the Future
Last review date	*26 October 2026*
Monitoring Committee	Infrastructure Committees
Lead Executive	Group Chief Infrastructure, Facilities & Environment Officer
Risk appetite	Open (High)

Risk Score		Impact	Likelihood	Overall Risk Score	Assurance rating
Inherent	May-26	5	5	25	Limited
Current	**Jun-26**	**5**	**4**	**20**	**Limited**
Target	Mar-28	5	4	20	Partial

Change since last review



Month	Jun-26	Oct-26	Dec-26	Mar-27	Jun-27	Oct-27	Dec-27	Mar-28	Jun-28	Oct-28	Dec-28	Mar-29
Risk Score	20	**20**										
Assurance	Limited	**Limited**										

	Key controls *What are we already doing to manage the risk?*	Assurances on controls *How do we have assurance that the controls are working?*	*Line of defence*	Control Strength
1	Estates Governance, Compliance and Assurance Framework – Governance, compliance and assurance of estate risks	Infrastructure Committee reporting, PAM reporting, statutory compliance reporting, fire safety, water safety, asbestos and health & safety reporting.	1st / 2nd	Moderate
2	Authorised Engineer and Independent Assurance Framework – Independent technical assurance of estate compliance	Authorised Engineer reports, specialist audits, external reviews and compliance inspections.	3rd	Moderate
3	Reactive and Planned Maintenance Framework – Planned and reactive maintenance of estate infrastructure	Maintenance performance reporting, backlog maintenance reporting, operational estates updates and engineering performance indicators.	1st / 2nd	Moderate
4	Capital Investment and Estate Modernisation Programme – Capital investment to maintain and modernise the estate	Capital programme reporting, business cases, estate strategy delivery and infrastructure programme updates.	1st / 2nd	Weak-Moderate
5	Major Estate Transformation Programme (SECH and estate reconfiguration)	Programme reporting, milestone reporting, business case development and Board oversight.	1st / 2nd	Weak-Moderate
6	Green Plan and Sustainability Framework – Sustainability and decarbonisation programmes	Green Plan reporting, sustainability metrics, ERIC reporting and programme updates.	1st / 2nd	Moderate
7	Estate Condition and Performance Intelligence Framework – Estate condition, compliance and performance intelligence	6-facet surveys, condition surveys, backlog maintenance assessments, ERIC benchmarking and estate intelligence reporting.	2nd / 3rd	Moderate

Group Board Assurance Framework 2026/27

Gaps in controls *What do we need to do to control the risk that we are not yet doing?*		*Linked controls*
1	**A Group-wide estates strategy has not yet been fully developed and implemented:** Whilst a range of estate programmes and initiatives are in place, there is currently no comprehensive Group-wide estates strategy setting out the long-term vision, priorities, investment requirements and delivery roadmap for the estate.	1, 4, 5
2	**Capital investment remains insufficient to address backlog maintenance, estate risk and strategic priorities:** Despite targeted investment and successful bids for specific schemes, available capital funding remains insufficient to address the scale of backlog maintenance, estate condition issues and wider strategic priorities. This results in continued reliance on mitigation measures and limits investment in estate modernisation, sustainability and service transformation.	4, 6, 7
3	**Estate condition remains a constraint on service delivery and modernisation:** The condition of parts of the estate continues to constrain operational flexibility, service development and the efficient delivery of care, requiring ongoing investment to maintain functionality.	3, 4, 7
4	**Long-term estate transformation remains dependent on external funding and national programme decisions:** Delivery of major estate transformation programmes, including Building Your Future Hospital, remains dependent on external funding approvals and national programme timelines.	4, 5
5	**Critical infrastructure resilience remains vulnerable in parts of the estate:** Ageing infrastructure and asset condition continue to create vulnerability across a number of critical systems, requiring ongoing mitigation and monitoring to maintain safe and effective operation.	2, 3, 7
6	**Delivery of sustainability and decarbonisation ambitions remains dependent on future capital investment:** Whilst progress is being made through the Green Plan, achievement of longer-term sustainability and decarbonisation objectives remains dependent on significant future investment and estate renewal.	4, 6

Material actions to address gaps in controls and assurances *What are we going to do, by when, to further manage and mitigate the risk?*		Control Gaps	Executive Lead	Due date	Progress
1	Develop and implement a Group-wide Estates Strategy setting out the long-term vision, priorities, investment requirements and delivery roadmap for the estate.	1	GCOFIE	Mar-28	On Track
2	Deliver the approved capital programme and prioritised backlog maintenance programme to address estate condition, compliance risks and operational constraints.	2, 3	GCOFIE	Mar-27	On Track
3	Develop interim estate modernisation and resilience initiatives pending Building Your Future Hospital commencement	4	GCOFIE	Mar-27	On Track
4	Deliver critical infrastructure replacement, resilience and compliance programmes, including priority fire, electrical and mechanical infrastructure improvements.	3, 5	GCOFIE	Mar-27	On Track
5	Deliver the Group Green Plan and decarbonisation programme	6	GCOFIE	Mar-28	TBC

Related risks on Corporate Risk Registers

Trust	Datix ID	Score	Summary risk description
SGH	762	20	Condition of Estate
SGH/ESTH	3218/2621	15	Climate Change Adaptation and Resilience
SGH/ESTH	3106/1953	15	Fire Safety
SGH	2061	15	Lack of Uninterruptible Power Supplies Site Wide
SGH	2036	15	Risk of Fire Starting in the Trust and Developing into a Major Fire
ESTH	1952	20	Failure of Critical Electrical Infrastructure
ESTH	1951	20	Poor Condition of Building Structures
ESTH	1956	20	Trust Wide Lifts
ESTH	1954	16	Sewage and Drainage Systems
ESTH	1962	16	Building Your Future Hospitals

Emerging risks

What could materially affect this risk over the next 12-24 months?

- Deterioration of estate condition may outpace available investment
- Failure of critical infrastructure may increase service disruption
- Capital funding pressures may constrain estate modernisation and sustainability programmes
- Changes in service demand and operational requirements may increase pressure on an already constrained estate.
- Estate failures, major works programmes or service reconfiguration may require further decant arrangements and temporary accommodation solutions, increasing cost and operational complexity.

Group Board Assurance Framework 2026/27

Strategic Risk	SR5	Research and Innovation

Event	Caused by	Results in
The gesh Group fails to maximise the benefits of research and innovation for patients, staff and the organisation.	*Insufficient research capacity and infrastructure, underdeveloped research and innovation partnerships, inconsistent participation in research activity, and failure to systematically adopt and spread innovation.*	*Reduced access to research opportunities, poorer patient outcomes and experience, missed opportunities to reduce inequalities, lower research income and funding, and reduced ability to attract and retain high-calibre staff.*

Current Risk Score: 12

Assurance: Partial

Strategic objective	Affordable Services Fit for the Future
Last review date	*16 October 2026*
Monitoring Committee	Quality Committees
Lead Executive	GCMO
Risk appetite	Seek (Significant)

Risk Score		Impact	Likelihood	Overall Risk Score	Assurance rating
Inherent	May-26	4	4	16	Limited
Current	**Jun-26**	**4**	**3**	**12**	**Partial**
Target	Mar-28	4	2	8	Reasonable

Change since last review: ⟺

Month	Jun-26	Oct-26	Dec-26	Mar-27	Jun-27	Oct-27	Dec-27	Mar-28	Jun-28	Oct-28	Dec-28	Mar-29
Risk Score	12	12										
Assurance	Partial	Partial										

	Key controls *What are we already doing to manage the risk?*	Assurances on controls *How do we have assurance that the controls are working?*	*Line of defence*	Control Strength
1	Research Strategy and Governance Framework – Strategic leadership and oversight of research and innovation (including TACRI, research governance and Group oversight arrangements)	Research and Innovation strategy development, research governance reporting, TACRI reporting and Board/Committee oversight.	1st / 2nd	Moderate
2	Research Infrastructure and Delivery Framework – Infrastructure and support arrangements required to deliver research (including JCRO and the NIHR Clinical Research Facility)	Research delivery performance, NIHR Clinical Research Facility reporting, finance reporting and research governance assurance.	1st / 2nd	Moderate
3	Research Partnerships and Collaboration Framework – Collaboration with academic, NHS and industry partners (including City St George's, RRDN and South London partnerships)	Partnership Board, performance reporting, collaborative research programmes, RRDN reporting and strategic partnership reviews.	1st / 2nd	Moderate
4	Research Workforce and Capability Framework – Research leadership, training and workforce capability (including fellowship and researcher development programmes), TACRI expansion across gesh	Fellowship programme reporting, research training activity and workforce capability reporting.	1st / 2nd	Moderate
5	Research Performance and Participation Framework – Research participation, patient recruitment, and research performance monitoring	Research recruitment data, study participation metrics, grant funding performance and benchmarking information.	1st / 2nd	Moderate

Group Board Assurance Framework 2026/27

Gaps in controls *What do we need to do to control the risk that we are not yet doing?*		*Linked controls*
1	**A Group-wide research and innovation strategy has been co-produced with staff and patients but not yet been approved and implemented:** Whilst research activity is well established across both Trusts, there is currently no agreed Group-wide research and innovation strategy setting out shared priorities, objectives, measures of success and arrangements for delivery.	1, 3
2	**A strategic partnership vision and delivery plan for research and innovation with City St George's has not yet been fully developed:** Whilst strong collaborative relationships exist between the Group and City St George's, opportunities remain to develop a shared strategic vision, priorities and delivery plan to maximise the benefits of research, innovation and academic partnership.	1, 3
3	**Research capacity, infrastructure and funding arrangements remain constrained in key areas:** Whilst research performance remains strong, constraints relating to workforce capacity, research support functions, infrastructure and the sustainability of research funding continue to limit opportunities for growth and participation.	2, 4
4	**Participation in research activity remains variable across services and specialties:** Research activity and participation are concentrated within a number of specialties and services, with opportunities to broaden participation and increase research activity across the Group.	5
5	**Arrangements for translating research and innovation into measurable organisational benefit continue to develop:** While the Group undertakes substantial research activity, further work is required to systematically evaluate, adopt and spread research findings to maximise benefits for patients, staff and the organisation.	2, 5
6	**Research performance and impact reporting are not yet fully developed at Group level:** Whilst research activity is monitored through a range of operational measures, opportunities remain to strengthen strategic reporting on research performance, impact, innovation and return on investment at Group level.	1, 5

Material actions to address gaps in controls and assurances *What are we going to do, by when, to further manage and mitigate the risk?*		Control Gaps	Executive Lead	Due date	Progress
1	Develop and implement a Group Research and Innovation Strategy	1	GCMO	Nov-26	On Track
2	Develop a strategic research and innovation partnership plan with City St George's	2	GCMO	Mar-27	On Track
3	Deliver agreed research infrastructure and workforce development initiatives	3	GCMO	Mar-27	On Track
4	Expand participation in research activity across services and specialties	4	GCMO	Oct-27	On Track
5	Develop arrangements to evaluate, adopt and spread research findings and innovation	5	GCMO	TBC	TBC
6	Develop Group-level research performance and impact reporting	6	GCMO	Mar-27	On Track

Related risks on Corporate Risk Registers

Trust	Datix ID	Score	Summary risk description
There are no research related risks on either Trust's Corporate Risk Registers. However SGH Risk 3185 (Clinical Research Facility Capital Build Delay – score **20**) is a new risk under consideration for escalation			

Emerging risks

What could materially affect this risk over the next 12-24 months?

- Changes to national research funding arrangements may reduce research capacity and capability
- The opportunity presented by the City St George's partnership may not be fully realised
- Workforce pressures may reduce participation in research activity
- Research infrastructure and support services may not keep pace with growth ambitions
- Competition for research funding, partnerships and research-active staff may increase
- Opportunities to adopt and spread innovation may not be realised at scale

Group Board Assurance Framework 2026/27

Strategic Risk	SR6	Timely Access to Care

Current Risk Score: 20

Assurance: Partial

Event	Caused by	Results in
The gesh Group is unable to provide timely access to care and maintain effective patient flow across urgent, emergency, elective diagnostic and cancer services	*Capacity constraints across beds, theatres, diagnostics and workforce; discharge delays; rising demand; and slower than planned delivery of transformation, productivity and flow improvement programmes*	*Poorer patient outcomes and experience, increased clinical risk, failure to meet constitutional standards, loss of income, reduced productivity and regulatory intervention*

Strategic objective	Right Care, Right Place, Right Time
Last review date	*21 October 2026*
Monitoring Committee	Finance & Performance Committees
Lead Executive	Site Chief Executives
Risk appetite	Cautious (Moderate)

Risk Score		Impact	Likelihood	Overall Risk Score	Assurance rating
Inherent	Jun-26	5	5	25	Limited
Current	**Jun-26**	**5**	**4**	**20**	**Partial**
Target	Mar-28	5	3	15	Reasonable

Change since last review: ⟺

Month	Jul-26	Oct-26	Dec-26	Mar-27	Jun-27	Oct-27	Dec-27	Mar-28	Jun-28	Oct-28	Dec-28	Mar-29
Risk Score	20	20										
Assurance	Partial	Partial										

	Key controls *What are we already doing to manage the risk?*	Assurances on controls *How do we have assurance that the controls are working?*	*Line of defence*	Control Strength
1	Comprehensive operational performance management arrangements covering urgent and emergency care, elective care, diagnostics and cancer performance.	IQPR reporting, NOF reporting, national oversight framework reporting, performance trajectories and F&P Committee reporting.	1st / 2nd	Moderate
2	Group and site arrangements to manage patient flow, bed capacity, escalation and operational resilience.	Flow metrics, bed occupancy reporting, length of stay reporting, corridor care reporting, site operational reviews and patient flow reporting.	1st / 2nd	Moderate
3	Programme of work to improve RTT performance, waiting list management and elective productivity.	RTT reporting, waiting list trajectories, 52-week wait reporting, validation activity and recovery programme reporting.	1st / 2nd	Moderate
4	Improvement programmes to improve urgent and emergency care performance and reduce operational pressures.	UEC performance reporting, ED metrics, corridor care reporting, site improvement plans and operational performance reviews.	1st / 2nd	Moderate
5	Programmes to improve diagnostic and cancer pathways and recovery performance.	Cancer performance reporting, diagnostics performance reporting, pathway reviews, deep dives and recovery programme reporting.	1st / 2nd	Moderate
6	System-wide discharge and flow arrangements with partners to support timely patient discharge and capacity management.	Discharge metrics, system flow reporting, community capacity reporting, escalation reporting and system oversight arrangements.	1st / 2nd	Moderate
7	Board, Committee and Executive oversight of operational performance and delivery of constitutional standards.	F&P Committee reporting, Group Executive Committee reporting, site governance reporting, Board reporting and performance review meetings.	2nd	Moderate
8	Transformation programmes designed to improve flow, productivity, outpatient transformation, non-elective care and delivery of sustainable access improvements.	Medium Term Plan reporting, transformation programme reporting, pathway redesign reporting, productivity reporting and programme governance arrangements.	2nd	Weak-Moderate

Group Board Assurance Framework 2026/27

Gaps in controls *What do we need to do to control the risk that we are not yet doing?*		*Linked controls*
1	**Patient flow remains constrained by discharge delays and wider system capacity pressures:** Whilst patient flow and escalation arrangements are established, discharge delays and wider system constraints continue to impact bed availability, patient flow and operational performance.	2, 6
2	**Capacity constraints continue to limit operational performance and recovery trajectories:** Capacity constraints across beds, theatres, diagnostics and workforce continue to affect the Group's ability to consistently achieve constitutional standards and improve flow.	2, 3, 4, 5
3	**Benefits from transformation, productivity and left-shift programmes have not yet been fully realised:** Delivery of planned improvements in access, flow and productivity remains dependent on transformation programmes that are still in delivery or early implementation phases.	8
4	**Operational performance remains vulnerable to rising demand and external system pressures:** The Group continues to experience demand growth and external system pressures which may offset improvements delivered through internal recovery and transformation programmes.	2, 4, 6, 8
5	**Variation remains in performance across pathways, services and sites:** Whilst improvement programmes are established, performance against constitutional standards remains variable across specialties, pathways and sites, indicating that improvements are not yet consistently embedded.	1, 3, 4, 5, 7
6	**Delivery of access and flow improvements remains dependent on investment in additional capacity and performance improvement initiatives:** Achievement of recovery trajectories and constitutional standards may require continued investment in workforce, capacity and improvement initiatives at a time of significant financial constraint. Balancing performance improvement requirements with financial sustainability objectives remains an ongoing challenge.	3, 4, 5, 8

Material actions to address gaps in controls and assurances *What are we going to do, by when, to further manage and mitigate the risk?*		Control Gaps	Executive Lead	Due date	Progress
1	Deliver agreed RTT recovery trajectories and reduce long waits through waiting list validation, pathway redesign and elective productivity improvements.	2, 5, 6	SCEOs	Mar-27	On Track
2	Deliver urgent and emergency care improvement plans to improve patient flow, reduce corridor care and improve emergency care performance.	1, 2, 5, 6	SCEOs	Mar-27	On Track
3	Deliver agreed cancer and diagnostics recovery trajectories and improve performance against national standards.	2, 5, 6	SCEOs	Mar-27	On Track
4	Implement agreed discharge and flow improvement plans with system partners to reduce discharge delays and improve bed availability.	1, 4	SCEOs	Mar-27	On Track
5	Deliver non-elective transformation and pathway redesign programmes to improve access, flow and productivity.	3, 4	SCEO-SGUH	Mar-28	On Track
6	Deliver outpatient transformation programme to improve access, flow and productivity.	3, 4	SCEO-ESTH	Mar-28	On Track

Related risks on Corporate Risk Registers

Trust	Datix ID	Score	Summary risk description
SGUH	2393	16	Regularising Flow
ESTH	1943	16	Patient Flow
ESTH	1942	20	Waiting Times
SGUH	3139	16	Operational Performance – Cancer
SGUH	3140	16	Operational Performance – Constitutional Standards (UEC)
ESTH	1946	20	Cancer diagnostics waits
SGUH	2240	16	Patients waiting longer than 18 weeks for elective cardiology
SGUH	2664	16	Cancellation of elective & urgent inpatient vascular patients

Emerging risks

What could materially affect this risk over the next 12-24 months?

- Demand growth may outpace planned capacity and productivity improvements.
- Discharge delays and wider system capacity pressures may continue to constrain patient flow.
- Workforce, estate and digital constraints may limit improvements in access and flow.
- National performance expectations and regulatory scrutiny may increase faster than improvements in operational performance.

Group Board Assurance Framework 2026/27

Strategic Risk	SR7	Patient Safety and Quality

Event	Caused by	Results in
The gesh Group fails to maintain and improve the quality and safety of care during a period of financial pressure and transformation.	*Weaknesses in quality governance, inconsistent implementation of the Quality Management System, and failure to consistently embed quality and safety within organisational decision-making.*	*Avoidable harm to patients, poorer clinical outcomes, widening inequalities, poor patient experience and regulatory scrutiny.*

Current Risk Score: 20

Assurance: Partial

Strategic objective	Right Care, Right Place, Right Time
Last review date	*16 October 2026*
Monitoring Committee	Quality Committees
Lead Executive	GCNO & GCMO
Risk appetite	Cautious (Moderate)

Risk Score		Impact	Likelihood	Overall Risk Score	Assurance rating
Inherent	May-26	5	5	25	Limited
Current	**Jun-26**	**5**	**4**	**20**	**Partial**
Target	Mar-28	5	3	15	Reasonable

Change since last review



Month	Jun-26	Oct-26	Dec-26	Mar-27	Jun-27	Oct-27	Dec-27	Mar-28	Jun-28	Oct-28	Dec-28	Mar-29
Risk Score	20	20										
Assurance	Partial	Partial										

	Key controls *What are we already doing to manage the risk?*	Assurances on controls *How do we have assurance that the controls are working?*	*Line of defence*	Control Strength
1	Quality Governance and Assurance Framework	Quality governance architecture and processes are defined, with clear Divisional, Site, Executive, Committee Board oversight frameworks	1st / 2nd	Moderate
2	Patient Safety Incident Response Framework (PSIRF)	Patient Safety Incident Reports, PSIRF reporting, learning response reviews and Internal Audit findings	1st / 2nd / 3rd	Moderate
3	Quality Impact Assessment Framework	Quality Impact Assessment reporting relating to Cost Improvement Programmes, winter plans, service change and transformation programmes	1st / 2nd	Moderate
4	Clinical Effectiveness and Standards Framework	NICE compliance reporting, Learning from Deaths reporting, clinical audit activity, professional standards reviews, and population health and health inequalities analysis to identify unwarranted variation in outcomes and access	1st / 2nd	Moderate
5	Clinical Quality and Safety Oversight Framework	Site nursing oversight of patient safety and fundamentals of care, supported by Group oversight of safeguarding and mental health, patient experience, complaints and PALS, and professional standards. Assurance should demonstrate how themes from these sources inform improvement priorities and how learning is shared across both Trusts.	1st / 2nd	Moderate
6	Quality Intelligence and Performance Reporting Framework	IQPR quality and safety metrics, mortality indicators, patient safety metrics and trend reporting. Reporting against the Group Quality Priorities, supported by triangulation of patient safety incidents, complaints, PALS, patient experience, safeguarding concerns and nursing quality measures, to identify emerging risks and monitor improvement.	2nd	Moderate

Group Board Assurance Framework 2026/27

Gaps in controls *What do we need to do to control the risk that we are not yet doing?*		*Linked controls*
1	**Further embedding and evaluation of strengthened quality governance arrangements:** Significant progress has been made through the Group Governance Improvement Programme in clarifying governance structures, accountability, reporting and escalation. Further work is required to demonstrate consistent application across services, divisions and sites, and to evaluate the impact on timely escalation, delivery of improvement actions and organisational learning.	1, 6
2	**A Group Quality Management System has not yet been fully implemented and embedded:** Development of a Group Quality Management System remains in progress and a consistent approach to quality planning, assurance, improvement and learning is not yet fully embedded across the organisation.	1, 4
3	**Continuous improvement capability and approaches are not yet consistently embedded across the Group:** Approaches to quality improvement, learning and continuous improvement remain variable across services and sites, limiting the pace and consistency of improvement.	1, 4
4	**Quality intelligence and triangulation are not yet fully mature:** The organisation receives a significant volume of quality, safety and performance information. Further development is required to strengthen triangulation, improve insight and support earlier identification of emerging quality and safety risks.	5, 6
5	**Assurance regarding the quality impact of major transformation and financial recovery programmes continues to develop:** QIA processes are established. However, the organisation continues to strengthen its ability to assess, monitor and evaluate the quality impacts of transformation and financial recovery programmes.	3
6	**Unwarranted variation remains in quality and safety outcomes between services, sites and population groups:** Quality intelligence, clinical assurance activity and health inequalities reporting continue to identify unwarranted variation in quality, safety and outcomes across services, sites and patient groups.	4, 5, 6

Material actions to address gaps in controls and assurances *What are we going to do, by when, to further manage and mitigate the risk?*		Control Gaps	Executive Lead	Due date	Progress
1	Deliver the Quality Governance Improvement Plan	1, 3	GCNO / GCMO	Dec-26	On Track
2	Develop and implement the Group Quality Management System	2, 3	GDCEO	Mar-28	On Track
3	Deliver the Group Quality Priorities 2026/27	3, 4	GCNO / GCMO	Mar-27	On Track
4	Strengthen Quality Impact Assessment processes and arrangements	5	GCNO / GCMO	Mar-27	On Track
5	Deliver improvement actions arising from internal and external reviews	1, 5, 6	GCNO / GCMO	Jun-27	On Track
6	Strengthen the identification and reduction of unwarranted variation and health inequalities	6	GCMO	Mar-28	On Track

Related risks on Corporate Risk Registers

Trust	Datix ID	Score	Summary risk description
SGUH/ESTH	2923/2255	20	Emergency Department Overcrowding
SGUH	2976	16	Maternity Services – Safety and Regulatory Standards
SGUH	2393	20	Regularising Flow
ESTH	1943	16	Patient Flow
ESTH	1948	16	Caring for adult mental health patients in ED and wards

Emerging risks

What could materially affect this risk over the next 12-24 months?

- Financial recovery and transformation programmes may increase quality and safety risk
- Increasing service demand and operational pressures may affect quality and safety outcomes
- Regulatory and external review findings may identify additional quality and safety improvement requirements
- Workforce pressures may affect quality improvement capacity and capability
- Unwarranted variation and health inequalities may become more pronounced during periods of change

Group Board Assurance Framework 2026/27

Strategic Risk	SR8	Workforce Sustainability

Current Risk Score: 20

Assurance: Partial

Event	Caused by	Results in
The gesh Group is unable to deliver a sustainable, affordable and well-deployed workforce.	*Workforce redesign and establishment reductions not being delivered at the pace required, continued reliance on temporary staffing, elevated sickness absence, and slower than planned workforce productivity improvements.*	*Elevated workforce costs, productivity shortfalls, increased safety risk, and slower delivery of transformation and operational objectives.*

Strategic objective	Empowered, Engaged Staff
Last review date	*13 October 2026*
Monitoring Committee	People Committees
Lead Executive	Group Chief People Officer
Risk appetite	Averse (Low)

Risk Score		Impact	Likelihood	Overall Risk Score	Assurance rating
Inherent	May-26	5	5	25	Limited
Current	**Jun-26**	**5**	**4**	**20**	**Partial**
Target	Mar-28	5	3	15	Reasonable

Change since last review: ⟺

Month	Jun-26	Oct-26	Dec-26	Mar-27	Jun-27	Oct-27	Dec-27	Mar-28	Jun-28	Oct-28	Dec-28	Mar-29
Risk Score	20	20										
Assurance	Partial	Partial										

	Key controls *What are we already doing to manage the risk?*	Assurances on controls *How do we have assurance that the controls are working?*	*Line of defence*	Control Strength
1	Workforce Controls and Establishment Management	Workforce establishment, recruitment and WTE reduction performance monitored against plan.	1st / 2nd	Moderate
2	Temporary Staffing Reduction Programme	Delivery of temporary staffing reduction targets and internal audit findings.	1st / 2nd / 3rd	Moderate
3	Attendance Management and Wellbeing Framework	Workforce availability and sickness trends monitored through People Committee reporting.	1st / 2nd	Moderate
4	Clinical Workforce Transformation Programme	Workforce productivity and transformation benefits monitored through programme governance.	1st / 2nd	Moderate
5	Admin and Clerical Workforce Transformation Programme	Workforce analytics, workforce/finance reconciliation, productivity opportunities and programme delivery reporting.	1st / 2nd	Weak-Moderate
6	Corporate Services Transformation Programme	Delivery of workforce optimisation, role redesign and productivity improvements.	1st / 2nd	Weak-Moderate
7	Workforce Performance Oversight	Routine oversight of workforce performance, risks and emerging pressures.	2nd	Moderate
8	Integrated Workforce and Financial Planning	Monitoring of workforce assumptions underpinning financial recovery and MTP delivery.	2nd	Moderate

Group Board Assurance Framework 2026/27

Gaps in controls *What do we need to do to control the risk that we are not yet doing?*		*Linked controls*
1	**Workforce affordability plans remain dependent on significant workforce reduction delivery:** A substantial proportion of planned workforce reductions and associated savings have yet to be realised.	1, 8
2	**Workforce productivity improvements are not yet evidenced at the scale required:** Planned benefits from workforce deployment, job planning, rostering optimisation, skill mix redesign, digital enablement and new ways of working remain largely unproven and are not yet embedded at scale.	4, 5, 6, 8
3	**Temporary staffing reductions remain challenging: D**elivery of planned reductions is reliant on improvements in workforce availability, sickness absence, substantive recruitment, workforce deployment and productivity.	2, 3
4	**Sickness absence remains above planned levels:** Sickness absence remains above target across the Group and is a key dependency for workforce availability, workforce productivity and temporary staffing reduction assumptions.	3, 7
5	**Workforce transformation programmes remain at an early stage of maturity:** The transformation programmes which underpin workforce productivity and affordability assumptions remain in mobilisation or early delivery phases, with benefits realisation largely dependent on future delivery.	4, 5, 6
6	**Workforce and financial plans remain highly interdependent:** Achievement of workforce, productivity and efficiency targets is dependent on concurrent delivery across multiple programmes.	1, 8

Material actions to address gaps in controls and assurances *What are we going to do, by when, to further manage and mitigate the risk?*		Control Gaps	Executive Lead	Due date	Progress
1	Deliver establishment management and workforce affordability plans underpinning the MTP and financial recovery programme.	1, 6	GCPO / GCFO	Mar-27	Off Track
2	Implement actions to reduce reliance on bank and agency staffing and deliver NHSE temporary staffing targets.	3, 4	GCPO	Mar-27	Off Track
3	Deliver sickness reduction and workforce wellbeing actions to improve workforce availability.	4	GCPO	Oct-27	On Track
4	Implement workforce deployment, job planning, rota management and workforce productivity improvements through the Clinical Workforce Transformation Programme.	2, 5	Programme SRO – GCNO	Mar-28	On Track
5	Implement workforce optimisation, role redesign, workforce analytics and productivity improvements through the A&C Workforce Transformation Programme.	2, 5	Programme SRO – COO-SG	Mar-28	On Track
6	Implement workforce redesign, operating model changes and digital enablement through the Corporate Services Transformation Programme.	2, 5	Programme SRO – GCOFIE	Mar-28	Off Track

Related risks on Corporate Risk Registers

Trust	Datix ID	Score	Summary risk description
SGUH/ESTH	3115/2493	20	Sickness Absence Rates
SGUH/ESTH	3129/2149	20	Industrial Action
SGUH/ESTH	2787/2173	16	Corporate Services Integration
ESTH	1930	16	Medical Staffing Shortages
ESTH	2073	20	Soft Facilities Management Staff Terms and Conditions

Emerging risks

What could materially affect this risk over the next 12-24 months?

- National workforce and employment policy changes may adversely affect workforce affordability and delivery assumptions.
- Industrial action or wider workforce relations pressures may affect workforce availability, productivity and financial performance.
- Workforce supply constraints in key staff groups may limit the organisation's ability to achieve workforce redesign and temporary staffing reduction plans.

Group Board Assurance Framework 2026/27

Strategic Risk	SR9	Organisational Culture and Inclusion

Event	Caused by	Results in
The gesh Group fails to embed an inclusive, psychologically safe and high performing culture	*Variable leadership behaviours, competing operational pressures, uneven embedding of organisational values, limited improvement capability, and barriers to speaking up and psychological safety*	*Lower staff engagement and wellbeing, higher turnover and sickness absence, weaker improvement and safety culture, failure to realise the benefits of a diverse and inclusive workforce, and reduced organisational effectiveness*

Current Risk Score: 16

Assurance: Partial

Strategic objective	Empowered, Engaged Staff
Last review date	*13 October 2026*
Monitoring Committee	People Committees
Lead Executive	Group Chief People Officer
Risk appetite	Cautious (Moderate)

Risk Score		Impact	Likelihood	Overall Risk Score	Assurance rating
Inherent	May-26	4	5	25	Limited
Current	**Jun-26**	**4**	**4**	**16**	**Partial**
Target	Mar-28	4	3	12	Reasonable

Change since last review: ⟺

Month	Jun-26	Oct-26	Dec-26	Mar-27	Jun-27	Oct-27	Dec-27	Mar-28	Jun-28	Oct-28	Dec-28	Mar-29
Risk score	16	16										
Assurance	Partial	Partial										

	Key controls *What are we already doing to manage the risk?*	Assurances on controls *How do we have assurance that the controls are working?*	*Line of defence*	Control Strength
1	Implementation of the Group People Strategy 2024-26 and associated delivery programme	Regular People Strategy progress reports to People Committee demonstrating delivery against strategic priorities and workforce outcomes	1st / 2nd	Moderate-Strong
2	Group-wide leadership, organisational development and performance framework to support development of inclusive and high-performing teams.	Reports on talent development, leadership initiatives, performance and development processes, and organisational development programmes.	1st / 2nd	Moderate
3	Implementation of the Group EDI Strategy, Inclusion Board and associated action plans.	WRES, WDES, Pay Gap reporting and EDI progress reports reviewed by People Committee and Board.	2nd / 3rd	Weak-Moderate
4	Group Freedom to Speak Up arrangements and processes supporting speaking up, psychological safety and organisational learning.	Quarterly FTSU reports, thematic analysis of concerns raised, and Staff Survey raising concerns indicators.	2nd / 3rd	Weak-Moderate
5	Structured staff engagement programme including Staff Survey, listening activities and staff involvement mechanisms.	Annual NHS Staff Survey results and associated action plans reviewed by People Committee and Board.	1st / 2nd	Weak-Moderate
6	Group health and wellbeing programme supporting staff wellbeing, attendance and resilience.	Health and wellbeing reports, sickness absence trends and workforce metrics reviewed by People Committee.	1st / 2nd	Moderate-Strong
7	Routine oversight of workforce performance indicators including turnover, sickness, retention and temporary staffing.	Workforce KPI reports reviewed regularly by People Committee.	1st / 2nd	Moderate
8	Regular Board and People Committee oversight of culture, inclusion, staff experience and workforce risks.	Biannual/quarterly review of strategic risks, Board reporting and Committee deep dives.	2nd	Moderate

Group Board Assurance Framework 2026/27

Gaps in controls *What do we need to do to control the risk that we are not yet doing?*		*Linked controls*
1	**Shared values and behavioural expectations are not yet consistently embedded across the Group:** The organisations do not yet have a consistently embedded set of values and behavioural expectations Group-wide, contributing to variation in culture, staff experience and leadership behaviours.	1, 2, 5
2	**Leadership behaviours and management capability remain inconsistent:** There is evidence of variation in staff experience, management conduct concerns, FTSU themes and employee relations issues, suggesting leadership behaviours and management capability are not yet consistently aligned with the Group's desired culture.	2, 5, 7
3	**People and Organisational Development capacity may be insufficient to deliver the scale of cultural change required:** Current People, OD and EDI capacity may not be sufficient to support the scale and pace of leadership, culture, inclusion and workforce transformation required across the Group.	1, 2, 3, 8
4	**Psychological safety and speaking up culture are not yet consistently embedded:** Although Freedom to Speak Up arrangements are mature and accessible, Staff Survey results, FTSU themes and internal audit findings indicate that confidence to speak up and challenge remains variable across services and staff groups.	4, 5
5	**Progress on inclusion and workforce equality remains uneven:** Despite established EDI programmes and governance arrangements, WRES, WDES and Pay Gap reporting continue to demonstrate inequalities in staff experience, representation and career progression across parts of the organisation.	3, 2
6	**Organisational culture is experienced inconsistently across staff groups and services:** Staff Survey, FTSU, WRES, WDES and other assurance sources indicate variation in staff experience, engagement, inclusion and psychological safety between different staff groups, professions and services.	2, 3, 4, 5

Material actions to address gaps in controls and assurances *What are we going to do, by when, to further manage and mitigate the risk?*		Control Gaps	Executive Lead	Due date	Progress
1	Develop and embed a consistent Group-wide values and behaviours framework	1, 2	GCPO	May-27	Off Track
2	Strengthen leadership capability and management practice	2, 3	GCPO	Mar-28	On Track
3	Deliver the EDI improvement programme (inc. Inclusion Board)	5	GCPO	Mar-28	Off Track
4	Deliver the Staff Survey improvement plan	4, 6	GCPO	Mar-27	Off Track
5	Strengthen People, OD and EDI capacity to deliver cultural transformation	3	GCPO	Apr-27	On Track
6	Implement a Group Freedom to Speak Up Strategy and strengthen organisational learning	4, 6	GCCAO	Dec-26	On Track

Related risks on Corporate Risk Registers

Trust	Datix ID	Score	Summary risk description
SGUH/ESTH	881/2491	16	Bullying and harassment
SGUH/ESTH	3115/2493	20	Sickness absence rates
SGUH/ESTH	1978/2070	16	Raising concerns
SGUH	2532	16	Capacity within the Employee Relations team
SGUH	2334	16	Violence and aggression against staff
ESTH	2073	20	Soft Facilities Management Staff Terms & Conditions

Emerging risks

What could materially affect this risk over the next 12-24 months?

- Workforce redesign, organisational change and financial pressures may adversely affect staff engagement, wellbeing and organisational culture.
- Increasing demands associated with transformation, financial recovery and service change may exceed current leadership capacity and capability.
- Failure to improve staff experience may impact recruitment, retention and workforce stability.
- Increasing concerns relating to management conduct, bullying and harassment may impact psychological safety and confidence in organisational processes.

Group Board Meeting (Public)

Meeting on Friday, 06 November 2026

Agenda Item	3.1	
Report Title	**Quality Committees Report**	
Executive Lead(s)	Richard Jennings, Group Chief Medical Officer Nicola Shopland, Site Chief Nursing Officer SGUH Theresa Matthews, Site Chief Nursing Officer ESTH	
Report Author(s)	Andrew Murray, Non-Executive Director Leonie Penna, Non-Executive Director	
Previously considered by	n/a	Click or tap to enter a date.
Purpose	**For Assurance**	

Executive Summary

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

1. **In**terstitial Lung Disease Update: The Committee recognised the seriousness of the issues being investigated and acknowledged the considerable progress made to date. Members were reassured by the transparent approach being adopted and the commitment to engaging openly with families while maintaining rigorous clinical review processes
2. Winter Plan Quality Impact Assessment**:** Members heard that the winter plan had undergone extensive review both internally and across the wider healthcare system. Members emphasised the importance of maintaining visibility of patient safety indicators during periods of operational stress and ensuring that escalation arrangements provided timely opportunities for intervention.
3. St Helier Frailty Unit Fall: Improvement Plan: Committees members welcomed the progress of implementing the improvement plan whilst emphasising the need to also give focus to implementing learning across the wider organisation. Members were keen to ensure that the incident was treated as a source of organisational learning rather than solely a local improvement exercise.

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 September and October 2026

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

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

Implications

Group Strategic Objectives

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

Risks

As set out in the paper

CQC Theme

☐ Safe	☐ Effective	☐ Caring	☐ Responsive	☒ Well Led

NHS system oversight framework

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

Financial implications

N/A

Legal and / or Regulatory implications

N/A

Equality, diversity and inclusion implications

As set out in the paper

Environmental sustainability implications

N/A

Quality Committees Report
Group Board, 06 November 2026

1.0 Purpose of paper

1.1 This report sets out the key issues considered by the Quality Committees at its meetings in September and October 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:

24 September 2026	29 October 2026
• gesh Safety and Compliance Report • Integrated Quality and Performance Report: Quality Metrics Focus • Patient Safety Incident Report • Perinatal Subcommittee Report • Interstitial Lung Disease Update • SWL Pathology Quality Safety Assurance • Pharmacy - Integrated Quality and Performance Report • Patient Experience and Involvement Report • Frailty Hub, St Helier Hospital • Group Quality Integrated Impact Assessment (QIIA)	• gesh Safety and Compliance Report • Integrated Quality and Performance Report: Quality Metrics Focus • Never Events and Barrier Analysis • Perinatal Subcommittee Report • Thirlwell Report: Recommendations and Actions • Winter Plans 2026/27: Quality Impact Assessments • Interstitial Lung Disease Update • Ward Accreditation Annual Report • Dementia and Delirium Annual Report • Health Inequalities Update • Quality Priorities Quarterly Review • Clinical Audit & Effectiveness Report • PSIRF Internal Audit Report: Follow-Up • Board Assurance Framework: Quality and Safety Risks

2.2 The Committees was quorate at both meetings.

3.0 24 September - Key issues for assurance and review

3.1 Patient Safety and Compliance Report

3.1.1 The Committee discussed the increase in SHMI at ESTH, noting that actual deaths had not increased, but changes in expected mortality calculations and data quality issues had caused SHMI deterioration. Upon initial review, it is evident that missing primary diagnosis coding has been a significant factor. A task-and-finish group has been established to investigate issues in greater detail. Committees members requested a report back from the Task and Finish Group once its investigation concludes.

3.1.2 Members sought clarification regarding references to sepsis alerts in the report. It was confirmed that the matter related primarily to electronic sepsis alert functionality, with an options appraisal underway to determine the best solution.

3.1.3 Members noted that the complaints performance has continued to deteriorate; it was advised that there has been sickness absence within the team which has had a detrimental effect on the ability to respond to complaints. Recovery plans are in place and the performance is monitored weekly.

3.2 Integrated Quality Performance Report: Focus on Quality and Safety Metrics

3.2.1 The Committee received the report, which detailed that based on overall metric scores, SGUH achieved Segment 2 and ESTH achieved Segment 3. Following application of the finance override, both trusts received a final adjusted segmentation of 3. Nationally, SGUH ranked 51st and ESTH 83rd out of 134 acute trusts.

3.2.2 The Chair drew particular attention to the recurring issue of fundamentals of care, noting that a number of indicators continued to demonstrate variation from the standards expected by the organisation. He reported that this issue had been discussed outside the meeting and that agreement had been reached for more focused assurance reports to be brought to the next committee meeting so that members could better understand performance trajectories, areas of risk and improvement plans. The Committee agreed that these reports would provide more comprehensive assurance regarding the effectiveness of improvement work in this area.

3.2.3 The Committees also discussed lengthy waits for diagnostic investigations, with members expressing concern regarding the significant proportion of patients waiting beyond national standards and highlighted the potential risk that serious conditions, including cancers, could remain unidentified whilst patients awaited investigations. Members sought assurance regarding the mechanisms used to identify and manage risk in patients experiencing prolonged waits.

3.3 Patient Safety Incident Report

3.3.1 The Committees reviewed the patient safety incident report and focused discussion on how learning is embedded following incidents. Members discussed whether investigations are achieving meaningful change and how learning is spread across divisions. Members emphasised the importance of ensuring improvement plans evolve where previous interventions have not succeeded

3.3.2 A detailed discussion took place regarding falls prevention following recent incidents. Members referred to concerns arising from the Frailty Hub incident and asked how the organisation would know whether current improvement initiatives were delivering meaningful improvements. In response, It was advised that programme of work, which included falls prevention training, post-falls management improvements, enhanced use of learning from incidents and the introduction of a compassionate post-falls care toolkit was taking place.

3.3.3 **Assurance rating: reasonable.** The Committee acknowledged that learning cultures take time to mature but was encouraged by the direction of travel being described. Members agreed that the report provided reasonable assurance regarding the systems in place to investigate incidents and drive organisational learning.

3.4 Maternity Services Report

3.4.1 A recurring concern throughout the discussion related to digital infrastructure. Members highlighted repeated references throughout the report to limitations associated with the current maternity information systems. Executive members agreed that digital challenges were becoming increasingly significant and confirmed that options were being actively explored to either improve or replace existing systems. Strong concern was expressed that the current arrangements could not continue indefinitely without affecting the pace of quality improvement.

3.4.2 Assurance rating: reasonable. The Committee concluded that the report demonstrated substantial improvement activity and provided reasonable assurance regarding oversight of maternity and neonatal services.

3.5 Interstitial Lung Disease Update

3.5.1 Committees members welcomed the update but remained concerned that the programme should not lose momentum, emphasising the importance of maintaining visibility of progress. Members stressed that the Committee needed sufficient oversight to identify slippage early rather than discovering delays late in the process. The Committees received assurance that robust programme management arrangements were being established.

3.5.2 Committees members requested that future reports contain more detailed milestone reporting, progress against planned trajectories, information relating to patient and family engagement and updates regarding the wider review of non-ILD patients.

3.6 SWL Pathology Quality Safety Assurance

3.6.1 The Committee explored whether the technology issues detailed in the report reflected a broader organisational challenge concerning digital infrastructure. KM noted that the emerging theme across multiple papers suggested a wider strategic risk associated with ageing digital systems and questioned whether the organisation was approaching a point where those risks might affect resilience. It was advised that significant work was underway to rationalise systems inherited through organisational mergers and historic arrangements.

3.6.2 **Assurance rating: reasonable.** The Committee concluded that although significant IT-related risks remained under management, pathology services were operating safely and effectively.

3.7 Pharmacy - Integrated Quality and Performance Report

3.7.1 Committees members explored risks associated with medication storage during periods of extreme heat. Members received assurance that pharmacy departments themselves were equipped with appropriate temperature control, monitoring systems and cold-chain management processes. However, executives acknowledged that challenges remained within ward environments and community settings, particularly during periods of exceptionally high temperatures.

3.7.2 Members discusses discharge medicines (TTOs) and their impact on hospital flow, noting that there are anecdotal reports suggesting that patients ready for discharge were often delayed whilst awaiting medications. It was advised that delays frequently originated before pharmacy involvement, as discharge prescriptions often required completion by medical staff before dispensing could commence.

3.7.3 **Assurance rating reasonable.** The Committees was satisfied that appropriate medicines governance arrangements remained in place and welcomed plans for a more strategic medicines safety programme.

3.8 Patient Experience and Involvement Report

3.8.1 Committees members received the report, which reflected substantial progress in embedding patient experience, co-production and statutory responsibilities across the organisation. Significant work had been undertaken to support carers, improve accessibility, strengthen patient involvement and enhance the use of patient feedback in service development.

3.8.2 The compliance with the Accessible Information Standard and implementation of the Reasonable Adjustment Digital Flag was discussed, with members noting that compliance remained incomplete and sought assurance regarding delivery timescales. In was advised that whilst the organisation would not meet its planned milestone by the end of September, significant foundational work had been completed. This included development of policies, enhancement of patient-facing systems and establishment of patient advisory groups.

3.8.3 Assurance rating: Reasonable.

3.9 Frailty Hub, St Helier Hospital: Quality and Safety Review – Findings, Assurance and Improvement Plan

3.9.1 Members commended the quality of the report but questioned whether sufficient emphasis had been placed on learning across the wider organisation. Whilst the report clearly described actions being taken within the Frailty Hub itself, members sought assurance that lessons learned would be disseminated broadly and that systemic risks elsewhere would be identified and addressed. Members were keen to ensure that the incident was treated as a source of organisational learning rather than solely a local improvement exercise.

3.9.2 Discussion also focused on cultural and behavioural reviews; the Site CNO- ESTH advised that additional work was being undertaken in response to issues identified during the investigation and that wider concerns relating to culture and leadership in medicine were also being considered. Particular attention was being given to staff who worked permanent night shifts, reflecting concerns about fatigue, isolation and the quality of supervision available outside normal daytime hours.

3.9.3 The Committee endorsed the proposed assurance ratings within the report whilst requesting further detail in future updates regarding progress in areas currently assessed as providing only partial assurance. A report on the wider culture and behaviour review will be presented to the Committee when it has concluded.

3.10 Group Quality Integrated Impact Assessment (QIIA) Panel Update: April 2026 to August 2026

3.10.1 The Committee reviewed the Group Quality Impact Assessment report relating to Cost Improvement Programmes and transformation initiatives. The Chair reflected on previous discussions regarding the role of the Quality Impact Assessment process and questioned whether clearer organisational principles were required when balancing quality against efficiency savings. He suggested that whilst patient safety should remain non-negotiable, greater clarity would be helpful regarding how the organisation wished to manage potential impacts on patient experience and clinical effectiveness. GCMO agreed with this reflection, noting that clearer articulation of principles would be beneficial and advised that future scheme sponsors would be given more explicit guidance regarding the Committee's expectations

3.10.2 **Assurance rating:reasonable.** The Committee agreed that the report provided reasonable assurance regarding current arrangements but requested ongoing refinement of both principles and scope.

4.0 29 October 2026 – Key issues for assurance and review

4.1 gesh Safety and Compliance Report

4.1.1 Members discussed the persistent challenge presented by the Summary Hospital-level Mortality Indicator (SHMI), particularly within ESTH. It was questioned whether the continued explanation that mortality variation may be linked to coding and data quality issues remained sufficient given the length of time that elevated mortality indicators had been reported. GCMO advised that two distinct workstreams had been established to determine the root cause, the first on validating the quality and completeness of coded data and understanding the impact of changes to national methodology and the second involved a broader clinical review programme intended to investigate whether variation in outcomes could be linked to factors such as service configuration, treatment pathways, waiting times, clinical decision-making, patient demographics or health inequalities. The Committee agreed that future updates should provide a structured description of the methodology being applied, the areas being investigated and the anticipated completion dates for key stages of work. The Committee were reassured that appropriate investigations and improvement programmes were in place and that further evidence would be required before definitive conclusions could be drawn regarding the causes of mortality variation

4.1.2 Members noted the report.

4.2 Never Events and Barrier Analysis

4.2.1 The report highlighted a number of areas where improvements had already been achieved. Members heard that focused interventions had significantly reduced the risk of retained guidewire incidents and had strengthened assurance in relation to wrong-site skin surgery. Attention was now turning towards ensuring greater consistency in the implementation of National Safety Standards for Invasive Procedures (NatSSIPs) and Local Safety Standards for Invasive Procedures (LocSSIPs) across all procedural settings.

4.2 **Assurance Rating: Limited Assurance** regarding the effectiveness and completeness of current preventative controls. **Reasonable Assurance** regarding the organisation's understanding of the gaps and the robustness of the improvement programme designed to address them.

4.3 Perinatal Subcommittee Report

4.3.1 Members discussed the maturity of the Perinatal Subcommittee and explored whether it was operating primarily as an assurance committee or whether its discussions continued to focus on operational management. Several members observed that while the work being undertaken was extensive and necessary, future reports would benefit from clearer articulation of the principal risks, controls and assurances required by the Quality Committee. The Committee also discussed progress against triage improvement work and benchmarking undertaken with peer organisations.

4.3.2 Further discussion took place regarding implementation of learning from national maternity reviews and home birth recommendations. The Committee noted that services were responding appropriately to external learning and incorporating recommendations into local improvement plans. Members emphasised the importance of ensuring that implementation could be evidenced and not simply described.

4.3.3 **Assurance Rating: Reasonable Assurance.** The Committee received reasonable assurance that appropriate governance and improvement arrangements were in place, whilst recognising that further development of assurance reporting remained necessary.

4.4 Thirlwall Inquiry Response

4.4.1 The Committee was assured that the organisation had responded promptly to emerging recommendations and had established governance arrangements capable of monitoring progress and ensuring accountability. Members emphasised the importance of maintaining visibility of delivery against all actions and noted that the progress against the action would be tracked through the Perinatal committee and reported back to Quality Committee via this route for future assurance.

4.5 Winter Plan Quality Impact Assessment

4.5.1 Members heard that the winter plan had undergone extensive review both internally and across the wider South West London healthcare system. The proposals had been subject to challenge by regional colleagues and system partners and had been designed specifically to mitigate the risks typically associated with increased seasonal demand.

4.5.2 Members emphasised the importance of maintaining visibility of patient safety indicators during periods of operational stress and ensuring that escalation arrangements provided timely opportunities for intervention. It was confirmed that quality monitoring would continue alongside operational monitoring and that governance arrangements were in place to identify emerging concerns rapidly.

4.5.3 **Assurance Rating: Reasonable Assurance.** The Committee received reasonable assurance regarding the adequacy of the winter plans and the consideration given to quality and patient safety impacts.

4.6 Interstitial Lung Disease (ILD) Harm Review

4.6.1 Significant discussion focused on the emerging findings from completed reviews. Members were informed that a number of cases had met Duty of Candour thresholds and that varying degrees of harm had been identified, including a small number of severe harm cases and one case where death may have been associated with shortcomings in care. The Committee explored the support available to affected families and sought reassurance that all statutory requirements relating to openness and transparency were being met. It was confirmed that direct engagement with families was underway and that disclosures were taking place in accordance with Duty of Candour obligations.

4.6.2 The Committee recognised the seriousness of the issues being investigated and acknowledged the considerable progress made to date. Members were reassured by the transparent approach being adopted and the commitment to engaging openly with families while maintaining rigorous clinical review processes.

4.6.3 **Assurance Rating: Reasonable Assurance.** The Committee received reasonable assurance regarding the governance and management of the review programme, whilst recognising that further work remained outstanding

4.7 Ward Accreditation Programme

4.7.1 The Committee welcomed the maturity of the accreditation programme and the evidence that it was supporting continuous improvement across both acute and community services.

Members considered the programme to be a valuable assurance mechanism and encouraged its continued development

4.7.2 **Assurance Rating: Reasonable Assurance.** The Committee received reasonable assurance regarding the effectiveness and expansion of the accreditation programme.

4.8 Dementia and Delirium Improvement Programme

4.8.1 The Committee recognised that genuine progress had been made in developing the programme and acknowledged the commitment demonstrated by the clinical teams involved. Nevertheless, members remained unconvinced that the information presented provided sufficient assurance regarding the overall effectiveness of dementia and delirium care pathways. It was agreed that further work was required to refine the reporting framework so that future updates clearly demonstrated the relationship between screening activity, assessment, intervention and patient outcomes

4.8.2 It was agreed that future dementia and delirium reports to present clear pathway metrics demonstrating the number of patients screened, identified as at risk, assessed using the 4AT tool and subsequently managed in accordance with agreed standards of care.

4.8.2 **Assurance Rating: Limited Assurance**. While the Committee recognised the progress that had been made and was encouraged by the direction of travel, members concluded that they could not yet derive sufficient assurance regarding the effectiveness of the overall dementia and delirium pathway because the available data did not clearly demonstrate end-to-end compliance or outcomes.

4.9 Health Inequalities Programme Update

4.9.1 The Committee welcomed the significant progress made in establishing the organisational foundations necessary to address health inequalities in a systematic and evidence-based manner. Members were encouraged by the development of the Health Equity Champion network, the introduction of population health dashboards and the identification of priority workstreams targeted at known areas of inequality. The Committee agreed that future updates should increasingly focus on outcome measures and evidence of impact to demonstrate the effectiveness of interventions being implemented

4.9.2 **Assurance Rating: Reasonable Assurance.** The Committee received reasonable assurance that appropriate governance, leadership and programme structures were in place to address health inequalities across the organisation. Members were satisfied that the direction of travel was positive, whilst recognising that many initiatives remained at an early stage and that longer-term outcome measures would be required to fully assess their effectiveness.

4.10 Quality Priorities Quarterly Review

4.10.1 The Committee acknowledged the considerable work being undertaken to progress the organisation's quality priorities and recognised evidence of improvement across a number of programmes. However, members felt that future reports should place greater emphasis on demonstrating impact and organisational learning, rather than simply reporting progress against individual actions. The Committee particularly requested a stronger narrative regarding the development and maturity of the organisation's quality governance framework and greater clarity regarding how improvement activities were contributing to better patient outcomes.

4.10.2 **Assurance Rating: Limited Assurance.** The Committee concluded that while progress was evident and a substantial programme of improvement work was underway, the information presented did not yet provide sufficient evidence of impact to support a higher level of

assurance. Members considered that further development of reporting arrangements would help strengthen confidence in delivery against the organisation's quality priorities.

4.11 Clinical Audit and Clinical Effectiveness Report

4.11.1 The Committee welcomed the achievement of full participation in national audit programmes and acknowledged the strengthening of governance arrangements supporting clinical audit and effectiveness activity. Members were encouraged by the progress made but considered that future reporting should place greater emphasis on demonstrating the impact of audit findings, the implementation of learning and the contribution of audit activity to improvements in patient care. The Committee also requested broader visibility of accreditation and peer-review arrangements to strengthen overall assurance regarding clinical effectiveness

4.11.2 Assurance Rating: Limited Assurance. The Committee concluded that while the report demonstrated strong progress in participation and governance processes, further evidence was required to demonstrate that audit activity was consistently resulting in measurable improvements in clinical practice and patient outcomes. Members therefore considered that only limited assurance could currently be derived regarding the effectiveness of the wider clinical effectiveness framework

4.12 Patient Safety Incident Response Framework (PSIRF) Internal Audit Report

4.12.1 The Committee welcomed the positive findings of the internal audit and noted the of all actions arising from the review. Members were satisfied that appropriate governance arrangements were in place to support implementation of the Patient Safety Incident Response Framework (PSIRF) and that significant progress had been made in strengthening the organisation's approach to incident oversight and learning. The Committee recognised that continued focus would be required to sustain implementation and embed the framework fully across all services but concluded that substantial progress had already been achieved

4.12.2 Assurance Rating: Substantial Assurance. The Committee received substantial assurance that governance arrangements supporting PSIRF implementation were operating effectively and that recommendations arising from the internal audit had been appropriately addressed. Members considered that the evidence presented demonstrated a strong level of organisational compliance and maturity in relation to patient safety incident management and learning

4.13 Board Assurance Framework

4.13.1 The Committee recognised the continued development of the organisation's governance and quality assurance arrangements and welcomed evidence of improvement across several areas of the Board Assurance Framework. Members supported the overall direction of travel but requested greater transparency regarding the evidence used to support changes in control effectiveness ratings. The Committee agreed that maintaining consistency between Board-level assurance assessments and detailed committee discussions was essential to the credibility of the framework

4.13.2 It was agreed that future reports would provide additional detail regarding the evidence and methodology used to support the revised control effectiveness assessment for quality governance and assurance risks within the Board Assurance Framework. The Committee discussed the operation of the Board Assurance Framework and the processes used to identify and monitor strategic quality risks. Members requested further evidence to support specific proposed improvements in control effectiveness ratings before fully endorsing the suggested changes

5.0 Recommendations

5.1 The Group Board is asked to note the issues escalated by the Quality Committees to the Group Board and note the update on wider issues discussed at the Committees meetings in September and October.

Group Board

Meeting in Public on Friday, 06 November 2026

Agenda Item	3.2	
Report Title	**Gesh Perinatal Sub-Committee Report**	
Executive Lead(s)	Michelle Cudjoe, Group Chief Midwifery Officer	
Report Author(s)	Michelle Cudjoe, Group Chief Midwifery Officer	
Previously considered by	Quality Committees	29 October 2026
Purpose	**For Assurance**	

Executive Summary

1.0 Purpose

This report was submitted to provide QCIC with a summary of the Perinatal Subcommittee meeting held on the 5th October 2026. All relevant papers are listed in Appendix 1 and have been shared with committee members.

The QCIC received reasonable assurance from the Perinatal Subcommittee that both organisations continue to make positive progress against MIS Year 8 requirements and NHS 10 Point Plan priorities, supported by established governance arrangements and ongoing executive oversight.

Assurance was provided that health equity programmes are now established across both Trusts, with clear delivery plans and monitoring arrangements in place.

The Committee welcomed confirmation that the MNSI thematic escalation relating to SGUH has been formally closed.

Whilst overall assurance remains reasonable, a number of risks continue to require oversight, including delivery of elements of the Maternal Care Bundle and Saving Babies' Lives Care Bundle, neonatal medical training compliance at SGUH, workforce capacity challenges, and the impact of delivering multiple national improvement programmes concurrently.

Future assurance will focus on demonstrable improvements in outcomes, experience and access for underserved populations, delivery of maternity triage improvement plans and resolution of the remaining MIS Year 8 compliance risks.

No issues were identified that require immediate escalation outside established governance arrangements; however, neonatal medical training compliance at SGUH and specific MIS Year 8 delivery requirements remain the principal areas requiring continued executive scrutiny.

2. Health Equity

Reducing inequalities in outcomes and experience remains a strategic priority for GESH Maternity and forms part of the MIS Year 8 requirement for quarterly Board oversight of health equity plans.

The Perinatal Subcommittee received updates from both ESTH and SGUH regarding progress on their respective maternity equity programmes. ESTH presented its updated Maternity Equality, Diversity and Inclusion Strategy, which is structured around five priority programmes: late booking and early access, antenatal education, induction of labour, communication and information, and data,

intelligence and assurance. The strategy includes defined outcome measures and a benefits realisation framework focused on reducing variation in access, experience and outcomes.

ESTH identified significant inequalities in access, particularly for women requiring interpreter services, who self-referred substantially later than women not requiring interpreter support. The analysis also highlighted higher rates of late self-referral amongst Global Majority communities, enabling more targeted interventions.

The Committee received an update on the SGUH's Equity and Positive Maternity Experience Strategy. The programme is organised around five strategic pillars: communication, continuity of care, workforce development, governance, and co-production with service users and stakeholders. A comprehensive programme structure and action plan have been established, including work to improve accessibility, continuity of care, staff capability, equity data and service-user involvement. A community engagement activity (Whose Shoes event) focusing on health equity has informed and strengthened the ongoing development of the programme.

The Committee noted that substantial preparatory work has been undertaken across both organisations to establish governance arrangements, delivery plans and metrics. However, assurance over the coming quarters needs to focus increasingly on evidence of measurable improvements in access, experience and outcomes, including reductions in identified disparities between population groups, rather than completion of planned actions alone. A further update will be received in the next quarter to assess progress against agreed outcome measures and health inequality indicators.

Board assurance: Whilst both organisations have established comprehensive equity programmes, future assurance will focus on demonstrable improvements in outcomes, experience and access, particularly for women from underserved communities.

3. MIS Year 8 Matters Considered by the Perinatal Subcommittee

The Committee received updates from both organisations regarding progress against MIS Year 8 requirements.

ESTH provided assurance that the maternity service remains broadly on track to achieve compliance with MIS Year 8 standards. Areas requiring continued focus include implementation of recommendations within the recently published Maternal Care Bundle and further progress against the Saving Babies' Lives Care Bundle. The Committee heard that recruitment to a Tobacco Dependency Advisor post is expected to strengthen delivery of the Saving Babies' Lives Care Bundle and support compliance with MIS Year 8 requirements

SGUH reported that further evidence had been reviewed and resubmitted against a number of individual MIS requirements to ensure full compliance with the detailed standards. These areas have now been assessed as meeting the required threshold. A new risk to full compliance was identified in relation to neonatal training requirements. This is currently under review by the Neonatal Clinical Lead and Site Chief Medical Officer, with a further update and assessment of any mitigating actions to be presented to the Subcommittee in November.

Agenda Item	Summary of discussion	Outcome
Pulse Oximetry	A new requirement in MIS Year 8 is the need for Trusts to develop a governance approved neonatal pulse oximetry guideline, with evidence of implementation and appropriate clinical governance**.**	Both Trusts gave assurance that they are on track to 'go-live' by the MIS timescale of November 2026.
Progress against thematic reviews	MIS Year 8 requires Trust boards to 'receive quarterly reports that demonstrate measures implemented to address recurrent themes, progress made and how	This information is included within quarterly PQOMS. SGUH shared

	learning is shared'.	a paper outlining progress against thematic reviews. The ESTH DOM provided a verbal update which included an update on the further work identified in the original thematic review paper. This included a review of late booking where service users have English as the non-primary language and a review of data indicating an increase in emergency CS rates within the Global Majority service user cohort.
Saving Babies Lives Care Bundle (SBLCB) Q1	The MIS Year 8 requirement is that all Trusts demonstrate progress across all six elements with quarterly reporting to Trust Board	The Subcommittee received assurance that both organisations have established oversight arrangements for SBLCB v3.2. Smoking cessation remains a common area requiring improvement across both sites and targeted actions are in place. SGUH saw a small increase in compliance from 86% in Q3 to 88% in Q4. Further progress will be achieved when a derogation is approved and this is underway. ESTH data showed a marginal decline in performance from 94% in Q3 to 93% in Q4. The unvalidated Q1 position was reported at 90% An implementation plan with a trajectory for improvement is in place and a tobacco dependency midwife has now been recruited. Progress will continue to be monitored via the Perinatal Subcommittee.
Integrated Workforce Plans	**SGUH:** Consultant Presence Audit SGUH and Demand and Capacity Modelling	• The SGUH audit was amended and shared to include all the RCOG elements (eclampsia, collapse, uterine rupture, return to theatre). The audit showed overall compliance

		• SGUH Demand and capacity modelling - Further work was undertaken to map the full pathway (pre-op, theatre, recovery, postnatal). The review concluded that the planned CS pathway remains sustainable. However, some internal operational issues were identified which will be resolved with a local action plan.

Board Assurance: The Committee was assured that both organisations have clear oversight of remaining areas of non-compliance and are actively managing the risks and actions required to achieve full MIS Year 8 compliance.

4. Maternity Triage

The Sub-Committee received the benchmarking undertaken against the national Maternity Triage Specification for all three maternity sites and noted that this was achieved within the required timeframe. The review demonstrated some areas of strength across the Group, including established 24/7 triage services, clinical assessment and robust escalation arrangements. However, no site was fully compliant with all aspects of the specification and a number of recurring themes were identified across the Group.

Common areas requiring further development included the consistency of women-centred information and signage, systematic capture of service-user feedback, implementation of triage-specific data and outcome reporting. Workforce and staffing models emerged as a significant challenge, particularly in relation to dedicated triage staffing, alignment and ensuring sufficient capacity to maintain separation between triage and other maternity functions. Both ESTH sites identified the need for investment in dedicated staffing models, whilst SGUH highlighted workforce pressures associated with maintaining a separate telephone triage service.

The benchmarking also identified estates and infrastructure challenges across sites. These included the need for improved signage and wayfinding, enhanced privacy and confidentiality for women attending triage, and environmental changes to support timely assessment and flow through the service. At SGUH, compliance gaps were identified relating to assessment space, waiting room visibility, privacy, and telephone triage infrastructure.

A further common theme was the need to strengthen the use of data to understand and reduce inequalities in access, experience and outcomes. Whilst ESTH had established processes for equity monitoring within triage services, SGUH identified significant challenges linked to collection and analysis of ethnicity, language, deprivation and experience data to support targeted improvement activity.

The Committee was assured that benchmarking had been completed across all sites and that the findings provide a clear understanding of the changes required to achieve alignment with the national specification. Improvement plans are being developed at each site, including assessment of workforce, digital and estates requirements. These plans, together with associated resource implications, will be presented to the Committee ahead of the December 2026 deadline.

Board assurance: The benchmarking exercise has identified maternity triage as a shared improvement priority across the Group. Future assurance will focus on delivery of the resulting

improvement plans, addressing workforce and infrastructure gaps, and demonstrating progress towards compliance with the national Maternity Triage Specification.

5.Homebirth Services

In line with the NHS 10 Point Plan, both ESTH and SGUH undertook a review of the actions implemented following the Manchester Prevention of Future Deaths (PFD) report to ensure that improvements remained relevant, effective and embedded within current service delivery.

ESTH provided assurance that the recommendations continue to be reflected within established governance, training, escalation and risk assessment processes.

SGUH completed a review of its homebirth service and associated action plan. The review confirmed robust multidisciplinary decision-making and risk management arrangements, whilst identifying opportunities to strengthen workforce resilience, competency assurance, governance oversight, lone-worker arrangements and service-user feedback mechanisms. These actions have been incorporated into an updated improvement plan and will continue to be monitored through established governance arrangement

Board Assurance: The Committee heard that both organisations have completed the required review of the Manchester PFD actions. Existing controls and improvements remain in place, with further actions identified where necessary to strengthen assurance, sustainability and oversight of homebirth services.

6. **Thirlwall Inquiry**

Following publication of the Thirlwall Inquiry, the Committee received assurance that immediate actions had been reviewed across all sites and that support arrangements were in place for families and the neonatal workforce. The Committee recognised that a number of recommendations will require national implementation guidance. A formal benchmarking exercise against the inquiry recommendations will be undertaken across both organisations, with oversight provided by Site Chief Nurses and within existing site governance structures.

Key Issues for the Board's Attention

- Progress against MIS Year 8 remains positive, although delivery risks remain in relation to implementation of specific care bundles at ESTH and neonatal medical training at SGUH.
- Health equity programmes are now established across both organisations; future assurance needs to focus on demonstrable improvements in outcomes and experience.
- Maternity triage has been identified as a shared Group-wide improvement priority, with workforce, estates and digital challenges requiring further consideration. A Group-wide task and finish group has been convened to oversee implementation of improvement plans
- Reviews of Manchester PFD actions with ongoing monitoring arrangements in place at each site to ensure implementation of required recommendations.
- Site Chief Nurses are leading on a comprehensive review of the Thirlwall Inquiry

Action required by Group Board

The Board is asked to:

a) Take reasonable assurance from the work of the Perinatal Subcommittee.
b) Note the key delivery risks relating to MIS Year 8 compliance, maternity triage and health equity.
c) Support ongoing oversight through established governance arrangements.

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	N/A

Implications

Group Strategic Objectives

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

Risks

- Delivery risk to full MIS Year 8 compliance arising from workforce, training and implementation capacity.
- Risk that maternity triage improvement requirements identify workforce, digital and estates investment requirements.
- Risk that limitations in data capture and interoperability constrain the ability to demonstrate reductions in health inequalities.

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 in Public on Friday, 06 November 2026

Agenda Item	3.3	
Report Title	**Thirlwall Assurance Report**	
Executive Lead(s)	Nicola Shopland, Site Chief Nursing Officer – SGUH Theresa Mathews, Site Chief Nursing Officer – ESTH	
Report Author(s)	Nicola Shopland, Site Chief Nursing Officer – SGUH Stephanie Sweeney, Group Director of Quality and Safety Governance	
Previously considered by	Group Executive Committee Quality Committee	20 October 2026 29 October 2026
Purpose	**For Assurance**	

Executive Summary

This paper updates GEC on the actions being taken across gesh in response to the Thirlwall Inquiry and the NHS England letter of 21 September 2026. It summarises the initial position at each site, the immediate requirements and the forthcoming deadlines.

The September staff communication requirement was completed at both sites by 28 September 2026. Work is continuing on insulin controls, bereavement care and safeguarding, which are currently rated Amber at both sites. Particular attention is being given to the requirement for CCTV covering insulin storage by 30 November 2026 and compliance with the GIRFT insulin access and storage requirements by 31 March 2027.

A wider assessment against the Inquiry recommendations is underway. This will identify the actions required within gesh and distinguish these from recommendations led by ICBs, NHS England and other national bodies.

This paper will be presented to the Trust Boards in November 2026, following GEC and QSCIC consideration, to support the public Board discussion requested in the NHSE letter. It sets out our initial response, progress to date and the forthcoming deadlines. The wider assessment and action plan will continue, with further updates brought through the governance process as the work progresses. GEC is asked to note the current position and planned next steps.

Background

The Thirlwall Inquiry examined events at the Countess of Chester Hospital between 2015 and 2018. Its findings highlight failures in safeguarding, leadership, organisational culture and the response to concerns raised by staff.

The NHS England letter of 21 September 2026 sets out immediate actions for Trusts and ICBs. It also asks Boards to consider whether similar events could occur within their organisations and whether sufficient arrangements are in place to protect patients. The learning applies across all services, not solely maternity and neonatal care.

The Inquiry made 17 recommendations addressed to a range of organisations. The gesh assessment will distinguish actions that we are responsible for delivering from those requiring ICB involvement or national changes. A summary of the recommendations, responsible bodies and timescales is included in **Appendix 1**.

Immediate actions

The initial site position is set out below. The September staff communication has been completed. Work is continuing on the Amber areas, with the forthcoming insulin deadlines requiring particular attention.

Action	SGH	ESTH	Timing
Board review	Green	Green	Report planned for November 2026
SUDIC staff communication	Green	Green	Completed by 28 September 2026
Bereavement care	Amber	Amber	Immediate improvement; neonatal death pathway by 31 August 2027
Neonatal Insulin controls	Amber	Amber	Insulin storage CCTV by 30 November 2026, until biometric access is in place; GIRFT access and storage requirements by 31 March 2027
Safeguarding	Amber	Amber	Immediate assurance on training and escalation

The table reflects the initial site ratings. The sites will confirm the outstanding actions and dates, with priority given to delivery against the forthcoming insulin deadlines.

What the immediate actions cover

SUDIC: The communication confirmed that the process applies to qualifying sudden and unexpected deaths of babies who have never left hospital, including those in neonatal units. SUDIC reporting runs alongside the Trust's internal reporting processes.

Bereavement care: Both sites will review their position against the National Bereavement Care Pathway for stillbirth and neonatal death and identify improvements needed, working with ICB partners where appropriate.

Insulin: Each site will confirm arrangements for safe access and storage and the work needed to meet the CCTV deadline of 30 November 2026 and the GIRFT requirements by 31 March 2027. The CCTV requirement concerns insulin storage and is separate from the national plans for in-cot cameras. Recordings must be retained for at least 28 days.

Safeguarding: Both sites will confirm compliance with the training requirements for staff and Board members, including Non-Executive Directors, and that staff know how to raise and escalate concerns. The Group Safeguarding team will support this work.

Parents and staff: The NHSE letter also asks organisations to consider reassurance and support for parents whose babies are receiving neonatal care and to review the support available to staff.

Next steps

The assessment will continue across both sites and relevant Group teams. It will identify what is already in place, the remaining gaps and the actions needed, with leads and completion dates. The assessment will distinguish Trust responsibilities from work led by ICBs and national bodies. A summary of the recommendations is included in **Appendix 1.**

The response and progress will be presented to the Trust Boards in November 2026. QSCIC consideration will follow the GEC discussion. Any immediate patient safety concerns or risk of missing a required deadline will be escalated through the existing governance arrangements. Quarterly updates to the Boards are proposed thereafter.

Action required by Group Board

The Board is asked to:

a) Note the response and completion of the September SUDIC staff communication at both sites.
b) Note the forthcoming deadlines and support completion of the assessment and relevant actions.
c) Support presentation of the response and progress to the Trust Boards in November 2026.

Appendices	
Appendix No.	**Appendix Name**
Appendix 1	Thirwell Recommendations

Implications

Group Strategic Objectives

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

Risks

There is a risk that gaps in safeguarding, escalation of concerns and safety monitoring could leave patients exposed to harm. Delays in completing the required actions, particularly the neonatal insulin controls due by 30 November 2026 and 31 March 2027, could affect patient safety and compliance with the NHSE requirements.

The ongoing assessment will identify gaps and the actions needed to address them, with named leads and completion dates. Any immediate safety concerns or risks to meeting the deadlines will be escalated through existing governance arrangements.

CQC Theme

☒ Safe	☒ Effective	☒ Caring	☒ Responsive	☒ Well Led

NHS system oversight framework

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

Financial implications

There may be costs associated with implementing the recommendations, particularly CCTV and access controls for neonatal insulin storage, alongside any additional training or service improvements identified through the assessment. Costs and funding requirements will be confirmed as the work progresses and taken through the usual approval processes. Any reliance on national funding will be identified separately.

Legal and / or Regulatory implications

The response will support the Trusts' safeguarding and patient safety responsibilities and address the requirements set out in the NHSE letter. Advice will be sought where needed on data protection and privacy in relation to CCTV, and on any employment changes arising from the recommendations.

Equality, diversity, and inclusion implications

Information and bereavement support should be accessible and responsive to the needs of all families. Staff should have equal access to training and feel supported to raise concerns. These considerations will form part of the assessment and any resulting actions.

Environmental sustainability implications

Any new equipment or digital storage required will be considered through the usual procurement processes, including energy use and the responsible disposal of equipment.

Appendix 1 Summary of recommendations

This summary identifies the main responsibilities and dates. Some recommendations have several parts; the full Inquiry recommendations will be used for the assessment.

No	Recommendation	Responsible body	Main timing
1	Roadmap for in-cot cameras in neonatal units	NHSE	31 March 2027
2	Safe insulin access and storage; CCTV of storage; national laboratory guidance	Trusts and national bodies	CCTV 30 November 2026; controls 31 March 2027
3	National Bereavement Care Pathway for neonatal death	Trusts; ICB coordination	31 August 2027
4	Safeguarding training and obligations in employment contracts	Trusts	Training ongoing; existing contracts March 2027
5	Route to interoperable NHS computer systems	NHSE	Route 31 March 2027; harmonisation December 2028
6	Board monitoring of child and baby deaths and escalation of concerning trends	Hospital Trusts	31 March 2027
7	Named MBRRACE lead reporter; regular data review and Board reporting	Hospitals with neonatal units	At least weekly input; six-monthly Board reports; urgent alerts immediately
8	SUDIC communication, revised guidelines and simpler forms	NHSE, DHSC and Trusts	Staff communication completed; guidelines 31 March 2027
9	Suspicion of Deliberate Harm Protocol and guidance	NHSE; Trusts to embed	National protocol 31 March 2027
10	Consider an independent panel of clinical experts	DHSC	No date specified
11	Neonatal death guidance and support for medical examiners	National Medical Examiner and DHSC	Document 31 March 2027; review in 2027
12	Increase paediatric and perinatal pathology training posts	DHSC and NHSE	June 2033
13	Manager barring system and wider accountability changes	DHSC, NHSE and Trusts for local elements	Barring system September 2027
14	Changes to inspection practice	CQC	No date specified
15	Review CQC performance	Health and Social Care Committee	Initially annually
16	Transfer National Guardian’s Office functions and expand Ombudsman powers	National action concerning PHSO	No date specified

17	Independent audit of inquiry recommendation implementation	National action concerning NAO	Work to begin September 2027

Trusts remain responsible for relevant local action while national guidance and changes are developed. ICBs have their own Board review responsibilities and a role in coordinating bereavement care improvements with providers.

Group Board

Meeting in Public on Friday, 06 November 2026

Agenda Item	4.1
Report Title	**Infrastructure Committees Report to Group Board**
Non-Executive Lead	Claire Sunderland Hay, Associate Non-Executive Director (SGUH), Chair of IT focused meetings. Phil Wilbraham, Associate Non-Executive Director (ESTH), Chair of Estates focused meetings.
Report Author(s)	Claire Sunderland Hay, Associate Non-Executive Director (SGUH) Phil Wilbraham, Associate Non-Executive Director (ESTH)
Previously considered by	n/a
Purpose	**For Assurance**

Executive Summary

This report sets out the key issues considered by the Infrastructure Committees at their meetings on 25 September 2026 (both Estates and IT focus) and 23 October 2026 (IT focus). The key issues the Committees wished to highlight to the Board are:

1. **Group Chief Officer - Facilities, Infrastructure & Environment (GCOFIE) Update**
   The Committees received and discussed a written update from the Group Chief Officer Facilities, Infrastructure and Environment (GCOFIE) on operational pressures and key infrastructure projects, including:
   - High temperatures during heatwaves impacted patient environments and maintenance, staff wellbeing and both reactive and planned maintenance activity. Future estate projects will focus on understanding building performance through thermographic surveys and thermal modelling to evaluate how the buildings handle temperatures. The findings will be used to guide future infrastructure and sustainability improvements.
   - Estates and Engineering teams faced significant challenges due to ongoing vacancies and sickness absence. The Committees highlighted the potential impact on staff wellbeing, service delivery, and programme implementation if these issues are left unaddressed. To help mitigate the impact of these capacity issues and strengthen operational management and compliance oversight, a new Head of Operational Estates has been appointed. The Committees requested continuous monitoring of workforce pressures and the associated organisational risks.
   - The Vanguard ITU project was experiencing delays and contractual challenges related to commissioning, water system defects, and unresolved fire safety requirements. Senior Executive meetings are in place to review progress.

2. **Digital Governance Restructure**
   The Committees discussed and supported a proposal to restructure digital governance by establishing a new Digital Board. This will replace the previous Digital Governance Group (DGG) to separate strategic decision-making and investment prioritisation from operational delivery detail. The new structure includes a "Digital Den" to assess new initiatives and aims to rebalance

membership towards senior clinical and operational leaders to ensure priorities are actively owned across the Group.

3. **Cyber Security**
The Committees received an update regarding the changing external cyber threat environment, particularly highlighting recent PHP vulnerabilities and third-party supplier exposures. A detailed baseline assessment is currently underway to establish a clear understanding of current capabilities and required improvements. The Committees were informed that both Trusts are covered by the NHS Security Operations Centre (SOC), irrespective of the email system in use. A 12-to-18-month improvement programme will be presented in January 2027. The Committees endorsed maintaining the strategic cyber risk rating at "High" to accurately reflect the ongoing external threat landscape and guard against complacency.

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 September and October 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 - Board Assurance Framework (BAF) Update – Strategic Estate and Digital 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

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, 06 November 2026

1.0 Purpose of paper

1.1 The report sets out the key issues considered by the Infrastructure Committees' meetings on 25 September 2026 and 23 October 2026 and includes matters the Committees specifically wish to bring to the attention of the Group Board.

2.0 Items considered by the Committees

2.1 At its meetings on 25 September 2026 and 23 October 2026, the Committees considered the following items of business:

25 September (Estates & IT)	23 October 2026 (IT focus)
• Group Chief Officer - Facilities, Infrastructure & Environment Update • Epsom St Helier Estate and Facilities Update (Fire Safety Update and Water Safety Update) • SGUH Estate and Facilities Update • Managing Violence and Aggression Report • Green Plan Annual Update • Digital KPI Presentation	• Bi-monthly Review: Digital KPIs (including risks) • Digital Priorities - Progress vs digital strategy • Capital Update Report • Cyber Resilience Improvement: Initial Review and Approach • Board Assurance Framework (BAF) Update. • Digital Governance Update

2.2 The Committees were not quorate on 25 September 2026 and 23 October 2026. Any decisions made during inquorate meetings are ratified by email or at the next quorate meeting.

3.0 Key issues for escalation to the Group Board

The Committees wish to highlight the following key matters for the attention of the Group Board:

3.1 **Group Chief Officer - Facilities, Infrastructure & Environment Update**

The Committees received and discussed a written update from the Group Chief Officer Facilities, Infrastructure and Environment (GCOFIE) on operational pressures and key infrastructure projects, including:

- High temperatures impacted patient environments and maintenance. Future mitigations are detailed in Green Plan Annual Update and include thermographic surveys and thermal modelling to better understand how the buildings handle temperatures and guide future infrastructure and sustainability improvements.
- Estates and Engineering teams faced significant challenges due to ongoing vacancies and sickness absence. Active recruitment programmes are currently ongoing to address the high vacancy rates, although management has acknowledged the specific challenges in recruiting for specialist Estates roles. To help mitigate the impact of these capacity issues and strengthen operational management and compliance oversight, a new Head of Operational Estates has been appointed. Furthermore, the Committee has requested the continuous monitoring of workforce pressures and the associated organisational risks.
- The Vanguard ITU project was experiencing severe delays and contractual challenges related to commissioning, water system defects, and unresolved fire safety requirements.

- The Grosvenor solar panel installation went live, EV charging infrastructure was installed, and the Committees explored options for a new photovoltaic array over the Epsom car park.
- Significant financial pressures from energy costs were actively monitored fortnightly, and work was underway to identify accelerated opportunities for in-year capital expenditure.
- An HSE improvement notice for the St George's Histopathology Laboratory was lifted, and initial proposals are being developed for a Mental Health Emergency Department at St George's Hospital.

3.2 Workforce Capacity and Vacancies

The Committees identified workforce capacity as a significant risk across both Estates and Digital services. Vacancy rates are approximately 23% within SGUH Estates, and within Digital Services stand at 15.1% at ESTH and 22% at SGUH. The Committees highlighted the potential impact on staff wellbeing, service delivery, and programme implementation if left unaddressed. Phase three of the IT restructure has been approved to remediate this, with expected support from the transformation fund.

3.3 Cyber Resilience Improvement: Initial Review and Approach

The Committees received an update regarding the changing external cyber threat environment, particularly highlighting recent PHP vulnerabilities and third-party supplier exposures. A detailed baseline assessment is currently underway to establish a clear understanding of current capabilities and required improvements. The Committees were informed that both Trusts are covered by the NHS Security Operations Centre (SOC), irrespective of the email system in use. A 12-to-18-month improvement programme will be presented in January 2027. The Committees endorsed maintaining the strategic cyber risk rating at "High" to accurately reflect the ongoing external threat landscape and guard against complacency.

3.4 Digital Capital Update Report

The Committees received an update on the Digital Capital plan, noting strong momentum with 60% (£15.22m) of the digital capital allocation now committed as purchase orders. Active collaboration between the IT, Finance, and Procurement teams has successfully unblocked previous delays. Moving forward, robust forecasting is being applied, and any potential capital underspends will be returned to the Group Capital Steering Group for reprioritization across the wider estate.

4.0 Key Issues on which the Committees received assurance

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

4.2 Digital KPI Presentation

The Committees received the newly formatted Digital KPI Dashboard and noted it as a significant improvement in reporting. Core clinical systems (including Iclip) maintained high availability (96.2%), and proactive IT leadership visits to clinical areas and wards have resulted in positive frontline engagement and an immediate reduction in broken equipment being left in clinical spaces.

The member stressed the importance of maintaining realistic RAG ratings and queried specific indicators, such as clinical systems optimisation being marked red, and training completion appearing green despite missing targets, which IT leadership clarified were formatting or presentation errors. High vacancy rates (exceeding 22% at SGUH and 15% at ESTH) remain

a critical risk to service delivery and programme implementation. The Committee noted that Phase 3 of the IT restructure had been approved, establishing a £22m pay budget to address historical underinvestment and align with national benchmarks. Members also stressed the urgent need to improve low staff appraisal completion rates to aid retention.

4.3 **Fire and Water Safety - ESTH**

The Committees were assured of substantial progress on fire safety enforcement notices, with Surrey Fire and Rescue stepping down 4 of 5 articles at Epsom. It was noted that remaining infrastructure remediation represented the most complex and intrusive phase of the programme. Members acknowledged the challenges of fire compartmentation in ageing buildings, noting a high likelihood of additional unforeseen costs and requested a consolidated estimate of total fire remediation expenditure across both sites to support strategic estate planning. The Committee agreed on a limited level of assurance.

The Committees also noted the E-Block water safety update and that detailed options for refurbishment solutions were being finalised to address the patient safety risk. Members stressed the need for timely decisions, as temporary mitigations had been active for two years and their safe lifespan remained uncertain. In addition to the patient safety considerations which were of primary importance, it was also highlighted that affordability would be a core consideration, as potential solutions may exceed the annual capital envelope and require application for external funding. The Committee agreed on a reasonable level of assurance.

4.4 **The SGUH Estate and Facilities update**

The ongoing operational pressures stemming from infrastructure failures were highlighted, including drainage issues, heat-related impacts, and significant workforce shortages. Vacancy levels within Estates and Engineering remain critically high at approximately 23%, exacerbated by sickness absences, though the recent appointment of a new Head of Operational Estates aims to strengthen operational management and compliance oversight. Despite these capacity challenges, compliance levels for Facilities Management and Medical Physics remain strong, supported by a positive outcome from the recent IR(ME)R CQC inspection. Furthermore, the City St George's lease variation had been finalised, the Premises Assurance Model was nearing completion to support future reporting, and Phase three integration programmes were progressing steadily.

During the discussion, the Committee expressed substantial concern regarding the sustainability of operating with such high vacancy levels. While active recruitment programmes were ongoing, the difficulty in recruiting specialist Estates roles was acknowledged, prompting the Committee to request continuous monitoring of workforce pressures and associated organisational risks.

Members also raised concerns over delays in receiving Authorising Engineer reports, noting that related contracts and performance are currently under review, and emphasised the critical importance of translating audit findings into prioritised, deliverable action plans. Following the discussion, the Committee noted the update and agreed with the proposed reasonable level of assurance.

4.5 Managing Violence and Aggression

The Committees received the Managing Violence and Aggression Report, noting a concerning increase in verbal abuse and threats, particularly in Accident and Emergency departments. Assurance was received regarding the enhanced staff wellbeing and practical incident support

available, alongside the appointment of a new Violence Prevention and Reduction Compliance Lead.

4.5 **Board Assurance Framework (BAF) Update – Strategic Estate and Digital Risks**

The Committees reviewed the BAF for Strategic Risk 4 (Digital Transformation) and Strategic Risk 5 (Estates Modernisation and Infrastructure). No changes were proposed to the overall risk scores, which remain at 20 for both. Digital remains at a partial assurance rating, and Estates at a limited assurance rating. The Committees agreed that the digital risk rating should not be lowered until the full cyber baseline review is completed and reviewed in January 2027.

5.0 Other issues considered by the Committees

5.1 **Digital Governance Restructure**

The Committees discussed and supported a proposal to restructure digital governance by establishing a new Digital Board. This will replace the previous Digital Governance Group (DGG) to separate strategic decision-making and investment prioritisation from operational delivery detail. The new structure includes a "Digital Den" to assess new initiatives and aims to rebalance membership towards senior clinical and operational leaders to ensure priorities are actively owned across the Group.

5.2 **Green Plan Annual Update**

The Committees received the Green Plan annual update, noting that sustainability considerations were being successfully embedded into wider estate improvement programmes and procurement processes. Members requested that future updates explicitly include information regarding the financial benefits, costs, and prioritisation of sustainability initiatives.

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 September and October 2026.

Group Board

Meeting on Friday, 06 November 2026

Agenda Item	5.1	
Report Title	**Report from Finance and Performance Committee**	
Non-Executive Lead	Bidesh Sarkar, Finance & Performance Committee Chair	
Report Author(s)	Bidesh Sarkar, Finance & Performance 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 September and October 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 fall 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. A paper on water safety at ESH was considered.

Equality, diversity and inclusion implications

n/a

Environmental sustainability implications

n/a

Finance and Performance Committee Report
Group Board, 06 November 2026

1.0 Purpose of paper

1.1 This report sets out the key issues considered by the Finance and Performance Committee (FPC) at its meetings in September and October 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 25th September and 30th October 2026, the Committee considered the following items of business:

25th September 2026	30th October 2026
PUBLIC MEETING • FPC briefing • IQPR • Winter Plans • Deep dive- Children's Services Waiting Times at Sutton • M5 Finance position including forecast • Costing update • Capital Governance	**PUBLIC MEETING** • FPC briefing • IQPR* • M6 Finance position including forecast* • Drivers of Underlying Deficit • Board Assurance Framework (BAF) risks for the committee* • South West London Procurement Partnership (SWLPP) quarterly 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) <u>M6 Financial position</u>

The Committee noted that both Trusts are on plan at M6. However, the adverse unmitigated year to date position at both Trusts was noted at £17.8m for ESTH and £22.0m for SGH. This had been mitigated by brought forward and additional non-recurrent benefits year to date.

b) <u>Drivers of Deficit</u>

The Committee were briefed on the movements in income, pay and non-pay since 2019/20 that have impacted on the changing underlying position of the two organisations.

c) Operational Performance

The Committee noted the areas of progress across operational performance and had longer discussions on 52 week waits and Diagnostic performance at SGUH, UEC performance and the proposed ED modular build at ESTH, and Delirium assessment, flu vaccination and the impending industrial action by Consultants across the group.

Both ESTH and SGUH achieved the three key cancer standards in August 2026, with 28-Day Faster Diagnosis Standard performance for both Trusts ranked in the Highest-scoring 25% nationally.

Lung cancer performance remains challenged across both sites due to constraints in specialist diagnostic and thoracic service capacity. At SGUH, breast pathway performance is further impacted by workforce shortages resulting in delays to secondary diagnostics, whilst ESTH continues to experience pressure within gastrointestinal pathways due to endoscopy delays and anaesthetic workforce constraints.

For non-urgent elective care (RTT), both Trusts delivered planned 18-week performance in August 2026. However, neither Trust achieved its 52-week wait trajectory. ESTH continues to make progress in reducing long waits, reporting 500 patients against a target of 471 (0.88% of the waiting list). Cardiology remains the principal specialty risk due to sustained outpatient demand, Cardiac MRI capacity constraints and ongoing workforce challenges. At SGUH, 52-week waits increased from 710 to 805 against a target of 620 (0.89% of the waiting list), with the longest wait cohorts within Gynaecology, General Surgery and Vascular. Waiting list growth also continues to rise and exceed plan, with Patient Tracking List (PTL) reaching 70,983 at the end of August, 3,061 above plan. Targeted recovery programmes, transformation initiatives and enhanced operational oversight remain in place to support delivery of elective recovery plans

Diagnostic performance at SGUH is significantly below plan, driven by non-obstetric ultrasound that has been heavily impacted by Sonographer shortage. The recovery plan includes targeted insourcing to reduce the aged backlog while maintaining routine activity. Subject to delivery of planned capacity, waits over six weeks are expected to reduce rapidly, with recovery anticipated by November 2026. The trust has approved the recruitment and retention rate to align with the rest of the region and all vacant sonographer posts are being recruited to, which should give stability.

Elective access for children's services at Sutton Health and Care continues to see improvement, with 52+ week waits reducing from 43 in August to 12 in September 2026, reflecting sustained progress in addressing the longest waits. Despite this, overall waiting list growth and waits over 18 weeks remain a significant challenge, mirroring the national position and driven primarily by rising demand and increasing complexity. 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 78.2% against the ED 4-hour standard in September 2026, below trajectory however maintaining top quartile performance nationally. The Trust also maintained delivery against the 12-hour wait

standard, with a continued downward trend in long waits. Performance at ESTH remains below the agreed improvement trajectory set out in the UEC Recovery Plan, delivering 70.8% against a revised target of 77%. Improving ED performance remains a Group priority, with renewed organisational focus to address challenges in patient flow, discharge processes, diagnostics and capacity. Following a detailed review, targeted actions are being implemented to strengthen operational leadership, improve front-door flow and support sustained performance recovery against trajectory. Non-Elective Transformation Programmes across both sites are progressing.

The 2-hour urgent community response target of 70% was met at both Surrey Downs and Sutton Health Care. Improved performance at Sutton has been supported by service adjustments alongside ongoing improvement initiatives which will support sustained performance.

d) Winter plans

The Committee received the two trusts' winter plans. Discussion focussed on the level of funding that has been allocated to the plans, flu vaccination targets for staff, Ambient Voice Technology at ESTH ED and the SWL approval of the Frailty Business Case. **The two winter plans were approved by the committee.**

e) Capital Governance

The Committee was informed of the new structure of strengthened capital governance aligned with transformation. Questions focussed on a more group-wide approach, ensuring appropriate clinical and operational engagement and the appropriate skills being available to make these changes.

f) Costing update

The National Cost Collection Submission for 2025/26 Financial year have now been submitted as reported to the September committee meeting. By the October meeting, the indexes had been published, with both trusts at 106 after normalising adjustments which show opportunities for improvements to the cost base, aligning with model system data.

g) SWLPP quarterly update

The Committee reviewed the information presented on contract awards, including breaches and waivers, and CIPs, and suggested improvements that could be made for future iterations. The committee asked for more information on what the plan was to improve SWLPP. The GCFO stated that a paper was being progressed through GEC in November which would outline a route to improved delivery and would come through to the Committee in the future

5.0 Risk Implications

5.1 The Committee received an updated paper in October. It did not consider any changes necessary to recommend to Group Board on the BAF operational-related risk SR 6 – Timely access to Care. The score remains '20' and Partial assurance. The target for the March 2028 is '15' and Reasonable assurance.

5.2 The Committee received an updated paper in October. It did not consider any changes necessary to recommend to Group Board on the BAF finance risk SR1 - Financial Sustainability and recommended no changes to the score of '25' and Limited assurance. The Committee considered that no change could be made to the current target date of March 2028 to achieve reasonable assurance (score of 15) until a revised medium term financial plan had been discussed and approved.

The Committee were keen to ensure that the timeframe proposed on BAF SR1 was stretching enough, including a 'path to green' that is clear and understood. There was also discussion on the complexity of the appetite for risk.

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 September and October 2026.

Group Board

Meeting in Public on Friday, 06 November 2026

Agenda Item	5.2	
Report Title	**Finance Report – Month 6**	
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	30 October 2026
Purpose	**For Noting**	

Executive Summary

- Both organisations remain on plan at M6, albeit using higher levels of non-recurrent measures than planned.
- While the trusts remain on plan at month 6 there is material pressure on the year end forecast. The Group executive remains committed to minimising risk in the financial plan. Both organisations have reported a year end forecast in line with plan to NHSE at M6.

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	

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

Equality, diversity and inclusion implications

Environmental sustainability implications

gesh

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

Finance Report M6
Public Board

Date: 6 November 2026

M6 CIP

Reported position to NHSE – mitigations applied

CIP	YTD Plan £'m	Actual £'m	Variance £'m	Annual Plan £'m	Forecast £'m	Variance £'m
Pay - Recurrent	4.61	1.43	(3.18) A	19.82	13.02	(6.79) A
Non-pay - Recurrent	6.34	5.34	(1.00) A	15.90	17.06	1.16 F
Income - Recurrent	1.46	0.19	(1.27) A	3.79	3.45	(0.34) A
Recurrent Efficiencies	**12.41**	**6.96**	**(5.45) A**	**39.51**	**33.54**	**(5.97) A**
Pay - Non-recurrent	1.40	2.38	0.98 F	6.27	11.36	5.09 F
Non-pay - Non-recurrent	1.79	3.24	1.45 F	5.54	6.74	1.20 F
Income - Non-recurrent	0.20	0.06	(0.14) A	1.36	1.04	(0.32) A
Non-Recurrent Efficiencies	**3.40**	**5.69**	**2.29 F**	**13.17**	**19.14**	**5.97 F**
26/27 CIP	**15.81**	**12.64**	**(3.16) A**	**52.68**	**52.68**	**0.00 F**
25/26 FYE	5.24	5.24	0.00 F	10.47	10.47	0.00 F
Total CIP	**21.04**	**17.88**	**(3.16) A**	**63.15**	**63.15**	**0.00 F**

Efficiency Progress	Pay £'m	Non Pay £'m	Income £'m	Total £'m
Fully Developed	9.05	15.58	1.34	25.97
Plans in Progress	10.77	6.76	1.80	19.33
Opportunity	4.57	1.44	1.37	7.38
Unidentified	0.00	0.00	0.00	0.00
Total	**24.39**	**23.77**	**4.51**	**52.68**

CIP	YTD Plan £m	Actual £m	Variance £m	Annual Plan £m	Forecast £m	Variance £m
Pay - Recurrent	10.21	4.86	(5.34) A	34.03	26.59	(7.44) A
Non-pay - Recurrent	8.16	5.25	(2.91) A	27.22	27.22	0.00 F
Income - Recurrent	2.04	2.65	0.60 F	6.81	6.81	0.00 F
Recurrent Efficiencies	**20.42**	**12.77**	**(7.65) A**	**68.06**	**60.62**	**(7.44) A**
Pay - Non-recurrent	3.40	4.71	1.31 F	11.35	14.32	2.98 F
Non-pay - Non-recurrent	2.72	3.17	0.45 F	9.08	11.31	2.23 F
Income - Non-recurrent	0.68	1.13	0.45 F	2.27	4.50	2.23 F
Non-Recurrent Efficiencies	**6.80**	**9.01**	**2.21 F**	**22.70**	**30.13**	**7.44 F**
26-27 CIP	**27.22**	**21.78**	**(5.44) A**	**90.75**	**90.75**	**0.00 F**
FYE 25-26 (Recurrent)	6.90	6.90	0.00 F	13.80	13.80	0.00 F
NHSE CIP metric	**34.12**	**28.68**	**(5.44) A**	**104.55**	**104.55**	**0.00 F**

Efficiency Progress	Pay £m	Non Pay £m	Income £m	Total £m
Fully developed	15.09	16.17	9.40	40.67
Plans in progress	15.84	16.62	6.21	38.67
Opportunity	2.81	4.18	4.37	11.36
Unidentified				0.00
Total	**33.74**	**36.97**	**19.99**	**90.70**

CIP commentary

ESTH

- ESTH has not fully delivered its CIP in month , with slippage of £0.7m against planned transformation schemes and £0.6m against BAU schemes (£1.35m overall).
- YTD, the Trust is £5.4m adverse on recurrent CIP efficiencies, partially offset by £2.3m favourable position on non-recurrent efficiencies.
- 49% of ESTH CIP is now fully developed across BAU in divisions and transformation programmes.
- Of the BAU 5% CIP within divisions, 66% is now fully developed, with a further 13% plans in progress. There remains £7.4m (20%) 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 £4.3m 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 6, with slippage of £1.49m against planned transformation schemes and £0.15m favourable against BAU target meaning a £1.34m variance overall in month.
- The Trust is £7.65m adverse on recurrent CIP efficiencies and £2.21m favourable on non-recurrent efficiencies.
- 45% of SGH CIP is now fully developed across BAU in divisions and transformation programmes.
- Of the BAU 5% CIP within divisions, 63% is now fully developed, with a further 17% plans in progress. There remains 20% 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 £4.5m of schemes to identify. Within Corporate divisions, Estates and Facilities are £1m over on total schemes with a shortfall of £1.1m in Other Corporate.

M6 ESTH

Reported position to NHSE – mitigations applied

M6 Commentary

The Trust was on plan in September, however on an unmitigated basis the Trust is adverse by £2.4m in month:

- £1.1m adverse on transformation CIP mitigated by slippage on the cost of delivery;
- £0.6m adverse on BAU CIP; and £0.54m exit run rate planning gap, £0.25m SWL pathology and Soft FM pressure.
- Trust has exhausted its technical mitigations.

Performance £'m	YTD Plan	Actual	Variance	Annual Plan	Forecast	Variance
Patient Care Income	351.20	358.77	7.57 F	702.40	707.37	4.97 F
Other Operating Income	22.85	23.06	0.22 F	47.80	47.50	(0.30) A
Total Income	**374.05**	**381.83**	**7.78 F**	**750.20**	**754.87**	**4.67 F**
Substantive	(225.93)	(226.39)	(0.47) A	(451.52)	(451.92)	(0.40) A
Bank	(26.15)	(30.71)	(4.57) A	(46.34)	(49.84)	(3.50) A
Agency	(2.02)	(2.02)	0.00 F	(3.80)	(3.80)	0.00 F
All Other pay	(1.04)	(1.04)	0.00 F	(2.09)	(2.09)	0.00 F
Total Pay	**(255.13)**	**(260.16)**	**(5.03) A**	**(503.75)**	**(507.65)**	**(3.90) A**
Non-Pay	(123.78)	(126.53)	(2.75) A	(239.13)	(239.79)	(0.65) A
Non Operating Items	(3.66)	(3.67)	(0.01) A	(7.32)	(7.43)	(0.11) A
Performance Target	**(8.52)**	**(8.52)**	**0.00 F**	**0.00**	**0.00**	**0.00 F**
DSF	(17.17)	(17.17)	0.00 F	(34.33)	(34.33)	0.00 F
Excluding DSF	**(25.69)**	**(25.69)**	**0.00 F**	**(34.33)**	**(34.33)**	**0.00 F**

Workforce	YTD Plan	Actual	Variance	Move From M5	Plan M12 26-27	Move to M12 Plan
	WTE	WTE	WTE	WTE	WTE	WTE
Substantive	6,413	6,365	48 F	-1 A	6,396	31 F
Bank	756	852	(96) A	56 F	842	(10) A
Agency	53	29	24 F	-2 A	44	15 F
Total	**7,222**	**7,246**	**(25) A**	**54 F**	**7,282**	**35 F**

YTD Commentary

Income

- Income is £7.8m favourable YTD, with patient care income £7.6m favourable and other operating income £0.2m favourable.
- Patient Care income is favourable due to the bringing forward of non recurrent income and the release of all provisions post contract agreement which had mitigated risk of claw back of prior year and £0.9m 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. The position includes £0.7m accrued for industrial action.
- Other Operating Income improved due to inflation being paid on education income.

Non pay & Non-Operating Items

- Non-Pay & Non-Operating items are £2.8m adverse YTD. This is driven by £2.8m on clinical supplies of which £0.6m is in Theatres and £0.6m in Renal; £1.3m on drugs in Medicine. These overspends are partially mitigated by non pay reserve slippage and £2.9m due to the delay in the TUPE to St Georges.

Pay and workforce

- Pay is £5.0m adverse to plan YTD of which bank spend is £4.6m adverse with £0.7m due to industrial action. £2.9m is due to the delay in TUPE to St Georges, this is offset in non pay. Medicine division is £3.4m adverse across all specialties and Planned Care is £0.9m adverse. Substantive is £0.5m adverse and agency is on plan.
- ESTH bank spend reduced by £0.8m in month but as a proportion of pay at 10% (in month) continues to be an outlier to SWL (7.8%) and London (7.2%) averages.
- The Trust is 25 WTE adverse to plan in M6, 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.
- The movement from M5 of 54 WTE is due to reductions in bank staff in month and follows a reduction of 48 WTE across categories in M5.
- The current staffing level is 35 WTE below the year end plan although this does not account for winter and seasonality.

M6 SGH

Reported position to NHSE – mitigations applied

M6 Commentary

The Trust is on plan in month although CIP is £1.34m adverse offset by Non-CIP mitigations. The Trust is forecasting being on plan for the year end in line with NHSE expectations. On an unmitigated basis the Trust is adverse by £4.10m:

- £2.22m of transformation CIP shortfall, partially mitigated by NR transformation slippage of £0.73m.
- £0.46m of BAU CIP shortfall, mitigated by £0.61m of other cost pressure releases (hence CIP is £1.34m adverse overall)
- £1.42m baseline pressure, mitigated by £2.56m NR technical stretch and £0.20m of further inflation release (hence non-CIP is £1.34m favourable).
- Trust has exhausted its technical mitigations.

Performance	YTD Plan	Actual	Variance	Annual Plan	Forecast	Variance
	£m	£m	£m	£m	£m	£m
Patient Care Income	555.78	560.33	4.55 F	1,111.65	1,112.65	1.00 F
Other Operating Income	98.43	93.84	(4.59) A	200.95	200.95	0.00 F
Total Income	**654.21**	**654.17**	**(0.04) A**	**1,312.60**	**1,313.60**	**1.00 F**
Substantive	(395.95)	(392.77)	3.18 F	(778.60)	(774.76)	3.83 F
Bank	(22.77)	(26.65)	(3.88) A	(42.39)	(48.26)	(5.87) A
Agency	(3.70)	(2.24)	1.46 F	(6.04)	(5.00)	1.04 F
Other Pay	(1.63)	(1.63)	0.00 F	(3.25)	(3.25)	0.00 F
Total Pay	**(424.05)**	**(423.29)**	**0.77 F**	**(830.28)**	**(831.28)**	**(1.00) A**
Non-Pay	(236.65)	(236.66)	(0.01) A	(460.40)	(460.06)	0.34 F
Non Operating Items	(10.84)	(11.56)	(0.72) A	(20.40)	(20.74)	(0.34) A
Performance Target	**(17.33)**	**(17.33)**	**0.00 F**	**1.52**	**1.52**	**0.00 F**
DSF	(10.81)	(10.81)	0.00 F	(21.63)	(21.63)	0.00 F
Excluding DSF	**(28.14)**	**(28.14)**	**0.00 F**	**(20.10)**	**(20.10)**	**0.00 F**

Workforce	YTD Plan	Actual	Variance	Move from M5	Plan M12 26-27	Move to M12 plan
	WTE	WTE	WTE	WTE	WTE	WTE
Substantive	10,209	10,185	24 F	(23) A	10,084	(101) A
Bank	753	677	77 F	73 F	787	110 F
Agency	24	53	(29) A	0 F	52	(1) A
Total	**10,986**	**10,915**	**71 F**	**50 F**	**10,923**	**8 F**

YTD Commentary

Income

- Income is £0.04m adverse YTD, with patient care income £4.55m favourable and other operating income £4.59m adverse.
- Patient Care income is driven by £0.75m industrial action income recognition, £1.58m of brought forward non-recurrent benefits and £2.24m of additional technical benefits.
- Other Operating Income is driven by £2.9m TUPE income not received from ESTH, £2.62m of income underperformance offset by costs underspends driven by R&I/SWLP/Commercial Pharmacy and £0.54m of CIP underperformance offset by £0.92m favourable variance on energy income.

Non pay & Non-Operating Items

- Non-Pay & Non-Operating items are £0.72m adverse YTD. This is driven by £2.18m of undelivered CIP target, £1.76m of energy costs increases from the War in the Middle East, and £2.60m of Clinical Division pressures, partially offset by £1.44m release of non-pay inflation, £1.58m of brought forward non-recurrent benefits and £2.99m of additional technical benefits.

Pay and workforce

- Pay is £0.77m favourable to plan YTD due to £2.10m of brought forward non-recurrent benefits, £2.24m of additional technical benefits, £2.9m of TUPE expenditure not incurred from ESTH and £0.90m of favourable R&I/SWLP variance offset in other income. This is partially offset by £2.72m under-delivery of CIP, £0.75m of Industrial Action costs, £2.80m of medical pay pressures and £1.54m of ward nursing pressures.
- Substantive and Agency are below plan, although Bank remains ahead of plan owing to M1 industrial action, and shortfall in CIP delivery.
- Trust is 71 WTE favourable to plan in M6. The variance is mainly explained by TUPE shortfall from ESTH of 70 (65 including Kingston and Richmond Occupational Health).
- The movement from M5 of 50 WTE reduction is mainly related to ward nursing.
- An increase of 8 WTE is required to deliver the year end WTE plan, although this is not adjusted for TUPE shortfall.

Group Board

Meeting in Public on Friday, 06 November 2026

Agenda Item	5.3	
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 Committee Group Executive Committee	30 October 2026 27 October 2026
Purpose	**For Review**	

Executive Summary

IQPR Changes

The IQPR has been updated to align with the measures set out in the NHS Oversight Framework. Following the Board's consideration of the H2 Refresh in early October, the report has also been revised to reflect the proposed key priorities ("Big Levers") and associated Driver Metrics that will be pursued during the second half of the financial year. The proposed Big Levers are:

1. Left Shift – deliver more care in community settings and closer to home.
2. Move to a smaller, more productive workforce.
3. Shift resources from routine outpatient follow-ups to increase capacity for new patients.
4. Strengthening employees' experience of effective and supportive line management.

Definitions of the supporting Driver Metrics are provided in Appendix 4 of the report.

To support interpretation, the statistical icons previously used within the report have been replaced with written descriptions of variation and assurance, providing greater clarity on performance trends and achievement against target.

Oversight and Assurance

ESTH remains under Level 3 (enhanced regional) oversight for Urgent and Emergency Care performance. The next monthly meeting with NHSE is on 28 October, where NHSE will seek assurance on the robustness of the revised recovery plan.

The London Provider Risk Ratings for the key access metrics (RTT, Diagnostics, A&E and Cancer) are due to be published in November. The ratings will inform the level of oversight NHSE applies to providers.

Operational Performance

Both ESTH and SGUH achieved the three key cancer standards in August 2026, with 28-Day Faster Diagnosis Standard performance for both Trusts ranked in the Highest-scoring 25% nationally.

For non-urgent elective care (RTT), both Trusts delivered planned 18-week performance in August 2026. However, neither Trust achieved its 52-week wait trajectory. ESTH continues to make progress in reducing long waits, reporting 500 patients against a target of 471 (0.88% of the waiting list).

Cardiology remains the principal specialty risk due to sustained outpatient demand, Cardiac MRI capacity constraints and ongoing workforce challenges. At SGUH, 52-week waits increased from 710 to 805 against a target of 620 (0.89% of the waiting list), with the longest wait cohorts within Gynaecology, General Surgery and Vascular. Waiting list growth also continues to rise and exceed plan, with PTL reaching 70,983 at the end of August, 3,061 above plan. Targeted recovery programmes, transformation initiatives and enhanced operational oversight remain in place to support delivery of elective recovery plans

Diagnostic performance at SGUH is significantly below plan, driven by non-obstetric ultrasound that has been heavily impacted by Sonographer shortage. The recovery plan includes targeted insourcing to reduce the aged backlog while maintaining routine activity. Subject to delivery of planned capacity, waits over six weeks are expected to reduce rapidly, with recovery anticipated by November 2026 although ongoing vacancies continue to pose sustainability and affordability risks and non-delivery against plan.

Elective access for children's services at Sutton Health and Care continues to see improvement, with 52+ week waits reducing from 43 in August to 12 in September 2026, reflecting sustained progress in addressing the longest waits. Despite this, overall waiting list growth and waits over 18 weeks remain a significant challenge, mirroring the national position and driven primarily by rising demand and increasing complexity. Harm reviews are ongoing, and an improvement plan is in place alongside a system health pathway review (gesh-Sutton Alliance Board-SHC). A committee deep dive is scheduled for September 2026.

For Urgent and Emergency Care (UEC), SGUH delivered 78.2% against the ED 4-hour standard in September 2026, below trajectory however maintaining top quartile performance nationally. The Trust also maintained delivery against the 12-hour wait standard, with a continued downward trend in long waits. Performance at ESTH remains below the agreed improvement trajectory set out in the UEC Recovery Plan, delivering 70.8% against a revised target of 77%. Improving ED performance remains a Group priority, with renewed organisational focus to address challenges in patient flow, discharge processes, diagnostics and capacity. Following a detailed review, targeted actions are being implemented to strengthen operational leadership, improve front-door flow and support sustained performance recovery against trajectory. Non-Elective Transformation Programmes across both sites are progressing.

The 2-hour urgent community response target of 70% was met at both Surrey Downs and Sutton Health Care. Improved performance at Sutton has been supported by service adjustments alongside ongoing improvement initiatives which will support sustained performance.

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 Board is asked to:

a) Note the report
b) Approve the proposed H2 Big Levers and Driver metrics as set out in the report.

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

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

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



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

Integrated Quality & Performance Report (IQPR)

September 2026

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Big Levers & Driver Metrics: What they mean

September 2026

The Integrated Quality and Performance Report (IQPR) has been refreshed for the second half of 2026/27 (H2) to strengthen alignment between organisational priorities, strategic objectives and operational delivery.

Key changes include:
- Reorganising metrics under a smaller number of strategic "Big Levers" to provide clearer lines of sight between organisational priorities and performance outcomes.
- Refining Driver Metrics to focus on measures that are most predictive of delivery and improvement.
- Introducing greater emphasis on performance trends, recognising both current achievement against target and the direction of travel over time.
- Streamlining reporting to support clearer Board oversight and prioritisation of improvement activity.

When reviewing the report:
Assurance (performance against target)
- **Achieving** indicates that performance is currently meeting the agreed target or standard consistently.
- **Not achieving** indicates performance is consistently below the expected level.
- **Variable** indicated performance is not being consistently achieved – hit and miss.

Variation (long term trend)
- **Improving** indicates a positive performance trend, even where the target has not yet been achieved. Typically, better-than-average performance over a few months or material step change.
- **Deteriorating** indicates performance is worsening and requires attention. Typically, worse-than-average performance over a few months or material step change.
- **No Change** the process is stable and operating within expected range/limits of natural variation.

This revised structure is intended to provide earlier visibility of emerging risks, support more focused performance management, and strengthen the link between operational actions and strategic outcomes.

Big Levers:	**Left Shift – move care into community**	**Move to a smaller, more productive workforce**	**Shift resources away from outpatient follow-ups into seeing new patients**	**Strengthening employees' experience of effective and supportive line management**
Purpose	Deliver more care closer to home	Improve Productivity and sustainability	Create capacity for new patients	Support and retain our people
Big Levers	• 4Hr ED performance • 12Hr A&E waits • Delays from discharge ready date to discharge • Reduction in occupied bed days	• Workforce (WTE) against plan • Temporary staffing spend • Sickness absence rates	• Patient Initiated Follow-up (PIFU) rates • DNA (Did not attend rates) • Outpatient first appointment activity • Outpatient discharge rates • Referral diversion rates	• NHS Staff survey- Line Management question • NHS Staff Survey –Recognition and feeling Valued

SGUH: Big Levers & Driver Metrics

September 2026

VARIATION	ASSURANCE: Achieving	ASSURANCE: Variable	ASSURANCE: Not Achieving	ASSURANCE: Target TBC
Improving	• 12-hour A&E waits vs. plan		• PIFU rates vs. 5% target	
No Change	• Temporary staffing spend vs. plan	▪ Average Delays from Discharge Ready Date to Discharge vs. plan	• 4-hour A&E performance vs. plan • Sickness absence rates vs. plan • DNA Rates vs. plan • Outpatient 1st and Procedure Rates vs. plan	• Referral Diversion Rates • Outpatient Discharge Rates • Reduction in Occupied Bed Days
Deteriorating	• WTE vs. plan			• Response to NHS Staff Survey questions relating to line management, 2024 vs. 2025 • Response to NHS Staff Survey questions relating to recognition and feeling valued, 2024 vs. 2025

Big Levers:	Left Shift – move care into community	Move to a smaller, more productive workforce	Shift resources away from outpatient follow-ups into seeing new patients	Strengthening employees' experience of effective and supportive line management

ESTH: Big Levers & Driver Metrics

September 2026

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VARIATION	ASSURANCE: Achieving	ASSURANCE: Variable	ASSURANCE: Not Achieving	ASSURANCE: Target TBC
Improving	• PIFU rates vs. 5% target		• Average Delays from Discharge Ready Date to Discharge vs. plan • WTE vs. plan • Temporary staffing spend vs. plan	• Outpatient Discharge Rates
No Change		▪ DNA Rates vs. plan	• Outpatient 1st and Procedure Rates vs. plan • Sickness absence rates vs. plan	• Reduction in Occupied Bed Days
Deteriorating			• 4-hour A&E performance vs. plan • 12-hour A&E waits vs. plan	• Referral Diversion Rates • Response to NHS Staff Survey questions relating to line management, 2024 vs. 2025 • Response to NHS Staff Survey questions relating to recognition and feeling valued, 2024 vs. 2025

Big Levers:	Left Shift – move care into community	Move to a smaller, more productive workforce	Shift resources away from outpatient follow-ups into seeing new patients	Strengthening employees' experience of effective and supportive line management

4

National Oversight Framework
Q1 2026/2027 Update

The NHS Oversight Framework (NOF) segmentations for Q1 2026/27 were published on 10 September 2026.

Based on the revised 2026/27 framework, which includes an expanded list of metrics, the segmentations use statistical thresholds to segment trusts, replacing the performance quartiles used under the previous methodology.

Unadjusted Segmentation	Overall metric score
1	<1.94
2	1.94 and 2.33
3	2.34 and 2.77
4	>2.77

Based on overall metric scores, SGUH achieved segment 2 and ESTH achieved segment 3, with a final adjusted segmentation of 3 for both trusts due to the finance override.

SGUH ranked 51st (down from 47th in Q4 25/26) and ESTH ranked 83rd (down from 66th in Q4 25/26), out of 134 acute trusts.

Assessment Period: Q1 2026/27			SGUH Q1		ESTH Q1	
		Trust Segment (adjusted)	3		3	
		Ranking (Acute Trusts)	51/134		83/134	
		Unadjusted Segment (pre finance override	2		3	
		Overall Metric Score (breakdown below)	2.32		2.51	
Domain	**No.**	**Metric**	**Data Period**	**Metric Scores**	**Metric Rankings**	**Metric Scores**	**Metric Rankings**
Access	1	RTT 18 weeks Performance	Jun-26	2.78	77	2.24	54
	2	RTT 52 Weeks Performance	Jun-26	2.73	50	2.82	56
	3	Diagnostic referrals waiting over 6 weeks	Jun-26	2.32	58	1.48	22
	4	Community Services patients waiting less than 18 weeks	Jun-26	1.00	45	1.00	9
	5	Community Services - % waits over 52 Weeks	Jun-26	1.00	1	2.76	44
	6	Cancer - 28-Day Faster Diagnosis Standard	Q1 2026/27	1.00	32	1.00	1
	7	Cancer - 62-Day Treatment Standard	Q1 2026/27	2.37	38	1.00	4
	8	A&E 4-Hour Wait Standard	Q1 2026/27	2.35	37	3.77	111
	9	A&E 12-Hour Waits (from arrival)	Q1 2026/27	2.24	51	3.83	115
		Access to services domain score		1.98	Quartile 1 (Highest Scoring 25%	2.21	Quartile 2 (2nd Highest Scoring 25%
Experience of Care	10	CQC inpatient survey satisfaction rate	2025	2.00	-	2.00	-
	11	NHS staff survey advocacy rate score	2025	2.22	55	2.60	72
	12	Percentage of intermediate care beds occupied by patients without criteria to reside	Q1 2026/27	N/A	N/A	1.39	4
		Effectiveness of care domain score		2.11	Quartile 2 (2nd Highest Scoring 25%	2.00	Quartile 2 (2nd Highest Scoring 25%
Effectiveness of care and population health	13	Delayed Induction of Labour'	Q1 2026/27	2.17	47	1.00	1
	14	Acute inpatient tobacco quit attempts	To Mar 2026	2.18	57	4.00	97
	15	% patients readmitted within 30 days of discharge – comparative band	2024/25	4.00	-	1.00	-
	16	Summary Hospital-level Mortality Indicator	TBC	2.00	-	3.00	-
		Effectiveness of care and population health domain score		2.59	Quartile 4 (Lowest Scoring 25%)	2.25	Quartile 3 (3rd Highest Scoring 25%

National Oversight Framework
Q1 2026/2027 Update

The scores show strong performance across access and effectiveness domains overall, and challenges across people and finance domains.

A few metrics impacted by data quality (adversely or favourably) have been identified with remedial actions already completed or progressing.

The IQPR has been updated to reflect most the access and quality metrics with further work underway to ensure appropriate oversight and reporting of all metrics.

Assessment Period: Q1 2026/27		SGUH Q1	ESTH Q1
	Trust Segment (adjusted)	3	3
	Ranking (Acute Trusts)	51/134	83/134
	Unadjusted Segment (pre finance override	2	3
	Overall Metric Score (breakdown below)	2.32	2.51

Domain	No.	Metric	Data Period	Metric Scores	Metric Rankings	Metric Scores	Metric Rankings
Patient Safety	17	Breadth and depth of clinical audit outliers score	2026/27	1.00	-	3.00	-
	18	NHS Staff Survey – raising concerns sub-score	2025	3.05	92	2.67	75
	19a	Rates of MRSA infections	To Jun 2026	2.24	-	2.64	-
	19b	Rates of C-Difficile infections	To Jun 2026	4.00	-	2.00	-
	19c	Rates of E-Coli infections	To Jun 2026	2.00	-	2.00	-
		Patient Safety domain score		2.27	Quartile 3 (3rd Highest Scoring 25%	2.63	Quartile 3 (3rd Highest Scoring 25%
People	20	Healthcare Worker Flu Vaccination Rate	Q1 2026/27	3.46	115	3.12	103
	21	NHS staff standards score	Q3 2025/26	3.32	104	2.33	60
	22	NHS staff survey engagement theme sub-score	2025	2.42	64	2.47	66
	23	National Education and Training Survey satisfaction rate	2025	2.61	50	3.94	130
	24	Sickness absence rate	To Mar 2026	2.12	62	3.00	104
	25	Temporary staffing cost relative band score	Q1 2026/27	1.00	-	3.00	-
		People domain score		2.49	Quartile 3 (3rd Highest Scoring 25%	2.98	Quartile 4 (Lowest Scoring 25%)
Finance, productivity and innovation	26	Combined finance score: planned & actual	Q1 2026/27	2.00	-	2.00	-
	27	Data Quality Maturity Index score	Apr-26	2.28	53	3.94	132
	28	Percentage of clinical trials set up within 90 days	Q1 2026/27	4.00	104	4.00	57
	29	Relative difference in costs	Dec-25	2.71	96	2.11	70
		Finance, productivity and innovation domain score		2.75	Quartile 3 (3rd Highest Scoring 25%	3.01	Quartile 4 (Lowest Scoring 25%)

Executive Summary
Safe, High-Quality Care

St George's Hospital

- **Never Events and PSIIs:** There were no Never Events or PSIIs declared in September 2026
- **Pressure Ulcers:** In September 2026 there were 10 acquired pressure ulcers. Six were medical device related with one category 4 pressure ulcer caused by a neck collar. A local action plan is in place.
- **Infection Control**: C.diff Infections tracking above plan over a 12-month rolling average. Multidisciplinary reviews continue, supported by enhanced hydrogen peroxide vapour decontamination. 29 cases at end of September 2026.
- **VTE Risk Assessments:** VTE risk assessment compliance was 86.5% in September 2026, below the 95% national target. The change in the clock start from admission to the decision to admit has had minimal effect on performance as pre. Digital workflow improvements are being implemented to support improvement.
- **SHMI**: The SHMI has risen but remains within the expected range. This increase was anticipated following the October 2025 change to how Same Day Emergency Care (SDEC) activity is recorded, with reporting moving to the Emergency Care Dataset (ECDS).
- **Delirium Assessments:** Delirium assessment completion remains below target, with ongoing specialist support to improve compliance.
- **Complaints:** In September 2026, 85% of complaints at SGUH were responded to within the agreed timeframe, and 98% were acknowledged within the required timeframe. All posts in the complaints team have been recruited to, and enhanced leadership support is in place. The site nursing leadership team is also working with divisions to improve the time taken to complete and return draft responses to the complaints team, which is affecting performance against target.
- **Friends and Family Test:** Scores remain within the range of normal variation. Response rates are low in some areas, and work is under way to review targets and identify opportunities to improve engagement.
- **Maternity:** Maternity services report through the national Perinatal Quality Oversight Model (PQOM). Work is under way to align this reporting with the Trust's IQPR, standardise definitions across gesh, and mitigate the known data quality risks arising from the maternity digital system implementation at SGUH.

Epsom & St Helier

- **Never Events and PSIIs:** No Never Events and two Patient Safety Incident Investigations (PSIIs) were declared in September 2026.
- **Pressure Ulcers:** One category 3 and zero category 4 pressures ulcer were reported in September 2026. Ongoing themes include documentation gaps, delayed escalation and patient complexity, with an external review planned.
- **Infection Control (Water Safety):** Weekly oversight of E Block water safety risks continues, with mitigations monitored through the Water Safety Group and regular staff communications in place. No clinical infections associated with the issue have been reported to date. E. coli infections are above planned level (adverse variance), based on 12-month rolling data.
- **VTE Risk Assessments:** The assessment rate was 81.2% in September 2026, below the national target of 95%. The revised NHSE guidance introduced in Q2 now starts the assessment clock at the decision to admit, which has affected performance. Work continues to improve compliance through shared learning and consistent application of the revised guidance.
- **SHMI–** The SHMI remains in the "higher than expected" range. This is driven by a fall in the modelled expected deaths rather than a rise in observed deaths, which have remained stable. Further analysis is under way to understand the cause.
- **Delirium Assessments:** Delirium assessment completion within 24 hours of ward admission has improved steadily across all three metrics (patients over 18, patients over 65, and patients with a dementia diagnosis). This reflects ongoing collaboration between the Dementia and Delirium CNS and the nursing, medical and SLT teams.
- **Complaints:** In September 2026, 87% of complaints were responded to within the agreed timeframe, and 100% were acknowledged on time. Leadership is working with the divisions with the longest complaint processing times to improve turnaround and strengthen performance against target
- **Friends and Family Test:** Scores remain within the range of normal variation. Response rates are low in some areas, and work is under way to review targets and identify opportunities to improve engagement.

Executive Summary

Operational Performance & Productivity

St George's Hospital

Successes

- RTT performance remained above plan at 63.9% in August 2026.
- All cancer performance standards against plan were achieved in August 2026: 85% for 28-Day Faster Diagnosis Standard, 96.1% for 31-Day and 77.6% for 62-Day Wait Standard.
- Theatre utilisation remains in the top national quartile. A refreshed 6-4-2 process will launch in October 2026 to improve consistency, scheduling discipline and utilisation across specialties. SGUH went live with electronic Preoperative Assessment (ePOA) on 24 September 2026, supporting earlier digital screening, risk identification and optimisation.
- A focused six-week pre-winter improvement programme is underway, using weekly operational sprints to accelerate improvements across key flow areas including Same Day Emergency Care (SDEC), discharge processes, patient safety and non-clinical transfer delays.
- Waits over 12 hours in the Emergency Department continue to reduce exceeding plan with corridor care seeing a reduction through September 2026

Challenges

- RTT waiting list and 52-week waits have increased. Recovery efforts are focused on restoring activity, reducing long waits, and driving outpatient transformation with strengthened oversight.
- While cancer performance remains on trajectory, there are emerging risks across modalities. These relate primarily to workforce shortages, diagnostic and theatre capacity constraints, and growing backlogs. Recovery actions are in place, including recruitment, additional clinics and operating lists, and targeted backlog reduction plans, but sustained performance will depend on successful delivery of these mitigations
- Diagnostics performance remains challenged by ultrasound capacity and workforce shortages. Recovery actions include temporary staffing, targeted recruitment, and insourcing support.
- 4-hour performance declined in month achieving 78.2%, against plan of 80.9%, this was impacted by a sustained increase of and higher acuity within the non-admitted pathway.
- Outpatient discharge rates remain strong and above peer benchmarks, although PIFU remain lower than the 5% ambition. Outpatient productivity remains a priority, with transformation programmes across gesh focused on expanding PIFU pathways, validating follow-up waiting lists, and reducing avoidable follow-up demand.

Epsom & St Helier

Successes

- All cancer performance standards were achieved in August 2026: 91.7% for 28-Day Faster Diagnosis Standard, 100% for 31-Day and 88.9% for 62-day Standard.
- RTT performance exceeded the 66.7% plan in August 2026, delivering a performance of 66.9%, with the waiting list size falling again to 56,723. While 52-week waits were above plan, they improved during the month, demonstrating continued progress in elective recovery and backlog reduction.
- Diagnostic performance remained ahead of the 8.4% plan with a performance of 7.7%.
- Theatre utilisation achieved 82% in September 2026, marking eleven consecutive months at 80% or above. The focus remains on sustaining this performance and progressing towards consistent delivery of 85% utilisation
- DNA rates remain stable and have remained below the 6% target for four consecutive months.
- Ambulance handover performance exceeded target, with 3.0% of handovers over 45 minutes against a 5% target (improved from 3.3% in August), while average handover times remained at 21 minutes, ahead of the 22-minute trajectory.
- Non-elective length of stay remained below target at 10.6 days (target 10.9), supported by a reduction in discharge delay days from 1.3 to 0.5 and improved patient flow.

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 improved to 70.8 % in September 2026; however, this remains below the revised plan target of 77%. A focused and comprehensive recovery plan is in place to support performance improvement and trajectory recovery including waits over 12 hours.
- Average daily corridor count continues to improve month on month, decreasing from 31 to 28. While the figure remains above the target, this improvement is indicative of the continued focus on reducing corridor care across both sites.
- Non-Elective Transformation Programmes across both sites are progressing, complemented by ESTH and place-based initiatives.

Executive Summary

Integrated Care Services

Quality & Safety

Pressure ulcers continues to have enhanced oversight for Integrated Care. A deep dive has been completed and presented.

AHP day 2026 was celebrated on 15th October, highlighting the contribution of AHPs to patient care, service transformation and prevention while recognising workforce achievements across the organisation.

Sutton Health & Care (SHC) Specific

- Safety and control indicators – no incidence of MRSA, *C. difficile and E. coli* reported for September 2026
- Patient Experience Review demonstrated strong overall performance, with an average 98% patients rating services as good or very good. However, engagement is low overall.
- Children's pathway and waiting list work continues across Dysphagia and Therapy referrals. The Group Executive Committee reviewed the recovery plan in September 2026.
- Reablement Unit closed 13 beds due to estates issues/structural concern
- Sexual Health/MSK issues ongoing – activity delivered elsewhere

Surrey Downs Health & Care (SDHC) Specific

- Safety and control indicators - no incidence of MRSA and E. coli reported for September 2026. X1 c diff in Mary Seacole Unit.
- The CASD Day held in East Elmbridge on 8 October was attended by over 200 residents and showcased the neighbourhood approach to managing patient care, promoting integrated working and community engagement.
- A patient known to the District nurses has unfortunately died by suicide. Following an unsuccessful visit, the team appropriately implemented a welfare check and escalation procedures in accordance with the access policy. All relevant notifications and governance escalation within the GSH system has been completed

Operational Performance

Sutton Health & Care (SHC)

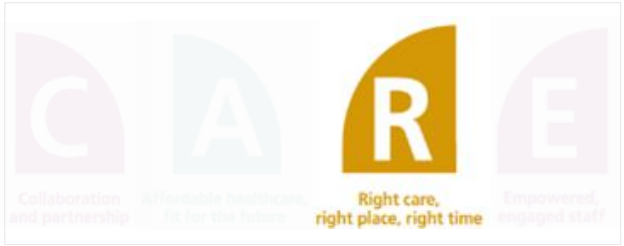
- 2-hour Urgent Community Response (UCR) performance has continued to exceed the 70% target, delivering 76.5% in September 2026 and maintaining compliance with the national standard. Performance has been supported by workforce and service redesign initiatives to better align capacity with increasing weekend and out-of-hours demand within the Integrated Care Community (ICC).
- 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.
- September 2026 saw a marked improvement in long-wait performance, with the number of children waiting more than 52 weeks reducing from 79 to 12. This substantial reduction demonstrates the impact of focused recovery actions. The remaining long waits are exclusively within Children's Speech and Language Therapy services, enabling targeted action to eliminate the residual breaches.
- Sickness rate in September increased sharply to 8.7%. The largest increase has been within Nursing and Midwifery rising to 11.07% from 6.43% in August 2026 (equating to 260 FTE to 433 FTE). This spike is due to short term sickness. The service is working with the short-term sickness team to ensure grip and control.

Surrey Downs Health & Care (SDHC)

- 2 –hour Urgent Community Response (UCR) performance remains strong, achieving 84.1% in September 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



Quality Dashboard

Patient Safety, Outcomes, Effectiveness and Experience

KPI	St George's Latest month	St George's Previous Month Measure	St George's This months 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 This months Measure	Epsom & St Helier Target	Epsom & St Helier Variation	Epsom & St Helier Assurance	Epsom & St Helier Benchmark
Never Events	Sep 26	0	0	0	No Change	Variable	N/A	Sep 26	0	0	0	No Change	Variable	N/A
Patient Safety Incident Investigations	Sep 26	0	0	0	No Change	Variable	N/A	Sep 26	0	2	0	No Change	Variable	N/A
Moderate and Severe Harm from Falls	Sep 26	0	1	2	No Change	Variable	N/A	Sep 26	2	1	1	No Change	Variable	N/A
Pressure Ulcers - Acquired Category 3	Sep 26	5	9	7	No Change	Variable	N/A	Sep 26	1	1	5	No Change	Achieving	N/A
Pressure Ulcers - Acquired Category 4	Sep 26	1	1	0	No Change	Variable	N/A	Sep 26	1	0	0	No Change	Variable	N/A
Infection Control - Number of MRSA	Sep 26	1	0	0	No Change	Variable	2nd Quartile	Sep 26	0	0	0	No Change	Variable	Lowest Quartile
C.difficile infections versus threshold (rolling 12 months)	Sep 26	51	48	43	Improving	Not Achieving	3rd Quartile	Sep 26	49	47	46	Improving	Not Achieving	Top Quartile
Ecoli infections versus threshold (rolling 12 months)	Sep 26	90	95	107	Improving	Not Achieving	Top Quartile	Sep 26	69	63	54	No Change	Not Achieving	Lowest Quartile
Delirium Assessment (Medical) Compliance 65+ within 24 hours of admission	Sep 26	7.1%	6.7%	-	Improving	-	N/A	Sep 26	44.4%	57.6%	-	Improving	-	N/A
30-Day Emergency Readmission Rate	Aug 26	8.2%	9.1%	-	No Change	-	TBC	Aug 26	11.3%	13.3%	-	No Change	-	TBC
VTE Risk Assessment	Sep 26	85.9%	86.5%	95.0%	No Change	Not Achieving	Lowest Quartile	Sep 26	79.7%	81.2%	95.0%	No Change	Not Achieving	Lowest Quartile
Mortality - SHMI	May 26	0.96	0.96	-	Deteriorating	-	As Expected	May 26	1.19	1.18	-	Deteriorating	-	Higher than Expected
% inpatients making a supported quit attempt with an in-house tobacco dependence service	Mar 26	73.0%	29.8%	-	-	-	2nd Quartile				-	-	-	N/A
Complaints - Responded to within 35 working days	Sep 26	84.0%	85.0%	85.0%	Deteriorating	Variable	N/A	Sep 26	91.0%	87.0%	85.0%	No Change	Variable	N/A
Complaints - Acknowledgement within 3 working days	Sep 26	100.0%	98.0%	100.0%	No Change	Variable	N/A	Sep 26	100.0%	100.0%	100.0%	No Change	Variable	N/A
Number of complaints not completed within 6 months from date of receipt	Sep 26	4	5	0	Deteriorating	Not Achieving	N/A	Sep 26	6	10	0	No Change	Not Achieving	N/A
Friends and Family Test - Inpatients Score	Sep 26	98.7%	98.9%	-	No Change	-	N/A	Sep 26	95.0%	96.0%	-	No Change	-	N/A
Friends and Family Test - Emergency Department Score	Sep 26	80.0%	72.6%	-	No Change	-	N/A	Sep 26	84.0%	80.0%	-	Improving	-	N/A
Friends and Family Test - Outpatients Score	Sep 26	95.0%	94.3%	-	No Change	-	N/A	Sep 26	95.0%	92.0%	-	Improving	-	N/A
Friends and Family Test -Inpatient Response Rate	Sep 26	33.7%	33.6%	-	No Change	-	N/A	Sep 26	13.0%	10.0%	-	Improving	-	N/A
Friends and Family Test -Emergency Department Response Rate	Sep 26	10.6%	9.8%	-	Deteriorating	-	N/A	Sep 26	4.0%	4.0%	-	Improving	-	N/A
Friends and Family Test - Outpatient Response Rate	Sep 26	10.8%	9.2%	-	No Change	-	N/A	Sep 26	4.9%	4.0%	-	Improving	-	N/A

Maternity Services Dashboard

Quality, Safety, Effectives, Experience and Workforce

	St George's							Epsom & St Helier						
KPI	Latest month	Previous Month Measure	This months Measure	Target	Variation	Assurance	Benchmark	Latest month	Previous Month Measure	This months Measure	Target	Variation	Assurance	Benchmark
% Births with 3rd or 4th degree tear	Sep 26	3.9%	2.8%	-	No Change	-	3.3%	Sep 26	2.3%	2.5%	-	No Change	-	3.1%
% Births Post Partum Haemorrhage >1.5 L	Sep 26	6.1%	1.9%	-	No Change	-	3.0%	Sep 26	2.2%	3.0%	-	No Change	-	3.0%
Stillbirths per 1,000 births (Rolling 12 mths)	Sep 26	3.6	4.0	-	No Change	-	3.5	Sep 26	1.8	1.8	-	Deteriorating	-	2.9
Neonatal deaths per 1,000 births(Rolling 12 mths)	Sep 26	5.6	6.0	-	Deteriorating	-	2.4	Sep 26	1.2	1.2	-	Deteriorating	-	1.1
Maternal Deaths	Sep 26	0	0	-	No Change	-	N/A	Sep 26	0	0	-	-	-	N/A
ITU Admissions	Sep 26	0	0	-	No Change	-	N/A	Sep 26	1	1	-	-	-	N/A
HIE (Hypoxic ischaemic encephalopathy) per 1000 births and rolling 12 months	Sep 26	1.8	1.3	2.0	No Change	Achieving	N/A	Sep 26	0.9	0.9	2.0	Deteriorating	Achieving	N/A
Rate of deliveries with a delayed induction (6+ hours) per 1000 deliveries	Jun 25	75.9	23.3	-	Improving	-	2nd Quartile	Jun 26	20	0	-	-	-	Top Quartile
PSII- National Reporting (MNSI referrals)	Aug 26	0	0	-	No Change	-	N/A	Sep 26	2	0	-	-	-	N/A
PSII – Local PSIIs	Aug 26	0	0	-	No Change	-	N/A	Sep 26	0	0	-	-	-	N/A
Friends and Family Test - Maternity Births Score	Sep 26	100.0%	86.7%	-	No Change	-	N/A	Sep 26	100.0%	100.0%	-	Improving	-	N/A
Friends and Family Test - Maternity Births Response Rate	Sep 26	0.5%	2.5%	-	Deteriorating	-	N/A	Sep 26	2.0%	4.3%	-	No Change	-	N/A
Maternity Appraisal Rate	Jul 26	73.5%	75.0%	90.0%	No Change	-	N/A	Aug 26	77.5%	78.3%	90.0%	-	-	N/A
Maternity Vacancy Rate	Jun 26	7.9%	7.9%	10.0%	No Change	-	N/A	Aug 26	11.8%	12.1%	10.0%	-	-	N/A
Maternity Turnover Rate	Jun 26	8.0%	8.1%	13.0%	No Change	-	N/A	Aug 26	0.7%	1.1%	13.0%	-	-	N/A

Maternity PSIIs are a subset of total Trust PSIIs
Maternity: data quality issues identified and are being worked through with the Maternity and BI Teams
MBRRACE- source for Maternity benchmarking and peer groupings

Integrated Care Quality Dashboard

Patient Safety and Experience

KPI	Latest month	Previous Month Measure	Latest Month Measure	Target	Variation	Assurance
Sutton Healthcare						
Patient Safety Incidents Investigated	Sep 26	0	0	0	No Change	Achieving
Number of Falls with Harm (Moderate and Above)	Sep 26	0	0	0	No Change	Achieving
Pressure Ulcers Category 3	Sep 26	7	2	0	No Change	Not Achieving
Pressure Ulcers Category 4	Sep 26	0	1	0	No Change	Variable
Infection Control - Number of MRSA	Sep 26	0	0	0	Improving	Achieving
Infection Control - Number of Cdiff	Sep 26	0	0	0	Improving	Variable
Infection Control - Number of Ecoli	Sep 26	0	0	0	Improving	Achieving
Community Friends and Family Test - Community Score	Sep 26	98%	99%	-	No Change	-
Community Friends and Family Test - Response Rate	Sep 26	0.70%	0.80%	-	No Change	-
Surrey Downs						
	Sep 26	0	0	0	No Change	Achieving
	Sep 26	0	0	0	No Change	Variable
	Sep 26	6	2	0	No Change	Not Achieving
	Sep 26	0	1	0	No Change	Variable
	Sep 26	0	0	0	Improving	Achieving
	Sep 26	0	0	0	Improving	Variable
	Sep 26	0	0	0	Improving	Variable
	Sep 26	96.5%	96.4%	-	Improving	-
	Sep 26	11.2%	10.5%	-	No Change	-

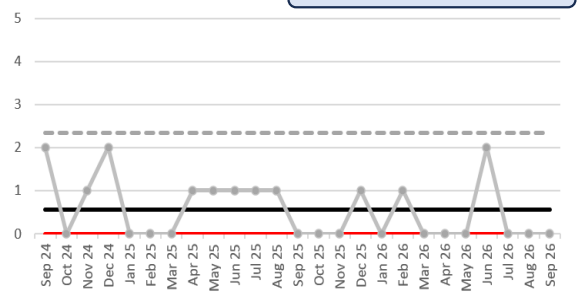
- Community FFT is a subset of Epsom and St Heliers FFT data.
- Infection Control data for Integrated Care is a subset of Epsom and St Heliers Infection Control data, national thresholds are set at Trust level including hosted IC services
- IC (Dorking and Molesey Hospitals – community do not have set national trajectories for HCAIs although all cases are reviewed and investigated)

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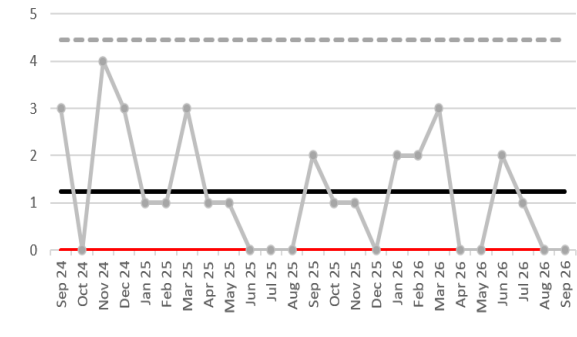
Overview of Incidents | SGUH and ESTH

St George's

Never Events — YTD 2026/27 – 2 Cases

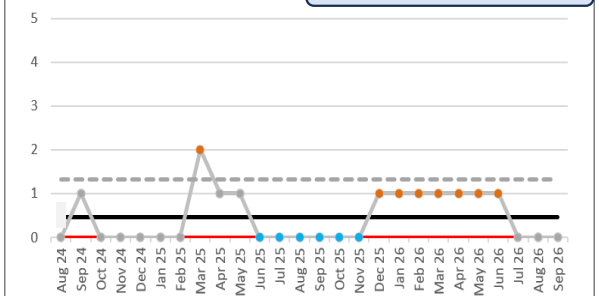


Patient Safety Incident Investigations — YTD 2026/27 – 3 Cases

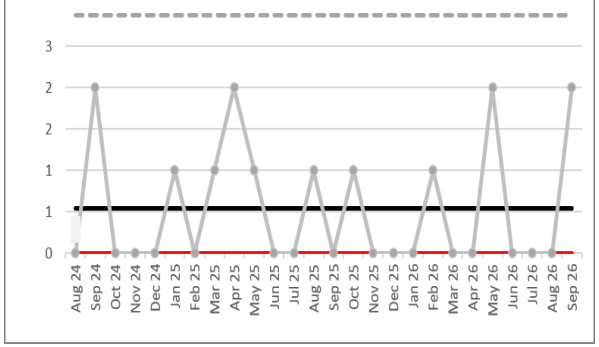


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Never Events — YTD 2026/27 – 3 Cases



Patient Safety Incident Investigations — YTD 2026/27 – 4 Cases



Summary and Actions:

SGUH

Never Events: No Never Events were declared in September 2026

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

ESTH

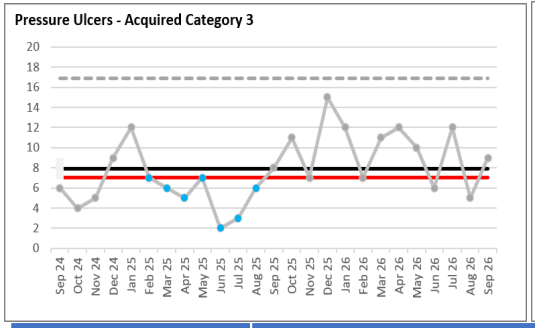
Never Events: No Never Events were declared in September 2026

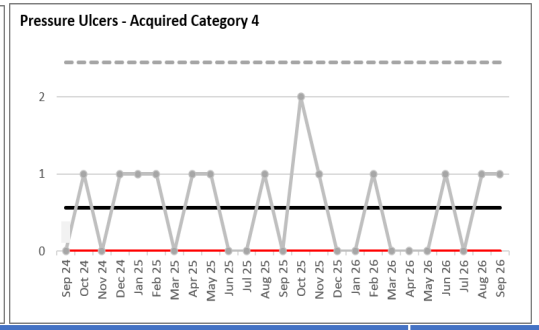
Patient Safety Incident Investigations : 2 PSIIs were declared in September 2026 and maternity related cases that meet the MNSI criteria. With family consent the investigations will be done externally by MNSI. The trust will await the report before deciding if there are any actions required. No other immediate actions were considered necessary.

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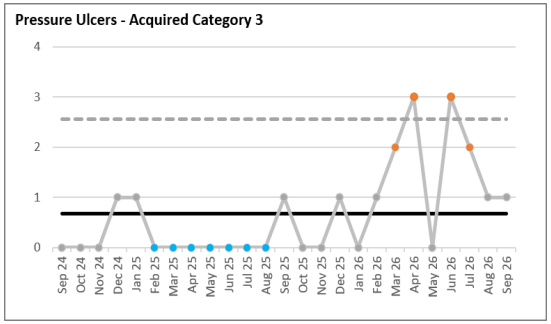
Exception Report | SGUH and ESTH - Category 3 & 4 Pressure Ulcers

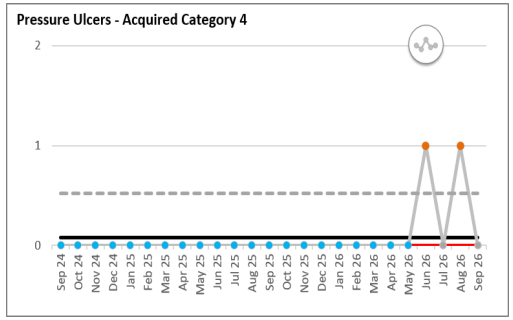
St George's





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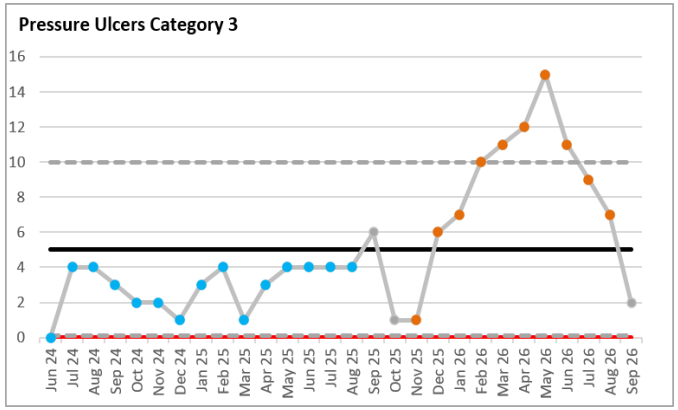


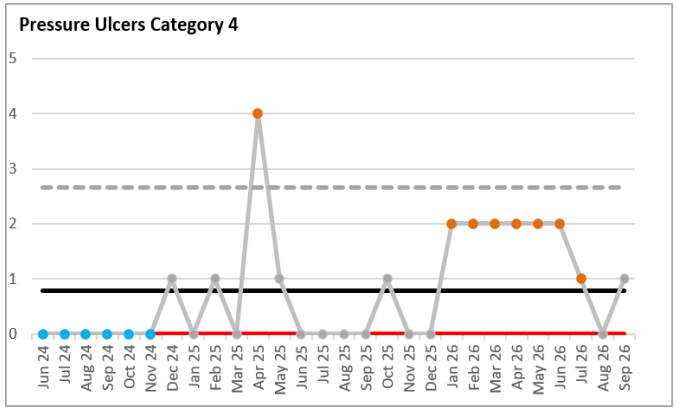


Site & Metric	Cause of variance/ non-compliance	Actions: Completed since last update, New, and Ongoing	Recovery Date
SGUH Pressure Ulcers Category 3: 9 Category 4: 1 **Data Quality:** Sufficient for assurance	In September 2026 there were 10 acquired pressure ulcers reported at SGUH. 6 were medical device related with 2 caused by neck collars and 3 by urinary catheters. The category 4 pressure ulcer was caused by a neck collar, as result the service has increased the frequency of collar checks for all patients and reviews between surgery and neurology to ensure collars are removed as soon as safe. Thematic analysis has shown an increase in pressure ulcer numbers in adult intensive care units.	• Theme identified – inappropriate dressing of deep tissue injuries, training materials shared with all services and discussed with those where issues found • Richmond AMU senior nursing staff attending tissue viability shadowing as part of the areas pressure ulcer improvement project • New SGUH body map and senior nurse review template trialled in iCLIP Pro in October 2026 • Thematic review meeting to be held with adult intensive care and Deputy Chief Nurse in October 2026	Nov 2026. Being reviewed at Site level
ESTH: Pressure Ulcers Category 3: 1 case Category 4: 0 Case **Data Quality:** Sufficient for assurance	• One patient has acquired a sacral category 3 PU in Chuder Ede. Patient was on palliative pathway and has been discharged from hospital. There were no Grade 4 Pressure Ulcers. • Arising themes for acquired pressure ulcer remains an increase in the number of complex patients admitted from the community with comorbidities).	• **Education and training:** Tissue Viability Nurses (TVNs) will run a monthly virtual open session for all staff from October, plus teaching sessions for Emergency Department staff, supporting correct terminology for skin changes (blanching redness, non-blanching redness, dark or purplish tissue). • **Hybrid mattress rollout:** over 200 staff trained since 14/09/2026 across STH, with implementation due to start from 21/10/2026 • **Governance and learning:** the monthly Pressure Ulcer Steering Group reviews emerging themes and improvements across ESTH, and Trust-acquired pressure ulcers are investigated in line with Patient Safety Incidents Response Framework, with a SWARM completed where appropriate to identify gaps in care and share learning.	Dec 2026. Being reviewed at site level.

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



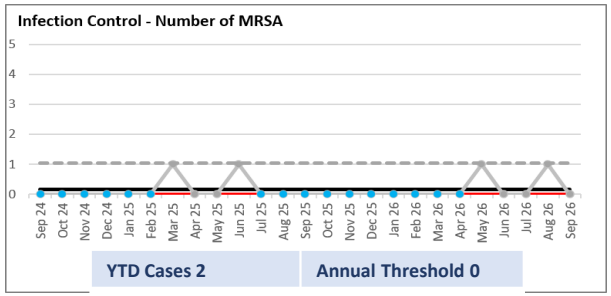


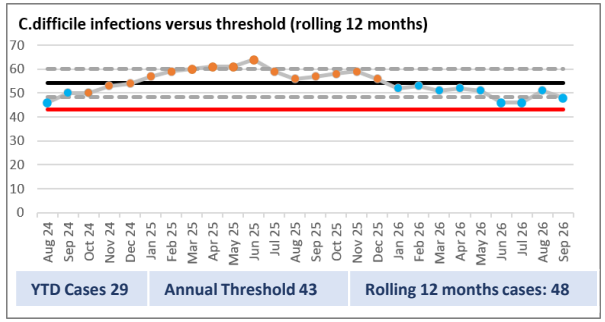
Site & Metric	Cause of variance/ non-compliance	Actions: Completed since last update, New, and Ongoing	Recovery Date
Sutton Health Pressure Ulcers Category 3 & 4 In September 2026, there were 2 Category 3 pressure ulcers compared to 7 in August 2026 and 1 Category 4 compared to zero in August 2026 Normal Variation **Data Quality:** Sufficient for assurance	Category 3 and 4 pressure ulcers have shown an upward trend since December 2025 with a downward trajectory seen in incident demonstrates compliance with embedded processes A recent deep-dive identified that the rise in pressure ulcers is multifactorial, reflecting increasing patient complexity in the community (frailty, multiple long-term conditions, reduced mobility, end-of-life care and pre-existing skin damage), compounded by workforce pressures, patient non-concordance and the challenges of care in the home	• 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 October 2026. • Additional assurance measures are now in place alongside PSIRF action plan to ensure senior nursing review of all Cat 3 & 4 ulcers	Moved to monthly assurance. Recovery date to be confirmed.

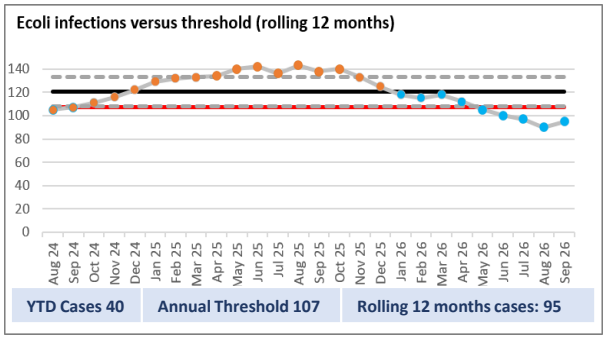
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Overview Infection Prevention and Control |SGUH and ESTH

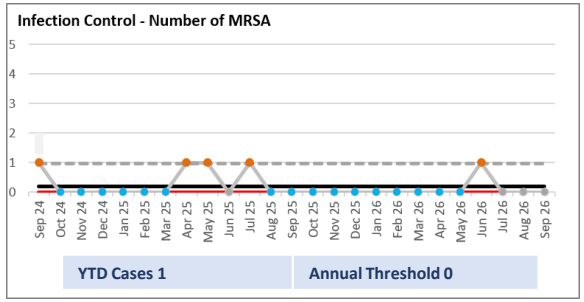
St George's

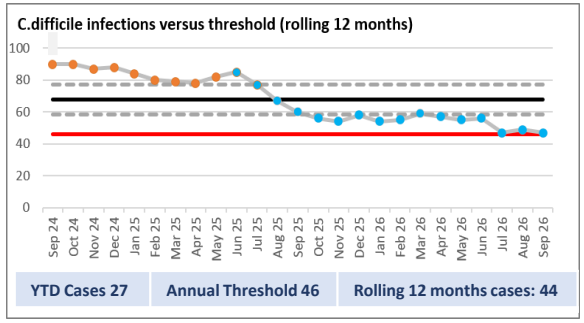


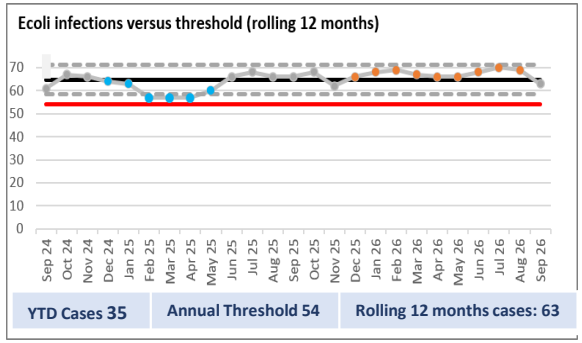




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Summary with cause of variance / non-compliance

SGUH

- 0 MRSA bloodstream infection (BSI) cases in September 2026. Total cases YTD 2
- 4 C. difficile cases in September 2026 : Total cases YTD 29
- 9 E-Coli cases in September 2026: Total cases YTD 41
- Multidisciplinary C. difficile ward rounds and learning reviews continue, enhanced environmental decontamination utilising Hydrogen Peroxide Vapour (HPV) is in place post-discharge/transfer.
- Neonatal Unit (NNU) MRSA Outbreak: 12 colonised cases identified between December 2025 to 6th May 2026 and 1x MRSA BSI case reported Aug 2026 (one of the 12 colonised babies). One new colonised case reported on NNU August, baby was born at SGH, screened MRSA negative, transferred to Croydon University Hospital after 5 days and screened positive on admission. No cases reported in September.

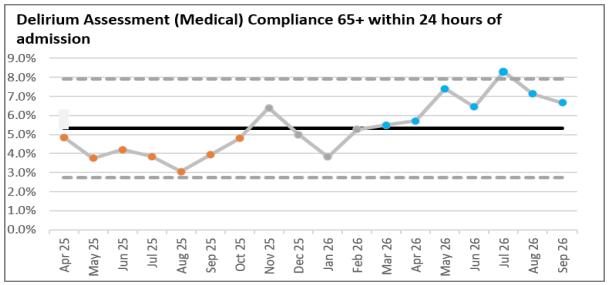
ESTH

- 0 MRSA BSI in September 2026: Total cases YTD 1
- 5 C. diff cases in September 2026: Total cases YTD 27.
- 6 E-Coli cases in September 2026; Total cases YTD 35
- Water safety risks remain under active monitoring through the Water Safety Group and Senior Leadership Team; weekly meetings continue to support oversight and progression of plans for E Block. Wider staff communications have been issued to support awareness and keep teams informed of ongoing plans. Reassuringly, no clinical infections associated with the water safety issues have been reported during the reporting period.

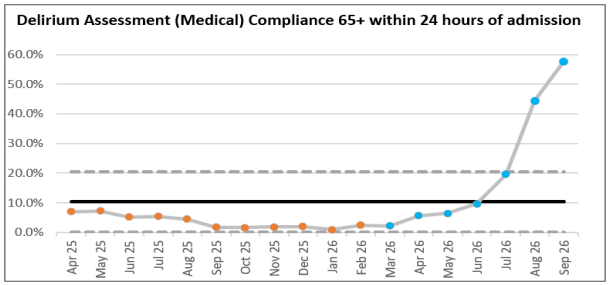
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Exception Report| SGUH & ESTH Delirium Assessment for 65+ years

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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.

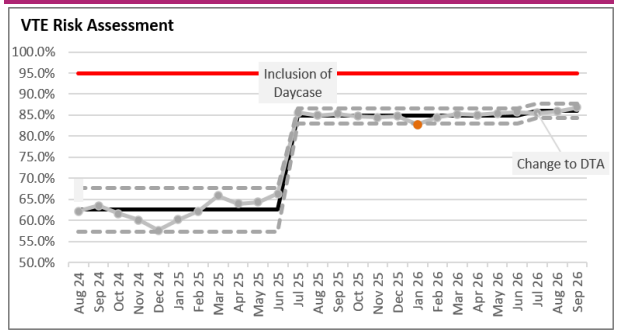
Please note this metric differs from the dementia assessment metric previously mandated by NHSE, which has now been discontinued.

Site & Metric	Cause of variance/ non-compliance	Actions: Completed since last update, New, and Ongoing	Recovery Date
SGUH: Delirium Assessment Medical within 24 hrs – 6.67% Delirium Assessment Nursing within 24 hrs – 44.51%% RADAR Compliance (Daily Ax) – 11.41% Data Quality – under review	• In September 2026, 69.42% of eligible patients received a delirium assessment, with 49.49% completed within 24 hours; proforma use remains inconsistent and free-text assessments cannot be measured • Delirium assessment proforma completion not consistently part of medical clerking • Nursing RADAR workflow not working as planned	• The Dementia and Delirium Clinical Nurse Specialist team have been visiting Richmond AMU 3 times a week since 10th August 2026 to promote and support with delirium assessment completion along with Dementia and Delirium Care. This resulted in an increase in delirium assessment completion within 24 hours of admission in August (15.7%) but has not been sustained in September. In response to this, the team have been working with Consultant colleagues in AMU with a plan to provide focused teaching in October 2026. • Changes awaited to iClip Pro Delirium assessment which aims to reduce the number of 'clicks'; joint Trust IT change meetings underway	under review
ESTH: Delirium Assessment Medical within 24 hrs – 57.5% Delirium Assessment Nursing within 24 hrs – 58.40% RADAR Compliance (Daily Ax) – 19.78% Data Quality – under review	• In September 2026, 83.5% of eligible patients received a delirium assessment, with 54.2% completed within 24 hours and 44.3% by a medical clinician within 24 hours, showing 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	• All divisions now have access to the dashboard, enabling daily monitoring of performance, while ongoing collaboration with the BI team has ensured the dashboard continues to evolve to support accurate and credible data capture. • The introduction of league tables and the inclusion of delirium screening and 4AT compliance within divisions and governance meetings have increased accountability and positively influenced staff attitudes towards performance improvement. • 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	

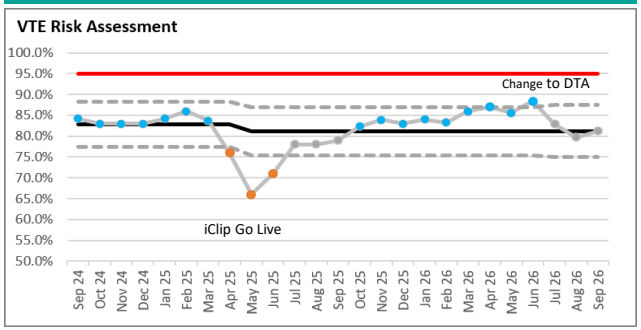
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Exception Report| SGUH & ESTH - VTE Risk Assessment Rates

St George's



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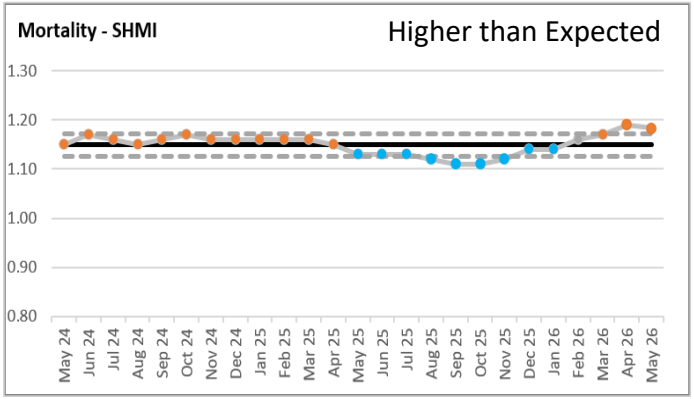


From July 2026, the IQPR applies the revised national definition: the percentage of acute hospital admissions (patients aged 16 and over at the time of admission) in the reporting month who were risk assessed for VTE within 14 hours of the decision to admit, using the criteria in NICE guideline NG89.

Site & Metric	Cause of variance/ non-compliance	Group Actions: Completed since last update, New, and Ongoing	Recovery Date
SGUH: VTE 86.50%. Not meeting target of 95% **Data Quality:** Sufficient for assurance	Rates remain below the 95% national target reporting 86.5% in September 2026. From July 2026 methodology has been updated to reflect changes in national guidance, minimal impact seen in performance as previous performance was understated due to exclusion of daycases. Work is underway to reinstate the VTE champion network with recruitment from all divisions, which will drive local improvements 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 and a working group has been established.	• A shared digital VTE risk assessment tool across the group is in development optimising Cerner functionality to improve compliance and is the current priority. Work is also underway to align data reporting and low risk cohorts.	under review
ESTH: VTE 81.2% Not meeting target of 95% **Data Quality:** Sufficient for assurance	• Rates remain below the 95% national target at 81.2% in September 2026. NHSE change in reporting guidance in July 2026 likely contributing factor to this drop in performance. • A review of low-risk cohorts for complete change/alignment with SGH is currently awaiting Site CMO approval. This will be presented at PSQG in October. • Reliant on clinical coding to be completed before being able to identify all exemptions therefore would expect performance to increase post coding completion. • Further data quality issues post change under review	• Retrospective Audit findings on VTE Risk Assessment and Thromboprophylaxis prescribing against National guidelines was presented at NMEC in August. To be presented at PSQG in October. • Ongoing work with SGH to improve VTE risk assessment compliance since change in reporting guidance • Site Hospital Thrombosis Group meetings to oversee progress are being arranged.	

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Exception Report | ESTH- SHMI

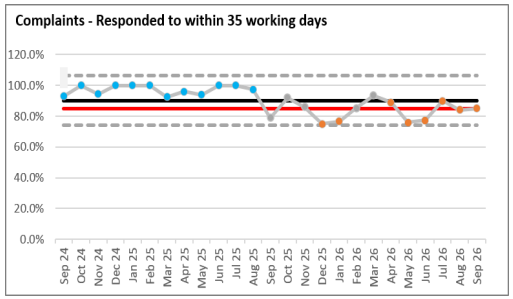


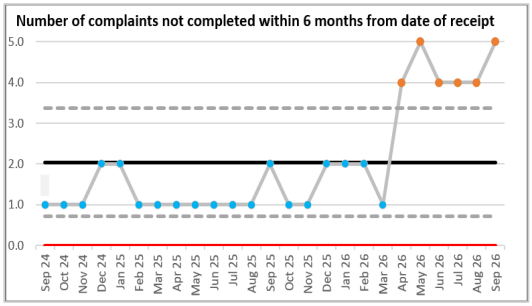
Site & Metric	Cause of variance/ non-compliance	Actions: Completed since last update, New, and Ongoing	Recovery Date
SHMI performance has increased higher than expected Special cause variation of a CONCERNING nature. **Data Quality:** Under review.	The SHMI index remains within the "higher-than-expected" 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. Analysis indicates the reduction in modelled expected deaths is attributable to data quality issues which coincide with implementation of the new EPR. The most recent SHMI period covers June 2025 to May 2026, so is reflective of a complete year of data post implementation.	• A clinical safety review, led by the Group CMO, will begin shortly to provide a deeper understanding of mortality at ESTH. • A weekly Task and Finish group, led by the Group Director of Performance, has been established to investigate the increase from a data and reporting perspective. Its membership includes the Group Head of Mortality and Effectiveness and the Clinical Coding and BI teams. • Data quality issues that may have affected the patient risk profile have been identified, and corrective action is in place where appropriate. These include primary diagnosis coding, allocation of site and depth of coding. Further work is under way to understand their impact. • External expert guidance has been sought to inform the investigation. • A planned change to SDEC data reporting, due by April 2027, will affect SHMI, and its implications are being discussed	To be confirmed

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Exception Report| SGUH & ESTH Complaints

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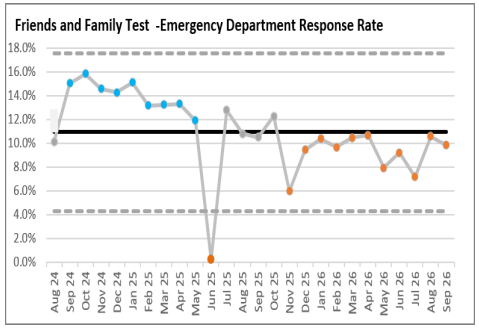


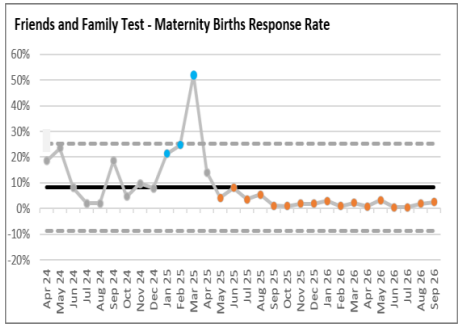
Site & Metric	Cause of variance/ non-compliance	Actions: Completed since last update, New, and Ongoing	Recovery Date
Complaints responded to within 35 working days	In September 2026 85% of complaints were responded to within the allocated timeframe at SGUH, and 87% at ESTH against the target of 85%. SGUH delivered 98% and ESTH delivered 100% acknowledging complaints within 3 working days in September 2026. At SGUH 5 complaints were not completed within 6 months and at ESTH it was 10 for September 2026. Performance has been impacted by; • 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 • More AI complaints which increases both length and number of complaints • lack of timely responses from the divisional teams to progress a complaint response	• Permanent recruitment is now complete for both sites, we are awaiting final new starter. • 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.	December 2026

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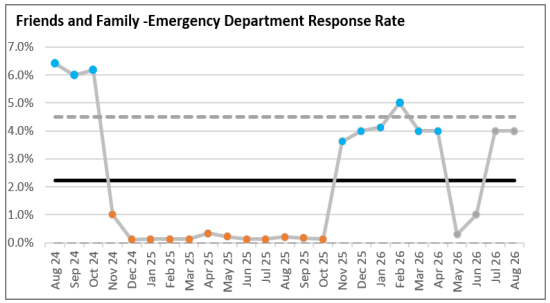
Exception Report| SGUH and ESTH | Patient Experience (Friends and Family Tests)

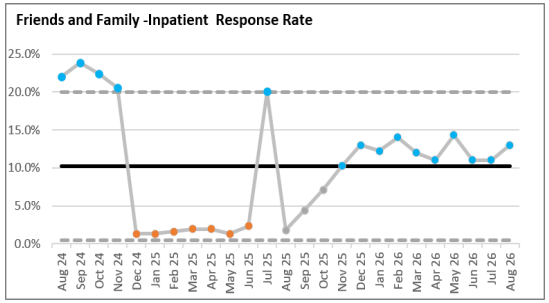
St George's





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Site & Metric	Cause of variance/ non-compliance	Actions: Completed since last update, New, and Ongoing	Recovery Date
SGUH & ESTH FFT Response Rates	There is no national requirement for Friends and Family Test (FFT) response rate targets. However, benchmarking indicates that response rates remain comparatively low, particularly in Emergency Department and Inpatient services. FFT response rates remain a challenge across both sites, with the greatest impact at ESTH. Participation fell following the implementation of iClip and GATHER and has not yet returned to previous levels, despite ongoing improvement activity. Given the scale of improvement required, recovery in FFT response rates is expected to be incremental. The introduction of an internal response rate target is being considered for deferral until 2027/28, with progress monitored in the interim through a phased trajectory of agreed improvement milestones.	Significant work is under way, but the required changes have time and resource implications and meaningful improvement will take time. To support improvement, the following actions are underway: • Outpatient activity codes used for FFT text messaging at ESTH are being reviewed to ensure services and clinical specialties are appropriately represented. • A comparative analysis of FFT text message distribution and response volumes at SGUH and ESTH is under way to identify variation and opportunities for improvement. • Discussions are progressing on a Group-wide approach to FFT participation, including the potential introduction of agreed improvement trajectories and performance expectations. These actions will inform opportunities to improve participation and support a consistent approach across the Group. They will also allow time for a formal response rate target or phased trajectory to be established.	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 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	Aug 26	1.01%	1.13%	0.91%	Deteriorating	Not Achieving	3rd Quartile	Aug 26	0.90%	0.88%	0.84%	Improving	Not Achieving	2nd Quartile
RTT - Percentage of waits within 18 weeks	Aug 26	64.60%	63.90%	60.78%	Improving	Achieving	3rd Quartile	Aug 26	66.9%	66.9%	66.7%	Improving	Achieving	2nd Quartile
Waiting List Community - Percentage of waits within 18 weeks	Aug 26	78.2%	76.4%	78.0%	No Change	Not Achieving	3rd Quartile					-	-	
Cancer - 28 Day Faster Diagnosis Standard	Aug 26	85.4%	85.0%	80.0%	No Change	Achieving	Top Quartile	Aug 26	89.7%	91.7%	80.0%	Improving	Achieving	Top Quartile
Cancer - 31 Day Decision To Treat to Treatment Standard	Aug 26	97.4%	96.1%	96.1%	Improving	Achieving	2nd Quartile	Aug 26	99.2%	100.0%	98.6%	Improving	Achieving	Top Quartile
Cancer - 62 Day Referral to Treatment Standard	Aug 26	83.0%	77.6%	76.0%	No Change	Achieving	2nd Quartile	Aug 26	86.8%	88.9%	79.0%	Improving	Achieving	Top Quartile
Diagnostics - 6 Week Waits	Aug 26	16.7%	24.4%	4.2%	Deteriorating	Not Achieving	3rd Quartile	Aug 26	6.9%	7.7%	8.6%	Improving	Achieving	2nd Quartile
4 Hour Operating Standard	Sep 26	81.7%	78.2%	80.9%	No Change	Not Achieving	Top Quartile	Sep 26	68.1%	70.8%	77.0%	Deteriorating	Not Achieving	3rd Quartile
4 Hour Operating Standard - Paediatrics <16 years	Sep 26	95.5%	90.9%	95.1%	No Change	Not Achieving	2nd Quartile	Sep 26	87.2%	77.7%	95.0%	No Change	Not Achieving	Lowest Quartile
Over 12 Hours in ED from arrival (%) Type 1	Sep 26	6.7%	5.2%	9.0%	Improving	Achieving	Top Quartile	Sep 26	17.3%	17.4%	12.2%	Deteriorating	Not Achieving	Lowest Quartile
Emergency Department Corridor Care (Average Daily Count)	Sep 26	22	20	-	No Change	-	3rd Quartile	Sep 26	31	28	-	Improving	-	Lowest Quartile
Ambulance handovers over 45 minutes	Sep 26	8.0%	8.1%	4.2%	No Change	Not Achieving	2nd Quartile	Sep 26	3.3%	3.0%	5.0%	Improving	Achieving	Top Quartile
Ambulance average Handover Time (min)	Sep 26	00:24:48	00:24:26	00:19:30	Deteriorating	Not Achieving	2nd Quartile	Sep 26	00:21:35	00:21:53	00:22:00	No Change	Achieving	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

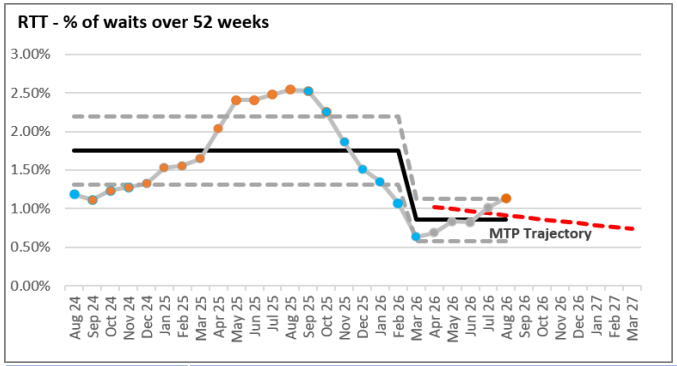
Overview Dashboard – Integrated Care

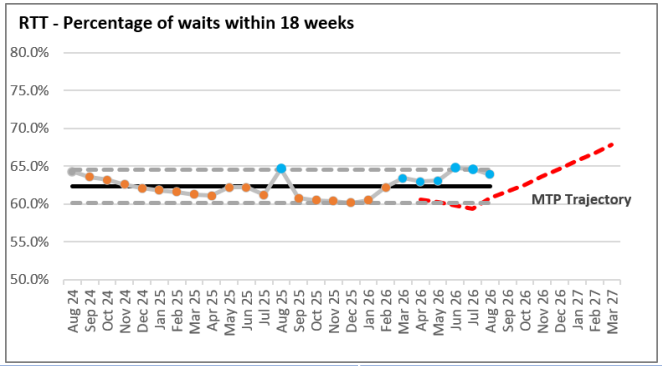
		Sutton Healthcare					Surrey Downs					
KPI	Latest month	Previous month measure	Lastest month measure	Target	Variation	Assurance	Latest month	Previous month measure	Lastest month measure	Target	Variation	Assurance
Two hour UCR performance	Sep 26	81.0%	76.5%	70.0%	No Change	Variable	Sep 26	87.0%	84.1%	70.0%	No Change	Achieving
Virtual ward - Bed Occupancy	Sep 26	54.1%	50.6%	80.0%	Deteriorating	Variable	Sep 26	86.7%	88.6%	80.0%	No Change	Achieving
Virtual ward - Average Length of Stay	Sep 26	4.3	4.9	-	Improving	-	Sep 26	8.7	8.3	-	No Change	-
% of Intermediate care beds occupied by patients without criteria to reside						-	Sep 26	7.2%	5.3%	-	No Change	-
Waiting List Community - Waits over 52 weeks	Sep 26	43	15	0	No Change	Not Achieving	Sep 26	0	0	0	No Change	Achieving
Waiting List Community - Percentage of waits within 18 weeks	Sep 26	86.9%	86.1%	78.0%	Improving	Achieving	Sep 26	96.4%	95.1%	78.0%	No Change	Achieving
Waiting List Community Children - Waits over 52 weeks	Sep 26	41	12	0	No Change	Variable						
Waiting List Community Children - Percentage of waits within 18 weeks	Sep 26	53.8%	53.3%	3.9%	Improving	Not Achieving						

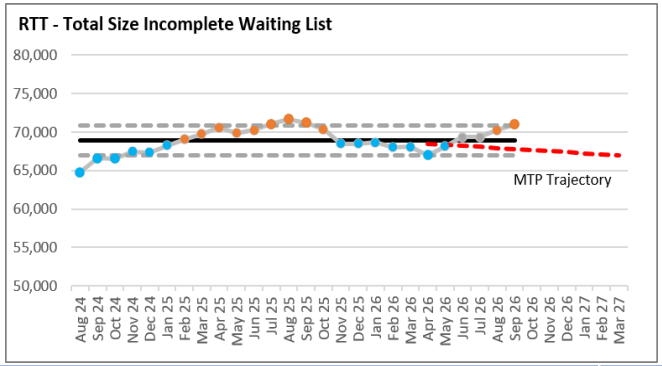
% of Intermediate care beds occupied by patients without criteria to reside
Relates to Surrey Downs - Molesey and Dorking wards only

Operational Performance

Key Metrics | SGUH Referral to Treatment RTT



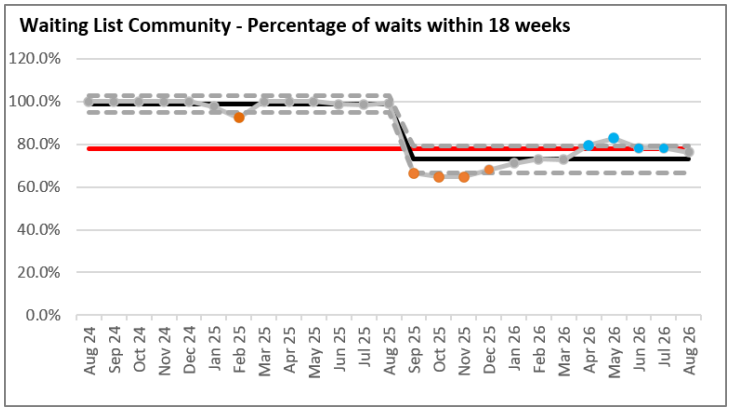




Site & Metric	Cause of variance/ non-compliance	Actions: Completed since last update, New, and Ongoing	Recovery Date
SGUH 52 Wk waits Waiting List Not Meeting Trajectories RTT Performance – meeting Trajectories **Data Quality:** Sufficient for assurance	At the end of August 2026, the number of patients waiting over 52 weeks increased to 805 (1.13% of the PTL), resulting in performance falling behind trajectory. Current long wait cohorts / current risk to delivery; • Gynaecology • General Surgery • Vascular The waiting list has grown steadily since April 2026, reaching 70,983 at the end of August, 3,061 above plan. Growth driven by reduced volume of clock stops compared to clock starts in July and August, except in ENT where there has been a notable increase in demand. With declining 18-week performance. Wait for first appointment has deteriorated, indicating outpatient activity is not keeping pace with demand. Outpatient activity levels overall have dropped in comparison to last year. RTT 18 week performance continues to exceed plan achieving 63.9% in August 2026 against plan of 60.78% St George's RTT performance is in line with the London provider profile overall.	**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 Elective Access meetings. **Ongoing/new:** • New format Elective Access meeting now in place. With a structured focus on reducing 52 week waits to <1% of the overall PTL and improving RTT performance. • Group Outpatient Transformation Programme workstreams is in progress. • Associate Director of Elective recovery in place until March 27 to support delivery of Surgical Strategy, and improve theatre productivity across the Group. • Deep dive into diagnostic delivery to support the overall RTT waiting times is in progress.	As per Plan 2026/27

Operational Performance

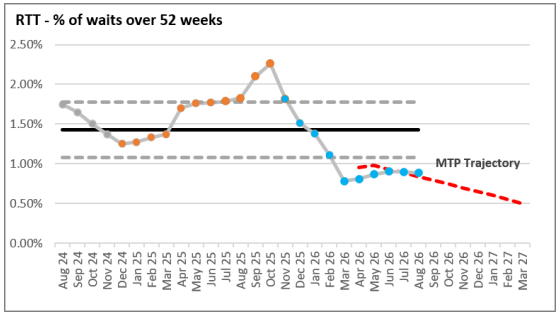
Exception Report | SGUH Community Services Waiting Times

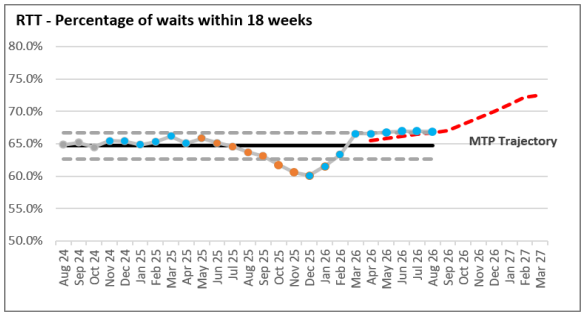


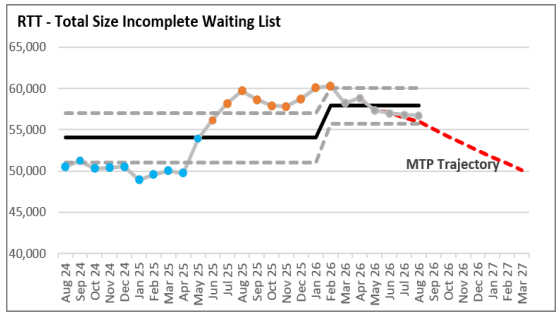
Site & Metric	Cause of variance/ non-compliance	Actions: Completed since last update, New, and Ongoing	Recovery Date
Community Services Waiting Times Normal Variation Not meeting Plan	**Paediatrics** Further deterioration in performance against the 18-week standard, with patients waiting over 18 weeks increasing while those waiting under 18 weeks decreasing. This indicates a growing backlog of longer waiters despite overall list size remaining relatively stable. Although August 2026 performance was mainly driven by seasonal variation with leave and patient choice a key driver, this has compounded significant vacancies in the team linked to consultant long-term sickness as well as recruitment delays. It is noted that although there has been a slight increase in overall patients on the waiting list, there has been a significant reduction since April 2025 (total number 662).	**Paediatric Actions:** - Recruitment to vacant Specialty Dr role- role added to Trac process ongoing - Additional PAs within budget to be offered to staff with appropriate qualifications not currently working within the service to support Neurodevelopmental capacity (2.2/PAs confirmed October to Dec 2026; with potential for this to increase to 4.4PAs/week from Jan 2026) - Recruitment to Substantive Consultant roles (currently on Trac) - Continued tracking of ASD backlog with funded additional sessions ongoing.	TBC

Operational Performance

Key Metrics| ESTH Referral to Treatment RTT



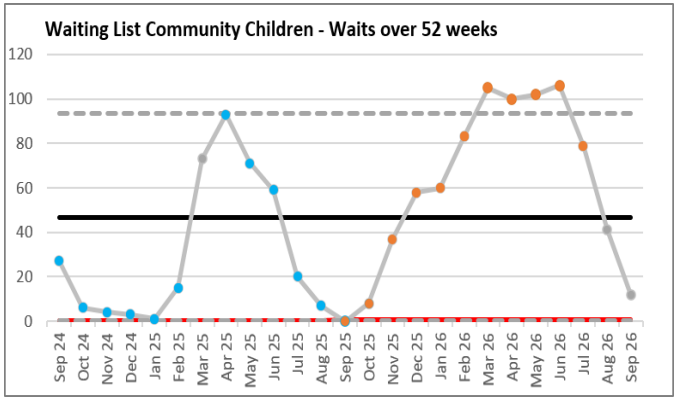


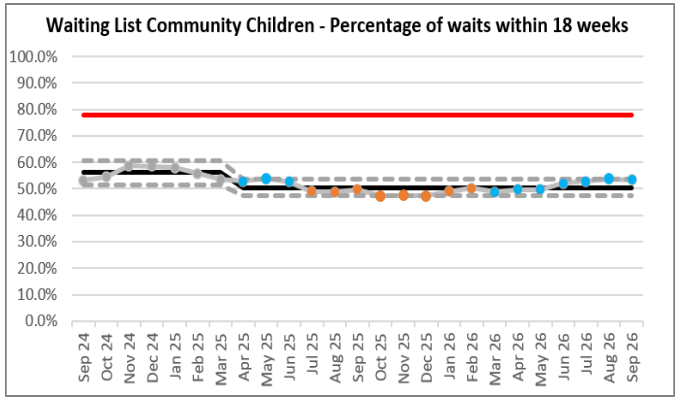


Site & Metric	Cause of variance/ non-compliance	Actions: Completed since last update, New, and Ongoing	Recovery Date
ESTH Total waits over 52 weeks – underachieved monthly trajectory of 471 Percentage within 18 weeks – overachieved monthly trajectory of 66.7%	• ESTH exceeded the August 2026 RTT trajectory (66.7%) with a performance of 66.85%. • 52-week waits reduced again to 500 in August 2026, from 510 in July, but did not achieve the planned trajectory of 471. • Cardiology remains the principal specialty risk due to sustained outpatient demand, Cardiac MRI capacity constraints and ongoing workforce challenges. • Other key drivers include Gynaecology, General Surgery and Paediatric Admitted pathways. • The overall RTT PTL reduced again from 56,820 to 56,723 during August, although it remains above plan, with the key driver being a 1.1k increase in Admitted pathways.	**Total RTT PTL** –Remains above trajectory due to EPR implementation, data quality issues and the iCLIP release. Recovery actions are in place, including additional validation capacity, external support, pathway validation and strengthened operational oversight. **Admitted PTL** – Recently increased by approximately 14%, equating to an additional ~1100 pathways. Recovery plans are being implemented. **Long Waiters -52WW** - Recovery plans remain in place across the most challenged specialties. • **Cardiology:** The service remains under significant pressure, with outpatient waits of approximately 20 weeks, a Cardiac Magnetic Resonance Imaging (CMRI) backlog of around 360 patients, and Direct Current Cardioversion (DCCV) waits of around nine months. Whilst three Consultant posts have been approved and CMRI capacity is planned to increase, the withdrawal of a planned radiographer appointment means outsourcing remains necessary, with limited external capacity available. Data quality issues and the large Patient Tracking List (PTL) continue to affect performance, with recovery constrained by limited resources and service capacity • **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, with UGI first waits increasing to 22 weeks in September. The admitted backlog continues to grow, exacerbated by the departure of the UGI fellow. Additional capacity utilisation remains limited, with only three theatre sessions and three clinics delivered during the month. Weekly PTL reviews, daily validation and ongoing clinical engagement continue to support reduction of the longest waits.	RTT performance trajectory achieved in August 2026. 52WW to return to trajectory by Q3 Total RTT PTL to achieve trajectory by December 2026 ***These recovery dates are subject to RTCS funding being approved

Operational Performance

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



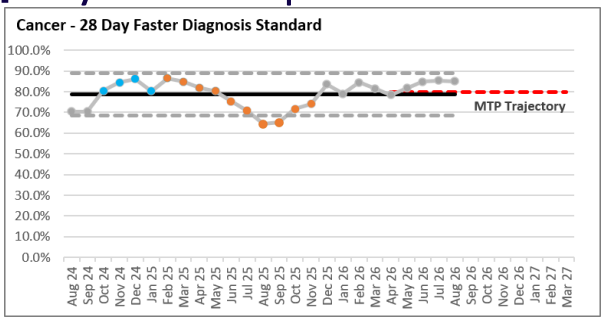


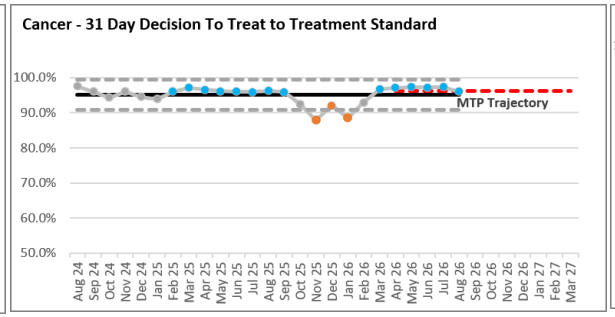
Site & Metric	Cause of variance/ non-compliance	Actions: Completed since last update, New, and Ongoing	Recovery Date

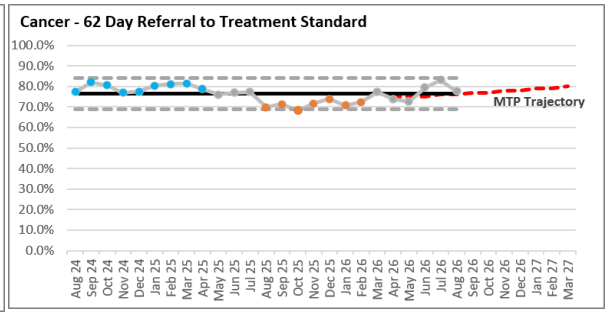
Sutton Health & Care waits over 52 weeks -
 	
Normal Variation
 	
Data Quality: Sufficient for assurance
	The number of children waiting more than 52 weeks for community services further reduced from 79 at the end of August 2026 to 12 in September 2026, reflecting continued progress in addressing the longest waits.
	
	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 continues to see 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 (productivity and improved flow) has also taken place. This is now in implementation phase with an evalutatory review scheduled for February 2027.
			TBC and dependant on wider SWL plan

Operational Performance

Key Metrics | SGUH - Cancer Performance Standards



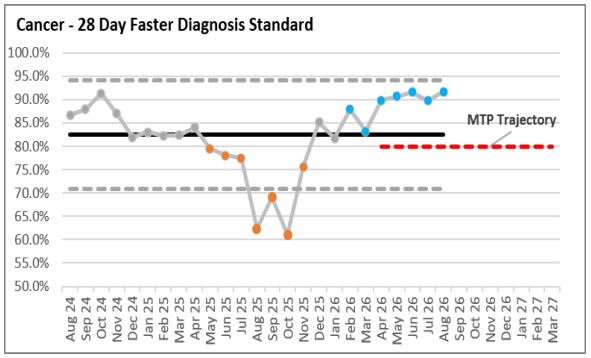


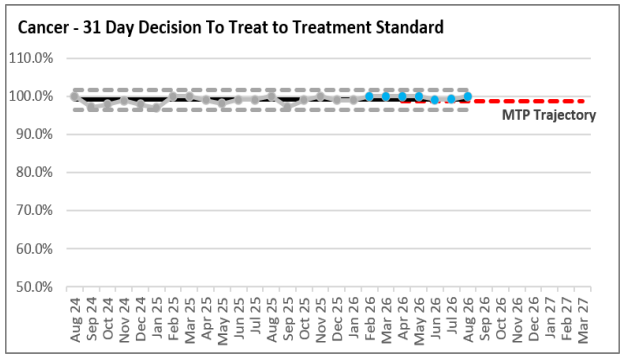


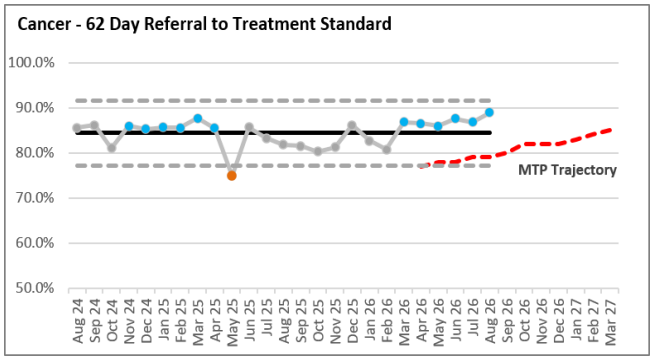
Site & Metric	Cause of variance/ non-compliance	Actions: Completed since last update, New, and Ongoing	Recovery Date
SGUH 28 Day FDS – Meeting Plan 62-Day standard Meeting Plan **Data Quality:** Sufficient for assurance	FDS performance remains ahead of Plan in August 2026 at 85%. **Head & Neck** FDS performance declined to 73.8% in August before recovering to 81.9% in September. Performance remains under pressure due to temporary workforce constraints arising from clinical rotations and staff sickness 62 Day : Performance exceeded trajectory of 76% achieving 77.6% in August 2026 **Key Challenges**: Breast radiology workforce shortages following the retirement of two consultant radiologists and sickness absence. This has delayed secondary diagnostics, including ultrasound, biopsy, MRI reporting, and breast screening processes. **Thoracic Surgery** - remains challenged (62-day: 60%; 31-day: 89%) due to demand for specialist surgical treatment and constraints in theatre and robotic capacity, specialist Lung surgical theatre access remain the principal constraints to achieving 62- and 31-day cancer targets. **Plastics** has developed a backlog for Wide Local Excisions and Sentinel Node Biopsies, driven by leave and limited capacity. Skin and melanoma clinic waits are 3-4 weeks **Dermatology** has a Backlog of 108 patients awaiting Minor Ops. There is a future risk to performance if the backlog is not addressed	**Breast**: Recovery actions include consultant returns from sickness absence, substantive recruitment (November 2026 start), additional diagnostic and reporting capacity through October and November, a six-month locum recruitment programme, and a £75k non-recurrent investment to improve pathway efficiency **Head & Neck**: An FDS backlog of approximately 30 patients has developed. Immediate pressures are being addressed through an additional RMP-funded clinic, while clinic template changes will provide 20 extra appointment slots to improve longer-term capacity **Thoracic Surgery** Mitigations: Additional Saturday operating lists are planned for November and December 2026, alongside the transfer of some robotic urology activity to Epsom to release weekday theatre capacity **Plastics** Recovery actions: Additional clinic capacity funded through RMP to accommodate 60 patients and further review of pathways to ensure cancer appointment slots are ring-fenced. **Dermatology** Recovery actions: Administrative staff have returned, strengthening PTL management and supporting focused backlog reduction plans. **Endoscopy**: backlog (30+ patients) persists, the service has put on an RMP funded Saturday list on 27/09 accommodating 20 patients with plans to run a second list of 30 patients on 07/11. Two additional lists will be opened per month at QMH from November 26.	Delivering against Plan

Operational Performance

Key Metrics| ESTH - Cancer Performance Standards



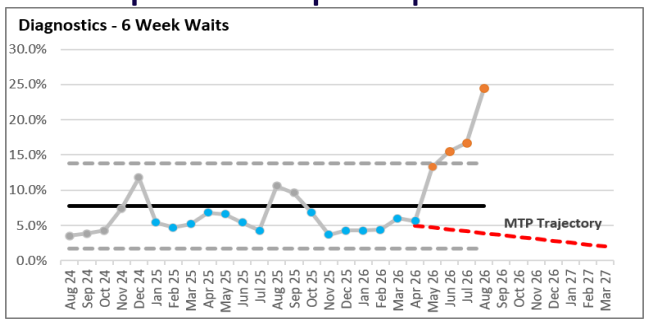




Site & Metric	Cause of variance/ non-compliance	Actions: Completed since last update, New, and Ongoing	Recovery Date
28 Day FDS Meeting Plan 91.7% 62 Day Standard Meeting Plan 88.9% **Data Quality:** Sufficient for assurance	**Lower GI (80%):**Limited Capacity for endoscopy.	**Lower GI**: Limited capacity 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 Plan
	Lung (68.6%): Delays to external diagnostic. **Upper GI (81.3%):**Complex diagnostic pathways. **Gynaecology (71.4%):** Limited capacity for GA and outpatient hysteroscopy services has contributed to delays in the diagnostic pathway.	**Lung:** Imperial has commenced navigational bronchoscopy, providing additional capacity and 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. **Upper GI**: Complex diagnostic pathways requiring multiple investigations have contributed to delays in completing diagnostic tests. Extended waiting times for endoscopic ultrasound (EUS) at the Royal Marsden Hospital (RMH) are a contributing factor to delays in diagnostic completion. ESTH is working to establish a local EUS service to improve timely access to diagnostics and reduce reliance on external providers. Awaiting a start date can be confirmed. **Gynaecology:** The service is experiencing significant capacity pressures due to sickness within the clinical team. Weekly review meetings are being held to monitor capacity shortfalls and identify mitigation measures. Where possible, routine activity is being converted to support urgent and cancer-related activity, helping to prioritise patients requiring timely assessment and treatment.	

Operational Performance

Exception Report| SGUH Diagnostic Performance

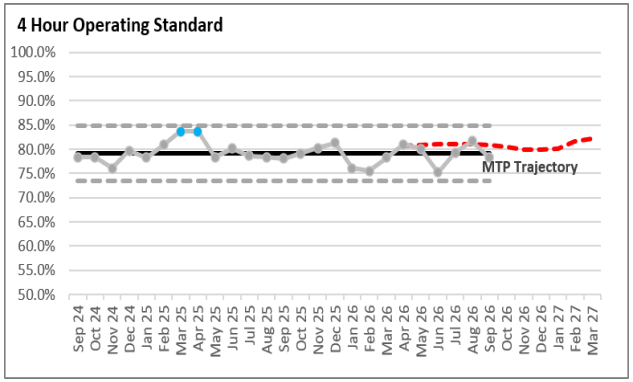


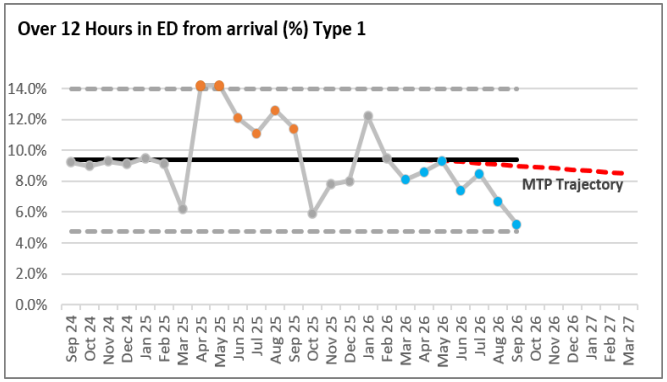
Modality	6 Week Waits	5 Week Performance
Non-obstetric ultrasound	3944	36.9%
Respiratory physiology - sleep studies	229	36.1%
Cardiology - echocardiography	109	9.3%
Magnetic Resonance Imaging	30	1.2%
Neurophysiology - peripheral neurophysiology	24	6.6%
Gastroscopy	18	4.0%
Cystoscopy	15	14.3%
Computed Tomography	7	0.6%
Urodynamics - pressures & flows	2	3.6%
Cardiology - electrophysiology	1	50.0%
Colonoscopy	1	0.4%
Flexi Sigmoidoscopy	1	1.1%
Audiology - Audiology Assessments	0	0.0%
DEXA Scan	0	0.0%

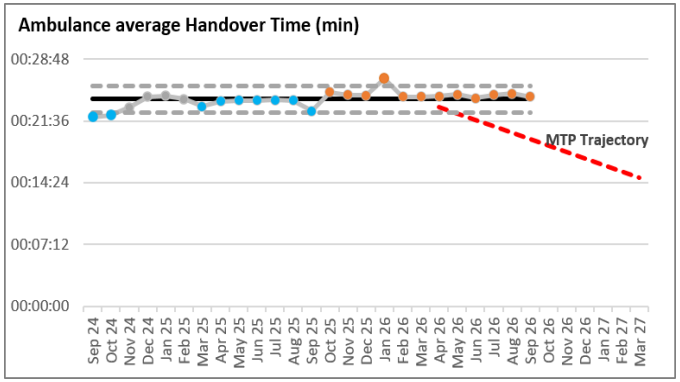
Site & Metric	Cause of variance/ non-compliance	Actions: Completed since last update, New, and Ongoing -	Recovery Date
SGUH Special cause variation of a CONCERNING nature– Not meeting Plan **Data Quality**: Sufficient for assurance	Diagnostic performance deteriorated further in August 2026, with 24.4% of patients waiting over six weeks against a 3.91% plan. Non-obstetric ultrasound remains the predominant driver of DM01 underperformance and accounts for most diagnostic breaches. Performance is expected to improve in September as recovery actions take effect. **Non-Obstetric Ultrasound:** Non-obstetric ultrasound remains the key driver of underperformance, with a 38% sonographer vacancy rate limiting capacity. Demand continues to exceed available provision, leading to growth in both the waiting list and six-week breach position **Respiratory Sleep Studies –** Sleep study waits reflect a wider London capacity challenge rather than a St George's-specific issue. Despite one of the largest pathway volumes in London, St George's maintains low numbers of patients waiting over 13 weeks. Capacity has increased to 80 tests per week, although demand continues to exceed available provision.	**Non-Obstetric Ultrasound** Recovery plan proposes targeted insourcing capacity to rapidly reduce the aged backlog while maintaining routine service delivery. Under the proposed plan, >6-week waits reduce rapidly following implementation of enhanced capacity, with recovery achievable by November 2026 subject to delivery of planned activity • Continued recruitment campaigns and retention initiatives. • Continue insourcing until vacancies filled • Additional insourcing and continued use of agency and bank shift • Weekly performance meetings with insourcing provider • Ongoing review of funding utilisation and affordability • Escalation process through operational and divisional governance **Respiratory Sleep Studies** • Demand and capacity modelling reviewed, additional capacity will require further funding approval • Expedite IT automation implementation that will enable any expansion • Align Medical Consultant new appointment capacity • Increase Virtual Clinical Evaluation capacity • Develop a capacity plan for downstream clinic activity Targeted deep dives into DM01 modalities to reduce duplicate referrals / entries on PTLs and trajectories for recovery and maintained performance being established	November 2026

Operational Performance

Key Metrics| SGUH A&E Waits and Ambulance Handovers



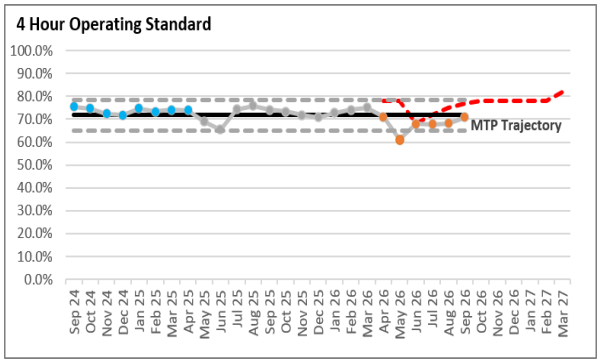


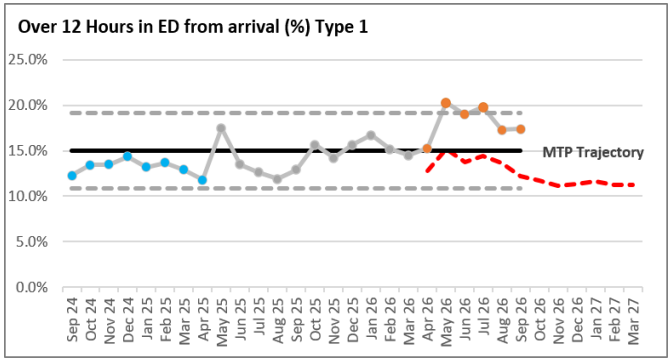


Site & Metric	Cause of variance/ non-compliance	Actions: Completed since last update, New, and Ongoing -	Recovery Date
SGUH **4 Hour Target** normal variation meeting Plan **12 Hour Waits (Type 1)** normal variation Meeting Plan Ambulance delays not meeting Plan **Data Quality:** Sufficient for assurance. Ambulance data supplied by NHSE is not validated	• September 2026 **4-hour performance** declined in month achieving 78.2%, against Plan of 80.9%, this was impacted by a sustained increase of attendances (additional 40 patients per day on average) and higher acuity within the non-admitted pathway. • On average 27 patients per day waited >12 hours before discharge in ED, an improvement from previous month • September 2026 saw 2,576 ambulance conveyances, with 74% offloaded within 15 minutes (75% previous month) • Patients awaiting admission from ED waited an average of 11 hours 47 minutes. **12 hour waits** continue to exceed plan showing a downward trend. • 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. • SGUH are ranked 2nd regionally and 14th Nationally for 4-hour performance over 6 weeks.	• 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 • Reviewing feedback from resident doctor local survey to improve flow within ED. • Plan to restore Extended Emergency Care Unit to improve 4-hour performance from 12 October . • Working with AMU colleagues to bolster senior input at front door, for increased redirection and front end investigations. • Working with PPG to establish a full list of OOH GP slots to be booked into over winter	October 2026

Operational Performance

Key Metrics| ESTH A&E Waits

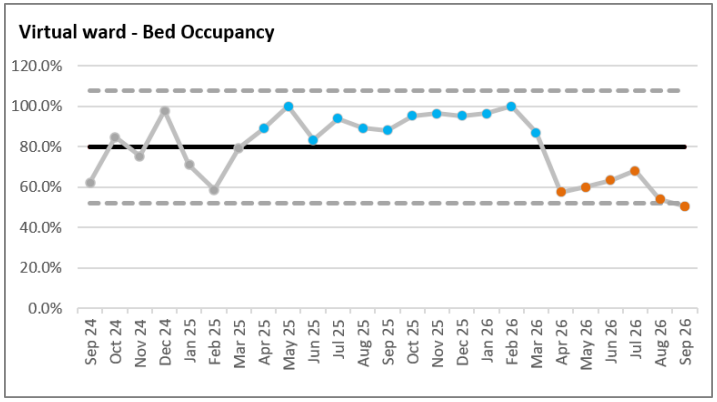




Site & Metric	Cause of variance/ non-compliance	Actions: Completed since last update, New, and Ongoing	Recovery Date
ESTH **4 Hour Target** normal variation below Plan **12 Hour Waits (Type 1)** Not meeting Plan **Data Quality:** Sufficient for assurance	• **4-hour performance** improved to 70.8% in September 2026 but remains below the revised target of 77%. **12-hour Type 1** waits remain above trajectory at 17% against a target of 12%. A recovery plan is in place to support trajectory improvements on both metrics. • Ambulance handovers >45 minutes improved to 3%, well below the 5% target, with average handover times sustained at 21 minutes against a 22-minute trajectory. • Average daily corridor care reduced from 31 to 28 patients versus last month, demonstrating continued month on month reduction despite remaining above target.	Tier 2 intervention: Recommendations arising from GIRFT UEC site visits (August to October 2025) continue to inform targeted actions to strengthen patient flow, enhance safety, and improve efficiency across the urgent and emergency care pathway. Key actions implemented and ongoing during the last month include: • From 14 September, a revised UTC First and Rapid Assessment and Triage (RAT) model commenced, introducing further simplified streaming processes, enhance senior clinical decision-making at the front door, and improved management of UTC waiting lists. The change aims to ensure patients are seen in arrival order, improve redirection to the most appropriate services, reduce unnecessary ED attendances, and support timely patient flow. Existing ED consultant support will remain in place, with one registrar redeployed to strengthen front-door streaming and decision-making. • A successful Trust-wide workshop reviewed the Trust's Internal Professional Standards and responsiveness. Short and medium term priorities and actions have informed a comprehensive action plan supported by ambitious delivery timescales. • Focus continues on the reduction of corridor care and includes a 'red line' for utilisation of the 'back' corridor in St Helier ED which has been broadly sustained throughout August and September. • 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 34

Operational Performance

Key Metrics| Sutton Health Virtual Ward Bed Occupancy



Site & Metric	Cause of variance/ non-compliance	Actions: Completed since last update, New, and Ongoing	Recovery Date
Sutton Health Virtual Ward Bed Occupancy below Target of 80%	Virtual Ward bed occupancy remained consistently above the 80% target throughout most of 2025 and early 2026; however, occupancy reduced significantly from April 2026 onwards, falling to around 55-65%. This reflects a planned reduction in admissions while transformational work is undertaken to refine the Virtual Ward cohort, ensuring the service operates as an effective alternative to hospital admission and supports improved patient outcomes	Deep-dive assessment completed: Review of clinical quality, patient acuity and complexity, workforce capacity and service performance completed to inform future service requirements. Operating model refresh completed: Cross-site development workshops undertaken to shape Future operating model across Sutton and Surrey Downs. Six-month delivery plan: Interim action plan developed, focused on: • Cross-site clinical leadership: Introducing interim joint clinical leadership arrangements, including a proposed shared Band 8b role, while progressing towards consolidated consultant leadership across both sites. • Consultant Leadership – Progress formalising cross site Medical Leadership to drive strategy and delivery • Workforce development: Developing a joint workforce plan, prioritising cross-site rotations, shared clinical training, competency development and more flexible deployment of staff. • Improvement trajectories and monitoring: Agreeing clear improvement trajectories for occupancy, patient acuity and clinical outcomes, supported by consistent cross-site performance reporting and oversight.	Jan 27



Section 2.2:
Operational Productivity

Operational Productivity

Overview Dashboard

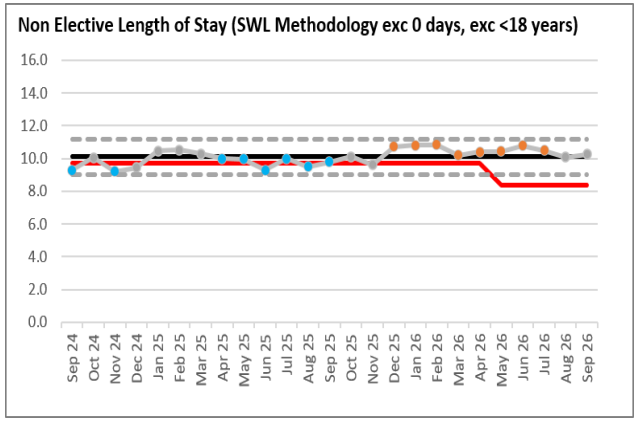
KPI	St George's Latest month	St George's Previous Month Measure	St George's Latest Month Measure	St George's Target	St George's Variation	St George's Assurance	St George's Benchmark	Epsom & St Helier Latest month	Epsom & St Helier Previous month measure	Epsom & St Helier Lastest month measure	Epsom & St Helier Target	Epsom & St Helier Variation	Epsom & St Helier Assurance	Epsom & St Helier Benchmark
Implied Productivity Growth YTD	Jun 26	-0.1%	0.6%	-	-	-	Quartile 3	Jun 26	8.5%	9.5%	-	-	-	Top Quartile
Cost Weighted Activity Growth YTD	Jun 26	-1.7%	-1.9%	-	-	-	Lowest Quartile	Jun 26	8.6%	8.8%	-	-	-	Top Quartile
Real Terms Resource Use Growth YTD	Jun 26	-1.7%	-2.5%	-	-	-	Top Quartile	Jun 26	0.1%	-0.7%	-	-	-	Top Quartile
Non Elective Length of Stay (SWL Methodology exc 0 days, exc <18 years)	Sep 26	10.1	10.3	8.4	No Change	Not Achieving	N/A	Sep 26	9.6	10.6	10.9	No Change	Variable	N/A
Average days from Discharge Ready Date to date of discharge (inc 0 day delays	Aug 26	0.8	0.8	0.5	No Change	Variable	2nd Quartile	Aug 26	1.3	0.8	0.5	Improving	Not Achieving	2nd Quartile
Average Discharge Delays (days) Pathway 0	Aug 26	0.2	0.1	-	No Change	-	N/A	Aug 26	0.4	0.3	-	No Change	-	N/A
Average Discharge Delays (days) Pathway 1	Aug 26	3.0	4.1	-	No Change	-	N/A	Aug 26	5.8	2.7	-	No Change	-	N/A
Average Discharge Delays (days) Pathway 2	Aug 26	5.7	5.6	-	No Change	-	N/A	Aug 26	8.7	6.2	-	No Change	-	N/A
Average Discharge Delays (days) Pathway 3	Aug 26	7.9	9.1	-	No Change	-	N/A	Aug 26	11.6	6.8	-	No Change	-	N/A
Theatre Utilisation (Capped)	Sep 26	83.6%	82.2%	85.0%	No Change	Variable	Top Quartile	Sep 26	83.4%	82.3%	85.0%	Improving	Not Achieving	Top Quartile
BADS All Daycase & Outpatient Procedures % of total procedures	May 26	79.7%	77.0%	87.0%	Deteriorating	Not Achieving	Lowest Quartile	May 26	69.6%	67.7%	87.0%	Deteriorating	Not Achieving	Lowest Quartile
Outpatients Patient Initiatied Follow Up Rate (PIFU)	Sep 26	2.9%	2.5%	4.4%	Improving	Not Achieving	Lowest Quartile	Sep 26	4.9%	6.0%	4.5%	Improving	Achieving	2nd Quartile
Outpatients Missed Appointments (DNA Rate)	Sep 26	9.4%	9.6%	8.0%	No Change	Not Achieving	Lowest Quartile	Sep 26	5.8%	5.5%	6.0%	No Change	Variable	2nd Quartile
Outpatient Diversion rate for 'all types of specialist advice'	Aug 26	18.5%	14.6%	-	Deteriorating	-	3rd Quartile	Aug 26	23.1%	19.7%	-	Deteriorating	-	2nd Quartile
Outpatient Discharge Rates	Jul 26	25.1%	25.3%	-	No Change	-	N/A	Jul 26	16.5%	16.5%	-	Improving	-	N/A
First and Procedure Attendances as a proportion of Total Outpatients	Sep 26	52.5%	50.3%	60.0%	Deteriorating	Not Achieving	N/A	Sep 26	42.9%	41.6%	60.0%	No Change	Not Achieving	N/A
Data Quality Maturity Index Score	Jun 26	93.4%	93.5%	-	No Change	-	2nd Quartile	Jun 26	93.3%	93.3%	-	No Change	-	2nd Quartile

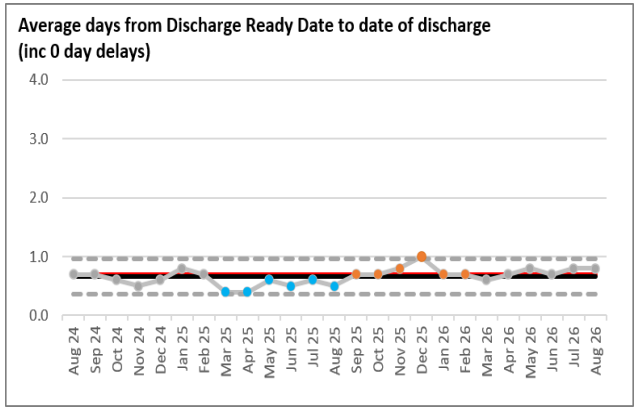
Notes for Implied Productivity – Q1 2026/27 Figures are currently provisional
First and Procedure attendances based on SLAM data and includes F/U Notes Review Clinics, methodology for internal reporting under review

Operational Productivity

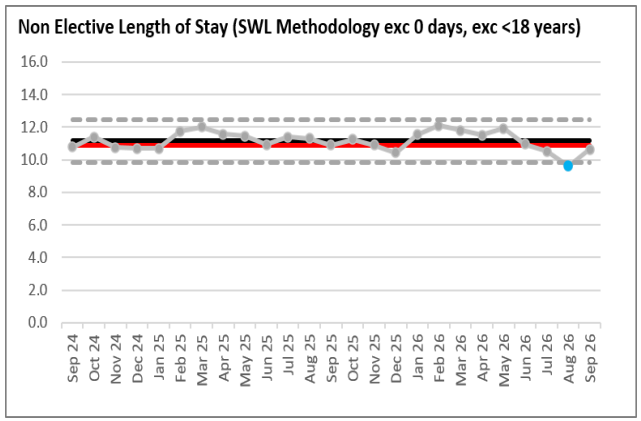
Bed utilisation

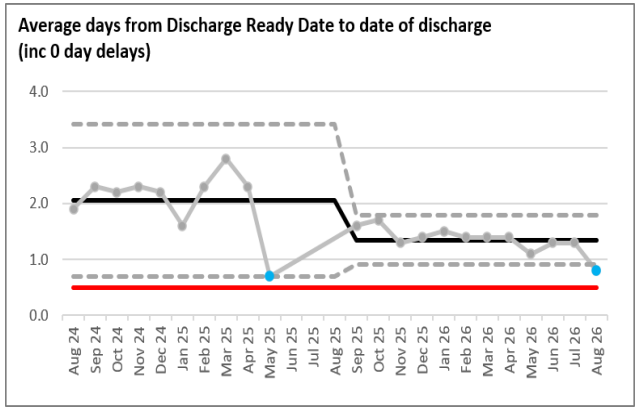
St George's





Epsom & St Helier





Analyses & Key actions

SGUH

Non-elective length of stay is 10.3 days due to a busy summer nationally following multiple heatwaves.

The **average days between 'discharge ready' and discharge remains** at 0.8 days, this places SGUH in the second quartile for performance and will be a key KPI over winter.

The three programmes of transformation continue:

1) Winter Schemes:
   - i) Additional capacity for direct booking into GP HUBs will be live 01/12/2026.
   - ii) Additional capacity in ED admission avoidance therapies will bolster up community admission avoidance via UCR: Nov 2026.

2) 6 week pre-winter programme under development to improve flow and operational performance:
   - i) Weekly sprints will look at: SDEC, Discharge lounge, Patient safety, NCTR, etc.

3) NEL Transformation: Geriatrician virtual ward, Home first and extended hours for UCR in progress, live for December 2026.

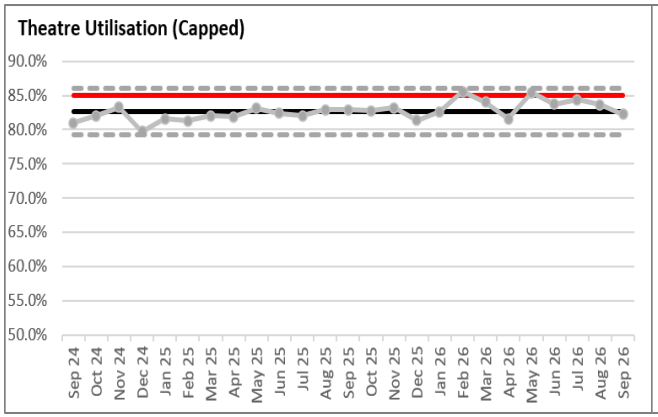
ESTH

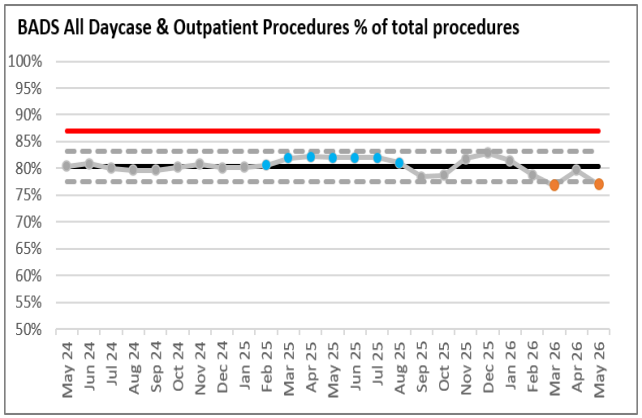
- Non-elective length of stay is reported at 10.6 days in September 2026, and remains stable below the mean. This has been supported by a reduction in **average discharge delay days** reflecting continued improvements in patient flow despite reduced G&A bed capacity.
- Phase 3 of the SWIFT and AMU relocation was completed with patients moved into their substantive location on SWIFT on 5th October 2026, the completion of this programme will improve patient flow, increase elective and private capacity and staffing establishment financial sustainability.
- A review of ESTH and Transfer of Care Hub performance has identified improvement opportunities to strengthen discharge processes and reduce variation. Delivery of funded initiatives through the SWL Frailty Programme will commence in October 2026 to support implementation and realise benefits within Sutton.

Operational Productivity

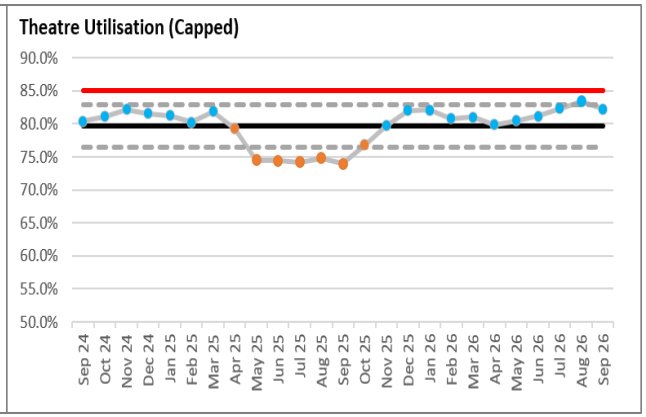
Theatre Utilisation

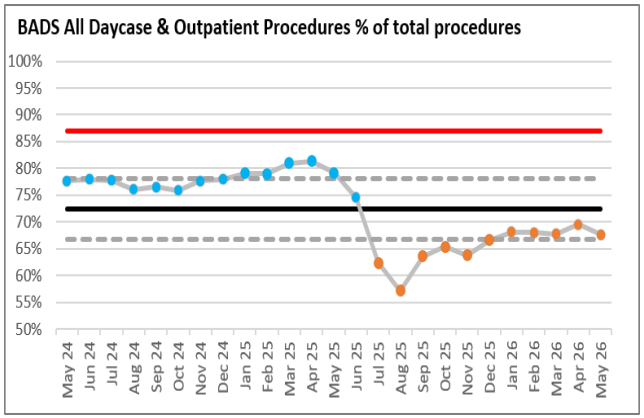
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Analyses & Key actions

Group-wide - SGH went live with ePOA on 24 September, supporting earlier digital screening, risk identification and optimisation. ESTH rollout is planned for mid November 2026, subject to the Patient Clinical Management Dashboard being available in iClip

SGUH

- Theatre utilisation remained above 82% in September 2026, demonstrating sustained performance. A refreshed 6-4-2 process is being launched in October 2026 as the first phase of a wider improvement programme, strengthening theatre scheduling discipline, accountability and forward planning.
- Phase two will review list planning practices to identify further opportunities to maximise available capacity, improve specialty-level productivity and increase utilisation beyond current levels.
- BADS performance has declined in recent months, falling from approximately 82% earlier in the year to 77% in May 2026. Improving case selection, procedure mix and list planning will be key priorities to reverse this trend.
- Phase one of the EPOA programme has now launched, supporting the wider elective improvement programme, with a focus on strengthening preoperative pathways and improving patient readiness for surgery.

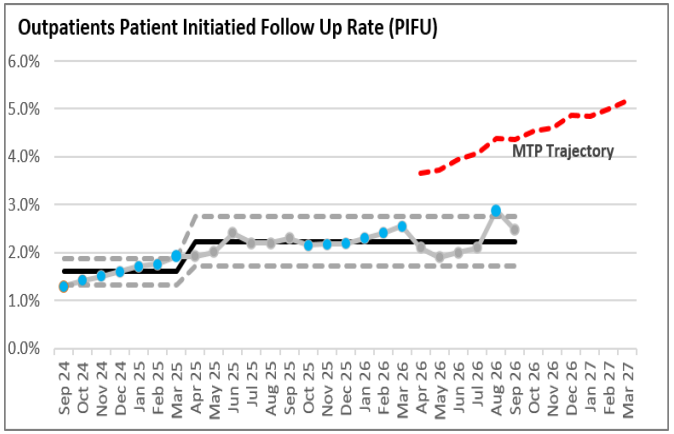
ESTH

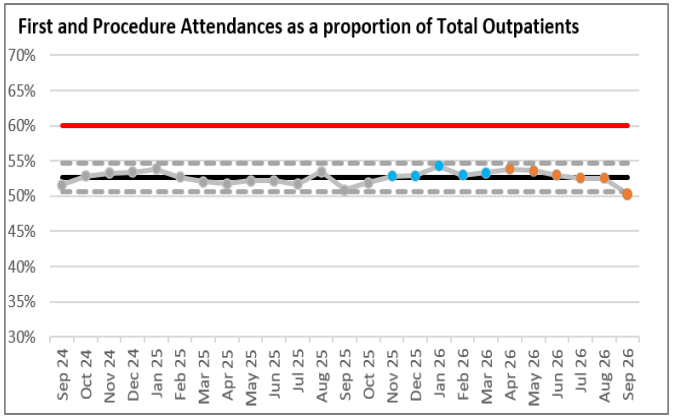
- Theatre utilisation achieved 82% in September, sustaining 80% or above for eleven consecutive months.
- Review of March–August on-the-day cancellations identified priorities for reduction in: insufficient theatre time, operations no longer required and patient-related cancellations.
- Work is underway to include rescheduled cancellations in BI reporting and establish consistent reporting across gesh.
- Weekly Theatre Performance reviews of lists below 83% utilisation and consistent recording of late-start reasons support targeted improvements. Next steps include piloting the Standby Patient pathway to fill gaps created by late cancellations.

Operational Productivity

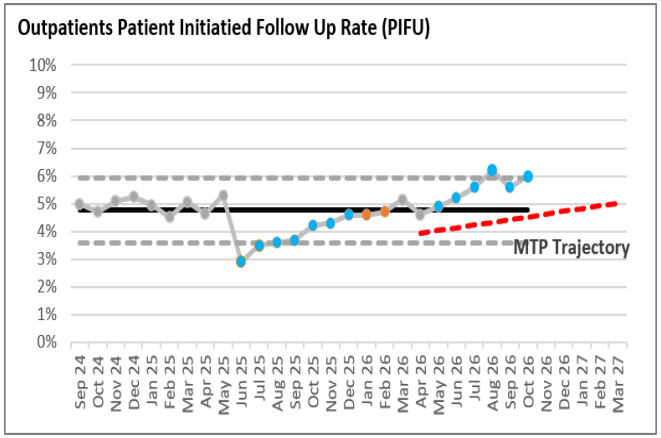
Outpatient Follow-ups

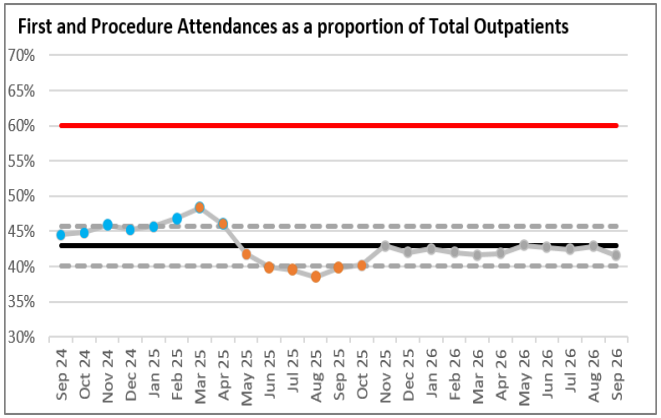
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Analyses & Key actions

SGUH

- Improve **PIFU** and **discharge** reporting to support clinician benchmarking and provide a balanced view of outpatient pathway performance
- OP Transformation Project Manager appointed; PIFU improvement programme now underway
- Agree plans to incorporate GIRFT best practice
- Look to expand cohorts of patients who would be considered appropriate for PIFU
- Develop and implement a PIFU to Follow up option for long term condition patients who require (annual) on going review
- Develop and implement PIFU Open Access for patient groups such as Sickle and Anti Coagulant etc
- Develop PIFU for post surgical and Post Endoscopy where appropriate
- Identify possible appointment types who may be suitable for a PIFU by default appointment outcome approach
- Undertake clinical Waitlist validation to identify patients with a future booking who are suitable for placement on a PIFU pathway or who could be discharged. Pilot agreed in Urology
- PIFU uptake remains low, while discharge rates rank among the highest in London. Detailed benchmarking is underway
- PSFU (cancer) activity has been identified but not yet reported in EROC. Plans to include this in future months.

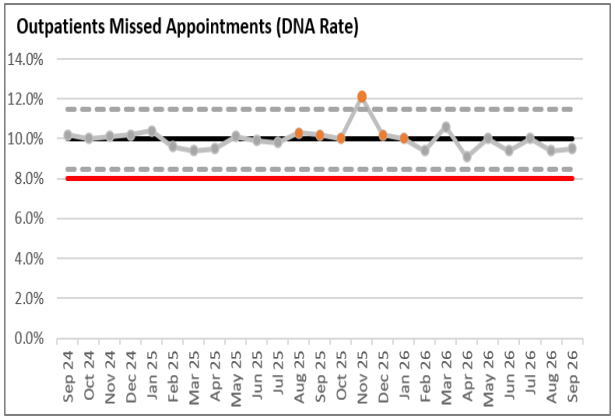
ESTH

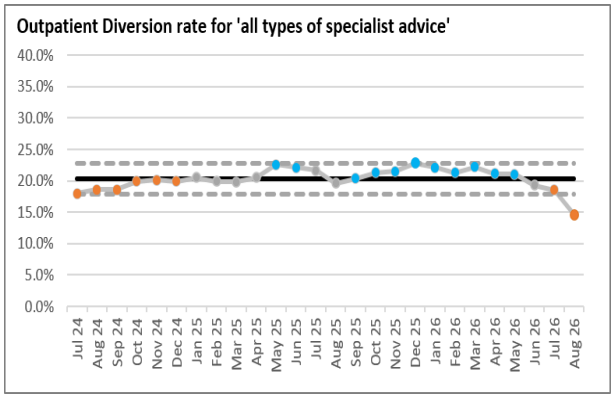
- **PIFU Rate** has stayed above the 5% target throughout Q2 (5.9% in September) and is well ahead of the Medium Term plan
- A review has identified a cohort of PIFU patients without associated orders due to an iClip transition issue. Corrective actions are underway, which are expected to further strengthen PIFU performance
- Targeted work underway to improve both PIFU uptake and **discharge rates** towards upper quartile benchmarks

Operational Productivity

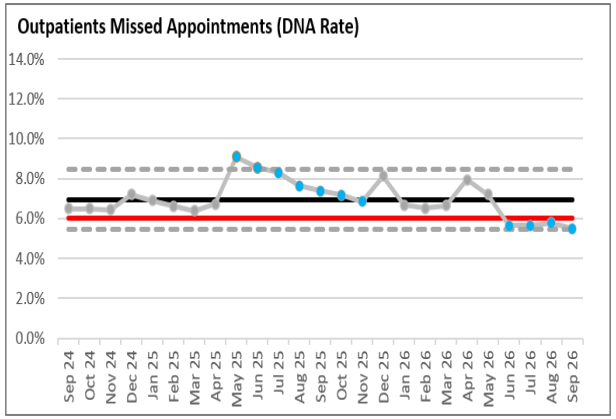
Outpatients – Missed Appointments (DNA Rates) and Diversion Rates

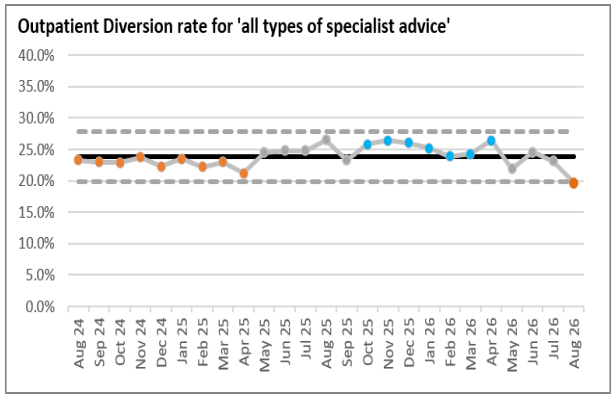
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Analyses & Key actions

SGUH

- There is early evidence that actions taken to improve attendance are having the desired effect, with the **DNA rate** becoming more consistent and moving in the right direction. Currently piloting four DNA reduction initiatives covering:
- DNA rebooking pathway (Plastics & Urology)
- Two-way appointment management via Netcall
- Standardised DNA methodology across gesh
- Automated call reminders successfully piloted using DNA predictor tool, Now to be focused on a whole service (Physiotherapy)
- Targeted RPA intervention for high-risk non-attenders
- Gain agreement from clinical leads and SLT for DNA rebooking pathway
- Launch pilots, track benefits and evaluate outcomes to prioritise rollout
- Complete testing and implementation of two-way communication functionality in Netcall.
- Resolve remaining technical and operational dependencies for RPA deployment.
- Establish DNA performance dashboards and benefits realisation reporting.
- TOCA e-triage rollout (Jan-Mar 2027) is expected to increase **referral diversion rates** through more effective clinical triage

ESTH

- **DNA rate** below target: below the 6% target for three consecutive months, following expanded text-reminder enrolment.
- Diversion Rates: Technical and operational readiness activities are progressing to support effective triage and referral gatekeeping. Specialty readiness work continues across job planning, SOP development, referral guidance, and clinical engagement
- TOCA e-triage rollout (Jan-Mar 2027) is expected to increase **referral diversion rates** through more effective clinical triage



Section 3:
People & Workforce



Section 3 - Our People

Overview Dashboard | People Metrics

St George's

KPI	Latest month	Previous Month Measure	This months Measure	Target	Variation	Assurance
Staff Sickness Absence rate	Sep 26	5.7%	5.6%	4.3%	No Change	Not Achieving
Mandatory and Statutory Training	Sep 26	88.3%	86.6%	85.0%	Deteriorating	Achieving
Vacancy Rate	Sep 26	8.3%	7.4%	10.0%	Deteriorating	Achieving
Appraisal Rate Medical	Sep 26	81.1%	79.8%	90.0%	Deteriorating	Not Achieving
Appraisal Rate Non Medical	Sep 26	77.0%	75.0%	90.0%	Deteriorating	Not Achieving
Turnover (12-month)	Sep 26	8.3%	8.3%	13.0%	Improving	Achieving
Percentage BAME staff band 8a and above	Sep 26	32.8%	33.0%	-	Improving	-
Workforce WTE All Staff Total	Sep 26	10965	10915	10986	-71	-
Substantive Total	Sep 26	10162	10185	10209	-24	-
Bank Total	Sep 26	750	677	753	-76	-
Agency Total	Sep 26	53	53	24	29	-

Epsom & St Helier

Latest month	Previous Month Measure	This months Measure	Target	Variation	Assurance
Sep 26	5.7%	6.3%	4.3%	No Change	Not Achieving
Sep 26	88.0%	88.1%	85.0%	No Change	Achieving
Sep 26	12.1%	11.7%	10.0%	No Change	Not Achieving
Sep 26	88.0%	87.0%	90.0%	Deteriorating	Variable
Sep 26	78.2%	77.0%	90.0%	No Change	Not Achieving
Sep 26	8.4%	8.5%	13.0%	Improving	Achieving
Sep 26	30.1%	31.0%	-	No Change	-
Sep 26	7301	7246	7222	24	-
Sep 26	6366	6365	6413	-48	-
Sep 26	908	852	756	96	-
Sep 26	27	29	53	-24	-

Sutton Healthcare

KPI	Latest month	Previous Month Measure	Latest Month Measure	Target	Variation	Assurance
Sickness Absence Rate	Sep 26	6.1%	8.7%	4.5%	No Change	Variable
Mandatory and Statutory Training	Sep 26	91.6%	90.9%	85.0%	Deteriorating	Achieving
Vacancy Rate	Sep 26	10.7%	10.6%	10.0%	Improving	Not Achieving
Appraisal Rate Medical	Sep 26	90.0%	100.0%	90.0%	No Change	Achieving
Appraisal Rate Non Medical	Sep 26	80.6%	77.0%	90.0%	No Change	Not Achieving
Turnover (12-Month)	Sep 26	9.6%	9.7%	12.0%	Improving	Variable
Percentage BAME staff band 8a and above	Sep 26	29.8%	30.0%	-	Improving	-

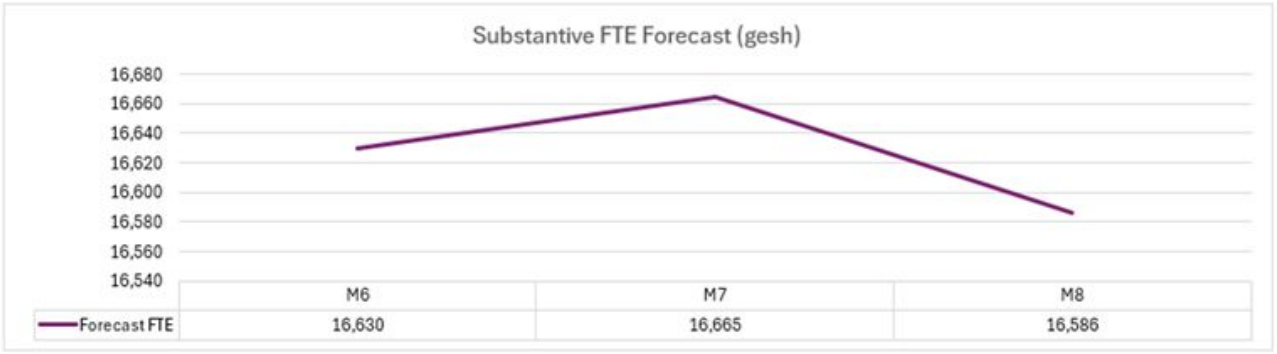
Surrey Downs

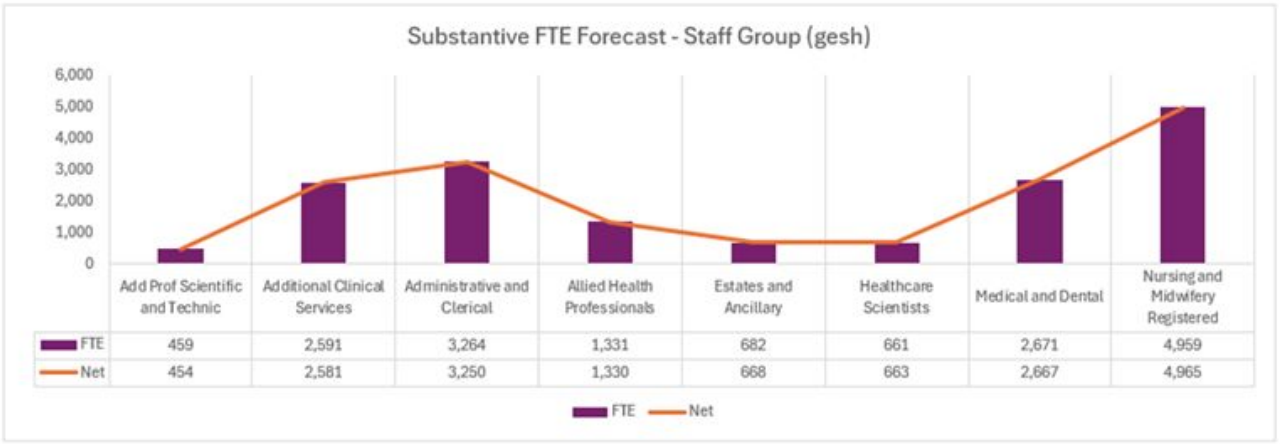
Latest month	Previous Month Measure	Latest Month Measure	Target	Variation	Assurance
Sep 26	6.2%	6.4%	4.5%	No Change	Variable
Sep 26	91.6%	90.8%	85.0%	Deteriorating	Achieving
Sep 26	10.7%	14.1%	10.0%	Improving	Not Achieving
Sep 26	90.0%	86.0%	90.0%	Deteriorating	Achieving
Sep 26	80.6%	77.0%	90.0%	No Change	Not Achieving
Sep 26	9.6%	11.8%	12.0%	No Change	Variable
Sep 26	12.3%	13.1%	-	Improving	-

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





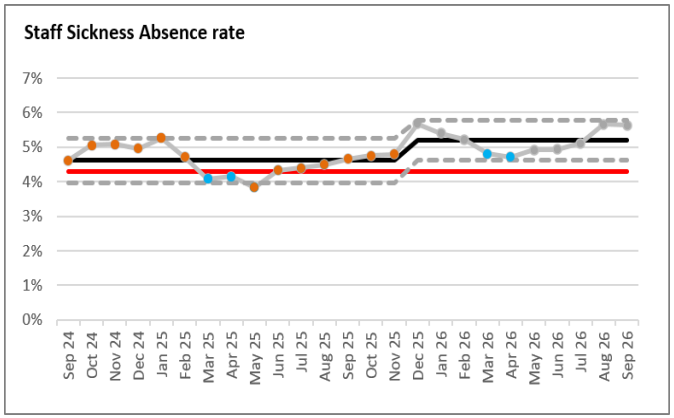
Forecasted FTE - Candidates in Unconditional Offer State with Confirmed Trust Start Date

	Substantive Forecast (FTE)	M6	M7	M8
STG	Permanent	10,245	10,245	10,258
	Average Leavers in Month	-	88	81
	Recruitment Pipeline	-	101	24
	Forecast	**10,245**	**10,258**	**10,201**
	Net Change	*31*	*13*	*-57*
ESTH	Substantive Forecast (FTE)	M6	M7	M8
	Permanent	6,385	6,385	6,407
	Average Leavers in Month	-	55	47
	Recruitment Pipeline	-	77	25
	Forecast	**6,385**	**6,407**	**6,385**
	Net Change	*2*	*22*	*-22*
GESH	Substantive Forecast (FTE)	M6	M7	M8
	Permanent	16,630	16,630	16,665
	Average Leavers in Month	-	143	128
	Recruitment Pipeline	-	178	49
	Forecast	**16,630**	**16,665**	**16,586**
	Net Change	*33*	*35*	*-79*

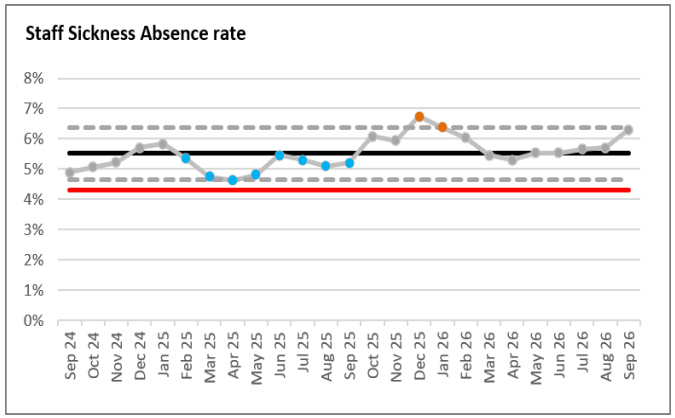
Our People

Exception Report| Sickness Absence Rate

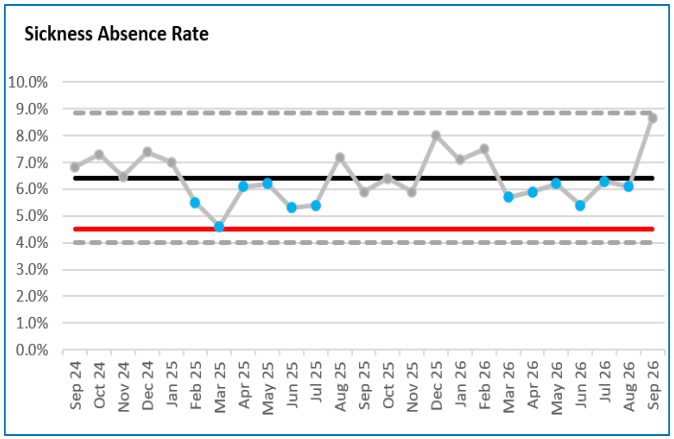
St George's



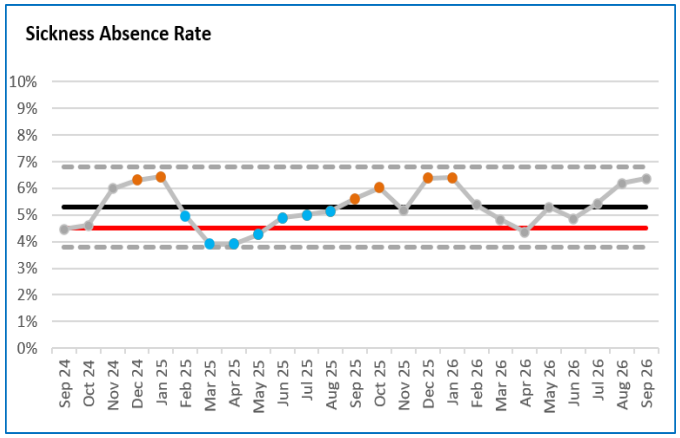
Epsom & St Helier



Sutton Healthcare



Surrey Downs



Analyses & Key actions

- Sickness absence remains high across gesh adversely affecting performance, quality and operational efficiency. The Clinical Workforce Transformation Programme has made reducing sickness absence a priority workstream for mobilisation. The workstream will identify the underlying drivers of absence and deliver targeted interventions to improve workforce resilience and attendance.
- Mobilisation is progressing: most programme posts have been recruited, governance arrangements are in place, and the Operational Delivery Group has been established. The priority is the management of long-term sickness absence, with targeted interventions to reduce the number of open cases, particularly those exceeding 18 months.

gesh

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

Appendices

Appendix 1 - Statistical Process Control (SPC)

Interpreting Tables and Charts

	Variation/Performance Markers		
Marker	***Technical Description***	***What does this mean?***	***What should we do?***
No Change	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.
Deteriorating	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?
Improving	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 Markers		
Icon	***Technical Description***	***What does this mean?***	***What should we do?***
Variable	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.
Not Achieving	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.
Achieving	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	This months Measure	Target	Variation	Assurance
Mixed Sex Accommodation Breaches	Sep 26	125	99	0	No Change	Not Achieving
Number of Complaints Received	Sep 26	123	126	-	Deteriorating	-
Number of re-opened complaints in month	Sep 26	4	9	-	No Change	-
Parliamentary and Health Service Ombudsman (PHSO) Received	Sep 26	2	2	-	No Change	-
Parliamentary and Health Service Ombudsman (PHSO) Closed	Sep 26	0	2	-	No Change	-
RTT - Total Size Incomplete Waiting List	Aug 26	70262	70983	67922	Deteriorating	Not Achieving
On the Day Cancellations not re-booked within 28 days	Aug 26	1	8	0	No Change	Variable
Utilisation rate for 'all types of specialist advice' in all specialties	Aug 26	23.1%	20.3%	-	No Change	-
Emergency Department Attendances per day	Sep 26	431	470	-	Improving	-
Mental health delays 4 Hour Breaches	Sep 26	123	152	-	No Change	-
Length of stay > 21 days (super stranded)	Sep 26	183	161	-	No Change	-
Overnight G&A beds occupancy - Adults	Sep 26	94.4%	92.2%	96.0%	No Change	Variable
Number of patients not meeting criteria to reside (Daily Avg)	Sep 26	116	101	-	Improving	-

Epsom & St Helier

Latest month	Previous Month Measure	This months Measure	Target	Variation	Assurance
Sep 26	36	35	0	No Change	Not Achieving
Sep 26	72	102	-	Deteriorating	-
Sep 26	0	3	-	No Change	-
Sep 26	1	2	-	No Change	-
Sep 26	2	1	-	No Change	-
Aug 26	56820	56723	56000	Deteriorating	Not Achieving
Sep 26	0	0	0	No Change	Variable
Aug 26	70.1%	69.7%	-	Improving	-
Sep 26	450	485	-	Improving	-
Sep 26	225	198	-	No Change	-
Sep 26	146	148	-	No Change	-
Sep 26	94.5%	9595.0%	88.0%	Deteriorating	Variable
Sep 26	185	192	-	No Change	-

Sutton Healthcare

KPI	Latest month	Previous Month Measure	Latest Month Measure	Target	Variation
Urgent Community Response (UCR) Referrals	Sep 26	373	388	-	Deteriorating
Virtual ward - Admissions	Sep 26	329	295	-	Deteriorating
Discharge to Assess- Pathway 0-3 Delays (Median Days)	Sep 26	0	0	-	Improving
Total number of adult patients on the waiting list	Sep 26	3625	3711	-	Deteriorating
Total number of children patients on the waiting list	Sep 26	1103	1039	-	Deteriorating
Total Number of Compliants Received	Sep 26	0	0	-	No Change

Surrey Downs

Latest month	Previous Month Measure	Latest Month Measure	Target	Variation
Sep 26	468	515	-	No Change
Sep 26	468	269	-	No Change
Sep 26	9	0	-	Improving
Sep 26	5758	6054	-	Deteriorating
Sep 26	0	0	-	No Change
Sep 26	1	0	-	No Change

Appendix 3 - Cancer Performance by Tumour Type

Overview Dashboard

28 Day Faster Diagnosis Standard

KPI	Latest month	Previous Month Measure	Latest Month Measure	National Average	Variation	Latest month	Previous Month Measure	Latest Month Measure	National Average	Variation
	St George's					Epsom & St Helier				
Suspected brain/central nervous system tumours	Aug 26	N/A	N/A	100.0%	No Change	Aug 26	86.7%	100.0%	100.0%	No Change
Suspected head & neck cancer	Aug 26	80.8%	73.8%	77.4%	Deteriorating	Aug 26	99.5%	98.5%	77.4%	Improving
Suspected breast cancer	Aug 26	92.7%	92.2%	92.8%	No Change	Aug 26	N/A	N/A	92.8%	-
Exhibited (non-cancer) breast symptoms - cancer not initially suspected	Aug 26	89.5%	85.9%	94.5%	No Change	Aug 26	N/A	N/A	94.5%	-
Suspected lung cancer	Aug 26	72.7%	82.5%	82.9%	No Change	Aug 26	75.0%	83.3%	82.9%	No Change
Suspected upper gastrointestinal cancer	Aug 26	74.6%	72.2%	77.9%	No Change	Aug 26	83.8%	81.7%	77.9%	No Change
Suspected lower gastrointestinal cancer	Aug 26	83.6%	85.1%	72.9%	Improving	Aug 26	72.8%	79.6%	72.9%	No Change
Suspected gynaecological cancer	Aug 26	86.5%	93.4%	76.4%	Improving	Aug 26	81.5%	87.0%	76.4%	Improving
Suspected testicular cancer	Aug 26	89.5%	80.0%	100.0%	No Change	Aug 26	N/A	N/A	100.0%	No Change
Suspected urological malignancies (excluding testicular)	Aug 26	83.5%	81.6%	75.9%	No Change	Aug 26	95.2%	95.7%	75.9%	Improving
Suspected haematological malignancies (excluding acute leukaemia)	Aug 26	68.8%	50.0%	75.0%	No Change	Aug 26	77.8%	100.0%	75.0%	No Change
Suspected skin cancer	Aug 26	88.2%	85.7%	92.9%	Improving	Aug 26	97.1%	99.3%	92.9%	Improving
Suspected sarcoma	Aug 26	N/A	100.0%	58.3%	-	Aug 26	N/A	N/A	58.3%	-
Suspected children's cancer	Aug 26	80.0%	100.0%	100.0%	No Change	Aug 26	N/A	N/A	100.0%	-
Suspected cancer - non-specific symptoms	Aug 26	53.6%	63.2%	60.2%	No Change	Aug 26	92.5%	93.5%	60.2%	-

Cancer 62 Day Referral to Treatment Standard

KPI	Latest month	Previous Month Measure	Latest Month Measure	National Average	Variation	Latest month	Previous Month Measure	Latest Month Measure	National Average	Variation
	St George's					Epsom & St Helier				
Gynaecological	Aug 26	100.0%	85.7%	63.5%	No Change	Aug 26	80.0%	71.4%	63.5%	No Change
Skin	Aug 26	94.9%	97.0%	94.1%	Improving	Aug 26	100.0%	92.9%	94.1%	No Change
Lung	Aug 26	56.3%	36.4%	65.2%	No Change	Aug 26	53.1%	68.6%	65.2%	No Change
Other (a) Other Rare Cancer Types	Aug 26	100.0%	88.2%	91.5%	No Change	Aug 26	88.9%	100.0%	91.5%	No Change
Lower Gastrointestinal	Aug 26	75.6%	62.1%	73.4%	No Change	Aug 26	95.0%	86.2%	73.4%	No Change
Head & Neck	Aug 26	100.0%	86.7%	62.7%	No Change	Aug 26	66.7%	100.0%	62.7%	No Change
Breast	Aug 26	82.1%	77.5%	73.8%	No Change	Aug 26	100.0%	100.0%	73.8%	No Change
Upper Gastrointestinal - Oesophagus & Stomach	Aug 26	N/A	0.0%	71.7%	-	Aug 26	66.7%	75.0%	71.7%	No Change
Haematological - Lymphoma	Aug 26	100.0%	60.0%	71.4%	No Change	Aug 26	92.9%	84.6%	71.4%	No Change
Upper Gastrointestinal - Hepatobiliary	Aug 26	75.0%	90.5%	76.8%	No Change	Aug 26	95.2%	83.3%	76.8%	No Change
Urological - Prostate	Aug 26	80.0%	91.9%	83.2%	No Change	Aug 26	95.5%	100.0%	83.2%	No Change
Urological - Other (a) Rare Urological cancers	Aug 26	90.3%	100.0%	75.0%	Improving	Aug 26	86.7%	94.1%	75.0%	No Change
Haematological - Other (a) Rare Blood cancer diagnosis	Aug 26	83.3%	89.5%	100.0%	No Change	Aug 26	100.0%	100.0%	100.0%	Improving

Appendix 4 – Metric definitions (Page 1 of 2)

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 National 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, MTP and H2 Driver Metric	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, MTP and H2 Driver Metric	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, MTP and H2 Driver Metric	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 and H2 Driver Metric and H2 Driver Metric	Model Hospital
Capped Theatre Utilisation Rate	The total needle to skin time of all patients within the planned session time as a proportion of 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
Intermediate care beds occupied by patients without criteria to reside	Percentage of intermediate care bed capacity occupied by patients who no longer meet Criteria to Reside. (Methodology Patients without Criteria to Reside ÷ available intermediate care beds (%)). To note Relates to Surrey Downs - Molesey and Dorking wards only	National Oversight Framework	Model Hospital

Appendix 4 – Metric definitions (Page 2 of 2)

Metric	Definition	Strategy Drivers	Data Source
30 day readmission rate band	Emergency readmissions to hospital within 30 days of discharge from a previous admission. (Emergency readmissions within 30 days ÷ eligible discharges (%))	National Oversight Framework	Model Hospital
Breadth and depth of clinical audit outliers	Composite assessment of the breadth and depth of clinical audit outliers, including severity and persistence of outlier status. Banded score based on number, seriousness and duration of audit outliers	National Oversight Framework	Model Hospital
Clinical Trials Set Up Within 90 Days	Percentage of commercial contract research studies recruiting their first participant within 90 days of approval. (Studies recruiting within 90 days ÷ eligible studies (%))	National Oversight Framework	Model Hospital
Rate of pregnant women with a delayed planned induction	The rate of deliveries with a delayed induction (6+ hours) per 1000 deliveries Numerator: Total number of patients in the period with a delay to induction of 6 hours or more Denominator: Total number of deliveries in the period	National Oversight Framework	Model Hospital
inpatients making a supported quit attempt with an in-house tobacco dependence treatment service	Percentage of people seen by an in-house tobacco dependence treatment service who commence a supported quit attempt (rolling 12 month). Numerator: Number of smokers identified on admission to hospital, who are referred to an in-house tobacco dependence treatment service and seen by that service who are provided with a care plan to support a quit attempt Denominator: Number of smokers identified on admission to hospital, who are referred to an in-house tobacco dependence treatment service and seen by that service.	National Oversight Framework	Model Hospital
National Education and Training Survey satisfaction rate	National Education and Training Survey overall experience score. The overall experience score is determined by responses to five specific questions in the survey. Full details of the methodology can be viewed on the NETS website.	National Oversight Framework	Model Hospital
Healthcare Worker Flu Vaccination Rate	The number of individuals who are frontline healthcare workers and had an NHS administered flu vaccination. Numerator: Number of frontline healthcare workers who had a flu vaccination administered by the NHS Denominator: Total number of frontline healthcare workers	National Oversight Framework	Model Hospital
Temporary staffing cost relative band	A banded score between 1 - 4 based on each trusts use of bank and agency staff. Source - NHS Improvement monthly finance return	National Oversight Framework	Model Hospital
Data Quality Maturity Index	Data Quality Maturity Index score - DQMI is defined as the average of the percentage of valid and complete entries in each field of each dataset. The DQMI methodology document is published on the DQMI website	National Oversight Framework	Model Hospital
Reduction in occupied bed days	Numerator :The sum of all beds occupied by NHS patients under the care of a consultant each day throughout the quarter Denominator: The sum of all consultants-led beds that were staffed and physically available to receive patients each day during the quarter	NHS Priority – National and Local gesh H2 Driver Metric	NHS Digital
Workforce(WTE) against plan	Total actual workforce capacity deployed or utilized during the reporting period (usually measure in Whole Time Equivalents). Denominator: The planned funded or budgeted staff establishment that the trust mapped out to safely deliver the designated care activity	NHS Priority – National and Local, gesh H2 Driver Metric	Model Hospital
Temporary staffing spend	(Agency Staff Spend + Bank Staff spend)/Total Staff Spend	National Oversight Framework; gesh H2 Driver Metric	Model Hospital
Sickness Absence	Numerator: Number of days sick. Denominator WTE days available	National Oversight Framework and gesh H2	Model Hospital
Did not Attend rates	The proportion of appointments where the patient failed to attend without prior warning. Numerator: Outpatient missed outpatient appointments (DNAs) Denominator: Total outpatient appointments	NHS Priority – National and Local gesh H2 Driver Metric	Model Hospital
Outpatient discharge rates	Numerator: Patients discharged from consultant-led outpatient care following an outpatient attendance (includes direct discharge and discharge onto an appropriate pathway where no routine consultant follow-up is required. Denominator: Total attended outpatient appointments during the reporting period	NHS Priority – National and Local gesh H2 Driver Metric	NHSE Elective Recovery Outpatient Collection (EROC)
Outpatient 1st and Procedures Rate	The proportion of outpatient attendances that comprise either a first appointment or a procedure (first or follow-up).	H2 Driver Metric	Local Data
Referral diversion rates	Numerator: Number of diverted requests. Denominator: Total specialist advice requests.	gesh H2 Driver Metric	Model Hospital
NHS Staff Survey- Line Management and Recognition and feeling valued	Response to NHS Staff Survey questions relating to line management, 2024 vs. 2025 Response to NHS Staff Survey questions relating to recognition and feeling valued, 2024 vs. 2025	National Oversight Framework and gesh H2 Driver Metric	NHS Staff Survey

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
PUSG	Pressure Ulcer Steering Group
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

Terms	Description
SOP	Standard Operating Procedure
TCI	To Come In
ToC	Transfer of Care
TWW	Two-Week Wait
UCR	Urgent Community Response
VTE	Venous Thromboembolism
VW	Virtual Wards
WTE	Whole Time Equivalent
WID	Widschwendter Initiative Diagnostics
W-OPEL	Ward based Operational Pressures Escalation Levels

Group Board Meeting (Public)

Meeting on Friday, 06 November 2026

Agenda Item	4.4
Report Title	**Audit and Risk Committee Report**
Non-Executive Lead	Pankaj Davé, Chair of the Audit and Risk Committee
Executive Lead(s)	Stephen Jones, Group Chief Corporate Affairs Officer Azara Mukhtar, Group Chief Finance Officer
Report Author(s)	Pankaj Davé, Chair of the Audit and Risk Committee
Previously considered by	n/a
Purpose	**For Assurance**

Executive Summary

The Audit and Risk Committees met in common on 16 September 2026. This report highlights the principal assurances received, progress recognised and priorities for improvement.

- **External audit:** The Committees welcomed timely completion of the 2025/26 audits, unmodified opinions for both Trusts and lessons informing the next audit cycle.
- **Internal audit:** Progress in completing actions was recognised, alongside the continuing need for timely delivery. The Committees supported a one-off Executive-led reset of ownership, relevance and deadlines, followed by clear accountability. Positive cyber assessments and progress on ESTH discharge and patient safety audit actions were welcomed. RSM remained confident of completing the annual programme.
- **Counter fraud:** The Committees reviewed prevention and investigation activity, welcoming work to strengthen staff awareness and reporting of investigation outcomes.
- **Financial controls:** Members considered salary overpayments, debt recovery and stock losses, welcoming joint Finance and People work to standardise processes and seeking measurable improvement.
- **Governance, risk and compliance:** The Committees welcomed stronger risk reporting, Executive oversight and more active management of corporate risks, supporting an 18-month improvement plan to embed consistent practice and effective mitigation. Declarations of interest compliance compared favourably with peers, with continued follow-up of outstanding returns.

Action required by Group Board

The Board is asked to:

a) Note the report of the Audit and Risk Committee following its meeting on 16 September 2026 and the issues highlighted to the Board by the Committee.

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

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

Implications

Group Strategic Objectives

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

Risks

The report highlights progress in strengthening risk management, audit follow-up and financial controls, alongside the priorities for further improvement. These include consistent risk ownership and review, timely completion of agreed management actions and evidence that controls and mitigations are effective. No new individual risk was identified for separate escalation to the Board.

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 summarises assurance over financial controls and the use of resources, including salary overpayments, debt recovery, stock losses and counter-fraud activity. Improvement work is intended to strengthen financial management and reduce avoidable losses. No additional expenditure or financial approval is sought through this report.

Legal and / or Regulatory implications

The report supports Board oversight of the Trusts' audit, governance, risk-management, data-security and counter-fraud arrangements. Relevant findings and follow-up actions are addressed within the report. No new legal or regulatory approval is sought.

Equality, diversity and inclusion implications

No specific additional equality, diversity or inclusion implications are identified in this Committee assurance report.

Environmental sustainability implications

No specific additional environmental sustainability implications are identified in this Committee assurance report.

Audit and Risk Committee Report

Group Board, 06 November 2026

1.0 Purpose of paper

1.1 The gesh Audit and Risk Committee met on 16 September 2026. The Committees agreed to bring the following matters to the attention of the Group Board.

2.0 External Audit

External Audit and Year End 2025/26 – Lessons Learnt

2.1 The Committees received a joint update from Grant Thornton and the Group's Finance teams reviewing the 2025/26 external audit and lessons learnt, informed by the post-audit meeting in July. They welcomed completion within the required timetable and unmodified opinions on both Trusts' financial statements. The review reported no material issues or significant control deficiencies arising from the financial statements audits.

2.2 The Committees recognised the effective collaboration between the auditors and Trust teams, with regular liaison helping to resolve queries and support timely completion. They acknowledged the competing demands on teams, including the ESTH CQC Well-Led inspection preparation and additional work on Electronic Patient Record implementation within the Value for Money audit. The positive outcome reflected considerable effort across the organisations.

2.3 Learning for the next cycle included earlier agreement of the audit timetable, clearer information requirements and early engagement with relevant Executive leads on regulatory improvement programmes. It was clarified that draft Annual Reports would be provided for review by the auditors in early May, rather than April, reflecting the availability of year-end information. Progress against external audit recommendations, including the significant weakness in financial sustainability identified in the Value for Money assessments, would return through the Group Executive Committee and these Committees ahead of the next audit cycle.

3.0 Internal Audit

3.1 The Committees received the regular report from the Group's internal auditors, RSM UK, covering delivery of the 2026/27 Internal Audit Plan and follow-up of agreed management actions. Four audits were in progress, covering flexible working, sickness absence, key financial controls and backlog maintenance. The remaining reviews had been scoped and were scheduled for the second half of the year. RSM remained confident of completing the programme by March 2027 to inform the Head of Internal Audit Opinions.

3.2 Members discussed how the programme could make best use of audit and management capacity. RSM confirmed that audit scopes were agreed with the relevant Executive leads and considered these appropriate. The Committees supported continued alignment of reviews across the Group, recognising that the current programme was already more integrated, with clear scopes and realistic delivery expectations remaining important as the next programme was developed.

3.3 The Committees welcomed further progress in completing management actions, with 11 closed since the previous report. RSM recognised that the number outstanding had reduced

considerably compared with earlier years. As previously reported to the Board, timely completion remained an area requiring attention, but members welcomed the Chief Executive's engagement and monthly scrutiny through the Group Executive Committee, supported by RSM.

3.4 The Committees supported the Executive-led reset of outstanding actions. Executive leads were being given a one-off opportunity to review actions with RSM, confirm or reassign ownership and agree realistic completion dates. Where necessary, deadlines could be reset once, with clear accountability thereafter for delivery rather than further extensions. Actions no longer relevant would be closed by agreement with RSM or replaced with more appropriate actions addressing the underlying issue. The emphasis was on establishing meaningful, deliverable commitments rather than simply changing dates or retaining actions which no longer reflected current circumstances.

3.5 The Committees received positive assurance from the independent Cyber Assessment Framework-aligned Data Security and Protection Toolkit reviews. Both Trusts received Low Risk and High Confidence assessments, with all 12 outcomes tested meeting the expected minimum requirements and matching the Trusts' self-assessments. The reviews covered areas including governance, access controls, resilience, backups and incident-management arrangements. A small number of improvement actions related principally to documentation and third-party network connections. The assurance related to the outcomes assessed.

3.6 The Committees also received six-month updates on two ESTH audits previously assessed as Partial Assurance:

- For discharge management, all seven actions, including two high-priority actions, were reported complete. Improvements included an updated discharge policy with clearer responsibilities, automated checks on discharge documentation in iClip, and stronger oversight through the Urgent and Emergency Care Delivery Group. Ongoing monitoring and re-audit were supporting the consistent use of these arrangements.

- For the Patient Safety Incident Response Framework (PSIRF), management reported completion of the medium- and low-priority actions, including improvements to incident documentation, recording of learning and governance oversight. At the September meeting, one high-priority action concerning Never Events oversight remained open and was reported on track for October 2026. The clinical team described the audit as helpful in supporting the cultural and practical changes required to embed the framework. The Committee agreed that the update should also be taken to the Quality Committee for review.

3.8 The Committees welcomed the evidence that both audits had supported practical improvement rather than simply administrative action closure. They recognised the importance of continuing local monitoring. In relation to discharge, members also clarified that the assurance concerned discharge processes; the separate question of higher readmission rates was being examined through the clinical audit programme, with reporting through the established Board arrangements.

4.0 Counter Fraud

4.1 The Committees received the quarterly report from RSM's Counter Fraud team covering prevention, awareness and investigation activity across both Trusts. They noted the timely submission of the annual Counter Fraud Functional Standard Returns, with both Trusts assessed as Green. The report outlined continued work to strengthen staff awareness through targeted training, regular communications and refreshed intranet guidance, including clear information on the confidential routes available for reporting concerns.

4.2 The Committees considered benchmarking of counter-fraud referrals and discussed differences between the two Trusts in the context of staff awareness and the types of matters referred. Management described targeted engagement with ESTH divisional teams to strengthen recognition and reporting of potential fraud. Members also welcomed the inclusion of counter-fraud awareness in SGUH induction arrangements and discussed extending this approach across the Group, alongside increasing participation in specialist and refresher training.

4.3 Following the Committees' earlier discussion, Finance, HR and Counter Fraud were strengthening arrangements to capture the management response and final outcomes of investigations. Members recognised that the absence of a recorded outcome in previous reports did not necessarily mean that no action had been taken. Regular joint working and clearer feedback into future reports were intended to provide a more complete picture of the action taken, including relevant management and employment processes, and strengthen assurance that investigations were appropriately followed through.

5.0 Finance Update

5.1 The Committees received the regular financial control reports covering debtors and bad debts, payment performance, losses and special payments, and salary overpayments. RSM's separate payroll benchmarking supported discussion of the effectiveness of controls and opportunities to improve consistency across the Group.

5.2 Quarter-one salary overpayments were £498k at SGUH and £255k at ESTH. RSM's benchmarking indicated that both Trusts' overpayment rates were above most comparators. The discussion focused on preventing errors at source, particularly through timely and accurate notification of leavers, changes in hours or contracts, and sickness absence. Members recognised the consequences for staff experience, as well as the financial and administrative costs of recovering overpayments.

5.3 The Committees welcomed joint work led by the Group Chief Finance Officer and Group Chief People Officer to review and standardise HR and payroll processes, clarify responsibilities and strengthen guidance and training. This would build a more consistent Group approach while reinforcing the role of line managers in submitting accurate information promptly.

5.4 Members considered recovery of longstanding debt, including balances between NHS organisations, and the importance of clear assurance on recoverability and provisions. Management described the impact of payment timing and disputed invoices on outstanding balances. The Committees also reviewed work to improve the completeness and classification of stock-loss reporting, alongside existing controls in high-value areas. Better information would help distinguish the causes of losses and identify opportunities to reduce avoidable waste.

5.5 Management advised that more complete stock-loss recording could initially increase reported losses before the benefits of improved controls became apparent. The GCFO agreed to return with improvement milestones and expected outcomes across the financial control areas discussed, enabling the Committees to assess progress against clearer measures.

6.0 Governance, Risk and Compliance

Risk management and the Board Assurance Framework

6.1 The Committees received the Group Risk Report, bringing together the Board Assurance Framework (BAF), Corporate Risk Registers and wider risk-management information. They

welcomed the improvement in the quality, depth and visibility of reporting, which supported a more informed discussion of the Group's risk position and the priorities for further development. Members recognised that the Committees' consideration of risk had become more substantive as the reporting and underlying arrangements had developed.

6.2 Members recognised steady progress over the preceding 18 months through the common Group Risk Management Policy, more regular Executive scrutiny and substantial refresh of the Corporate Risk Registers. Since April 2025, 43 corporate risks had been closed or de-escalated and 22 added, demonstrating more active management of the corporate risk profile. The refreshed nine-risk BAF approved by the Board in July provided a clearer strategic framework. These developments built on the progress recognised in the Reasonable Assurance internal audit review reported in June.

6.3 The Committees recognised that the next stage was to embed these arrangements more consistently across sites, divisions and corporate services. The report continued to identify overdue reviews and gaps in recorded mitigation, including for some higher-rated risks. Priorities included timely risk reviews, clear ownership, complete records of controls and mitigating actions, and evidence that actions were reducing or managing exposure. Members emphasised the importance of risk registers being used as practical management tools, informing decisions and priorities rather than operating as a separate compliance process.

6.4 The Committees supported plans by the GCCAO to develop an 18-month Risk Management Improvement Plan, building on the existing foundations. This would bring together immediate work to validate risk records and address overdue reviews with longer-term improvements in staff capability, guidance, systems and action tracking. The plan was being developed through the Group Executive Committee, with presentation to these Committees scheduled for December 2026 and Board consideration in January 2027 alongside a revised Group Risk Management Policy.

6.5 Reflecting on the discussion at the September Board meeting, members also supported the use of the BAF to further support oversight of merger, transformation and organisational delivery capacity. The discussion highlighted the value of distinguishing these risks more clearly, recognising delivery capacity below Executive level and understanding the interdependencies between finance, workforce, estates and operational risks. Realistic risk-reduction trajectories and alignment with the Group's priorities would remain important. No new individual risk was identified for separate escalation to the Board.

Declarations of interest

6.6 The Committees considered the declarations of interest benchmarking report, which provided comparative assurance on compliance with annual declaration requirements. Reported compliance among decision-making staff was 93% at SGUH and 94% at ESTH, with both Trusts comparing favourably against the acute-sector average of 87% within RSM's benchmarking sample. This provided further positive context to the strong performance previously reported through the annual review of declarations of interest.

6.7 The Committees welcomed the favourable comparison and noted the importance of sustaining this performance while addressing the remaining outstanding declarations. The report reinforced the need for continued follow-up and escalation, particularly where staff repeatedly failed to submit their annual return. The emphasis was on building on the high level of participation already achieved while securing compliance from the remaining minority of staff.

6.0 Recommendations

6.1 The Board is asked to:

a) Note the report of the Audit and Risk Committee following its meeting on 16 September 2026 and the issues highlighted to the Board by the Committee.

Pankaj Davé
Audit and Risk Committee Chair, NED

Group Board

Meeting in Public on Friday, 06 November 2026

Agenda Item	6.1	
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 October 2026 and the matters the Committees wish to bring to the attention of the Group Board. The key issues the Committees wish to highlight to the Board are:

- Group Chief People Officer (GCPO) Update: The Committees received an update covering workforce planning, employment legislation and organisational development activity. The members discussed the implications of the Employment Rights Act and the significant programme of work required to review and harmonise policies across the group. They also considered progress in transforming Employee Relations services, noting the additional investment in ER capacity and increasing focus on improving management capability, reducing escalation of formal cases and supporting earlier resolution of workplace issues. The GCPO also reported early signs of improvement from the new Sickness Intervention Programme, including a reduction in long-term sickness cases.

- Guardians of Safe Working (GOSW), Q2 2026/27: The Committees received limited assurance regarding the findings of the Guardian of Safe Working reports following a significant increase in exception reporting across both organisations. Whilst improved reporting culture is viewed positively, the Committees requested further benchmarking and triangulation work to better understand the extent to which this reflects wider NHS trends and any implications for workforce sustainability and patient safety.

- Improving Resident Doctors' Working Lives (IRDWL) - Estates & Facilities: The Committees received reasonable assurance regarding governance arrangements but limited assurance regarding pace of delivery. Progress continues across the Estates & Facilities elements of the NHS 10 Point Plan, but concerns remain regarding the speed with which improvements are being delivered, particularly relating to doctors' mess facilities, on-call accommodation and workspace provision. The Committees requested a further update at its next meeting, not just on Estates & Facilities but on the wider IRDWL programme.

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 October 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

The refreshed Group BAF contains two strategic risks on which the People Committee leads on providing assurance to the Board:

- SR8 Workforce Sustainability with a current risk score of 20 and Partial Assurance.
- SR9 Organisational Culture and Inclusion with a current risk score of 16 and Partial Assurance.

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, 06 November 2026

1.0 Purpose of paper

1.1 This report sets out the key issues considered by the People Committees at its meeting in October 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 22 October 2026, the Committees considered the following items of business:

22 October 2026
• Group Chief People Officer Update • People Strategy Progress Report • Mandatory and Statutory Training Alignment Update • Organisational Development (OD) Support for Transformation • General Medical Council (GMC) National Training Survey • Guardian of Safe Working Report, Q2 2026/27 • Improving Resident Doctors' Working Lives (IRDWL) Estates & Facilities Update • Workforce KPI Performance Report • Board Assurance Framework (BAF) - People Risks • Group Freedom To Speak Up (FTSU) Q2 2026/27 Report • Flu Campaign Update • Undergraduate Medical Education Report • Consultant Mentoring Update

2.2 The Committees, chaired by Yin Jones, meet every two months as agreed by the Group Board. An informal meeting between the Chair and GCPO takes place in the month between two public Committee meetings. The meeting on 22 October 2026 was quorate.

3.0 Key issues for escalation to the Group Board

The Committees wish to highlight the following matters for the attention of the Group Board:

3.1 Guardian of Safe Working (GOSW)

There was a significant discussion around the marked increase in exception reporting. Members sought further analysis, benchmarking and triangulation with other workforce indicators.

3.2 Improving Resident Doctors' Working Lives (IRDWL) - Estates & Facilities

Members expressed concern about the pace of delivery and whether resident doctors would see tangible improvements quickly enough. Although governance arrangements were considered sound and the GCPO highlighted an improvement in payroll errors to below 5%, there were concerns about

the delivery and the Committees requested another update, not just on Estates & Facilities but on the wider IRDWL programme, at its next meeting.

3.3 Group Freedom To Speak Up (FTSU) Q2 2026/27 Report

The Committees received reasonable assurance regarding the operation of the Freedom to Speak Up service but limited assurance regarding the wider speaking-up culture and timely resolution of concerns. Additional investment in Employee Relations capacity is expected to support stronger management capability and earlier resolution of concerns.

4.0 Key Issues on which the Committees received assurance

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

4.1 Group Chief People Officer Update

The Committees received an update covering workforce planning, employment legislation and organisational development activity. The members discussed the implications of the Employment Rights Act and the significant programme of work required to review and harmonise policies across the group. They also considered progress in transforming Employee Relations (ER) services, noting the additional investment in ER capacity and increasing focus on improving management capability, reducing escalation of formal cases and supporting earlier resolution of workplace issues. The GCPO also reported early signs of improvement from the new Sickness Intervention Programme, including a reduction in long-term sickness cases.

4.2 People Strategy Progress Report

The Committees received reasonable assurance regarding progress against the People Strategy. Significant progress has been achieved in stabilising transactional HR services, strengthening compliance, improving responsiveness to staff queries and implementing the gesh People Management Programme. The Committees noted that a full evaluation of the 2024-26 People Strategy will be undertaken in early 2027.

4.3 Mandatory and Statutory Training (MAST) Alignment Update

The Committees received reasonable assurance regarding progress to standardise mandatory and statutory training (MAST) requirements across the group. The Committees endorsed the common group standards and agreed closure of the original alignment programme, whilst noting that several speciality-specific areas remain subject to further review.

The Committees also noted forthcoming national reforms to the Core Skills Training Framework, which aim to streamline mandatory training requirements across the NHS, reduce duplication and improve transferability of training records between employers. The Group will need to review its aligned MAST standards once the national framework is finalised.

4.4 General Medical Council National Training Survey

The Committees received reasonable assurance regarding the quality of postgraduate medical education. Survey results continued to demonstrate sustained improvement across the Group, with a number of specialties receiving formal recognition from NHS England for high performance. All urgent

concerns raised through the survey process have been addressed and closed. Focus remains on specialties subject to self-report requirements and those under enhanced monitoring arrangements.

4.5 Guardians of Safe Working (GOSW), Q2 2026/27

The Committees received limited assurance regarding the findings of the Guardian of Safe Working reports following a significant increase in exception reporting across both organisations. Exception reports have approximately doubled compared with the previous quarter and cover a wide range of specialties, grades and issues including late finishes, missed breaks and missed educational opportunities.

Whilst improved reporting culture is viewed positively, the Committees requested further benchmarking and triangulation work to better understand the extent to which this reflects wider NHS trends and any implications for workforce sustainability and patient safety.

4.6 Improving Resident Doctors' Working Lives (IRDWL) Estates & Facilities Update

The Committees received reasonable assurance regarding governance arrangements but limited assurance regarding pace of delivery. Payroll errors have reduced to below 5% and improvement activities are ongoing to reduce this further. Progress continues across the Estates & Facilities elements of the NHS 10 Point Plan, but concerns remain regarding the speed with which improvements are being delivered, particularly relating to doctors' mess facilities, on-call accommodation and workspace provision. The Committees requested a further update at its next meeting, not just on Estates & Facilities but on the wider IRDWL programme.

4.7 Workforce KPI Performance Report

The Committees received reasonable assurance regarding workforce performance. Workforce numbers continue to reduce gradually through recruitment controls and workforce transformation initiatives. The Committees discussed continued challenges relating to sickness absence and temporary staffing, but noted early signs of improvement from the new sickness intervention programme, including reductions in long-term sickness cases.

4.8 Board Assurance Framework (BAF): People Risks

The Committees reviewed the strategic risks relating to Workforce Sustainability and Organisational Culture. Members noted improvements in the strength of several controls, including progress in workforce planning, leadership development and People Strategy delivery. However, the Committees recognised continuing challenges relating to sickness absence, workforce sustainability, staff experience, speaking-up culture and organisational culture. The Committees received assurance that appropriate mitigation plans are in place and continue to be monitored through the Board Assurance Framework.

4.9 Group Freedom To Speak Up (FTSU) Report – Q2 2026/27

The Committees received reasonable assurance regarding the operation of the Freedom to Speak Up service but limited assurance regarding the wider speaking-up culture and timely resolution of concerns. Particular concern was noted regarding perceived detriment cases and organisational learning arising from collective concerns. Additional investment in Employee Relations capacity is expected to support stronger management capability and earlier resolution of concerns.

5.0 Other issues considered by the Committees

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

5.1 Organisational Development (OD) Support for Transformation

The Committees received an update on organisational development programmes supporting cultural transformation, leadership development and workforce engagement. Members emphasised the importance of clear success measures, evaluation arrangements and accountability for delivery to ensure that OD interventions translate into measurable organisational improvements.

5.2 Flu Campaign

The Committees received an update on the 2026 flu campaign. Both organisations are working towards the national ambition of achieving 60% vaccination uptake amongst frontline staff. A range of initiatives are underway including peer vaccinators, targeted engagement activity and incentive schemes aimed at improving participation amongst harder-to-reach staff groups.

5.3 Undergraduate Medical Education

The Committees noted continued strong performance in undergraduate medical education, with over 3,000 learners supported across the group. The Committees welcomed the £1.7m investment secured from City St George's to support educational facilities and workforce development, whilst noting ongoing work regarding tariff transparency and accommodation arrangements.

5.4 Consultant Mentoring

The Committees received an update on consultant mentoring arrangements and noted ongoing work to expand and strengthen mentoring provision across both organisations. Members recognised the value of mentoring in supporting consultant development, leadership capability, wellbeing and retention, and welcomed efforts to establish a more consistent and accessible offer across the group. The Committees noted the importance of measuring participation and outcomes as the programme continues to develop.

6.0 Recommendations

6.1 The Group Board is asked to note any issues escalated to the Group Board and the wider issues on which the People Committees received assurance on 22 October 2026.

Group Board

Meeting in Public on Friday, 06 November 2026

Agenda Item	6.2	
Report Title	**Group Freedom to Speak Up Report Q2 2026/27**	
Executive Lead(s)	Stephen Jones, Group Chief Corporate Affairs Officer	
Report Author(s)	Karyn Richards-Wright, Group Freedom to Speak Up Guardian	
Previously considered by	Group Executive Committee People Committee	20 October 2026 22 October 2026
Purpose	**For Assurance**	

Executive Summary

This report provides the Group Board with a thematic analysis of concerns raised with the Freedom to Speak Up Guardians across the gesh Group during Q2 2026/27. The report has been considered by the People Committee and the Group Executive Committee.

Total concerns raised in Q2 across the group totalled 87.

St George's

Administrative and clerical staff accounted for the largest share of cases, with 19 (33.9%), followed by medical and dental staff with 14 (25.0%) and registered nurses and midwives with 10 (17.9%). Medical and dental cases increased from three in Q1, representing the largest staff group increase. Medicine and Cardiovascular Division recorded 20 cases (35.7%) and Children and Women 14 (25.0%). Together these divisions accounted for 60.7% of SGUH cases. Collective contacts were the largest contact classification, with 23 cases (41.1%), compared with two in Q1.

Epsom and St Helier

Administrative and clerical staff accounted for 15 cases (48.4%), up from six in Q1. Registered nurses and midwives accounted for nine cases (29.0%), compared with 11 in Q1. Medicine recorded six cases (19.4%) and Women and Children five (16.1%); Planned Care and Renal each recorded four (12.9%). Advice accounted for 13 cases (41.9%), unchanged in number from Q1. Escalations increased from three to 10 and represented 32.3% of Q2 cases. This shows an increase in cases escalated for response. Management conduct was the largest named theme across GESH, with 36 entries. SGUH recorded 17 patient safety and quality entries and 17 patient experience entries. ESTH recorded six detriment entries, double the Q1 count, alongside seven worker safety entries.

We adopted the new national Freedom to Speak Up Policy as one of the first Group-wide policies, in line with national guidelines from NHS England in early 2025. We have also developed a standardised process, within the team, for triaging concerns raised to the FTSU service to help ensure consistency in the way in which concerns are dealt with and escalated, which includes clarity on how the service escalates immediate patient safety concerns and its process for undertaking an early stage assessment of the risk of concern raisers encountering detriment. We have seen an increase in staff raising that they fear detriment due to raising concerns as opposed to actually suffering detriment. As

such, in line with national guidance from the National Guardian's Office, our triage process also sets out our process for checking in with concern raisers six and 12 months after raising a concern. Timely resolution of concerns, particularly grievances, remains an issue across the Group. Staff continue to approach the FTSU service with concerns about delays in investigations and outcomes, and about formal HR processes not being followed within expected timescales.

In line with NHSE guidelines, the report also highlights a number of recommendations from the Guardian to the Trust, based on learning from recent concerns.

Action required by Group Board

The Board is asked to:

a. Note the number of concerns reported to the FTSU Guardians in Q2 and during the year-to-date 2026/27 for both SGUH and ESTH and the staff groups reporting.
b. Note the themes emerging from FTSU cases in this period.
c. Note the recommendations for organisational learning from the Group FTSU Guardian as set out in section 5 of the report
d. Note the priorities of the Group FTSU service in the coming months.

Committee Assurance

Committee	People Committees-in-Common
Level of Assurance	Reasonable Assurance is proposed for the level of assurance in relation to the resourcing, structure and operation of the Group Freedom to Speak Up Service. This also reflects the "reasonable assurance" findings of internal audits at both SGUH and ESTH on the FTSU services. However, more broadly, in relation to how confident our staff are in speaking up, the timely resolution of concerns, the ability of our managers to deal confidently and appropriately in handling concerns, and our triangulation of concerns with other metrics to provide insight into areas that may require early support and / or intervention, limited assurance is proposed.

Appendices

Appendix No.	Appendix Name
Appendix 1	Q2 2026/27 FTSU Heat Maps

Implications

Group Strategic Objectives

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

Risks

Failure to comply with the requirements around Freedom to Speak Up, a regulatory requirement, risks undermining staff confidence in the leadership of the Trust and would be a reputational risk to the organisation.

CQC Theme

☒ Safe	☒ Effective	☒ Caring	☒ Responsive	☒ Well Led

NHS system oversight framework

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

Financial implications
There are no specific financial implications relating to this report.
Legal and / or Regulatory implications
NHSE, Freedom to Speak Up Policy for the NHS. Sir Robert Francis QC, Freedom to Speak Up: An independent report into creating an open and honest reporting culture in the NHS, 2015.
Equality, diversity and inclusion implications
The report identifies discrimination-related themes within concerns raised during the quarter, particularly at ESTH. These signals require further triangulation with workforce and employee-relations intelligence. The case-management system also enables monitoring of speaking-up patterns by protected characteristic, subject to sufficient numbers and appropriate confidentiality safeguards.
Environmental sustainability implications
There are no specific environmental sustainability implications of this report.

Group Freedom to Speak Up Report, Q2 2026/27
Group Board, 06 November 2026

1.0 Purpose

1.1 This report provides the Group Board with a thematic analysis of concerns raised with the Freedom to Speak Up Guardians across the Group during Q2 2026/27. The report sets out key themes and trends in the number, type and origin of concerns and highlights cross cutting and emerging issues.

2.0 Background

2.1 In February 2015, the independent report into Freedom to Speak Up, by Sir Robert Francis QC set out 20 principles to guide the development of a healthy speaking up culture throughout the NHS. Among these was the recommendation that every NHS trust appoint a Freedom to Speak Up Guardians. As the report stated, “every organisation needs to foster a culture of safety and learning in which all staff feel safe to raise a concern…we need to get away from the culture of blame, and the fear that it generates, to one which celebrates openness and commitment to safety and improvement”.

2.2 Freedom to Speak Up Guardians support workers to speak up when they feel that they are unable to in other ways. Workers can speak up about things such as but not limited to, unsafe patient care, a criminal offence maybe that has been, or is being committed, unsafe working conditions or other breaches of Health and Safety, inadequate induction or training for workers, lack of, or poor response to, a reported patient safety incident, suspicions of fraud, bullying and harassment.

2.3 The importance of speaking up has been reinforced in both the NHS Patient Safety Strategy, published in July 2019, which sees speaking up as a fundamental part of establishing effective patient safety cultures in NHS trusts, and in the new NHS People Plan, published in August 2020, which describes speaking up as essential to building a culture of belonging in the NHS, one in which patients and staff feel safe. The NHS People Plan stated that “making sure staff are empowered to speak up – and that when they do, their concerns will be heard – is essential is we are to create a culture where patients and staff feel safe.”

2.4 In September 2020, the SGUH Board approved the St George’s first Freedom to Speak Up vision and strategy. It set out the following vision for raising concerns:

> *“We aim to create a culture of safety and learning in which all staff feel safe, supported and confident to raise concerns without fear or detriment, and where speaking up is visibly championed as a core part of providing outstanding care every time to our patients, staff and the communities we serve.*
>
> *“We aim to become a leader in establishing a positive speaking up culture by encouraging and supporting staff to speak up, listening to their concerns and acting on them. Staff will not fear speaking up and will be thanked for doing so”.*

It also set out five strategic priorities for Freedom to Speak Up:

1. We will support our staff to feel confident about speaking up

2. We will make it safe for our staff to speak up
3. We will investigate concerns promptly, fully and fairly
4. We will ensure that speaking up makes a difference
5. We will support the positive development of our organisational culture

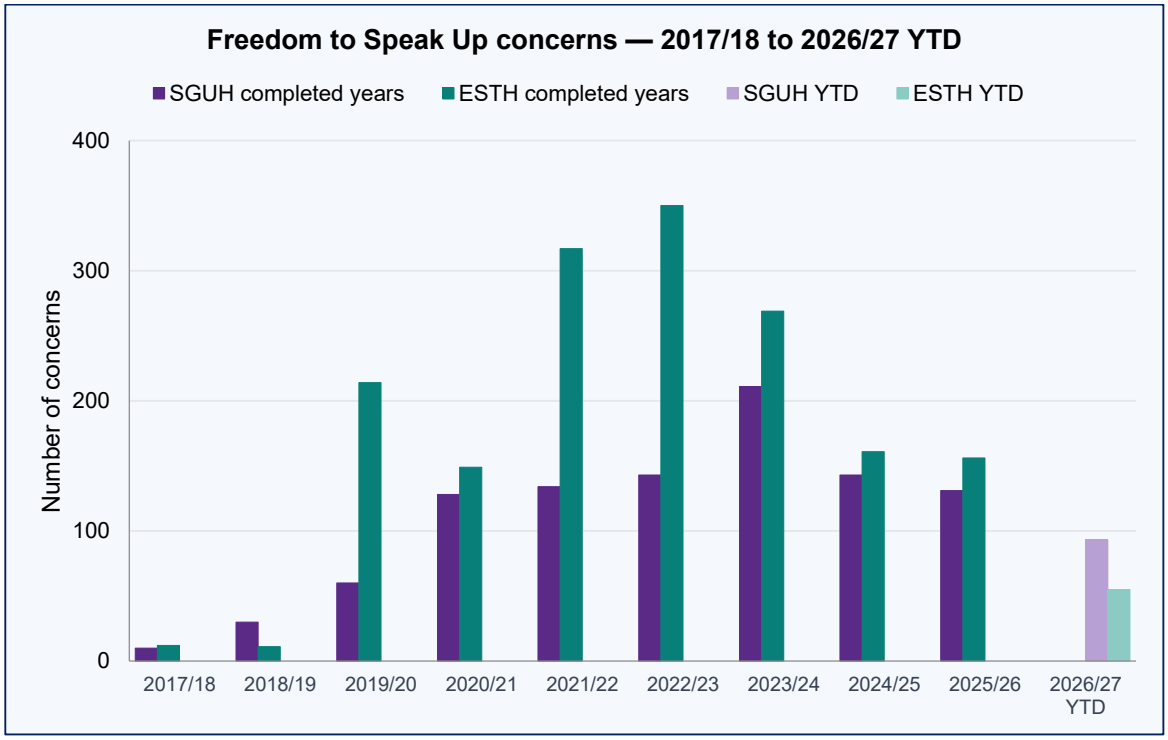
2.5 There is currently no corresponding FTSU vision and strategy approved by the Board for ESTH, but the principles and approach adopted in the SGUH strategy could equally apply at ESTH, and the paper sets out the development of a Group-wide FTSU vision and strategy as an important step in strengthening our approach to speaking up.

3.0 Current SGUH and ESTH FTSU activity and themes

(a) Total number of concerns raised via Freedom to Speak Up in Q2 2026/27

3.1 During Q2 2026/27 (1 July–30 September 2026), 87 concerns were raised with the Freedom to Speak Up Service across the gesh Group: 56 at SGUH and 31 at ESTH. This brings the total for the first six months of 2026/27 to 148 concerns, comprising 93 at SGUH and 55 at ESTH.

3.2 The number of concerns raised in Q2 was 67% higher than in the corresponding quarter of 2025/26, when 52 concerns were recorded. This increase was concentrated at SGUH, where concerns rose from 22 to 56. Activity at ESTH remained broadly unchanged, with 31 concerns compared with 30. Across the first six months of the year, the Group recorded 32% more concerns than in the same period last year (148 compared with 112).



(b) Concerns raised by staff group in Q2 2026/27

3.3 The charts below show concerns raised by staff group at SGUH and ESTH during the first two quarters of 2026/27. Administrative and clerical staff and registered nurses and midwives account for the largest numbers of concerns at both trusts on a year-to-date basis, together representing 64% of concerns across the Group. Administrative and clerical staff were the largest group at SGUH in both quarters. At ESTH, the largest group changed from registered nurses and midwives in Q1 to administrative and clerical staff in Q2.

3.4 A notable development in Q2 was the increase in concerns raised by medical and dental staff at SGUH, from three in Q1 to 14 in Q2. They accounted for a quarter of all concerns raised at SGUH during Q2 and were the second-largest staff group using the service that quarter. This increase was in large part due to a collective concern raised by 14 consultants in elderly care at SGUH, which has increased the recorded figures (given national guidelines require collective concerns to be logged for each of the staff members who are part of the collective concern). The concerns related to bed closures impacting on patient safety and quality. The concern was escalated to the Divisional Triumvirate who are engaging directly with the consultants, who in turn have indicated they are content with the discussions underway.



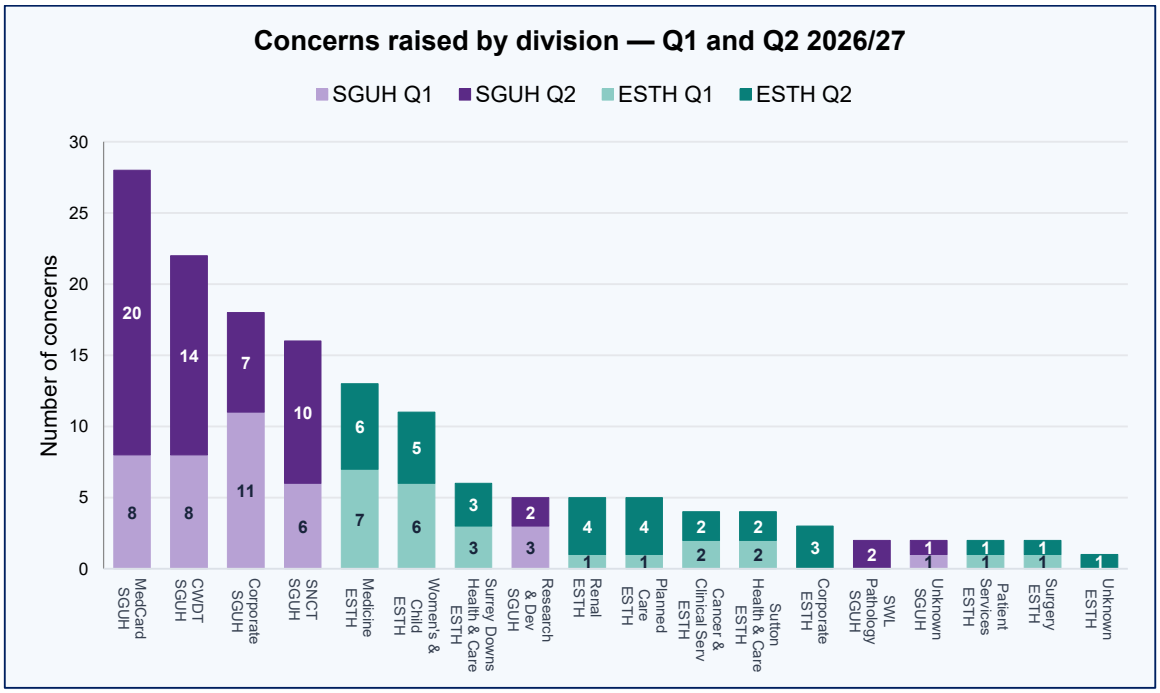
(a) Concerns raised by Divisions in Q2 2026/27

3.5 The chart below shows the distribution of concerns across divisions and services at both trusts during Q1 and Q2 2026/27. Comparisons should take account of differences in organisational structure and workforce size. Each of SGUH's three clinical divisions is substantially larger than the individual divisions at ESTH and covers a broader range of services. The chart shows numbers of concerns rather than rates adjusted for workforce size, so higher volumes should not automatically be interpreted as indicating greater prevalence of concerns or a poorer speaking-up culture.

3.6 At SGUH, Medicine and Cardiovascular (MedCard) recorded the largest number of concerns in Q2, increasing from eight in Q1 to 20. Its year-to-date total of 28 already exceeds the 25 recorded during the whole of 2025/26. This represents a change from the second half of 2025/26, when Surgery, Neurosciences, Cancer and Theatres (SNCT) recorded the highest number, partly associated with collective concerns from theatres staff. The 2025 NHS Staff Survey provides additional context. Although all three SGUH clinical divisions recorded the same Raising Concerns sub-score of 6.2, MedCard and SNCT had both declined from 6.4 in 2024, while CWDT remained unchanged. The increase in MedCard's FTSU activity therefore warrants consideration alongside this earlier decline in staff-reported speaking-up experience. It does not, by itself, establish whether the increase reflects more underlying concerns, greater confidence in approaching the Guardian, or a combination of factors.

3.7 At ESTH, Medicine and Women's and Children's remained the largest sources of concerns in Q2, with six and five respectively. Medicine recorded 13 concerns during the first half of 2026/27, compared with 40 during the second half of 2025/26. Renal and Planned Care each recorded four concerns in Q2, compared with one each in Q1. The 2025 NHS Staff Survey results reinforce the case for continued attention to Medicine, Women's and Children's and Planned Care, whose Raising Concerns sub-scores were 6.0, 6.1 and 6.1 respectively, below the ESTH average of 6.3. Clinical Services also warrants attention following a decline from 6.0 to 5.5: low numbers of concerns reaching FTSU would not, in themselves, provide reassurance about staff confidence. Conversely, Renal's comparatively strong score of 6.8 illustrates why an increase in FTSU activity should not automatically be interpreted as evidence of deteriorating culture.

3.8 Corporate Services at SGUH recorded seven concerns in Q2, compared with 11 in Q1. Differences between the trusts should also be considered in the context of the consolidation of group-wide corporate functions, largely at SGUH. This may partly explain the higher number of corporate concerns attributed to SGUH. Further interpretation should consider the functions involved, as the FTSU corporate category brings together services reported separately in the Staff Survey and may conceal different experiences within individual teams.

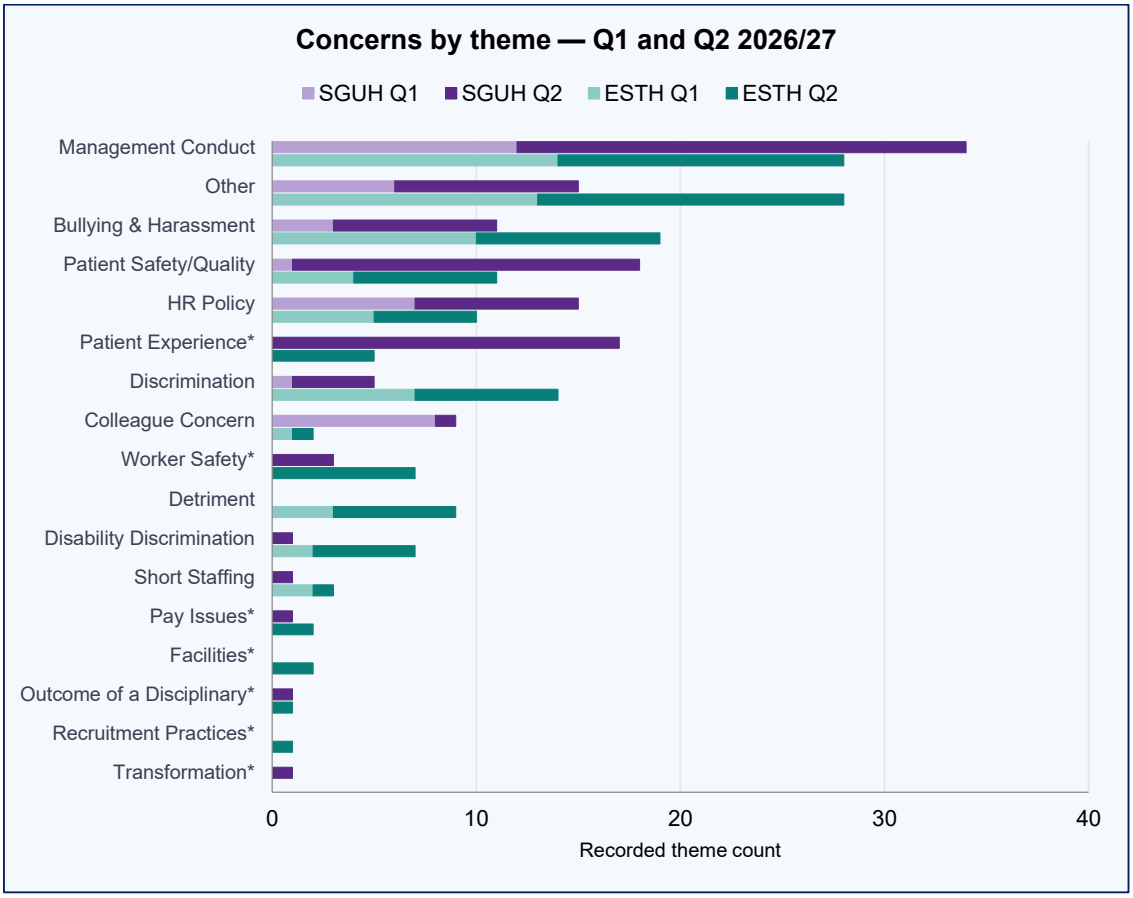


(c) Themes in concerns raised with the Group FTSU Guardians in Q2

3.9 The chart below shows the themes within concerns raised across the Group. Individual concerns may involve several themes.

3.10 Management conduct remains the leading specific theme, featuring in 36 concerns in Q2 (41% of the caseload), alongside 17 involving bullying and harassment. These themes have featured prominently across successive reports, reinforcing the importance of consistent leadership behaviours, fair application of policies and timely resolution of concerns. At ESTH, concerns involving detriment increased from three in Q1 to six in Q2, highlighting the continuing need to support and protect staff who speak up.

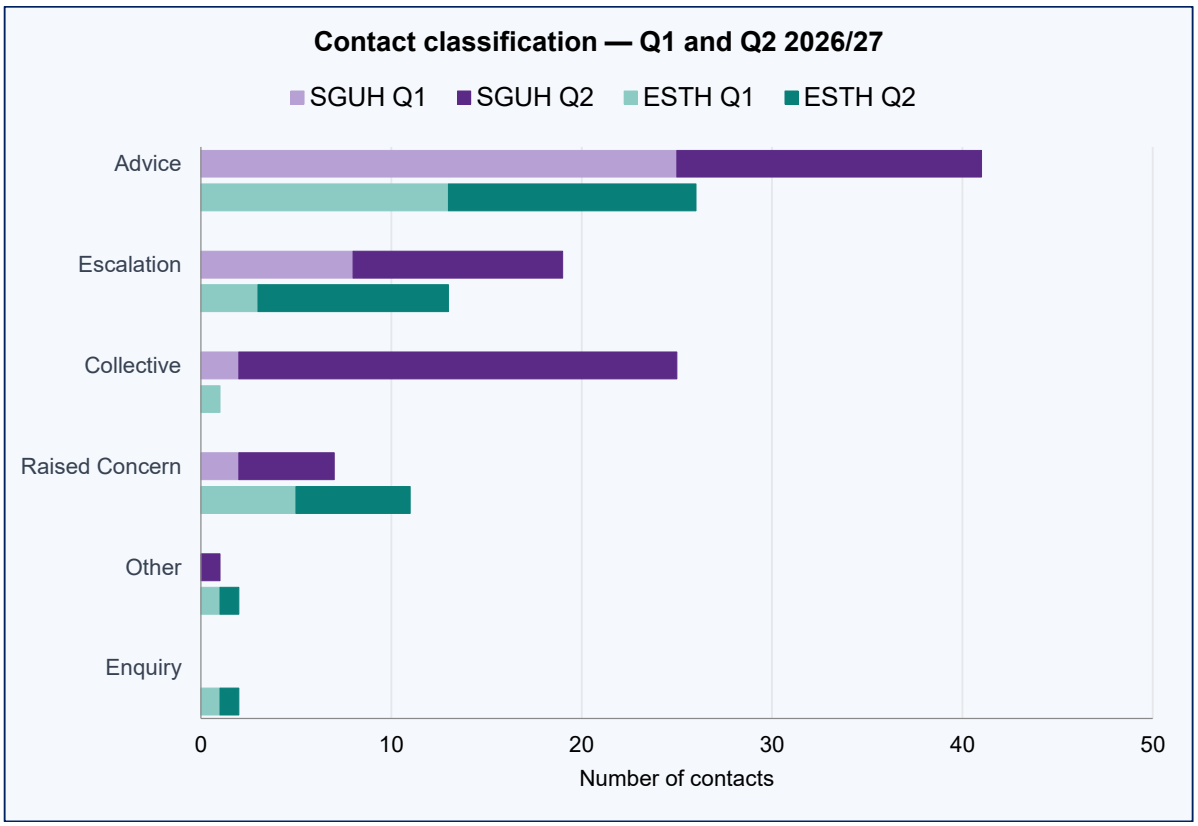
3.11 Patient safety and quality featured in 24 concerns in Q2, compared with five in Q1, bringing the year-to-date total to 29. This compares with 50 during the whole of 2025/26. The change is particularly notable at SGUH, where 18 concerns in the first six months already match the previous full-year total of 18. This increase is largely driven by the collective concern from 14 consultants at SGUH relating to elderly care (see above for more details). ESTH recorded 11, compared with 32 during the previous full year. The figures therefore indicate increased reporting at SGUH. It is welcome that staff are bringing patient safety concerns forward, creating opportunities to identify risks and improve care. Increased reporting does not, however, establish whether underlying risks or confidence in speaking up have changed. Patient experience also featured in 22 concerns in Q2. The Guardian is seeking incident, complaints and employee relations information to identify shared issues, gaps in organisational response and any further action required.



** No concerns recorded in these categories in Q1 2026/27*

4.0 Contact classification

4.1 The chart below shows how contacts with the FTSU service were classified during Q2 2026/27, distinguishing requests for advice from escalations, formally raised concerns, collective concerns and enquiries or other contacts.



4.2 The contact classification types are as follows:

- **Advice:** A contact where a worker is seeking guidance on an issue, available options or about how to raise a concern;
- **Escalation:** A contact from a worker where the FTSU Guardian takes a concern forward to an appropriate manager or senior lead for response or action, including where further escalation is needed;
- **Collective:** A concern raised by, or on behalf of, more than one worker about a shared issue;
- **Raised concern:** A contact where a worker has already raised the concern themselves, for example with their manager or through another organisational route, and then contacts the FTSU Guardian service for support or follow-up;
- **Enquiry:** A request for information or clarification about FTSU or the speaking up process; and
- **Other:** A contact that does not fit the above defined categories, for example personal issues affecting a member of staff at work.

5.0 Timely resolution of concerns

5.1 Timely resolution of concerns continues to be a challenge across the Group. This is particularly the case where concerns are escalated into formal HR processes, where staff report increased anxiety and sickness. The recent decision to invest in enhanced Employee Relations capacity is welcomed by the Guardian in this context. The FTSU Guardian has a monthly meeting with senior HR representatives to understand the delays on particular cases.

5.2 Advice cases to FTSU are on average being closed within 4-6 weeks.

5.3 Challenges with the timely resolution of concerns continues to impact staff experience, and concerns with delayed processes impact on both staff confidence in speaking up in general and into staff perceptions of FTSU as a whole.

6.0 Recommendations for organisational learning

6.1 The themes emerging from concerns raised during Q2 identify opportunities for wider organisational learning and improvement. The recommendations below focus on the recurring issues identified through FTSU cases and are intended to support earlier resolution, strengthen management practice and improve staff confidence that concerns will be handled fairly, consistently and compassionately:

i. **Connect speaking up themes with patient safety and experience**
The increase in patient safety and quality concerns at SGUH supports a coordinated review of FTSU themes alongside incident reports, complaints and PALS feedback.

ii. **Review protection and equitable treatment following speaking up**
The increase in reported perceived detriment and disability discrimination at ESTH warrants focused review alongside FTSU, EDI and ER Data to ascertain what themes are coming up i.e. access to support, consideration of reasonable adjustments etc. The Guardian is working with colleagues to assist in this triangulation and themes for learning and actions by divisional leaders as necessary.

iii. **Turn collective concerns into shared organisational learning**
The increase in collective concerns at SGUH provides an opportunity to examine whether the concerns reflect recurring departmental issues. Relevant divisional leaders should look at this data to identify any actions or learning that can be shared across divisions.

7.0 Priorities for FTSU Service Going Forward

7.1 The key priorities for the FTSU Guardian Service and Executive Lead for FTSU over the coming months are:

- Developing a Group-wide FTSU strategy to establish clear organisational commitments and priorities for building the speak up culture we want to foster across our Group, which will also help to address the CQC's findings on speaking up and the staff survey feedback on raising concerns;

- Using staff feedback, FTSU themes and data into a practical delivery plan with clear measures for success across both organisations.

- Strengthening divisional oversight of speaking up themes by introducing regular divisional reporting to support focussed divisional actions and learning.
- Progressing actions arising from the internal audit on speaking up by taking forward the agreed recommendations.
- Developing a clear Group-wide approach to addressing concerns about detriment;
- Systematising learning from speaking up and ensuring these are widely disseminated across the organistaion;
- Continue with listening events and evaluate themes coming from listening events alongside wider data and learning from concerns.

8.0 Recommendations

8.1 The Board is asked to:

a) Note the number of concerns reported to the FTSU Guardians in Q2 and during the year-to-date and the staff groups reporting.
b) Note the themes emerging from FTSU cases in this period.
c) Note the recommendations for organisational learning from the Group FTSU Guardian as set out in section 5 of the report
d) Note the priorities of the Group FTSU service in the coming months.

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

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Appendix 1:
FTSU Heat Maps
Year-to-date (1 April to 30 September 2026)

Group Board
6 November 2026

Freedom to Speak Up – 2026/27 YTD
Activity Heat Map: St George's University Hospitals NHS Foundation Trust

91 total concerns
Two case not attributable to a stated area

8.7 cases per 1,000 staff
91 mapped cases across 10,516 staff

28 largest concentration
Medicines and Cardiovascular

Division	Staff*	Number of Concerns	Concerns Per 1,000	Manage-ment Conduct	Bullying & Harassment	HR Policy	Patient Safety	Patient Experience	Discrim-ination	Worker Safety
Medicine & Cardiovascular	2,512	28 Q1: 8; Q2: 20	11.1	4	0	4	14	15	0	1
Children's, Women's, Diagnostics and Therapies	3,462	22 Q1: 8; Q2: 14	6.4	12	1	1	3	2	0	1
Corporate (inc. E&F)	1,518	18 Q1: 11; Q2: 7	11.9	4	2	7	1	0	2	2
Surgery, Neurosciences, Cancer & Theatres	2,239	16 Q1: 6; Q2: 10	7.1	6	7	3	0	0	2	1
Research & Development	96	5 Q1: 3; Q2: 2	52.1*	5	1	0	0	0	0	1
SWL Pathology	689	2 Q1: 0; Q2: 2	2.9	1	0	0	0	0	0	1

** Rate based on five cases among 96 staff and therefore sensitive to small changes*

How to read this
Heat colours show reported activity in concerns raised through FTSU Service. They do not constitute an assessment of divisional culture or performance.

Interpretation
Higher reporting can reflect underlying concerns, greater awareness of FTSU, or greater confidence in speaking up.

Future iterations of FTSU heat mapping will triangulate with Staff Survey, ER data, safety and local leadership intelligence.

Signals to explore

1. **MedCard** — Significant increase in the number of concerns relating to patient safety and patient experience in Q2
2. **CWDT** — Largest concentration of concerns with a theme of management conduct
3. **Research & Development** — 5 cases, all involving management conduct. The high rate is based on a small workforce and should be interpreted cautiously

**Staff denominators are based on workforce figures recorded in the 2025 NHS Staff Survey. Rates are indicative and should be interpreted alongside case numbers and other workforce intelligence.*

Freedom to Speak Up – 2026/27 YTD
Activity Heat Map: Epsom & St Helier University Hospitals NHS Trust

51 total concerns
Four case not attributable to a stated area

7.1 cases per 1,000 staff
51 mapped cases across 7,188 staff

13 largest concentration
Medicine Division

Division	Staff*	Number of Concerns	Concerns Per 1,000	Management Conduct	Bullying & Harassment	Discriminat-ion	Detriment	Patient safety	Worker Safety
Medicine	1,465	**13** Q1: 7; Q2: 6	8.9	6	6	4	3	3	1
Women's & Children's	904	**11** Q1: 6; Q2: 5	12.2	4	3	4	1	0	3
Surrey Downs Health & Care	618	**6** Q1: 3; Q2: 3	9.7	3	4	3	2	1	1
Renal	322	**5** Q1: 1; Q2: 4	15.5	2	0	0	1	0	0
Planned Care	1,240	**5** Q1: 1; Q2: 4	4.0	2	2	2	0	0	2
Cancer and Clinical Services	817	**4** Q1: 2; Q2: 2	4.9	3	0	2	0	0	0
Sutton Health & Care	435	**4** Q1: 2; Q2: 2	9.2	2	2	2	1	1	0
Corporate Services	1,095	**2** Q1: 0; Q2: 2	1.8	1	1	1	1	1	0
SWLEOC	292	**1** Q1: 1; Q2: 0	3.4	1	0	1	0	0	1

Interpretation

Higher reporting can reflect underlying concerns, greater awareness of FTSU, or greater confidence in speaking up.

Future iterations of FTSU heat mapping will triangulate with Staff Survey, ER data, safety and local leadership intelligence.

Signals to explore

1. **Medicine Division** — Strongest combined signal: 13 concerns YTD, with recurrent themes of management, bullying, patient safety, discrimination and detriment
2. **Women's & Children's** — 11 cases and the second highest rate of concerns per 1,000 staff (12.2).

**Staff denominators are based on workforce figures recorded in the 2025 NHS Staff Survey. Rates are indicative and should be interpreted alongside case numbers and other workforce intelligence.*