St George's University Hospitals
NHS Foundation Trust

Council of Governors

Agenda

Meeting in Public on Wednesday, 30 September 2026, 13:45 – 15:45

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

Feedback from Governor visits					
Time	**Item**	**Title**	**Presenter**	**Purpose**	**Format**
13:45	-	Feedback from visits to various parts of the site	Governors	Note	Verbal
	-	Feedback on governor community engagement	Governors	Note	Verbal

1.0 Introductory items					
Time	**Item**	**Title**	**Presenter**	**Purpose**	**Format**
14:00	1.1	Welcome and Apologies	Chair	Note	Verbal
	1.2	Declarations of Interest	All	Note	Verbal
	1.3	Minutes of previous meeting	All	Approve	Verbal
	1.4	Action Log and Matters Arising	All	Note	Verbal

2.0 TRUST UPDATES					
Time	**Item**	**Title**	**Presenter**	**Purpose**	**Format**
14:05	2.1	Group Chief Executive's Report	GCEO	Update	Report
14:20	2.2	Finance Report	Chair / GCFO	Update	Report
14:35	2.3	Performance Report	Leonie Penna / Andrew Murray / MD-SGUH	Update	Report
14:55	2.4	Equality, Diversity and Inclusion Report (WRES and WDES)	Yin Jones	Update	Report
15:15	2.5	Health Bill Update	GCCAO	Update	Report

3.0 Council of Governors: Governance and Membership					
Time	**Item**	**Title**	**Presenter**	**Purpose**	**Format**
15:30	3.1	Report from the Membership Engagement Committee (to include update on Membership Engagement activity)	Jackie Parker	Note	Report

4.0 Closing Items					
Time	**Item**	**Title**	**Presenter**	**Purpose**	**Format**
15:40	4.1	Any Other Business	All	Note	Verbal
	4.2	Reflections on Meeting	All	Note	Report
15:45	-	CLOSE			

St George's University Hospitals
NHS Foundation Trust

Council of Governors Purpose	The general duty of the Council of Governors and of each Governor individually, is to act with a view to promoting the success of the Trust so as to maximise the benefits for the members of the Trust as a whole and for the public.

Membership and Attendees		
Members	**Designation**	**Abbreviation**
Mark Lowcock	Trust Chair	Chair
Sophia Agha	Associate Governor (Young Members)	SA
Nasir Akhtar	Public Governor, Merton	NA
Afzal Ashraf	Public Governor, Wandsworth	AAs
Alfredo Benedicto	Appointed Governor, Merton Healthwatch	AB1
Ashok Bhat	Public Governor, Rest of England	AB2
James Bourlet	Public Governor, Rest of England	JB
Luisa Brown	Public Governor, Merton	LB
Jane Curley	Public Governor, Wandsworth	JC
Munir Dean	Public Governor, Rest of England	MD
Michelle Ellis	City St George's University of London	MA
Xavier Fernandes	Public Governor, Rest of England	XF
Dympna Foran	Staff Governor, Nursing and Midwifery	DF
Sarah Forester	Appointed Governor, Healthwatch Wandsworth	SF
Judith Gasser	Appointed Governor, Wandsworth Council	JG
John Hallmark	Public Governor, Wandsworth	JH1
Khalid Khan	Staff Governor, Non-Clinical	HS
Hann Latuff	Public Governor, Merton	HL
Lucy Mowatt	Public Governor, Wandsworth	LM
Ifeanyi Nwike	Public Governor, SW Lambeth	IF
Augustine Odiadi	Public Governor, Wandsworth	AO
Jackie Parker	Public Governor, Wandsworth	JP
Abul Siddiky	Staff Governor, Medical and Dental	AS
Georgina Sims	Appointed Governor, Kingston University	GS
Shuile Syeda	Appointed Governor, Merton Council	SS
In Attendance		
Natalie Armstrong	Non-Executive Director	NA
Matthew Shaw	Group Chief Executive Officer	GCEO
Pankaj Davé	Non-Executive Director	PD
Stephen Jones	Group Chief Corporate Affairs Officer	GCCAO
Yin Jones	Non-Executive Director	YJ
Khadir Meer	Associate Non-Executive Director	KM
Azara Mukhtar	Group Chief Finance Officer	AMr
Andrew Murray	Non-Executive Director	AMy
Leonie Penna	Non-Executive Director	LP
Kate Slemeck	Site Chief Executive Officer – SGUH	SCEO-SGUH
Claire Sunderland Hay	Associate Non-Executive Director	CSH
Apologies		
Bidesh Sarkar	Non-Executive Director	BS

Governors' Visit Report

Visit date: 19 August
Governors attending: Michelle Ellis, Dympna Foran and Augustine Odiadi
Areas visited: Dalby Ward, Caesar Hawkins Ward and Amyand Ward

The Governors visited three wards providing care for older, frail, acute medical and specialist patients. Staff were open, constructive and clear about the strengths of their services and the pressures affecting patient care.

The strongest recurring issue was delayed discharge. This was raised in all areas and appears to be driven largely by factors outside the immediate control of ward staff, including social care capacity, specialist services, suitable housing, local authority processes, property deep-cleaning arrangements and community support. The consequences are significant: reduced patient flow, longer lengths of stay, increased pressure on other wards, longer waits in the Emergency Department, corridor care, infection risk, deterioration in patient resilience and increased cost to the wider health and care system.

Governors were also concerned that bed closures and capacity reductions introduced for cost-saving reasons may create hidden downstream costs. Savings made within one ward may be offset by pressures elsewhere in the hospital, particularly where reduced capacity contributes to Emergency Department delays, outliers on other wards, avoidable boarding and longer stays.

Dalby Ward

The visit to Dalby Ward was led by **Farisha, Head of Nursing**. Dalby Ward is an inpatient unit specialising in senior and older people's healthcare. It has six bays, each with three beds.

Staff spoke positively about the patients' and relatives' room and the entertainment materials provided through charitable support. Volunteers are sometimes available to support use of this room. Governors considered this a positive contribution to patient and family experience.

The main concern was delayed discharge. Governors were told that discharge delays can affect between one-third and, at times, a much higher proportion of the ward's patients. At the time of the visit, around four patients were awaiting discharge. The main causes were the time taken for social services and specialist services to assume responsibility for patients who were medically ready to leave hospital.

Governors also heard that charities help mitigate some of the impact. In particular, the Wandsworth-based charity **RISE+** supports older people through activities such as luncheon clubs and other community-based provision.

The ward's normal capacity of 22 patients had been reduced to 18 for cost reasons. Governors recognised the immediate cost-saving rationale, but felt further assurance was needed on whether those savings are outweighed by costs transferred elsewhere, including longer stays, pressure on other wards, infection risk, Emergency Department waits and corridor care.

Caesar Hawkins Ward

The visit to Caesar Hawkins Ward was led by **Jenni, Head Nurse**, and **Cynthia, Ward Manager**. Caesar Hawkins is a medical short-stay ward in the Lanesborough Wing. It manages acute medical conditions rather than cases requiring surgical intervention. Many patients come from Richmond Ward.

The ward has 23 beds. On the day of the visit, Governors were told that 27 patients required beds. A Covid outbreak was one factor adding to pressure. Governors were also told that there were four outliers on other wards because of difficulties with timely discharge.

Delayed discharge was again a major issue. Five homeless patients with complex care needs presented challenges, as safe discharge options can be limited. Staff indicated that in some cases discharge can take up to eight weeks. This creates prolonged bed blocking, additional cost, increased infection risk and potential decline in mental resilience and independence.

A specific cause of delay was the time required to arrange deep cleaning of properties, often belonging to vulnerable people. Governors were told that local councils normally require three quotations before cleaning can be approved and carried out. While this may be appropriate for procurement assurance, it can cause avoidable delay when a medically fit patient is waiting to return home, adding cost to the public purse.

The ward environment also raised concerns. Caesar Hawkins was very hot. Governors were told that side rooms had no air conditioning because of electrical overload in the hospital. This is particularly concerning for clinically vulnerable patients, including those with respiratory problems.

Staff also raised the lack of a visitors' room. There is no suitable space for families to take a break or for staff to hold sensitive conversations, including the delivery of bad news. Governors considered this an important patient and family experience issue.

Amyand Ward

Amyand Ward is a short-stay medical ward for patients aged from 18 to over 100. It is not solely a senior care ward. It also accommodates patients with lymphoedema and rheumatology conditions requiring inpatient management. The ward includes a day unit, but Governors were told there is no day room for patients and no doctors' room. Both were identified as needed facilities.

Partial ward closures have reduced capacity from 32 to 16 beds as a cost-saving measure. Staff reported that this has affected length of stay. This was consistent with the wider concern that bed closures may increase pressure elsewhere in the hospital, including the Emergency Department and corridor care.

Staff also raised concerns about insufficient IT provision. The desk area is due to be refurbished in September, but staff will need to maintain normal ward functioning during the work. There is no room for additional WOW machines, limiting options to improve IT access within the existing space. Governors considered this important because IT access, workspace and clinical facilities affect efficiency, communication, staff workload and patient care.

Main themes

The visit highlighted five linked themes. First, delayed discharge is a system-wide problem being managed at ward level. Ward staff are dealing with the consequences, but many causes lie outside their direct control.

Second, bed closures and capacity reductions may not represent genuine savings if they lead to longer stays, increased Emergency Department pressure, corridor care, outliers, infection risk and deterioration in patient wellbeing.

Third, ward environment matters. Lack of family space, excessive heat, no air conditioning in side rooms, no patient day room and no doctors' room all affect dignity, communication, safety and staff effectiveness.

Fourth, IT and workspace constraints have direct operational consequences. Amyand Ward's limited space for WOW machines and the forthcoming refurbishment require careful management to avoid further disruption.

Fifth, voluntary and community organisations make an important contribution. RISE+ and similar organisations may help reduce some discharge pressures, but this support needs to be better understood and, where possible, strengthened.

Recommendations and areas for assurance

The Governors suggest the following areas for further consideration.

1. **Research into the true cost of capacity reductions**. The Trust should consider commissioning or supporting research into the downstream and unintended costs of reducing ward capacity. This should include Emergency Department length of stay, corridor care, outliers, boarding, infection risk, discharge delay, staff workload and patient deterioration. This may be a suitable project for St George's University.
2. **Deep-cleaning and local authority discharge delays**. Local authority-nominated Governors may wish to explore whether councils could replace or supplement the requirement for three separate quotations with a tendered or framework-based process. This could allow urgent fixed-price cleaning to be arranged more quickly while preserving proper procurement safeguards.
3. **Support for RISE+ and similar organisations**. Community-based Governors may wish to consider whether they can support RISE+ and similar organisations through fundraising, volunteer recruitment or community links.
4. **Ward environment and facilities**. The Trust should review whether suitable family, patient and staff spaces can be provided on Caesar Hawkins and Amyand Wards. This should include the lack of a visitors' room, day room and doctors' room, as well as the impact of excessive heat and lack of air conditioning in side rooms.
5. **IT and workspace constraints**. The Trust should consider whether Amyand Ward's IT provision is adequate and whether there are alternative ways to improve digital access where physical space prevents additional WOW machines. The September desk refurbishment should include a plan to minimise disruption to staff and patient care.

Conclusion

The Governors were impressed by the openness and commitment of ward staff, who are working under significant operational pressure. The visit also highlighted good practice, including the patients' and relatives' room on Dalby Ward and the contribution of charitable support.

However, the visit raised important issues requiring further assurance. Delayed discharge is affecting patients, staff, bed availability, the Emergency Department and overall cost. Capacity reductions may be creating unintended consequences across the hospital. Environmental and facilities issues, including heat, lack of air conditioning, lack of suitable family space, lack of patient day space and insufficient IT provision, also affect patient care and staff effectiveness.

The Governors therefore recommend that the Trust considers the wider costs of capacity reduction, the systemic causes of delayed discharge, ward environmental conditions, IT and workspace constraints and opportunities for closer collaboration with local authorities, universities and community organisations.

Community feedback

This report sets out the feedback given to governors from Merton and Wandsworth residents and from discussions at Meet your Governor events. There is specific feedback below, but there are clearly issues that are emerging each time governors engage with patients. However, despite this most patients are happy with the care they receive and many praise the dedication and professionalism of staff.

The common themes across these concerns are **communication, accessibility, appointment management and continuity of care**. Patients want clear, accurate and timely information and need to be able to access that information in a way that works for them.

There is particular concern about the increasing reliance on digital systems and the potential for this to disadvantage patients who might be older, less digitally confident or unable to access online platforms. Ensuring that paper and non-digital alternatives remain readily available, alongside improving the reliability of appointment information, PALS responses, booking services and hospital navigation, could significantly improve the patient experience.

The feedback regarding routine appointments being moved by six months or, in some cases, up to a year also warrants further understanding. In particular, it would be helpful to establish the reasons for these changes, how patients are informed, whether clinical risk is considered when appointments are rescheduled, and what safety-netting or alternative contact arrangements are provided to patients whose routine follow-up has been significantly delayed.

Community Feedback from Merton residents

Feedback from members of the local community has highlighted largely positive feedback on the care received at St Georges:

- The Colonoscopy Service was described as “exceptionally smooth” with the procedure seen to be thorough and professional and discharge from the ward seamless. The staff were caring, considerate and reassuring throughout. An excellent service from start to finish.
- A&E was praised, with all tests being done rapidly and professionally. The patient was checked on regularly and given good information and follow up care.
- Cardiac Care was praised for the excellent care given “but what stood out was the kindness, compassion and professionalism.” “I came away feeling extremely fortunate to have been admitted to St George’s. My experience was of a hospital that genuinely puts its patients first and combines outstanding professional care with humanity and compassion”. This patient sent heartfelt thanks to the staff who cared for him at a difficult time.
- Renal Unit was described as outstanding “the dedication, compassion and professionalism of the doctors and nurses is truly remarkable. However, this patient had had a poor experience in the Urology department.
- Eye clinic (Moorfields) was described as excellent (in and out within 2 hours as opposed to the predicted 4+ hours).
- The Respiratory and Oncology departments were described as very cramped units on the ground floor, directly opposite each other and the patient felt that respiratory care does not receive the importance or resources it deserves, despite supporting patients with serious, complex and often lifelong conditions.

There are however several recurring concerns regarding communication, appointment systems, accessibility and continuity of care at St George's Hospital. While some patients report positive experiences with individual staff members, there are several themes where improvements appear to be needed.

1. PALS – response times and communication

There are concerns regarding the timeliness of responses from PALS. Patients report having to make repeated contact to obtain a response or progress an issue, with some experiencing poor communication and a lack of follow-up. This can leave patients feeling frustrated, particularly when they are already trying to resolve a concern or obtain support from the hospital.

2. Appointment letters and incorrect information

Patients have raised concerns about appointment correspondence containing incorrect or inconsistent information, particularly regarding the location of appointments. There are also reports of repeated letters being sent advising that an appointment date or time has changed, only for the replacement appointment details to be exactly the same as those previously provided.

This appears to indicate potential system or administrative errors and creates unnecessary confusion for patients. It also results in avoidable use of paper, postage and staff time.

3. Routine appointments being significantly rescheduled

Community feedback has also highlighted concerns about patients having routine follow-up or regular check-up appointments rescheduled significantly further into the future. In some reported cases, appointments have been moved by a further six months and, in some instances, by as much as a year.

The feedback raises questions about the reasons for these significant changes and whether patients are being given sufficient information about why their appointment has been moved and what this means for their ongoing care.

Where a patient has been routinely monitored by a service, a substantial extension to the interval between appointments may cause uncertainty and concern, particularly if the patient does not understand why the change has occurred or whether their clinical circumstances have been taken into consideration.

There is therefore a need for clear communication when routine appointments are rescheduled for substantially later dates. Patients should be provided with an explanation for the change where appropriate, reassurance about the arrangements for their ongoing care, and clear information about who to contact if they have concerns about waiting for their review or if their condition changes.

It would also be useful to understand whether these rescheduled appointments reflect planned changes to clinical follow-up intervals, capacity or waiting-list pressures, or administrative/system issues, as the underlying reason may have implications for patient experience and confidence in the continuity of their care.

4. Central Booking Line

Experiences of the Central Booking Line appear to be inconsistent. Some patients have reported very helpful and supportive staff who have assisted effectively with changing appointments. However, there is also significant negative feedback about other experiences, including difficulties obtaining the required assistance and poor communication. This

inconsistency is contributing to frustration among patients trying to manage their appointments.

5. Digital appointment letters and accessibility for older patients

The increasing use of digital platforms and portals for appointment letters is creating difficulties for some patients, particularly older people who may not have the confidence, ability or access required to use these systems.

Patients have reported specifically requesting paper appointment letters but continuing to receive text messages directing them to an online portal instead. For those unable to access or navigate the portal, this creates a significant barrier and could potentially result in appointments being missed.

There is a concern that digital communication should not replace accessible alternatives for patients who are unable to use digital systems.

6. Hospital map/app and poor connectivity

The hospital map application is another area where the community has identified difficulties. Although the app has the potential to help patients navigate the hospital, poor mobile signal/connectivity within the hospital can prevent people from accessing or using it effectively.

This can be particularly problematic for patients who are unfamiliar with the hospital or attending for the first time. Difficulties finding departments can result in additional anxiety, frustration and patients potentially arriving late for appointments.

Community Feedback from Wandsworth residents and from two Meet your Governor events, both held in Grosvenor Wing, St George's.

Generally, care received at St George's was again seen as mostly very good, for example A and E gives excellent care (but again there were reports about cleanliness of the department at times). Fracture clinic was praised as staff there were said to 'go the extra mile', with similar views about Atkinson Morely Neurology, Moorfields and Cancer clinics.

Other issues that came up include;

- Poor feedback from some patients on hospital food, and especially for diabetic patients who felt what they were offered was not particularly healthy e.g. Toast with non-diabetic jam.
- There are problems with the availability of wheelchairs at reception. Governors were told there were only 21 available with 40 more waiting to be mended. This caused a stressful situation for a patient with poor mobility as it caused him to be late for his appointment.
- There was very positive feedback on the maternity services, but one patient who had to use both hospitals commented how different the technology is between Epsom and St Georges is, with Epsom being on an App and St Georges on paper. This had led to the patient nearly missing an appointment at St Georges.
- One patient (who was very positive about his own hospital stays) reported being called in to say goodbye to his wife who was dying but when he reached St George's at 6am there was no one who could tell him where to go to see her and he got there too late. He was haunted by the experience which had happened around 4 years ago, and he acknowledged it could have been due to Covid.
- Paediatric blood testing – a family with a 9-week-old baby at the weekend had to wait several hours for a blood test which got lost and had to be repeated. Staff said this

was not uncommon and they had been advised to hand deliver to the lab rather than use the pod system, often impossible due to staffing constraints.

- The lack of accessibility to the shower in Vernon ward was raised again.
- Good support from the McMillan teams noted.
- Two issues with children in outpatients- difficulties in the provision for children with SEN and in ENT no provision for children.
- Muslim funeral preparations- an issue was raised on the timing of the release of the deceased to allow for religious traditions – greater awareness of these religious requirements (and the same is also true of other religions) and timely release where circumstances allow, would be gratefully appreciated.
- Transport was reported at times to be poor. Patients reported some long waits (2 hours plus) for transport.
- Appointments sometimes cancelled at the last minute and then patients report being on hold for over an hour to rebook an appointment, one man was told he was 70th in the queue to speak to someone. Patients reported having to chase up follow up appointments themselves, rather than receiving timely communication about the next stage in their care.

NHS
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Minutes of the Meeting of the Council of Governors (In Public)
Thursday 25 June 2026
Via MS Teams

Membership and Attendees		
Members	**Designation**	**Abbreviation**
Mark Lowcock	Trust Chair	Chair
Sophia Agha	Associate Governor (Young Members)	SA
Nasir Akhtar	Public Governor, Merton	NAk
Afzal Ashraf	Public Governor, Wandsworth	AAs
Alfredo Benedicto	Appointed Governor, Merton Healthwatch	AB1
Ashok Bhat	Public Governor, Rest of England	AB2
James Bourlet	Public Governor, Rest of England	JB
Luisa Brown	Public Governor, Merton	LB
Jane Curley	Public Governor, Wandsworth	JC
Munir Dean	Public Governor, Rest of England	MD
Michelle Ellis	Appointed Governor, City St George's University	ME
Xavier Fernandes	Public Governor, Rest of England	XF
Dympna Foran	Staff Governor, Nursing and Midwifery	DF
Sarah Forester	Appointed Governor, Healthwatch Wandsworth	SF
Judith Gasser	Appointed Governor, Wandsworth Council	JG
John Hallmark	Public Governor, Wandsworth	JH1
Khalid Khan	Staff Governor, Non-Clinical	KK
Hann Latuff	Public Governor, Merton	HL
Ifeanyi Nwike	Public Governor, SW Lambeth	IF
Augustine Odiadi	Public Governor, Wandsworth	AO
Jackie Parker	Public Governor, Wandsworth	JP
Abul Siddiky	Staff Governor, Medical and Dental	AS
Georgina Sims	Appointed Governor, Kingston University	GS
Shuile Syeda	Appointed Governor, Merton Council	SS
In Attendance		
Matthew Shaw	Group Chief Executive Officer	GCEO
Lizzie Alabaster	Interim Group Chief Finance Officer	IGCFO
Natalie Armstrong	Non-Executive Director	NAr
Pankaj Davé	Non-Executive Director	PD
Wendy Doyle	Group Head of Patient Experience (item 2.3)	GHPE
Stephen Jones	Group Chief Corporate Affairs Officer	GCCAO
Leonie Penna	Non-Executive Director	LP
Kate Slemeck	Managing Director - SGUH	MD-SGUH
Victoria Smith	Group Chief People Officer	GCPO
Claire Sunderland Hay	Associate Non-Executive Director	CSH
Stephanie Sweeney	Group Director of Quality and Safety Governance	GDQSG
Apologies		
Andrew Murray	Non-Executive Director	AM
Yin Jones	Non-Executive Director	YJ

Feedback from Governor Engagement

Governor Feedback from Visits

The Council received feedback from Governor visits undertaken on 5 May 2026, covering Surgical and Site Services, and on 10 June 2026, covering a range of Outpatient services. The Chair thanked Governors for the detailed reports, which were taken as read to allow discussion to focus on the principal themes arising.

The Managing Director – St George's (MD-SGUH) highlighted recurring issues including Critical Care Outreach capacity and psychology support; patient transport; PALS; outpatient administration and appointment management; estates and facilities; and pressures within the Emergency Department. She outlined work already underway, including review of Critical Care Outreach provision, a new patient

transport contract, the PALS improvement programme and the wider Outpatient Transformation Programme, including partial booking and work to reduce Did Not Attend rates.

The GCEO observed that many of the issues identified through Governor visits reflected wider organisational challenges rather than isolated operational problems. Digital infrastructure, estates, staff experience and corporate services required longer-term improvement, while specific examples raised by Governors remained valuable in identifying where systems were not working as intended.

Governors sought clarification on a number of issues arising from the visits, including implementation of Martha's Rule in paediatric and maternity services; ambulance handover delays; the practical advice Governors should give to patients experiencing outpatient appointment difficulties; concerns about ward-based nursing capability; and training arrangements for Foundation Year doctors undertaking night duties. The MD-SGUH and GCEO responded to the issues raised and agreed that specific matters requiring further follow-up would be taken forward with the relevant teams.

Sarah Forester proposed that an interested group of Governors meet with the leads for the Outpatient Transformation Programme to explore the programme in greater depth, including how patient experience was informing service redesign. The MD-SGUH welcomed this proposal, with a wider update to be brought back subsequently to the Council.

Governors also returned to the issue of the accessible shower on Marnham Ward and questioned whether facilities required for basic patient care should depend on charitable funding. The GCEO acknowledged the concern and highlighted the difficult choices arising from the scale of backlog maintenance compared with the capital available. He suggested that Governors should have greater visibility of the capital prioritisation process and the schemes which could not currently be funded.

Governors reflected that many of the issues identified through visits were also evident in other sources of intelligence, including patient feedback, the Staff Survey and performance reports. Afzal Ashraf emphasised the importance of considering these as cross-cutting organisational issues where appropriate. The GCEO agreed that the Board needed to focus on the wider programmes of change required to address underlying causes, while the Chair emphasised that Governors should continue to bring forward specific examples which could identify practical improvements.

The Council noted the feedback from the Governor visits and the responses provided. It was agreed that the existing actions relating to PALS/complaints and Outpatient Transformation would remain open, with the latter to include an opportunity for an interested group of Governors to meet with the Outpatient Transformation leads in advance of a wider Council update.

Action: A future Council discussion to be arranged later in the year on capital programme prioritisation, including the choices being made within available capital resources and the implications for schemes which could not currently be funded.

Community Engagement Feedback

The Council received the report of feedback gathered by Governors through their community engagement. The feedback was strongly positive about the quality and compassion of clinical care, while identifying recurring concerns in areas including outpatient administration and communication, the patient experience within the Emergency Department, estates and facilities, digital and IT reliability, service navigation and the responsiveness of PALS. These themes substantially reflected those already discussed through the Governor visit reports.

The Chair invited Jackie Parker to identify any significant matters from the community feedback which had not already been covered. She considered that the principal themes had been addressed during the preceding discussion. The MD-SGUH agreed to review the specific examples contained within the feedback with the relevant teams.

The Council noted the community engagement feedback and thanked Governors for continuing to bring the experience of patients, members and local communities into the work of the Council.

DRAFT

1.0	**OPENING ADMINISTRATION**
1.1	**Welcome and Apologies**
	Following conclusion of the Governor feedback session, the Chair formally opened the public meeting and welcomed Governors, Non-Executive Directors, Executive colleagues and other attendees. The Chair noted that the meeting was being held virtually rather than in person as a result of the business continuity incident associated with the exceptionally high temperatures during the current heatwave. Staff who were able to work from home had been asked to do so and the Hyde Park Room, where the Council would ordinarily have met, had been made available as a cooler working space for staff. The Chair welcomed Matthew Shaw to his first formal meeting of the Council of Governors as substantive Group Chief Executive Officer and Michelle Ellis, attending her first meeting as the newly appointed Governor representing City St George's University. Apologies for absence were recorded as set out above.
1.2	**Declarations of Interest**
	No new declarations of interest were made.
1.3	**Minutes of the previous meeting**
	The minutes of the public meeting held on 25 March 2026 were approved as a true and accurate record.
1.4	**Action Log and Matters Arising**
	The Council reviewed the outstanding actions. The action relating to PALS and complaints was agreed to remain open. Governors noted that the Patient Experience Report on the agenda did not provide the substantive update previously requested. A further update would therefore be scheduled later in the year, with December suggested to allow time for the current improvement work to progress. The action relating to winter staffing and staff wellbeing initiatives would also remain open pending circulation of the information previously requested. The MD-SGUH provided a brief verbal update on the support provided during the previous winter. The Council noted the remaining actions and that a number of substantive items were due to return later in the year. The Chair advised that the September agenda would need to be prioritised, with some items potentially deferred to December.
2.0	**Trust Updates**
2.1	**Group Chief Executive Officer's Report**
	The Group Chief Executive Officer (GCEO) presented his first report to the Council since taking up post in April 2026. Reflecting on his first ten weeks, he identified organisational culture, quality and operational pressures within maternity and emergency care, and financial sustainability as his principal areas of focus. The GCEO highlighted continuing pressure within the lung cancer pathway and the Emergency Department, including the impact of increasing numbers of patients requiring mental health care. He also emphasised the importance of protecting staff from violence and aggression. In relation to estates, discussions were continuing with the New Hospital Programme about the proposed renal development and wider capital requirements. The GCEO updated Governors on the proposed merger with Epsom and St Helier, confirming that the planning assumption had moved to April 2028. A work programme was being developed with the Board covering merger preparation, transformation, culture and changes to the operating model while maintaining safe and effective day-to-day services. Turning to organisational culture, the GCEO described the 2025 Staff Survey results as particularly disappointing. Improving staff experience would be a major priority, with a focus on strengthening leadership capability; expectations around behaviours, civility and psychological safety; equality,

	diversity and inclusion; and staff recognition. He also considered that the People function required greater capacity to support the scale of improvement needed. Governors welcomed the GCEO's focus on culture but emphasised that similar concerns had been raised over a number of years. Alfredo Benedicto stressed the need to demonstrate whether cultural interventions were delivering measurable improvement and highlighted the central importance of leadership. The GCEO agreed, describing the organisation as too reactive in some areas and emphasising the need for stronger line management, clearer expectations of behaviour and earlier resolution of concerns. Governors questioned the revised merger timetable and sought assurance that merger was not being treated as a predetermined outcome. The GCEO explained that April 2028 had been adopted as the planning assumption following discussion with NHS England, but emphasised that merger remained subject to the required approval processes and further development of the case. He also highlighted the opportunities to share good practice and strengthen services across the Group. Governors discussed equality, diversity and inclusion, including the relationship between diversity and merit in recent senior appointments. The GCEO confirmed that successful candidates had been appointed on merit following competitive processes, while stressing the need to address barriers within recruitment and progression. Governors also raised the importance of digital capability, with the GCEO recognising the impact of poor digital infrastructure on both productivity and staff experience. Governors reflected on the relationship between culture, staff voice and organisational assurance, including the risk that problems might not be visible at Board level where staff did not feel able to raise concerns. The GCEO agreed that effective line management, regular team conversations and stronger relationships between managers and staff were essential to creating an environment in which issues could be identified and addressed earlier. The Council also discussed the implications of the recently published Ockenden report on maternity services at Nottingham. The GCEO emphasised that the organisation should not assume that the cultural and safety issues identified nationally could not occur locally, and the Group Chief Medical Officer confirmed that the recommendations were already being reviewed against existing maternity improvement work. **The Council noted the Group Chief Executive Officer's Report and welcomed the GCEO's focus on organisational culture, leadership, staff experience and the wider transformation required across the Group.**
2.2	**NHS Staff Survey results, themes and actions**
	The Group Chief People Officer (GCPO) presented the 2025 NHS Staff Survey results and the proposed organisational response. Staff engagement had remained stable and slightly above the national average, but performance had declined across the other People Promise measures and morale, with St George's ranked 17th of 17 London acute and community providers on the composite comparison used in the report. The GCPO highlighted significant variation between services and confirmed that targeted support was being focused on lower-performing teams and those with low survey response rates. Governors questioned what would constitute adequate improvement. The GCPO did not propose a specific league-table target, but considered that the objective should be sustained year-on-year improvement from the current baseline. Governors sought assurance that the findings relating to discrimination and reasonable adjustments were being treated as legal and workforce risks as well as equality issues. The GCPO confirmed that these were significant organisational concerns. Additional capacity had been introduced to support reasonable adjustments, alongside work to improve recruitment practices, line-management capability and staff experience. The Council discussed low response rates and local accountability for improvement. The GCPO agreed that low participation could itself indicate disengagement and confirmed that such teams would be included within the targeted support programme. Greater emphasis was also being

	placed on local leaders owning and delivering Staff Survey action plans, rather than regarding the Survey as primarily an HR responsibility. Governors asked how workforce information was being triangulated with quality and patient experience. The MD-SGUH advised that service and ward-level heatmaps increasingly brought together workforce, quality and operational indicators to identify areas requiring intervention. The importance of effective line management was emphasised, together with the need to strengthen accountability for staff experience. Governors also discussed lower participation among medical staff and disparities in career progression, particularly for Black, Asian and Minority Ethnic staff. The GCPO advised that work was underway to strengthen recruitment practices, career conversations and succession planning, and agreed that medical colleagues should be encouraged to participate in the Survey on the same basis as other staff groups. The GCPO also outlined the formal grievance process and the alternative routes available for staff to raise concerns, including Freedom to Speak Up. She acknowledged that delays in grievance processes remained a challenge. **The Council noted the 2025 Staff Survey results and the planned response, including the focus on strengthening local leadership accountability, targeted support for lower-performing and low-response teams, improving equality of staff experience and achieving sustained improvement from the current baseline.**
2.3	**Patient Experience Report**
	The Group Head of Patient Experience (GHPE) presented the bi-annual Patient Experience Report covering April to September 2025. She highlighted progress in patient involvement and co-design, support for unpaid carers, the Armed Forces programme and accessibility, while acknowledging that the reporting period was now out of date. Governors welcomed the emphasis on co-design and asked how this could be embedded more consistently across services. The GHPE advised that work was underway to strengthen patient involvement in service change and transformation, including through revised governance arrangements and staff training. Governors questioned whether the existing reporting cycle provided sufficiently timely assurance. The GHPE agreed that it did not and confirmed that patient experience reporting would move to a quarterly cycle. She also accepted that future reports should better reflect the potential financial consequences of failing to meet statutory patient experience requirements and should strengthen the triangulation of patient experience with complaints, PALS, survey data and staff experience. The GHPE identified implementation of the Accessible Information Standard and Reasonable Adjustments Digital Flag as the most immediate priority. St George's had not yet achieved full compliance with the Accessible Information Standard, and the intention was to have the necessary local processes in place by September 2026. Improved patient experience data and further embedding of co-design were also identified as priorities. Governors also discussed how unpaid carers were identified and supported. The GHPE advised that alternative approaches were being developed beyond outpatient check-in, including through pre-assessment, ward-based identification and other patient-contact points. She reported substantial growth in the number of carers being identified. The Council welcomed proposals to share the Patient Experience newsletter more widely with Foundation Trust members and to increase Governor involvement in patient forums and engagement groups. **The Council noted the Patient Experience Report, including the move to quarterly reporting and the priority being given to accessibility, improved triangulation of patient experience intelligence and greater use of co-design.**
2.4	**Operational Activity Report**

	The Managing Director – St George's (MD-SGUH) presented the Operational Activity Report, highlighting continued progress in elective and cancer performance alongside significant pressures within urgent and emergency care. A particular concern was the increasing number of patients presenting to the Emergency Department with mental health needs. At times, between 10 and 15 patients requiring mental health care had been within the department, occupying a substantial proportion of the majors area. This created an unsuitable environment for those patients and additional pressure on the care of patients with physical health needs. Work was underway with mental health partners on short-, medium- and longer-term solutions, including consideration of alternative models of care and additional specialist capacity. The MD-SGUH also highlighted the increasing national focus on corridor care, which included patients spending more than 45 minutes receiving care in an Emergency Department corridor and those boarding on wards. Reducing corridor care remained a significant priority, supported by work to expand Same Day Emergency Care, virtual wards and frailty pathways, and to improve patient flow and discharge. Governors asked that future reporting provide greater insight into the impact of corridor care on patient dignity and safety, particularly for older and vulnerable patients, rather than focusing solely on the number of patients affected. Sarah Forester also distinguished between corridor care within the Emergency Department and boarding on wards, noting that these could have different implications for patients. The MD-SGUH confirmed that the two were monitored separately operationally and agreed that reporting should better reflect the impact on dignity and vulnerability. Governors welcomed the real-time oversight of patient flow provided through the Trust's capacity management arrangements. The MD-SGUH explained that these enabled teams to identify bottlenecks across the hospital and monitor flow and discharge throughout the day, supporting operational decision-making. Cancer performance remained mixed. The Trust was achieving the Faster Diagnosis Standard, with the report recording performance of 81.5%, while performance against the 62-day standard remained below target at 72.4%. Particular pressure remained within the lung cancer pathway because of high referral volumes and thoracic capacity constraints. Work continued both locally and with system partners to improve performance. Diagnostic performance also remained challenging in a number of areas. Plans were in place to address waits in cardiac diagnostics and endoscopy, while non-obstetric ultrasound was particularly affected by shortages of sonographers. The MD-SGUH noted both the national workforce shortage and recruitment pressures arising from enhanced payments being offered by some neighbouring organisations. Elective recovery continued to improve, with the proportion of patients waiting more than 52 weeks reduced to approximately 0.6%, against a plan of 1%, and 18-week performance improved to approximately 63%. The focus was now on sustaining this improvement without reliance on additional non-recurrent activity and expenditure, with productivity improvements forming part of the longer-term approach. Governors also sought assurance regarding violence and aggression within the Emergency Department. The MD-SGUH confirmed that incidents were formally reported and reviewed for themes and that a range of measures were in place to protect staff. Staff support teams provided direct support following significant incidents, and the Trust took further action where appropriate in response to serious or deliberate abusive behaviour. **The Council noted the Operational Activity Report, welcomed the progress in elective and cancer performance, and recognised the significant continuing pressures within urgent and emergency care, particularly in relation to mental health demand and corridor care.**
2.5	**Health Bill**
	The Group Chief Corporate Affairs Officer (GCCAO) presented a report on the Health Bill 2026 and its potential implications for NHS foundation trusts and Councils of Governors. He highlighted proposals which, if enacted in their current form, would remove the statutory requirement for

	foundation trust membership and Councils of Governors and change aspects of foundation trust accountability. The GCCAO emphasised that the Bill remained at an early stage of its Parliamentary passage and was subject to further scrutiny and amendment. Until the legislation changed, the existing statutory framework remained in force and Council meetings, Governor elections and membership arrangements would continue as currently required. No transitional guidance had at that point been issued suggesting otherwise. Governors discussed the potential implications for their future role. Alfredo Benedicto advised that Governors intended to meet separately to consider the proposals and emphasised that, whatever the eventual statutory arrangements, the experience and knowledge built up through the Council should continue to benefit the Trust. Hann Latuff asked whether the proposed legislation affected the rationale for merger, given the historic distinction between NHS trusts and foundation trusts. The GCCAO advised that, while the statutory distinction remained, the practical differences had reduced considerably and the underlying case for bringing St George's and Epsom and St Helier together was not dependent upon the foundation trust model. Sarah Forester highlighted the proposed changes affecting both Councils of Governors and Healthwatch and asked how meaningful patient and community engagement would be maintained. The Chair and GCCAO agreed that preserving an effective community voice would be essential and that the organisation should begin considering how the experience, diversity and networks currently provided through the Council could inform future arrangements, while awaiting further national guidance. The GCEO added that organisational form was ultimately secondary to providing high-quality care and experience and maintaining sustainable services. The Chair confirmed that the Council would return to the implications of the Health Bill in the autumn, when the position was expected to be clearer. **Action:** Add an update on the NHS Modernisation Bill to the Council of Governors agenda in September 2026. **The Council noted the report and the continuing uncertainty while the Bill progressed through Parliament.**
3.0	**Governance and Membership**
3.1	**Report from the Membership Engagement Committee**
	Jackie Parker, Chair of the Membership Engagement Committee, presented the Committee's report and the proposed Membership Engagement Strategy 2026–2028. She noted that progress with the Committee's work programme had been affected by recent staff changes and sickness, but welcomed the support now being provided by the Communications Team. She highlighted work underway to refresh the Trust's membership webpages, develop a programme of events and talks for members, and make greater use of social media. Particular thanks were recorded to Sophia Agha for her recent social media contribution promoting the Governor role and opportunities for members to become involved. The written report also set out plans to strengthen member communications and engagement, including further Meet Your Governor activity, a programme of membership talks, development of a Governor and Members newsletter and improved use of digital channels. The Strategy proposed a particular focus on improving two-way engagement, increasing the representativeness of the membership and engaging more effectively with younger members and under-represented communities. Jackie Parker noted that overall membership remained at an appropriate level, although significant growth had not been achieved and further work was required to broaden participation. There being no substantive questions, the Chair invited the Council to approve the Strategy. **The Council:**

	• **approved the Membership Engagement Strategy 2026–2028;** • **noted the report of the Membership Engagement Committee; and** • **noted the continuing work to strengthen engagement with members and local communities.**
4.0	**Closing Items**
4.1	**Any Other Business**
	Hann Latuff commented that the agenda had not included the usual finance update and asked why this had been omitted. The GCCAO explained that the agenda had deliberately been kept to a manageable number of substantive items to allow sufficient time for discussion. In addition, the Finance Team had been particularly occupied that week with completion and submission of the annual accounts to NHS England.
4.2	**Council of Governors Calendar of Events**
	The Chair confirmed that the forward calendar of Council of Governors meetings and events had been circulated to Governors.
4.3	**Reflections on Meeting**
	No separate reflections were discussed. The Chair thanked Governors, Executive Directors and colleagues for their contributions and closed the public meeting before the Council reconvened in private.

Date of next Meeting:
30 September 2026, 13:45 – 16:15, Hyde Park Room, St George's Hospital

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Council of Governors (Public) - 30 September 2026

NHS St George's University Hospitals NHS Foundation Trust

Action Log

ACTION REFERENCE	ITEM	ACTION	WHEN	WHO	UPDATE	STATUS
COG.25.06.26/06	Health Bill	Health Bill updates: Add an update on the NHS Modernisation Bill to the September Council of Governors agenda.	30 September 2026	GCCAO	On Agenda	PROPOSED FOR CLOSURE
CoG.10.12.25/06	GCEO Report	The Council requested that WRES and WDES information, including leadership diversity data and progress, be included in a future report to the Council.	30 September 2026	GCPO	On Agenda	PROPOSED FOR CLOSURE
COG.25.03.26/02	Governor Visit Feedback	Guidance for governors on outpatient enquiries - Provide governors with clearer guidance on the appropriate routes for patients experiencing difficulties with outpatient appointments.	30 September 2026	MD-SGUH	Update at Council meeting on 25 June 2026: It was agreed that a small group of Governors be invited to engage with the Outpatient Transformation Programme.	DUE
CoG.10.12.25/02	CQC Well Led Report	The Council requested that the CQC Well Led Action Plan be presented to the Council following review and approval by the Board.	30 September 2026	GCCAO / MD-SGUH	Update: Work to develop the SGUH CQC Well Led response has progressed and an Executive workshop is planned for October to develop a Group-wide Well Led response, following receipt of the Epsom & St Helier Well Led Report in draft in September 2026. An integrated Well Led action plan is in development to respond to both Trusts' Well Led reports, with defined Group-wide improvement actions and Site-specific improvement actions. The current intention is to bring the integrated Well Led Improvement Plan through the Board in November, and this can then be added to the Council agenda for December 2026.	DUE
CoG.24.07.25/02	GCEO Report	AI pilot in Emergency Department: Provide a follow-up update on AI pilot evaluation results and governance safeguards at a future meeting	10 December 2026	GDCEO	Update June 2026: A wider update on digital transformation to be presented to the Council in later in the year. The AI update will be part of this wider update.	NOT YET DUE
COG.25.06.26/01	Governor Visit Feedback	A Council discussion to be arranged for later in the year on capital programme prioritisation, including the choices being made within available capital resources and the implications for schemes which could not currently be funded.	10 December 2026	GCFO		NOT YET DUE
CoG.24.07.25/08	People Report	The Chair suggested inviting the Group Freedom to Speak Up Guardian to a future Council of Governors meeting.	10 December 2026	GCCAO		NOT YET DUE
COG.25.06.26/05	Patient Experience report	Patient Experience – demonstrate improvements from feedback - Future Patient Experience reports to demonstrate how patient feedback and complaints have translated into measurable service improvements.	10 December 2026	GCNO/Patient Experience		NOT YET DUE
CoG.25.03.25/01	5 Year Forward Vision	GCCAO to provide a training session to Governors on the refreshed Board Assurance Framework, once the new BAF has been reviewed and approved by the Board.	10 December 2026	GCCAO	Update: The Board approved the new Group Board Assurance Framework in July 2026. Dates for a Governor development session in October / November are currently being explored, and the BAF item will be included in this.	NOT YET DUE
CoG.10.12.25/03	Operational Activity Update	The Council requested that Outpatient Transformation, including PIFU, be brought back to a future meeting for a more detailed discussion.	25 March 2027	GDCEO / MD-ESTH (as SRO)		NOT YET DUE
COG.25.06.26/04	NHS Staff Survey	NHS Staff Survey Future updates to demonstrate the impact of actions taken in response to staff feedback.	25 March 2027	GCPO		NOT YET DUE
CoG.25.03.25/02	Health Inequalities	GCMO to provide a future update on the development of measures and indicators to assess the impact of the Group's work on health inequalities at a future meeting.	25 March 2027	GCMO		NOT YET DUE

Council of Governors

Meeting in Public on Wednesday, 30 September 2026

Agenda Item	2.1	
Report Title	**Group Chief Executive Officer's Update**	
Executive Lead(s)	Matthew Shaw, Group Chief Executive Officer	
Report Author(s)	Matthew Shaw, Group Chief Executive Officer	
Previously considered by	Group Board	11 September 2026
Purpose	**For Noting**	

Executive Summary

This report updates the Council of Governors on significant developments at St George's and across the Group since June. It covers senior leadership changes, development of shared values and behaviours, work to strengthen the People function, and the continuing focus on financial sustainability.

An update on the proposed Mental Health Emergency Department explains the initial £1.9 million funding, partnership working and intended benefits for people experiencing crisis. It emphasises safe links with physical healthcare and patient involvement, while recognising that detailed arrangements remain under development and subject to approval.

The Adult Inpatient Survey records positive feedback on dignity, kindness and compassion, alongside priorities for improving ward environments, discharge planning and individual support. The report also addresses the Thirlwall Inquiry, reinforcing the importance of listening, speaking up and effective safeguards, with Board consideration scheduled for November.

The success of the gesh CARE Awards and Big Thank You Week provides an opportunity to recognise colleagues' contribution, alongside further examples of outstanding care. Updates on partnership working and the Annual Members' Meeting highlight our continuing commitment to engagement with members and communities.

Action required by Council of Governors

The Council of Governors is asked to note the updates set out in the report, including in relation to continuing work to strengthen culture, support financial sustainability, improve services for patients and deepen engagement with colleagues and communities.

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

Implications

Group Strategic Objectives

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

Risks

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

CQC Theme

☒ Safe	☒ Effective	☒ Caring	☒ Responsive	☒ Well Led

NHS system oversight framework

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

Financial implications

The report includes workforce and service developments with financial implications; financial performance is covered under the finance item on the Council's agenda.

Legal and / or Regulatory implications

The report covers learning from a national inquiry and patient feedback.

Equality, diversity and inclusion implications

Relevant themes include inclusive values and behaviours, patient involvement in service development, and responding to cultural, language and accessibility needs identified in patient feedback.

Environmental sustainability implications

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

Group Chief Executive Officer's Update

Council of Governors, 30 September 2026

1.0 Purpose of paper

1.1 This report provides the Council of Governors with an update on significant developments across the Trust since the previous Council meeting on 25 June 2026. It focuses particularly on our people and culture, leadership, financial sustainability, developments in patient care and experience, and our engagement with partners, colleagues and communities.

2.0 Key Issues

Leadership changes

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

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

2.3 In November, we will also welcome Tracy Luckett as Group Chief Nursing Officer, bringing significant experience of nursing leadership, patient safety, workforce development and quality improvement from Great Ormond Street Hospital. Elaine Clancy completed her period as Interim Group Chief Nursing Officer at the end of August 2026 and is taking up a new role as Chief Nurse and Quality Officer across the South West and South East London ICBs. I would like to thank Elaine for the contribution she has made to gesh and particularly for her continued emphasis on strengthening the nursing voice and ensuring colleagues feel able to speak up and challenge. Until Tracy arrives, Nicola Shopland and Theresa Matthews, Site Chief Nursing Officers for St George's and Epsom and St Helier respectively, will jointly provide cover for the Group Chief Nursing Officer responsibilities.

2.4 Victoria Smith will leave the Group on 6 November after more than two years as Group Chief People Officer. We are currently in the process of recruiting a successor, with interviews scheduled for early November. Vic has led the People function through a considerable period of organisational change and I would like to thank her for her contribution to bringing teams across the Group closer together and strengthening our approach to people and organisational development.

Culture, values and behaviours

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

2.6 We are therefore beginning the next phase of work to develop a single Group-wide values and behaviours framework, replacing the separate arrangements currently in place across the two Trusts. We have selected Kaleidoscope Health to provide external support to this work. The

framework will be developed with meaningful involvement from colleagues across the Group and will build on the work already undertaken through our Living Our Values programme.

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

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

Strengthening the People function

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

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

Financial sustainability and MARS

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

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

New Mental Health Emergency Department at St George's

2.13 I know Governors are particularly interested in plans for a Mental Health Emergency Department at St George's. As reported to the public Board on 11 September, an initial £1.9 million has been secured to progress the development. We are working with South West London and St George's Mental Health NHS Trust and other NHS partners, with specialist mental health teams providing the clinical staffing. The intention is to locate the service as close as possible to our existing Emergency Department.

2.14 The starting point is the experience of someone seeking help at a moment of crisis. A busy acute Emergency Department can be a difficult environment in which to receive mental health care. Our aim is to provide a calmer, more appropriate setting for specialist assessment and

support, with the potential also to reduce pressure on the main department. The proposed service is not yet open, and work with partners on the detailed arrangements continues.

2.15 St George's was included among the locations announced nationally in August for additional mental health emergency departments. The national model emphasises rapid specialist assessment and same-day support for people who do not require acute physical treatment in ED, followed by the right ongoing care. This may mean support at home, community services or an inpatient mental health admission where needed. It is therefore about improving the response to a crisis and the next stage of care, rather than simply creating another place to wait.

2.16 Close working between mental and physical healthcare is essential. Some people experiencing a mental health crisis also need urgent assessment or treatment for a physical illness or injury. A dedicated service must complement that care, with safe assessment, clear clinical responsibility and reliable transfer between teams, rather than create a barrier to necessary physical healthcare. Patients, carers and people with lived experience will be directly involved in shaping the local model.

2.17 The development also needs to be understood as part of the wider crisis care system. A better environment and earlier specialist assessment should support better care, but cannot, on their own, resolve every delay in accessing ongoing support. For me, success should be judged by patients' experience, timely assessment and a safe move to the next stage of care, not simply by moving people out of the main Emergency Department.

2.18 The initial funding is an important step, but the detailed service and implementation arrangements remain under development and subject to the necessary approvals.

Listening to patients: Adult inpatient survey

2.19 The latest CQC Adult Inpatient Survey provides both recognition for colleagues and a clear view of where patients' experience can improve. The St George's results, published on 2 September, draw on feedback from more than 400 patients who stayed at least one night in hospital during November 2025. Respect and dignity scored 9.2 out of 10, and kindness and compassion 9.1. Overall experience scored 8.3. Across all 12 survey areas, the Trust's formal comparison was 'about the same' as other NHS trusts.

2.20 The feedback also identifies areas requiring attention: noise on wards, discharge planning, information about medicines and ongoing support, and earlier conversations about equipment or adaptations needed at home. Patients highlighted opportunities to improve virtual wards and better meet individual cultural, language and accessibility needs.

2.21 Steps already taken include providing eye masks and ear plugs and introducing a 24-hour discharge lounge. These practical changes sit alongside the need to involve patients more consistently in decisions about leaving hospital and their subsequent care. I am grateful to everyone who shared their experience and to the teams using that feedback to improve services.

Thirlwall Inquiry

2.22 The Thirlwall Inquiry report was published on 15 September. The findings concerning events at the Countess of Chester Hospital are difficult reading for everyone working in healthcare, and particularly for colleagues in maternity and neonatal services. Our thoughts are first and foremost with the families at the heart of the Inquiry. We will consider the findings and recommendations carefully and identify what more we need to do to keep patients and babies safe.

2.23 Our message to colleagues on 22 September emphasised the importance of listening to patients and families, taking concerns seriously and ensuring that colleagues feel able to speak up. When something goes wrong, we must be open about what has happened and clear about our response. Being proud of the care our teams provide must go hand in hand with being open to challenge and willing to learn.

2.24 We have already strengthened Non-Executive Director oversight of maternity and neonatal services and increased the involvement of external panel members in maternal and neonatal mortality reviews. These are steps on which to build, not a reason for complacency. We will consider the Inquiry's recommendations alongside the work already under way and identify where further action is needed. NHS England has requested all Trusts to consider the findings at their next available public meetings, reflect on whether similar events could occur within their own organisations and seek assurance that effective safeguards are in place. The Board will be reviewing this at its meeting on 6 November.

Celebrating colleagues: gesh CARE Awards 2026

2.25 The gesh CARE Awards on 23 September at the Kia Oval were a fantastic success. We celebrated 400 colleagues from across the Group, with moving patient stories and examples of kindness, expertise and teamwork. More than 800 nominations had recognised over 630 individuals and teams. The evening was a reminder of the difference colleagues make to patients, families and one another, often in ways that are not captured in our routine reports.



2.26 St George's colleagues and teams were recognised across a wide range of awards, from research and innovation to compassionate care and the services working behind the scenes. I would particularly like to congratulate the following recipients:

Award	Recipient and contribution
Better Health Award	Dr Eva Galiza and the St George's Vaccine Institute — improving access to vaccines and vaccine research, and championing inclusive research.
Future NHS Award	Intensive Care Unit Sustainability Team — reducing the environmental impact of clinical care and introducing more sustainable equipment and products.

Award	Recipient and contribution
Better Value Award	Data Quality & Income Recovery Team — jointly with the Epsom and St Helier Data Quality Team, addressing coding and activity-data gaps following the new Electronic Patient Record.
Quality Improvement and Innovation Award	Professor Debasish Banerjee — developing integrated cardio-renal care for people with chronic kidney disease and heart failure.
Collaborative Award	Neurosciences Case Management Pilot Team — bringing together health, social care and voluntary-sector partners across two Integrated Care Systems.
Volunteer of the Year	Alan Bowen, St George's Hospital Charity — joint recipient, recognised for his contribution as a much-loved charity ambassador.
High Performing Teams Behind-The-Scenes	Subject Access Request Team — helping patients and families access information about their care while protecting confidentiality.
Chair and Chief Executive's Choice Award	Lymphoedema Team — combining specialist expertise with compassionate, personalised care.

2.27 I would also like to thank everyone who nominated a colleague, the event organisers, our hospital charities and local business supporters. The celebrations were fully funded by the hospital charities and local businesses. Their support makes it possible to recognise colleagues in this way.

2.28 In addition to the gesh CARE Awards, earlier this summer, we also held our first ever Group-wide Big Thank You Week, bringing colleagues together across our hospitals and community services to recognise the contribution they make every day. With support from our hospital charities, activities took place across the Group, including wellbeing events, team celebrations and opportunities to thank colleagues personally, alongside more than 10,000 meals and ice creams for staff working across different sites and shift patterns.

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



Further examples of outstanding care

2.30 The Venous Access Team achieved Gold accreditation on 18 August, an achievement recognised in our September staff news. I would like to congratulate the whole team on the work and dedication behind this recognition.

2.31 Dr Maria Victoria Rodriguez Noci received the September Excellence in End of Life Care Award for her work as a Foundation Year 1 doctor on Richmond Ward in July. Her proactive approach to advance care planning, careful documentation and clear communication with the Palliative Care Team helped a family consider important decisions about future care. This is a valuable example of the difference thoughtful, compassionate conversations can make.

Working with partners, members and communities

2.32 South West London and South East London Integrated Care Boards are working more closely through a shared leadership arrangement while remaining separate statutory organisations. Strong relationships with our ICB and place-based partners remain important to St George's, including for neighbourhood health, service transformation, capital investment and providing more care closer to home.

2.33 Our Annual Members' Meeting on 30 September, alongside publication of the 2025/26 Annual Report, is an opportunity to account for our performance, hear from members and communities and look ahead to the coming year. I would like to thank Governors for bringing those perspectives into our work, and all our colleagues for their continued commitment to the people we serve.

3.0 Recommendations

3.1 The Council of Governors is asked to note the updates set out in the report, including in relation to continuing work to strengthen culture, support financial sustainability, improve services for patients and deepen engagement with colleagues and communities.

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

Finance Report M4
Council of Governors

Date: 30 September 2026

Introduction from GCFO

Key messages

- Month 4: **SGH has reported on plan at month 4**. In order to do this some additional non-recurrent benefit has been added to help support that position. This brings forward other planned benefits and mean the challenge for later in the year increases. The Trust remains committed to delivering the financial plan in 26/27.
- CIPs. **Overall, adverse to plan at month 4 by £1.97m**, owing to shortfalls in recurrent CIPs, although this has been mitigated by non-recurrent technical actions that have not been classified as CIP.
- Workforce. **SGH is 50 WTE favourable** to plan, driven by a TUPE variance with ESTH/KRFT of 65.
- The Council of Governors is asked to note that while the position is on plan, the unmitigated position remains highly challenging in delivering the forecast for 26/27 and a balanced financial plan in 27/28 and 28/29.

M4 SGH

Reported position to NHSE – mitigations applied

M4 Commentary

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

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

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

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

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

YTD Commentary

Income

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

Non pay & Non-Operating Items

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

Pay and workforce

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

M4 CIP

Reported position to NHSE – mitigations applied

CIP		YTD Plan £m	Actual £m	Variance £m	Annual Plan £m	Forecast £m	Variance £m
Pay - Recurrent		5.67	1.91	(3.76) A	34.03	34.03	0.00 F
Non-pay - Recurrent		4.54	2.55	(1.99) A	27.22	27.22	0.00 F
Income - Recurrent		1.14	1.31	0.17 F	6.81	6.81	0.00 F
Recurrent Efficiencies		11.34	5.76	(5.58) A	68.06	68.06	0.00 F
Pay - Non-recurrent		1.89	3.95	2.06 F	11.35	11.35	0.00 F
Non-pay - Non-recurrent		1.51	2.88	1.36 F	9.08	9.08	0.00 F
Income - Non-recurrent		0.37	0.56	0.19 F	2.27	2.27	0.00 F
Non-Recurrent Efficiencies		3.78	7.39	3.62 F	22.70	22.70	0.00 F
26-27 CIP		**15.12**	**13.15**	**(1.97) A**	**90.75**	**90.75**	**0.00 F**
FYE 25-26 (Recurrent)		4.60	4.60	0.00 F	13.80	13.80	0.00 F
NHSE CIP metric		**19.72**	**17.75**	**(1.97) A**	**104.55**	**104.55**	**0.00 F**

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

CIP Commentary

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

SGH CIP performance

BAU CIP planning maturity

- Overall £30m (52%) of BAU CIP is fully developed with a further £10m (17.5%) plans in progress.



BAU (£k)	M1	M2	M3	M4	M5	M6	M7	M8	M9	M10	M11	M12	Total
Fully developed	2,341	2,289	2,254	3,610	2,496	2,419	2,433	2,321	2,560	2,418	2,423	2,529	30,093
Plans in progress					1,491	735	1,148	979	979	1,123	943	3,215	10,612
Opportunity					168	1,049	2,941	2,976	2,976	2,711	2,611	1,262	16,695
Unidentified													
Total	**2,341**	**2,289**	**2,254**	**3,610**	**4,154**	**4,202**	**6,522**	**6,276**	**6,516**	**6,252**	**5,977**	**7,006**	**57,400**
Target	**1,914**	**1,914**	**1,914**	**3,828**	**3,828**	**3,828**	**6,699**	**6,699**	**6,699**	**6,699**	**6,699**	**6,699**	**57,417**

GESH CIP performance - Transformation

Transformation CIP planning maturity

Overall £4.3m (9%) of Transformation CIP is fully developed with a further £45.7m (91%) plans in progress.
Up to M4 there is a gap of £4m against the transformation target.
YTD- the BAU schemes delivered above target to compensate for the transformation scheme under delivery. This was delivered non recurrently via central reserves and non recurrent funding.



BAU (£k)	M1	M2	M3	M4	M5	M6	M7	M8	M9	M10	M11	M12	Total
Fully developed	1,072	1,060	1,050	1,124	0	0	0	0	0	0	0	0	4,306
Plans in progress	0	0	0	0	3,378	3,378	6,583	6,583	6,583	6,583	6,583	6,021	45,693
Opportunity													0
Unidentified													0
Total	**1,072**	**1,060**	**1,050**	**1,124**	**3,378**	**3,378**	**6,583**	**6,583**	**6,583**	**6,583**	**6,583**	**6,021**	**50,000**
Target	**1,667**	**1,667**	**1,667**	**3,333**	**3,333**	**3,333**	**5,833**	**5,833**	**5,833**	**5,833**	**5,833**	**5,833**	**50,000**

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

SGUH Integrated Quality & Performance Report

July 2026



Outstanding Care, Together: Our strategy 2023 to 2028

Publication Date: 18/09/2026 | Contact: gesh.performance@stgeorges.nhs.uk

Executive Summary
Quality & Safety

St George's Hospital

Key Messages

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

Executive Summary
Operational Performance

St George's Hospital

Successes

- Performance continues to outperform Medium Term Plan (MTP) trajectories for Referral to Treatment (RTT) and 52-week waits. Focus remains on sustaining progress through productivity-led transformation, supported by specialty-level RTT improvement plans and enhanced oversight through close monitoring of key performance metrics.
- All cancer performance standards against MTP were achieved in June 2026: 84.8% for 28-day Faster Diagnosis Standard, 97.2% for 31 Day and 79.5% for 62 Day pathway .
- Theatre utilisation remains in the top national quartile, with ongoing work to reduce variation and improve consistency across specialties.
- Progress has been made on the DNA reduction programme, with four initiatives progressing to pilot phase to improve attendance and maximise capacity.
- Three transformation programmes are supporting the transition into winter, including a NEL programme aligned to GIRFT and NHS England guidance to eliminate corridor care through coordinated system initiatives

Challenges

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

Statistical Process Control (SPC)

Interpreting Charts and Icons

	Variation/Performance Icons		
Icon	***Technical Description***	***What does this mean?***	***What should we do?***
	Common cause variation, NO SIGNIFICANT CHANGE.	This system or process is **currently not changing significantly**. It shows the level of natural variation you can expect from the process or system itself.	**Consider if the level/range of variation is acceptable**. If the process limits are far apart you may want to change something to reduce the variation in performance.
	Special cause variation of a CONCERNING nature.	**Something's going on!** Something a one-off, or a continued trend or shift of numbers in the wrong direction	**Investigate** to find out what is happening/ happened. Is it a one off event that you can explain? Or do you need to change something?
	Special cause variation of an IMPROVING nature.	**Something good is happening!** Something a one-off, or a continued trend or shift of numbers in the right direction. Well done!	Find out what is happening/ happened. **Celebrate** the improvement or success. Is there **learning** that can be shared to other areas?

	Assurance Icons		
Icon	***Technical Description***	***What does this mean?***	***What should we do?***
	This process will not consistently HIT OR MISS the target as the target lies between the process limits.	The process limits on SPC charts indicate the normal range of numbers you can expect of your system or process. If a target lies **within** those limits then we know that the target may or may not be achieved. The closer the target line lies to the mean line the more likely it is that the target will be achieved or missed at random.	Consider whether this is acceptable and if not, you will need to change something in the system or process.
	This process is not capable and will consistently FAIL to meet the target.	If a target lies **outside of those limits in the wrong direction** then you know that the target cannot be achieved.	**You need to change something in the system or process if you want to meet the target.** The natural variation in the data is telling you that you will not meet the target unless something changes.
	This process is capable and will consistently PASS the target if nothing changes.	If a target lies **outside of those limits in the right direction** then you know that the target can consistently be achieved.	**Celebrate the achievement**. Understand whether this is by design (!) and consider whether the target is still appropriate; should be stretched, or whether resource can be directed elsewhere without risking the ongoing achievement of this target.

Safe, High-Quality Care

Overview Dashboard

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

Safe, High-Quality Care

Overview Dashboard – Patient Experience

	St George's				
KPI	Latest month	Previous month measure	Lastest month measure	Variation	Benchmark
% Births with 3rd or 4th degree tear	Jul 26	1.6%	3.9%		3.3%
% Births Post Partum Haemorrhage >1.5 L	Jul 26	4.4%	6.1%		3.0%
Stillbirths per 1,000 births rolling 12 months	Jul 26	2.6	2.6		3.5
Neonatal deaths per 1,000 births rolling 12 months	Jul 26	4.5	5.0		2.4
Maternal Deaths	Jul 26	0	0	-	N/A
ITU Admissions	Jul 26	0	0		N/A
HIE (Hypoxic ischaemic encephalopathy) per 1000 births and rolling 12 months	Jul 26	0.7	0.7		N/A
PSII- National Reporting (MNSI referrals)	Jul 26	0	0	-	N/A
PSII – Local PSIIs	Jul 26	0	1	-	N/A
Friends and Family Test - Maternity Births Score	Jul 26	100.0%	100.0%		N/A
Friends and Family - Maternity Births Response Rate	Jul 26	0.5%	0.5%		N/A
Maternity Appraisal Rate	Jul 26	73.5%	75.0%	-	N/A
Maternity Vacancy Rate	Jun 26	7.9%	7.9%	-	N/A
Maternity Turnover Rate	Jun 26	8.0%	8.1%	-	N/A

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

Operational Performance

Overview Dashboard

	St George's						
KPI	Latest month	Previous month measure	Lastest month measure	Monthly MTP Trajectory	Variation	Assurance	Benchmark
RTT - % of waits over 52 weeks	Jun 26	0.83%	0.82%	0.97%			2nd Quartile
RTT - Percentage of waits within 18 weeks	Jun 26	63.10%	64.80%	59.77%			3rd Quartile
Waiting List Community - Percentage of waits within 18 weeks	Jun 26	82.8%	78.2%	78.0%			TBC
Cancer - 28 Day Faster Diagnosis Standard	Jun 26	81.8%	84.8%	80.0%			Top Quartile
Cancer - 31 Day Decision To Treat to Treatment Standard	Jun 26	97.4%	97.2%	96.1%			2nd Quartile
Cancer - 62 Day Referral to Treatment Standard	Jun 26	72.6%	79.5%	75.0%			2nd Quartile
Diagnostics - 6 Week Waits	Jun 26	13.3%	15.5%	4.5%			3rd Quartile
4 Hour Operating Standard	Jul 26	75.2%	79.3%	81.0%			Top Quartile
4 Hour Operating Standard - Paediatrics <16 years	Jul 26	91.2%	91.4%	94.5%			2nd Quartile
Over 12 Hours in ED from arrival (%) Type 1	Jul 26	8.3%	6.5%	9.3%			2nd Quartile
Emergency Department Corridor Care (Average Daily Count)	Jul 26	20	22	-		-	TBC
Ambulance handovers over 45 minutes	Jul 26	8.4%	8.4%	6.4%			3rd Quartile
Ambulance average Handover Time (min)	Jul 26	00:24:15	00:24:38	00:21:45			2nd Quartile

Our People

People Metrics

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

Council of Governors

Meeting on Wednesday, 30 September 2026

Agenda Item	2.4	
Report Title	**Equality, Diversity and Inclusion (EDI) Overview, including approval of our 2026 WRES and WDES reports**	
Executive Lead(s)	Victoria Smith, Group Chief People Officer	
Report Author(s)	Joseph Pavett-Downer, Head of EDI (Workforce)	
Previously considered by	Group Board People Committee-in-Common	11 September 2026 20 August 2026
Purpose	**For Approval / Decision**	

Executive Summary

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

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

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

Action required by Council of Governors

The Council is asked to:

a. Discuss and note the Workforce Race Equality Standard Report
b. Discuss and note the Workforce Disability Standard Report;
c. Discuss and note the progress in delivering the EDI Action Plan, and the work of the Board and the People Committee in overseeing delivery of the Plan.

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

Implications

Group Strategic Objectives

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

Risks

Workforce Sustainability: Failure to improve WRES and WDES outcomes may lead to reduced staff engagement, higher turnover, increased sickness absence and greater challenges in recruiting and retaining a diverse workforce.
Quality of Care: Persistent inequalities in staff experience may undermine inclusion, psychological safety and teamwork, potentially impacting the quality, safety and experience of patient care.
Legal and Regulatory Compliance: Lack of progress may increase the risk of discrimination claims and make it more difficult for the Trust to demonstrate compliance with the Equality Act 2010, the Public Sector Equality Duty and NHS England's EDI expectations.
Reputation and Stakeholder Confidence: Poor equality outcomes may damage the Trust's reputation and reduce confidence amongst staff, patients, partners and regulators in the organisation's commitment to fairness and inclusion.

CQC Theme

☐ Safe	☐ Effective	☐ Caring	☐ Responsive	☒ Well Led

NHS system oversight framework

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

Financial implications

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

Legal and / or Regulatory implications

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

Equality, diversity and inclusion implications

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

Environmental sustainability implications

N/A

Equality, Diversity and Inclusion (EDI) Overview

Council of Governors, 30 September 2026

1.0 Purpose of paper

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

2.0 Background

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

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

3.0 Key issues for consideration

3.1 **WRES Summary**

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

However, the report also highlights several persistent inequalities. Both Trusts continue to report disparities in recruitment outcomes, with White applicants more likely to be appointed from shortlisting than BME applicants, and BME staff remaining more likely to enter formal disciplinary processes. Whilst Executive Board representation remains below workforce representation at both organisations, the most significant challenges are evident within staff experience measures at ESTH, where reports of harassment, bullying and abuse have increased and confidence in career progression opportunities has declined. These findings reinforce the importance of continuing delivery of the Group EDI Action Plan and Talent Management Plan, using the latest WRES data to target interventions, monitor impact and focus effort on the areas where inequalities remain greatest.

3.2 WDES Summary

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

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

3.3 EDI Action Plan progress summary

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

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

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

Alongside the update on the EDI Action Plan, we have included an overview of the Inclusion Board programme midpoint, where evaluation findings demonstrate strong progress against

the programme's intended objectives. The People Committee have expressed a desire to continue to have an Inclusion Board and have made suggestions for improvements.

3.4 Key Challenges

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

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

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

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

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

3.5 Strategic Response

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

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

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

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

3. *Embedding Inclusive Culture and Leadership*

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

4.0 Recommendations

4.1 The Council is asked to:

a. Discuss and note the Workforce Race Equality Standard Report
b. Discuss and note the Workforce Disability Standard Report;
c. Discuss and note the progress in delivering the EDI Action Plan, and the work of the Board and the People Committee in overseeing delivery of the Plan.

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Workforce Race Equality Standard (WRES) 2026 Report

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

Workforce Race Equality Standard Report 2026

Purpose, background and definitions

Purpose

- This paper provides an overview of the 2026 Workforce Race Equality Standard (WRES) findings.

Background

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

Definitions of ethnicity: people covered by the WRES

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

Overview of Workforce Numbers

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

Workforce Race Equality Standard Report 2026

Indicator Overview

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

WRES Indicator		STG						
		2022	2023	2024	2025	2026	vs. LY	Compared to White Staff
1	% of BME staff in organisation	50.1%	51.9%	53.6%	54.7%	**55.4%**	**Increased**	
2	Relative likelihood of White applicants being appointed from shortlisting compared BME applicants	1.26	1.50	2.2	1.77	**1.76**	**Static**	
3	Relative likelihood of BME staff entering the formal disciplinary process, compared to that of White staff	1.65	1.67	1.48	1.17	**1.98**	**Declined**	
4	Relative likelihood of White staff accessing non-mandatory training and CPD compared to BME staff	0.98	0.95	0.87	0.93	**0.96**	**Static**	
5	% of BME staff experiencing harassment, bullying or abuse *from patients, relatives or the public* in the last 12 months.	23.3%	27.0%	25.7%	25.2%	**25.3%**	**Static**	
6	% of BME staff experiencing harassment bullying or abuse *from staff* in the last 12 months	25.9%	27.3%	26.9%	28.0%	**25.8%**	**Improved**	
7	% of BME staff believing that organisation provides equal opportunities for career progression or promotion	42.1%	43.8%	44.0%	45.2%	**45.1%**	**Static**	
8	% of BME staff personally experiencing discrimination at work from *manager/leader/ or other colleagues*.	16.6%	16.9%	15.9%	16.4%	**15.8%**	**Static**	
9	% difference between the board voting membership and its overall BME workforce	-32%	-43%	-35%	-25%	**-22%**	**Improved**	
	% difference between the board executive membership and its overall BME workforce	-36%	-41%	-41%	-42%	**-55%**	**Declined**	

Workforce Race Equality Standard 2026
EDI Action Plan

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

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

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



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

Workforce Race Equality Standard 2026

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

Workforce Race Equality Standard Report 2026

Trust: STG

Executive summary

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

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

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

Improved indicators

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

Static indicators

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

Declined indicators

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

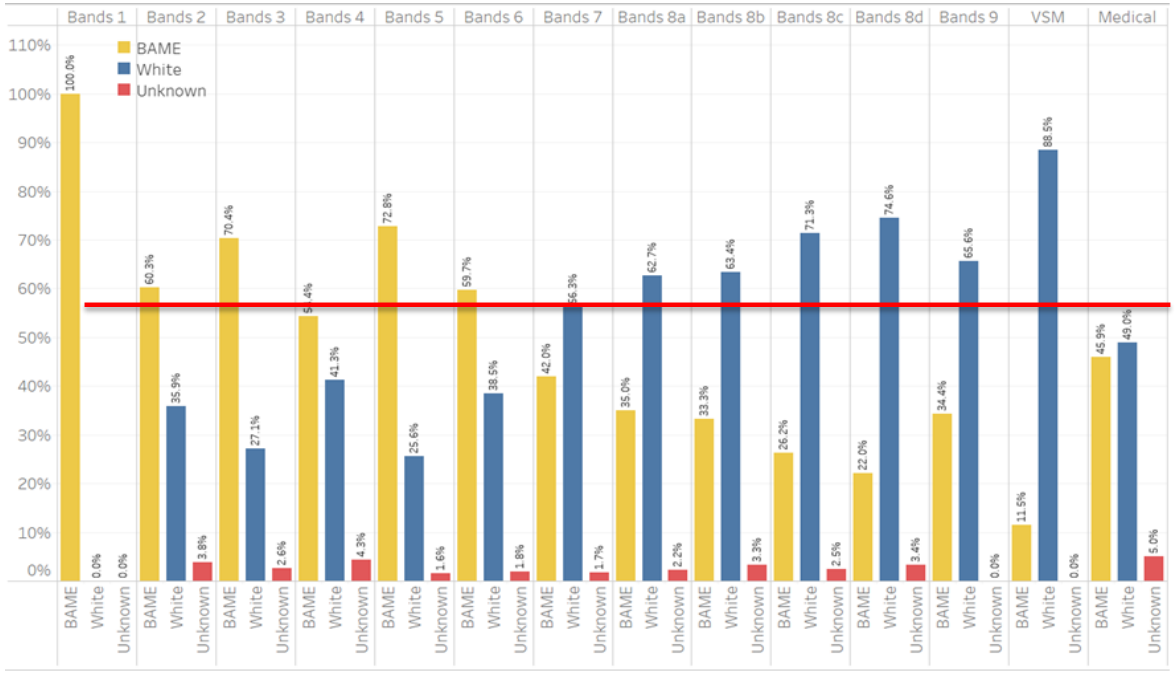
While progress has been made in workforce representation, colleague experience and Voting Board representation, the 2026 WRES data highlights ongoing challenges in recruitment, disciplinary processes and Executive Board representation. These findings will be used to further refine and target delivery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

Workforce Race Equality Standard Report 2026

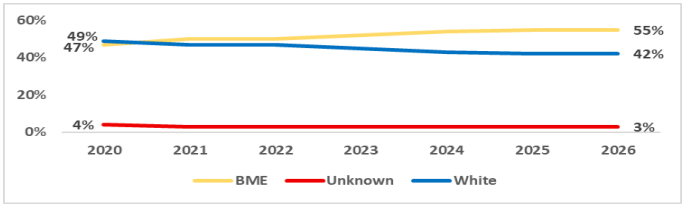
Trust: STG

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

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

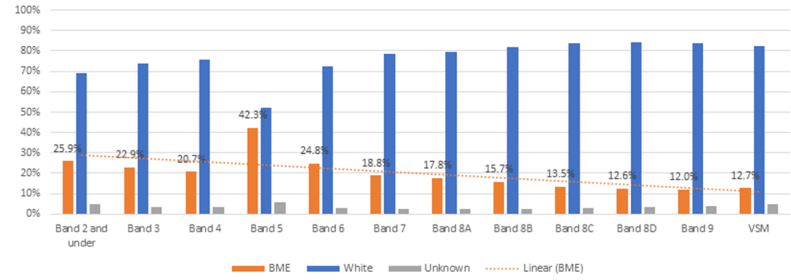


Note: The solid red line indicates the target for St George's to be representative across all AFC pay bands.



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

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



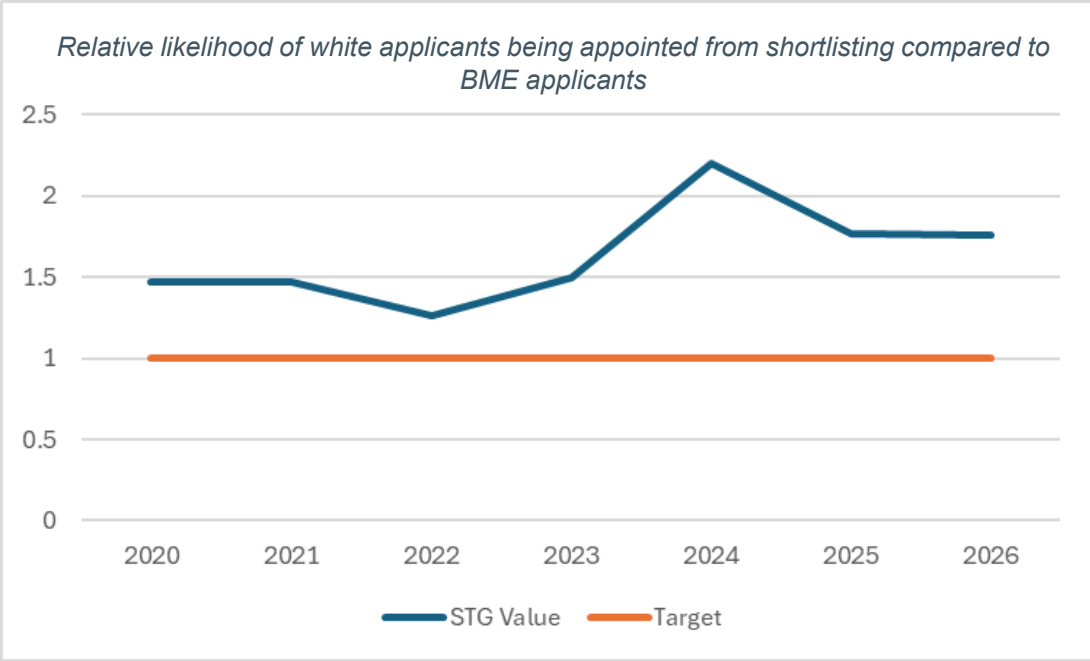
Workforce Race Equality Standard Report 2026

Trust: STG

Indicator 2

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

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



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

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

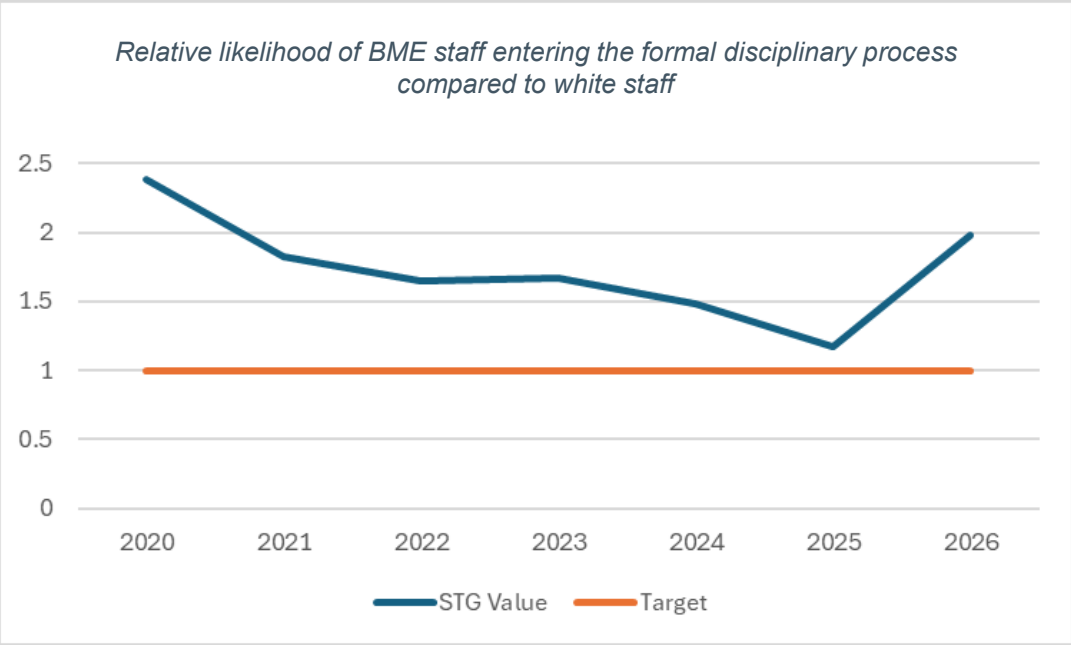
Workforce Race Equality Standard Report 2026

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Indicator 3

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

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



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

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

Workforce Race Equality Standard Report 2026

Trust: STG

Indicator 4

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

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

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

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

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

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

Workforce Race Equality Standard Report 2026

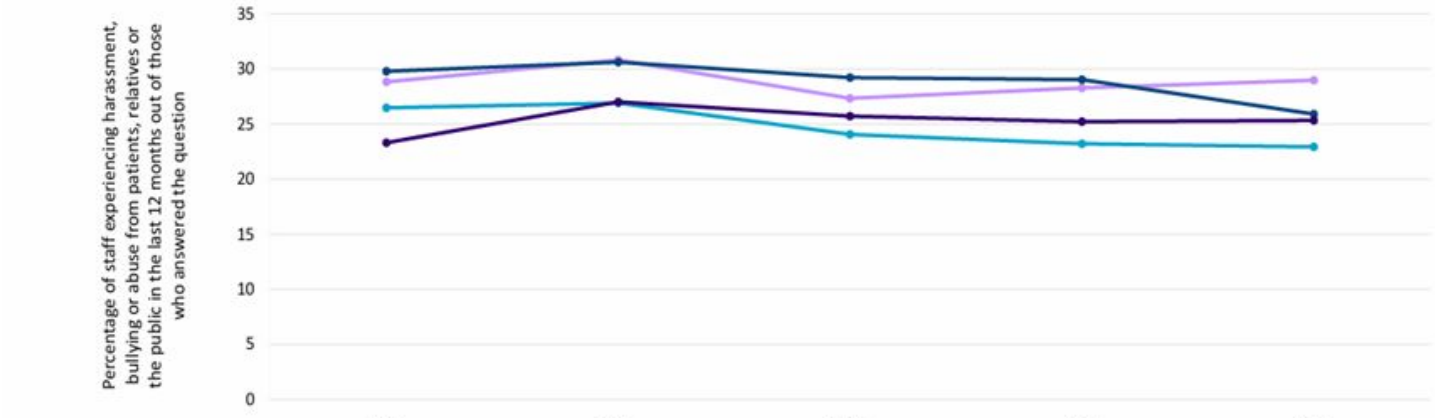
Trust: STG

Indicator 5

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

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

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



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

*Staff from all other ethnic groups combined

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

Workforce Race Equality Standard Report 2026

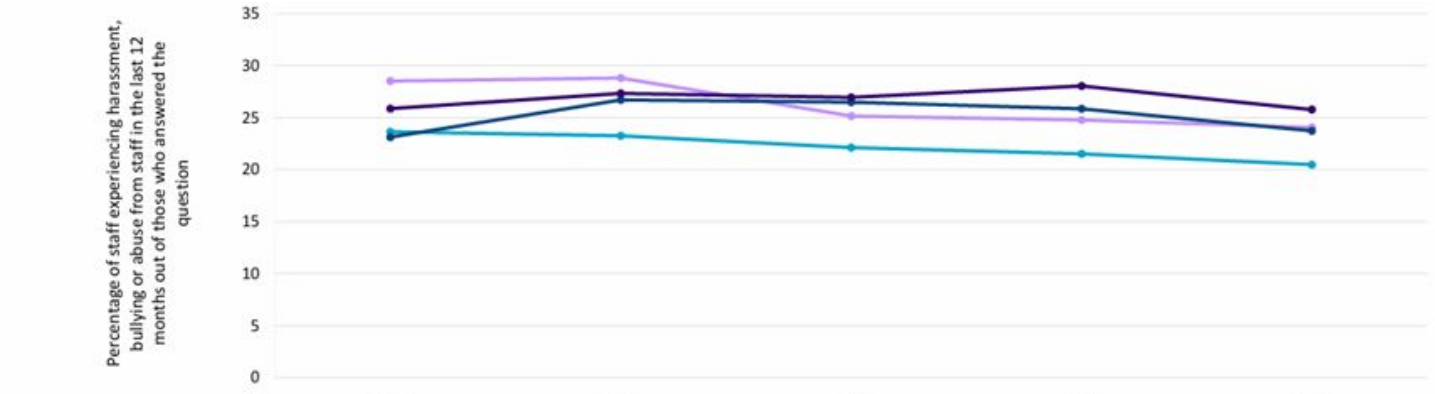
Trust: STG

Indicator 6

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

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

% of staff experiencing harassment, bullying or abuse from staff



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

*Staff from all other ethnic groups combined

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

Workforce Race Equality Standard 2026

Trust: STG

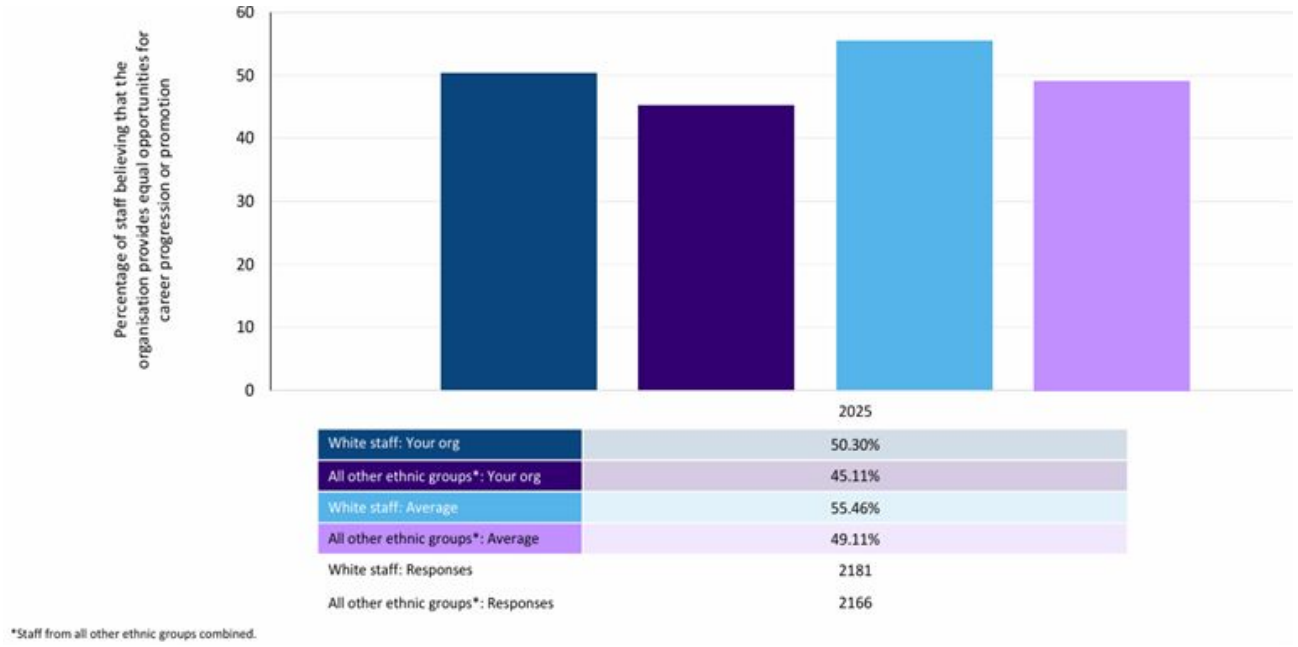
Indicator 7

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

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

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

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



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

Workforce Race Equality Standard Report 2026

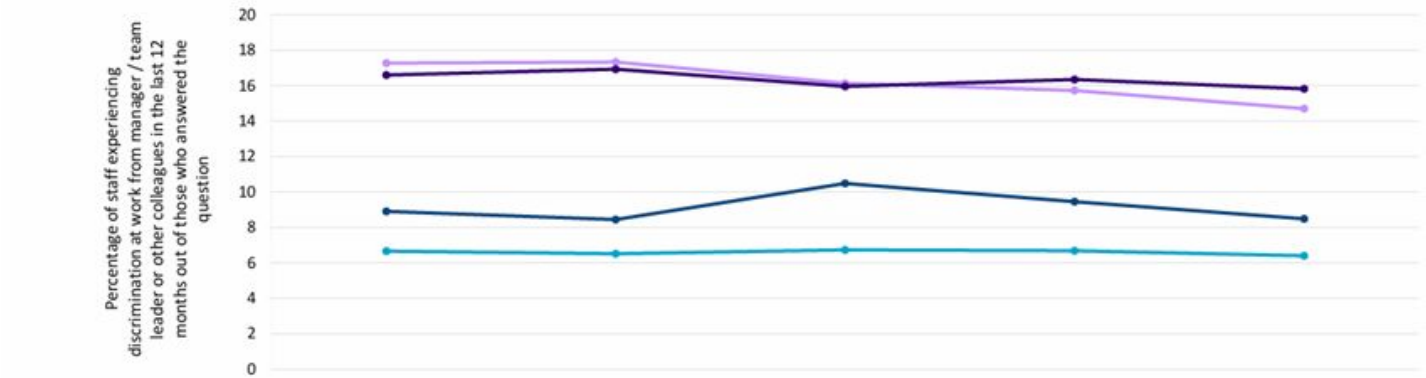
Trust: STG

Indicator 8

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

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

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



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

*Staff from all other ethnic groups combined

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

Workforce Race Equality Standard Report 2026

Trust: STG

Indicator 9

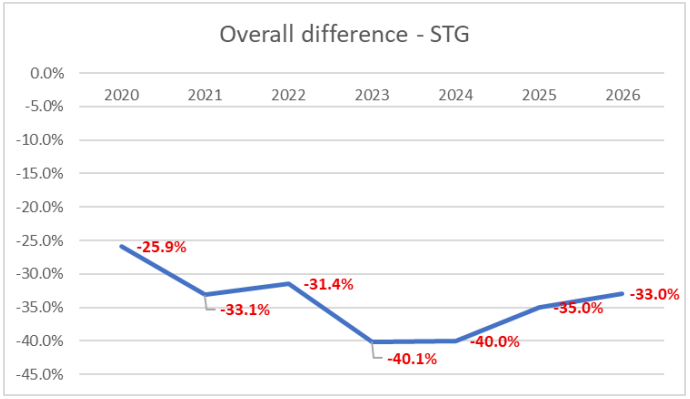
% of board members by ethnicity compared to BME workforce

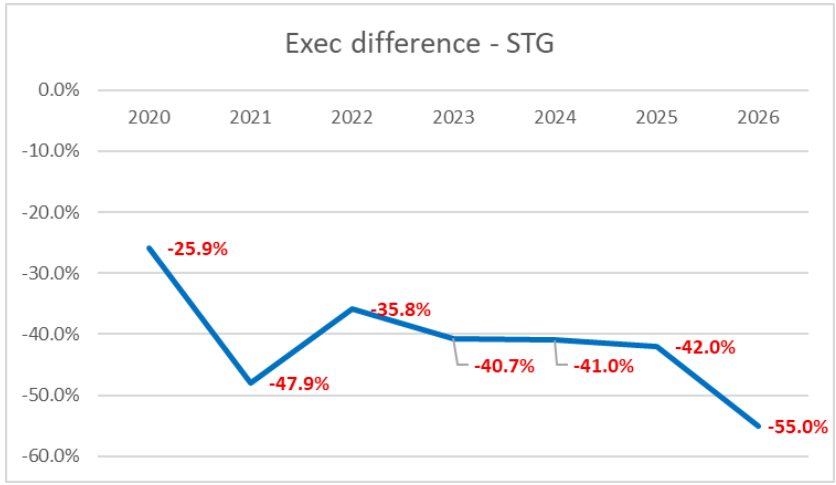
As at 31 March 2026, the Trust Board comprised 18 members, four of whom identify as Black, Asian and Minority Ethnic (BME).

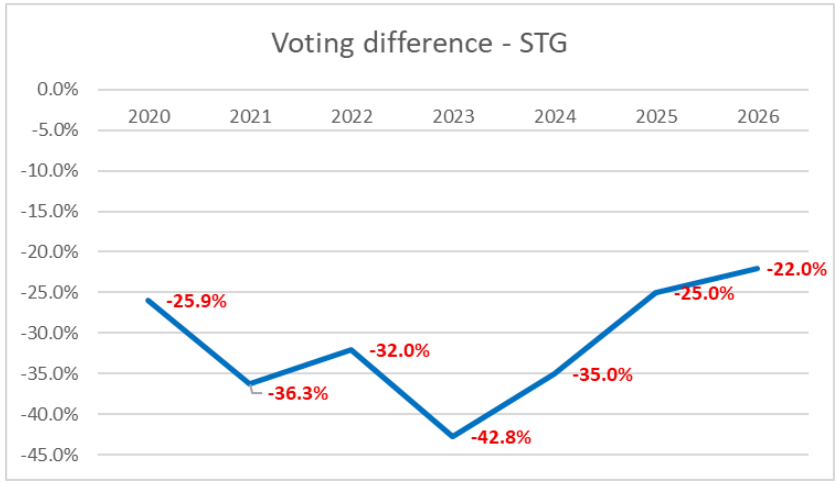
All four BME Board members were Non-Executive Directors. The Voting Board comprised nine members, including six Non-Executive Directors and three Executive Directors. Three Voting Board members identify as BME, resulting in a difference of -33% between overall Board representation and the Trust's BME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

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

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







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Workforce Disability Equality Standard (WDES) 2026 Report

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

Workforce Disability Equality Standard (WDES)

Background

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

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

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

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

Workforce Disability Equality Standard (WDES)

Our ambition

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

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

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

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

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

Workforce Disability Equality Standard 2026
Purpose and Terminology

Purpose

- This paper provides an overview of the 2026 Workforce Disability Equality Standard (WDES) findings.

Terminology: people covered by the WDES

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

Overview of Workforce Numbers

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

Workforce Disability Equality Standard 2026

Indicator Overview

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

WDES Indicator		STG						
		2022	2023	2024	2025	2026	vs. LY	Compared to colleagues
1	% of Disabled staff in organisation	2.9%	3.5%	3.7%	4.3%	**4.7%**	**Increased**	
2	Relative likelihood of non-Disabled candidates compared to Disabled candidates being appointed from shortlisting across all posts.	1.21	1.15	1.26	0.97	**1.04**	**Static**	
3	Relative likelihood of Disabled staff compared to non-disabled staff entering the formal capability process, as measured by entry into the formal capability procedure	4.78	4.26	4.08	0.00	**1.59**	**Declined**	
4a	% of staff experiencing harassment, bullying or abuse from patients/ service users	34.8%	37.1%	35.1%	30.9%	**29.5%**	**Improved**	
4b	% of staff experiencing harassment, bullying or abuse from managers in the last 12 months	21.1%	20.1%	21.1%	17.6%	**20.7%**	**Declined**	
4c	% of staff experiencing harassment, bullying or abuse from other colleagues	31.6%	32.1%	29.3%	31.2%	**27.7%**	**Improved**	
4d	% of staff saying that the last time they experienced harassment, bullying or abuse at work, they or a colleague reported it	47.9%	44.3%	50.7%	52.9%	**47.7%**	**Declined**	
5	% of staff believing that the Trust provides equal opportunities for career progression or promotion	40.1%	44.1%	41.5%	45.9%	**37.3%**	**Declined**	
6	% of staff saying that they have felt pressure from their manager to come to work, despite not feeling well enough to perform their duties	35.2%	32.0%	29.0%	29.6%	**30.6%**	**Static**	
7	% of staff saying that they are satisfied with the extent to which their organisation values their work	31.0%	29.9%	31.3%	34.1%	**30.3%**	**Declined**	
8	% of staff saying that their employer has made reasonable adjustment(s) to enable them to carry out their work	-	61.7%	68.9%	67.1%	**67.6%**	**Static**	
9	Staff Engagement score (0-10)	6.25	6.33	6.26	6.34	**6.28**	**Static**	
10	% difference between the organisation's Board voting membership and its organisation's overall workforce	-3.0%	5.6%	14.0%	16.0%	**-5%**	**Declined**	

Workforce Disability Equality Standard (WDES) 2026

EDI Action Plan

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

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

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



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

Workforce Disability Equality Standard 2026

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

Workforce Disability Equality Standard 2026

Trust: STG

Executive summary

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

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

Improved indicators

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

Reduced / static indicators

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

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

Workforce Disability Equality Standard 2026

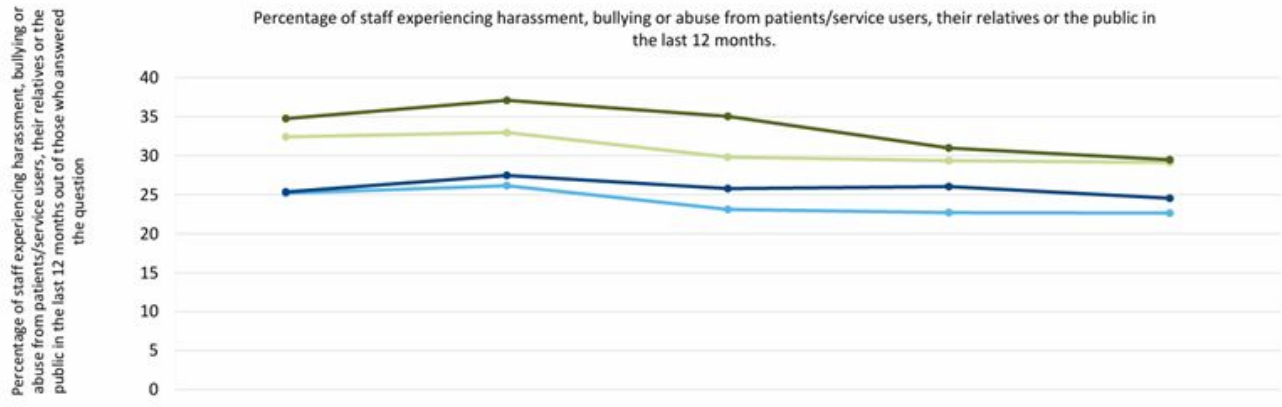
Trust: STG

Indicator 4a

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

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

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



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

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

Workforce Disability Equality Standard 2026

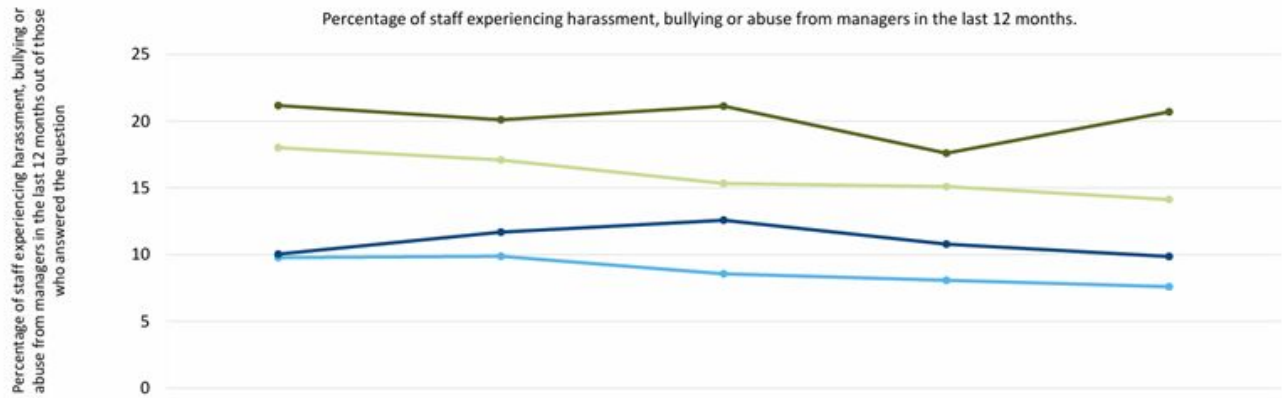
Trust: STG

Indicator 4b

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

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

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



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

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

Workforce Disability Equality Standard 2026

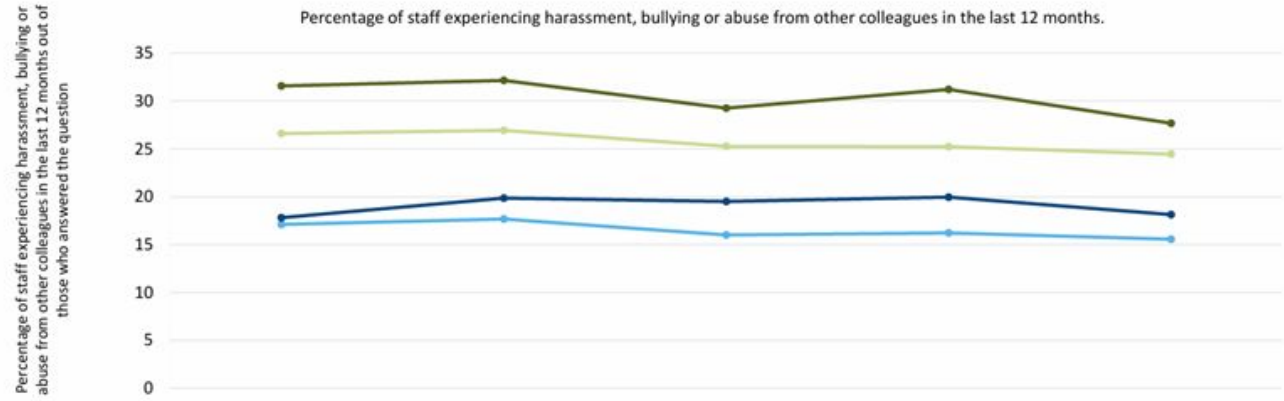
Trust: STG

Indicator 4c

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

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

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



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

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

Workforce Disability Equality Standard 2026

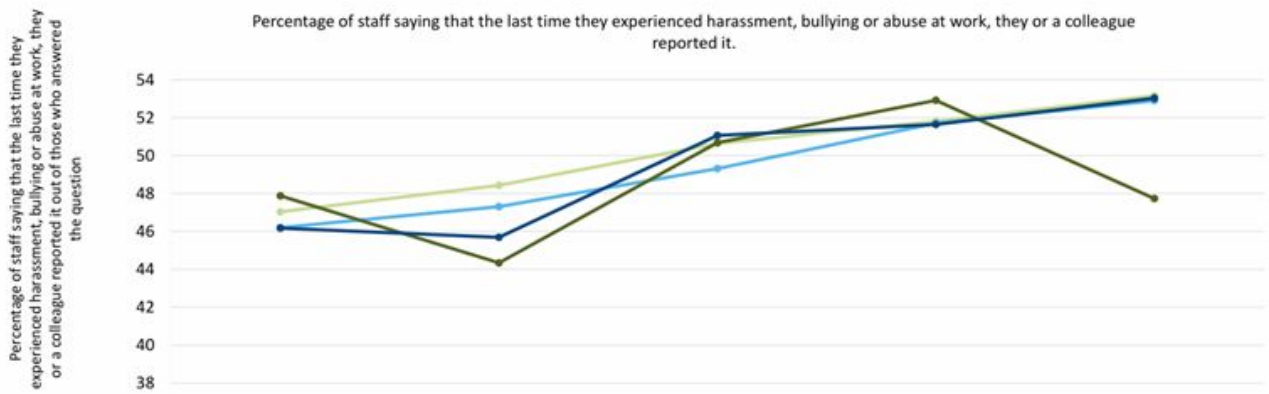
Trust: STG

Indicator 4d

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

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

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



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

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

Workforce Disability Equality Standard 2026

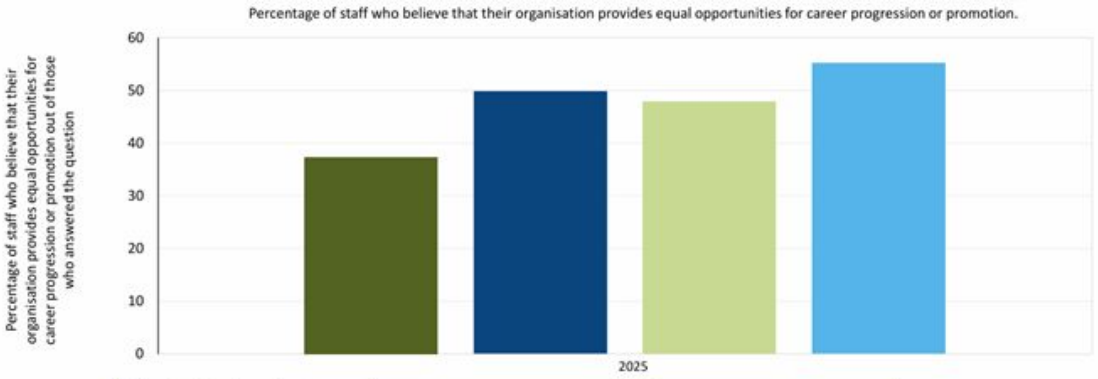
Trust: STG

Indicator 5

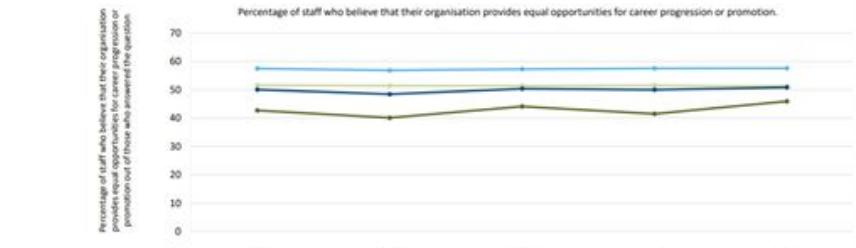
% of staff who believe that their organisation provides equal opportunities for career progression or promotion

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

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



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



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

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

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

Workforce Disability Equality Standard 2026

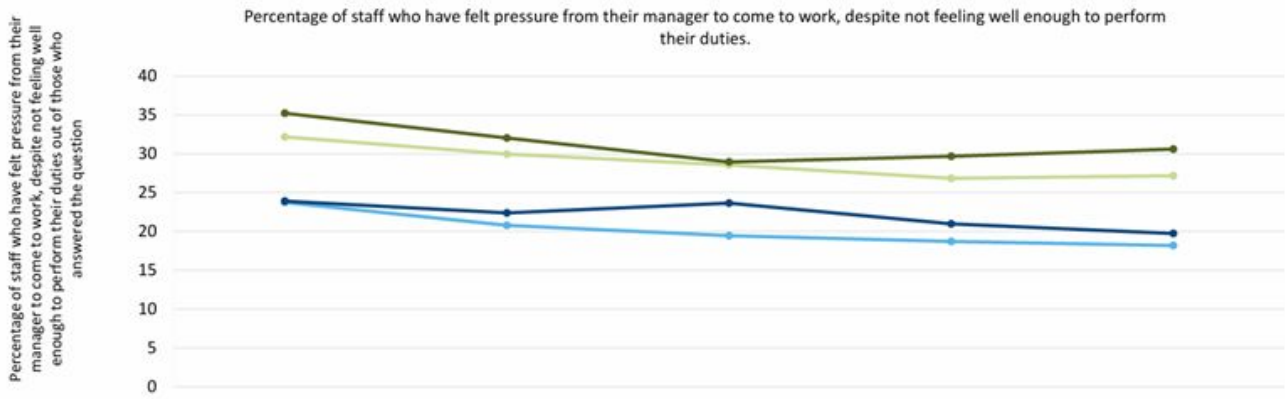
Trust: STG

Indicator 6

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

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

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



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

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

Workforce Disability Equality Standard 2026

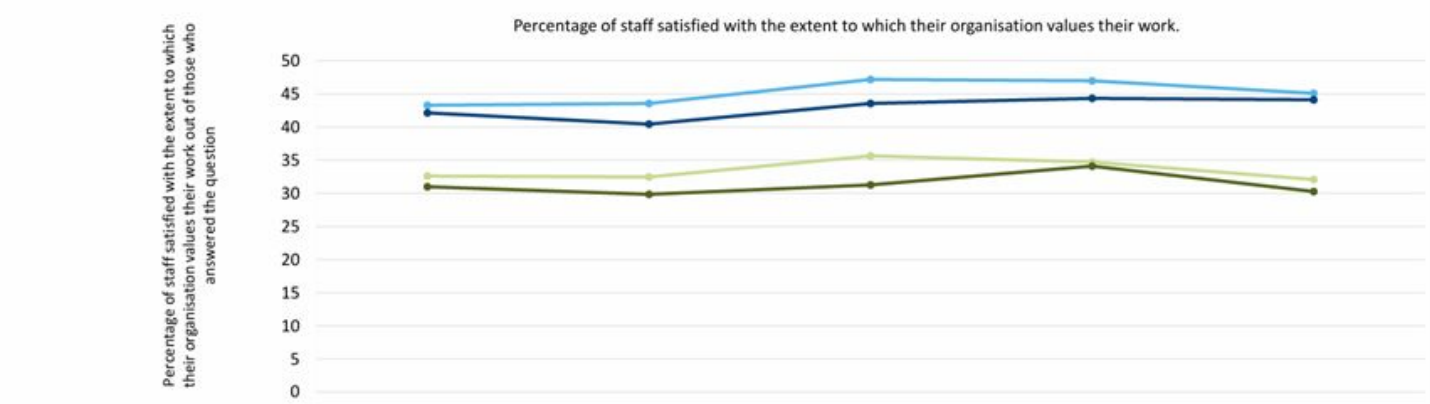
Trust: STG

Indicator 7

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

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

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



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

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

Workforce Disability Equality Standard 2026

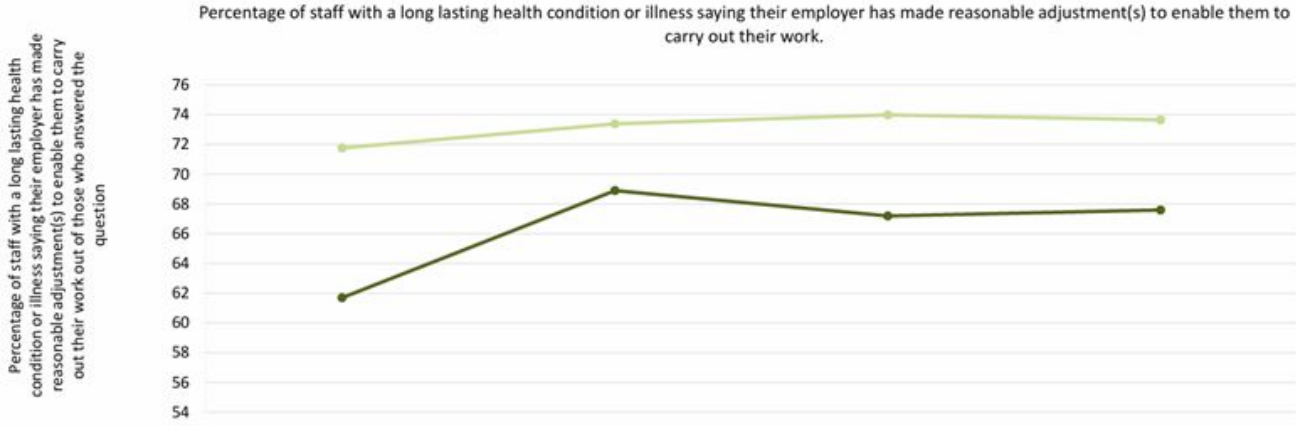
Trust: STG

Indicator 8

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

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

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



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

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

Workforce Disability Equality Standard 2026

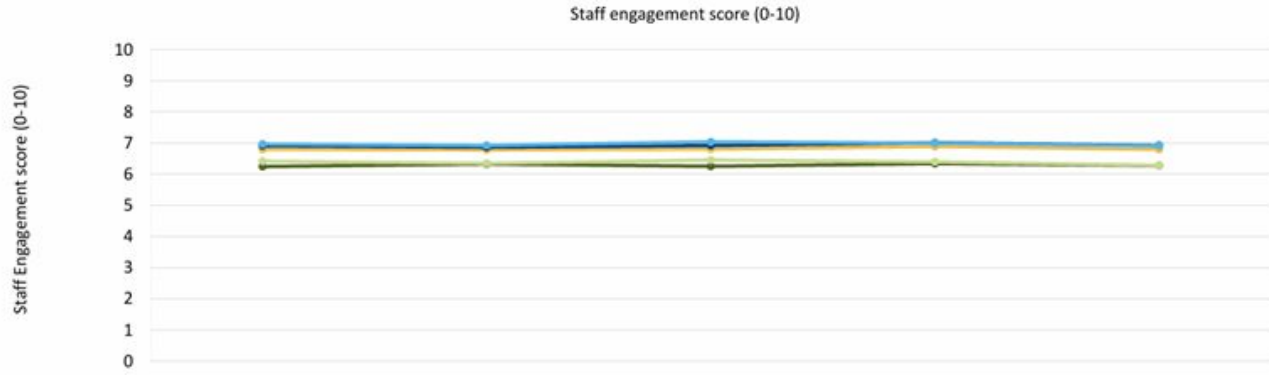
Trust: STG

Indicator 9

Staff engagement score (0-10)

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

Staff engagement score (0-10)



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

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

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

Workforce Disability Equality Standard 2026

Trust: STG / ESTH

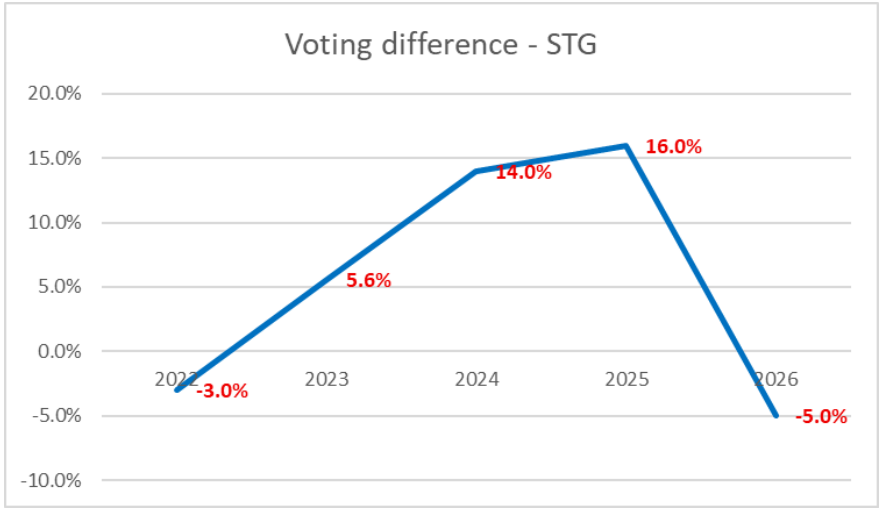
Indicator 10

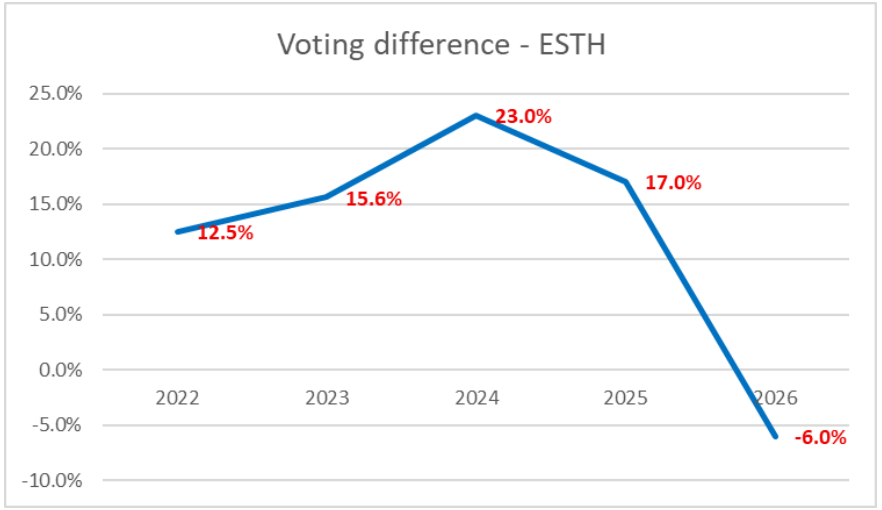
% difference between the organisation's Board voting membership and its organisation's overall workforce

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

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

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





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EDI Action Plan Update

Joseph Pavett-Downer
Group Head of EDI (Workforce)

Date 28/07/2026

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EDI Action Plan Update

Our Equality, Diversity & Inclusion (EDI) Action Plan was formally approved, by the Board, in 2025. Since then, we have focused on building understanding, engagement and support across teams. This has included attending team meetings to present the plan, explain key actions, and begin embedding the work into day-to-day activity. These engagement efforts are ongoing and in conjunction with other approaches which will support communicate the plan more widely and at speed, for example website and comms stories.

It's worth noting that several action deadlines were set close to the plan's approval date and coincided with a significant and complex consultation and restructure within the People function leadership team. This overlap has diverted some attention and contributed to delays in a few areas. However, overall progress is strong and delivery is underway across several key actions. We have reviewed actions that are likely to be delayed or are already overdue and will be taking the necessary steps to prioritise progress in these areas.

Of the 58 actions, 46 are complete / moved to business as usual (BAU). Of the remaining 11 actions, 1 is track for delivery, 4 are paused and 7 overdue:

Key Successes

- Network Executive Sponsorship
- Talent Management Plan Approved
- Introduce effective Communications Training
- Launch Flexible Working Policy
- Launch Menopause training and guidance
- Wellbeing Toolkits to guide managers in supporting staff wellbeing
- Launch Disability in the Workplace Policy
- Reasonable Adjustment advice/resources are readily accessible
- D&I presence at all inductions, including Corporate, Medical and International.
- Embed Ask Aunty initiative across the group, including App launch.
- ERAF/EQIA for Talent Management Pilots
- RIS Process embedded at ESTH
- Stakeholder engagement (Talent and Career Development)
- Improved VSM and Board level JDs and expectations
- Culture / EDI questions (incl. on all VSM interviews)

Paused

- Integrate CARE objectives in the PDR Process
- Launch Neurodiversity in the Workplace module
- Gender Reassignment and Sexual Orientation topics (MAST)
- Launch LGBTQ+ Awareness Module (ESTH)

All actions above are paused due to national MAST review and the change in our OLM platform across the group.

Overdue

- Embed Coaching Culture
- Consider Mend the gap recommendations
- Develop and Implement Health Passport for Staff
- Introduce Cultural Intelligence Training Offer
- Bullying, Harassment and Abuse reduction targets Launch 'Just Culture' to ensure restorative approach to ER processes
- Roles and responsibilities of those involved in ER cases

As these actions were established over 12 months ago, subsequent changes in priorities, business context and delivery approaches have impacted progress and, in some cases, require reassessment of the original scope and intended outcomes.

See appendix A for a full overview of our EDI action plan actions

Inclusive Recruitment

How we will make recruitment more inclusive and drive improved outcomes

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Inclusive Recruitment is a one of six programmes of work in our gesh Talent Management Strategy. There are 8 initiatives within this programme (see overview), initiatives in green indicated those that are complete, those in amber are on track and in progress.

What has been actioned?

- RIS Process embedded at ESTH.
- Introduced a pre allocation process group wide to improve compliance.
- This has seen compliance at STG increase from 39% (April) to 78% (June). For ESTH this increased from 0% (April) to 58% (June).
- Updated scoring criteria and guidance launched.
- Clear guidance for Executives and SLT to support inclusive practice at senior recruitment.
- New Recruitment Toolkit launched (see appendix C).
- Updated Recruitment and Selection Training live.
- Inclusive Recruitment Practice included in our core Leadership and Management Development programmes.
- Gesh Inclusive Recruitment Session offered group wide as part of our Dive-In to Diversity series.
- Golden Ticket Live at STG, with 3 interns successfully securing permanent paid employment (under the scheme) since it's launch.

Launching soon:

- Initially we proposed the introduction of an Independent chair model, however following stakeholder feedback, we are exploring an alternative option which is likely more operationally sustainable and better received/supported by leaders.
- Standardised job descriptions is now part of the SWL Recruitment review. The EDI team will continue to support the hub and anticipate this launching later in 2026.

Overview of Inclusive Recruitment Programme

1. Embed Recruitment Inclusion Specialist (RIS) Across All Sites
- Provides impartiality and challenge to ensure fairer hiring decisions
- Drives consistency in EDI practice across divisions
- Strengthens accountability recruitment processes

2. Standardise Job Descriptions for Target Roles
- Removes unnecessary criteria to widen access
- Uses clear, inclusive language to improve accessibility and attraction
- Supports equitable banding and role clarity across the organisation

3. Implement Consistent, Structured Interview Scoring
- Reduces bias and subjectivity through standardised evaluation criteria
- Enables fair comparison of candidates across panels and sites
- Improves transparency and auditability of hiring decisions

4. Clarify Recruitment Roles, Responsibilities and Process
- Defines clear accountability at each stage of recruitment and selection
- Reduces variation and improves process consistency across teams
- Empowers staff to challenge and uphold inclusive practices

5. Introduce Independent Chairing of Interview Panels
- Minimises conflicts of interest and informal hiring practices
- Promotes balanced, objective decision-making within panels
- Reinforces fairness and organisational integrity in recruitment

6. Deliver Comprehensive Inclusive Recruitment Training
- Builds capability and confidence in inclusive hiring practices
- Aligns behaviours with NHS EDI priorities and legal requirements

7. Create a Supported Pathway from Internship to Employment
- Establishes a sustainable pipeline of neurodivergent talent into permanent roles (Golden Ticket Scheme)
- Reduces barriers associated with traditional recruitment processes

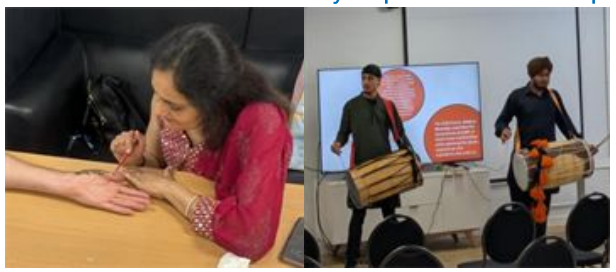
8. Strengthen Inclusive Recruitment for Senior Roles
- Expands diverse talent pipelines beyond traditional networks
- Embeds fair and transparent hiring practices
- Improves representation at senior levels, supporting inclusive leadership

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EDI Engagement Update

- Elected new leadership team for REACH (STG)
- Facilitated coffee mornings to support collaborative working across the networks
- Set up stalls at ESTH to promote the networks and encourage staff to become members
- Celebrated Staff Networks Day with an online session which highlighted the vital role our networks play in shaping an inclusive and representative workplace culture.
- International Women's Day at STG welcomed guests including the D. Mayor of Wandsworth.
- July marked Pride month, the LGBTQ+ Network and EDI team recognised this via:
  - Pride Flag raising at all site
  - Network vice chair took part in ESTH Charity abseil.
  - Around 40 staff, including some Exec/SLT sponsors, marched in London Pride and Trans Pride.
  - Weekly emails and comms campaigns focused on LGBTQ+ inclusion.
- Monthly Dive In to Diversity Awareness Sessions for all staff.
- South Asian Heritage Month – celebrated with a range of activities across the group including face to face events at St Georges and an online event held by ESTH Women's and Allies network welcoming Mumbai based author Rageshri Dhairyawan.
- LGBTQ+ Network held a safe space for trans and non-binary colleagues in light on Equality Act legislation
- ESTH Women's and Allies network held a series of talks with the focus of 'Give to Gain' – the theme for international women's day, welcoming a range of internal speakers.
- Our DaWN Network supported the implementation of our organisational Wellness Action Plan.







Appendix A: EDI Action Plan Overview

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Action Plan RAG Tracker															
1	**WORKSTREAM ONE: Leadership Commitment (including Board development and Executive Sponsorship)**	**Description**	VSM and Board level JDs Review/ Guidance	Culture / EDI questions (VSM Int.)	Board EDI dash board to drive accountability and monitor progress	EDI Objective (Board)	EDI Objective (Individual)	EDI Updates routinely taken to Board / Exec	EDI Compliance updates to Board / Exec	Network Executive Sponsorship	Quarterly Meetings Chair, CEO and Network Chairs	Board approval of all mandatory EDI reporting	Report routinely on current/new legislation and best practice	Execs actively promote the benefits of allyship	
		Action No.	1.4.1	1.4.2	1.7.1	1.1.1	1.1.2	1.2.1	1.2.2	1.2.3	1.2.4	1.3	1.5	1.6	
		Due	Jul-25	Jul-25	Mar-26	Jul-25	Jul-25	Apr-25	Apr-25	Apr-25	BAU	BAU	BAU	BAU	
2	**WORKSTREAM TWO: Inclusive Recruitment and Talent Management**	**Description**	Pilot Talent Management Plan	Widen Recruitment opportunities across SWL (via hub)	Inclusive Recruitment Projects (gesh wide)	Integrate CARE objectives in the PDR Process	Embed Coaching Culture	Embed Neuro-diversity in the workplace training	Review recruitment practices to ensure they are fully inclusive of all ages and removing bias	Talent Management Plan Approved	Diversifying our Leadership (Options Appraisal)	Introduce effective Communications Training	ERAF/EQIA for Talent Management and Career Development Programmes	Stakeholder engagement (Talent and Career Development)	Launch group wide Flexible Working Policy
		Action No.	2.1.2	2.2.1	2.2.2	2.3.1	2.3.2	2.4.3	2.5	2.1.1	2.1.3	2.3.3	2.4.1	2.4.2	2.6.1
		RAG	Dec-25	BAU	Oct-26	Pending Appraisal review	Dec-25	Pending national MAST review	See action 2.2.1	Dec-24	Dec-24	Jul-25	Sep-25	Sep-25	Mar-25
		Description	Launch My Health Matters Too Campaign (ESTH)	Explore recommendations from the Inclusive Recruitment Programme	Ensure FW Policy includes advice in relation to flexible retirement	Promote Flexible Working Policy	Collaborate and engage with SWL recruitment initiatives	Explore Propel Train the Trainer offer							
		Action No.	2.9.1	2. 10	2.6.2	2.7.1	2.8	2.9.2							
		RAG	Jul-26	Dec-25	Mar-25	Mar-25	BAU	Apr-25							
3	**WORKSTREAM THREE: Eliminating pay gaps**	**Description**	Consider Mend the Gap review recommendations	Introduce Annual Pay Gap Report	Implement an effective flexible working policy	Use the EDI dashboard to scrutinise progress	Focus on closing the gender pay gap and improving the experiences of the lowest paid people								
		Action No.	3.1.1	3.2.1	3.3	3.4	3.5								
		RAG	Jul-25	Jul-25	See action 2.6.1	See action 1.7	See actions 3.1-4								

Complete / BAU	
On track	
Potential delay	
Delayed / behind plan	

Appendix A: EDI Action Plan Overview

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Action Plan RAG Tracker															
4	**WORKSTREAM FOUR: Improving Health and Wellbeing**	**Description**	Embed Wellness Action Plan into appraisal process	Develop and implement Health Passport for Staff	Gender Reassignment and Sexual Orientation topics to be covered in mandatory training	Launch our LGBTQ+ awareness module at ESTH.	Launch Menopause training and guidance	Develop a series of Wellbeing Toolkits to guide managers in supporting staff wellbeing	Continue collaborative approach with SWL ICB	Launch Disability in the Workplace Policy across the group.	Ensure Reasonable Adjustment advice and resources are promoted and readily accessible across the group intranet.				
		Action No.	4.1.1	4.1.2	4.3.1	4.3.2	4.1.3	4.1.4	4.2	4.4.1	4.4.2				
		RAG	Dec-25	Dec-25	Pending national MAST review	Pending move to ESR OLM	Jul-25	Jul-25	BAU	Apr-25	Apr-25		**Complete / BAU**		
5	**WORKSTREAM FIVE: Supporting internationally recruited staff**	**Description**	Introduce robust Cultural Intelligence Training offer	Clear and comprehensive pre employment information for all international staff	Bespoke onboarding programme is in place for all international recruited nursing and midwifery staff.	Ensure continued D&I presence at all inductions, including Corporate, Medical and International.	Continue to embed Ask Aunty initiative across the group, including App launch.	International recruits will have equitable access to training and CPD available across the group					**On track**		
		Action No.	5.3.3	5.1	5.2	5.3.1	5.3.2	5.4					**Potential delay**		
		RAG	Dec-25	BAU	BAU	Dec-25	Dec-25	BAU					**Delayed / behind plan**		
6	**WORKSTREAM SIX: Safeguarding our Workforce**	**Description**	Reduction targets to be considered by Group Executive, SLT and relevant service leads.	Launch 'Just Culture' to ensure a restorative approach to ER processes	Explore ER Inclusion Specialist (ERIS) to support ER cases for employees from BME communities or those with a Disability.	Review roles and responsibilities of those involved in supporting or offering guidance and advice in relation to ER cases	As part of our Policy Review, review and launch a group wide disciplinary policy	Complete gesh DASV launch and commitment	Launch Sexual Misconduct Policy	Finalise assurance reporting structure	Introduce training on speaking up and raising concerns	Provide comprehensive psychological support for all staff	Have mechanisms to ensure staff who raise concerns are protected by their organisation.		
		Action No.	6.1.1	6.2.1	6.2.2	6.2.3	6.2.4	6.3.1	6.3.2	6.3.3	6.4	6.5	6.6		
		RAG	Jul-25	Dec-25	Dec-25	Dec-25	Dec-25	Apr-25	Apr-25	Apr-25	BAU	BAU	BAU		

Appendix B:

Equality, Diversity and Inclusion (EDI) Action Plan

As part of our ongoing commitment to inclusion, and in response to staff survey results and staff network feedback, we have launched our 2025 EDI Action Plan. This plan is structured into six workstreams, each aligning with NHSE's EDI Improvement Plan.

1. Leadership Commitment

Chief executives, chairs and board members must have specific and measurable EDI objectives to which they will be individually and collectively accountable.

2. Inclusive Recruitment and Talent Management

Embed fair and inclusive recruitment processes and talent management strategies that target under-representation, particularly at leadership levels.

3. Reducing pay gaps

Develop and implement an improvement plan to reduce pay gaps.

4. Improving Health and Wellbeing

Develop and implement an improvement plan to address health inequalities within the workforce.

5. Supporting Internationally Recruited Staff

Implement comprehensive induction, onboarding and development programme for internationally- recruited staff.

6. Safeguarding our Workforce

Create an environment that eliminates the conditions in which bullying, discrimination, harassment and physical violence at work occur.

Search **"EDI Action Plan"** on the intranet to find out more, or contact: diversity.inclusion@stgeorges.nhs.uk

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Appendix C: Snapshot of SWL Recruitment Toolkit







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Inclusion Board Mid-Programme Evaluation Report

Executive Summary

The Inclusion Board Programme was launched in April 2026 as a strategic leadership and inclusion initiative designed to amplify diverse voices within Group decision-making, build understanding of Board behaviours and governance, and create a future pipeline of diverse senior leaders.

This is a six-month programme with 16 participants running alongside 6 Group Board meetings, simulations covering key topics in parallel to Board papers and mentoring.

At the programme midpoint, evaluation findings demonstrate strong progress against the programme's intended objectives. Attendance and engagement have remained consistently high, with attendance exceeding 87.5% throughout the programme.

Feedback from participants, Board members and The King's Fund as co-partners in delivery, indicates that the programme is increasing confidence, strategic thinking, leadership capability and understanding of Board behaviours and processes. Participants also report feeling more connected to the wider organisation and more confident in contributing within senior leadership environments.

Evaluation feedback has included:

- *"The programme is a soft landing to being a Board member"*
- *"Amazing opportunity and pivotal to leadership growth*"
- *"I am finding value in this and am at a different place from when I applied"*
- *"Phenomenal experience"*

The programme has also demonstrated value for the Group Board. Inclusion Board members have contributed diverse perspectives informed by lived and professional experiences, helping strengthen discussions on strategic priorities and providing valuable insight from frontline services and communities.

As expected at the midpoint stage, opportunities remain to further strengthen participants' understanding of governance and assurance processes, alongside providing clearer feedback on how Inclusion Board contributions have influenced Board discussions and decision-making.

Whilst it remains too early to assess the long-term impact on the talent pipeline and Board representation, there is compelling evidence that the programme is successfully developing leadership capability and creating greater inclusion within organisational decision-making.

Original Purpose and Objectives

The Inclusion Board was designed to create a step change in how participants and the executive leadership of the organisation embark on a talent programme that harnesses future and under-represented leaders by building on real-world experience, capability and leadership confidence.

gesh is a collaboration between St George's University Hospitals NHS Foundation Trust and Epsom and St Helier University Hospitals NHS Trust.

The programme was established around three strategic objectives:

1. To amplify diverse voices and ensure lived experience informs strategic decision-making at the highest level.
2. To build leadership capability through exposure to Board-level governance, strategy and inclusive leadership practices.
3. To create a diverse talent pipeline for future senior and executive leadership roles across the Group.

Although outcomes relating to future Board appointments and career progression will require longer-term evaluation, the programme is already demonstrating strong progress against the first two objectives.

Key Learning and Insights

Building Confidence and Leadership Capability

A consistent finding across all evaluation data is the significant increase in participants' confidence. Participants reported greater confidence speaking in senior forums, engaging with colleagues outside their professional disciplines and contributing to strategic discussions. Many describe a shift in how they perceive themselves as leaders, coupled with greater ambition and confidence about future career opportunities.
Participant feedback has included:

"Recognising the social construct of power has helped me position myself on an equal footing in senior leadership meetings and allowed more courage to speak up and challenge."

"It has helped with how I present at work, confidence building and networking. It has also helped broaden and shape my strategic thinking."

Understanding Governance and Board Dynamics

Board simulations continue to be the most highly valued element of the programme. Participants consistently identify these sessions as helping them understand governance processes, assurance, accountability and strategic decision-making in practical and meaningful ways.

Participants reported increasing confidence in contributing strategic perspectives, moving beyond operational questions towards broader organisational considerations and solutions.

Those who have attended Group Board meetings described the experience as *"enlightening", "insightful" and "the best learning experience",* citing greater understanding of Board dynamics, governance and leadership accountability.

Inclusion Through Lived Experience

A key insight emerging from the programme is the value of creating structured opportunities for diverse voices to influence strategic discussions.

Participants have consistently demonstrated an ability to challenge assumptions, offer alternative perspectives and bring frontline experience into conversations about organisational priorities. This has strengthened both participant learning and Board insight. Feedback comments have included:

"I feel more engaged as I've got a sense of the bigger picture and some influence."

"It made me ask what I could do as an individual to influence the wider world of the organisation and do my part to make it a fairer environment for all."

The Importance of Mentoring and Sponsorship

Executive mentoring relationships continue to be viewed as one of the programme's most valuable features.

Participants described mentoring as supporting personal growth, career planning, increased confidence and understanding of senior leadership roles. Several participants specifically highlighted the openness and generosity of senior leaders and Board members in sharing knowledge and experience.

Feedback themes from Participants

Consistent strengths emerge from participant feedback:

- Board simulation exercises.
- Attendance at Group Board meetings.
- Mentoring and networking opportunities.
- Access to Executive and Non-Executive Directors.
- Safe and inclusive learning environment.
- High quality facilitation from the OD Team and The King's Fund.

Opportunities for Improvement

Participants would welcome:

- More time for discussion and reflection.
- Additional feedback following simulations and Board attendance.
- Greater understanding of governance, assurance and Board roles.
- Increased opportunities to meet with Executive and Non-Executive Directors.
- Further support around career planning and Board readiness.
- More visibility on how Inclusion Board recommendations have influenced Board discussions and decisions.

Feedback from The King's Fund

The King's Fund has highlighted the programme as a significant organisational development and culture change intervention. Participants have consistently reported

increased confidence, greater self-awareness and growing competence as future Board members.

The King's Fund identified several strengths:

- Strong participant engagement and commitment.
- High-quality mentoring relationships.
- Responsive and adaptive programme design.
- Effective balance between governance learning and adaptive leadership development.
- Attention to power, privilege, inclusion and self-awareness alongside technical Board knowledge.

The King's Fund views the programme as a longer-term cultural intervention that extends beyond leadership development alone and has the potential to influence organisational inclusion and decision-making more broadly.

Feedback from Board Chairs

Yin Jones, Non-Executive Director highlighted the significant value that Inclusion Board participants have brought to Board discussions through diverse perspectives and lived experience.
"The insights and perspectives of participants have not only helped to inform Board discussions but have also enabled the Board to hear directly from the frontline, including during strategic discussions relating to the merger."

It was also observed that participants have become noticeably more confident and settled in their roles as the programme has progressed. Yin Jones has suggested that future cohorts could benefit from exposure to a wider range of Board Chairs to experience different leadership and chairing styles and noted that some less vocal participants may benefit from additional support to maximise their contribution.

Mark Lowcock, Chairman echoed the positive impact of the programme and highlighted an opportunity for future programmes to have a strengthened selection process by identifying individuals with both strong aspirations and realistic prospects for future Board-level roles. He suggested greater involvement of Executive Directors within the recruitment and selection process to support this ambition.

Next Steps

To maximise impact during the final phase of the programme, the following actions were endorsed by the Board:

- Increase structured developmental feedback for participants.
- Create additional opportunities for engagement with Executive and Non-Executive Directors.
- Further develop participants' understanding of governance, assurance and Board roles.
- Provide clearer feedback loops demonstrating how Inclusion Board observations, insights and recommendations have informed Board discussions and decision-making.

Looking beyond the pilot, the evaluation supports continuation of the Inclusion Board model as both a leadership development intervention and a mechanism for bringing diverse perspectives into strategic decision-making. The Board agreed at its meeting in September 2026 that a second cohort should be commissioned for 2027, incorporating learning from the pilot and involving current participants in future programme design and delivery.

Council of Governors

Meeting in Public on Wednesday, 30 September 2026

Agenda Item	2.5	
Report Title	**Health Bill Update**	
Executive Lead(s)	Stephen Jones, Group Chief Corporate Affairs Officer	
Report Author(s)	Stephen Jones, Group Chief Corporate Affairs Officer	
Previously considered by	Council of Governors – Initial overview	25 June 2026
Purpose	**For discussion**	

Executive Summary

This paper updates the Council on the Health Bill since its meeting on 25 June 2026, with particular reference to the future of governors, and the implications for the next governor elections and local patient and community involvement.

The Bill completed its Commons stages on 8 September and received its Lords First Reading on 9 September. Lords Second Reading is scheduled for 13 October 2026. The proposals remain subject to amendment and are not yet law.

The Bill continues to propose the removal of the statutory Council of Governors and foundation trust membership framework. The Bill does not prescribe a statutory successor council or patient forum. Existing obligations continue until the relevant changes take legal effect.

The proposed election round comprises 12 seats: nine public and three staff, including the existing Merton and AHP vacancies. Terms would commence on 1 February 2027. The Trust should proceed with preparations and elections under the present framework, while reviewing any confirmed national transitional arrangements.

A small working group involving interested governors and other relevant participants is proposed to help develop future patient and community arrangements. This paper seeks agreement to that direction of travel, not approval of a particular model, detailed membership or terms of reference.

Action required by Council of Governors

The Council of Governors is asked to:

a) **Note** the legislative update and continuing statutory responsibilities;
b) **Note** the proposed approach to the 12-seat election round; and
c) **Support** establishing a small working group over the coming weeks, with further information to return to the Council.

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

Premature withdrawal from current statutory arrangements; interruption of public or staff representation; confusion about governor terms; loss of knowledge and community relationships during transition; and insufficient preparation for future engagement. The proposed approach maintains current arrangements while beginning proportionate preparatory work.

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 election exercise will incur returning-officer, communication and ballot costs. The initial working group is proposed within existing capacity. Any additional resource proposal will be considered separately.

Legal and / or Regulatory implications

The Bill has not been enacted. The existing legislative framework and Trust constitution continue to govern the elections and the Council's work. Any departure from the current election arrangements would require a specific lawful basis and appropriate confirmation before implementation. The paper does not propose a constitutional amendment.

Equality, diversity and inclusion implications

Election communications and participation in the proposed design work should be accessible. Future arrangements should consider the range of communities served, including patients and carers less often heard. The government's equality assessment recognises that the effect of reform will depend on local implementation.

Environmental sustainability implications

No direct material environmental implication is identified at this stage. Appropriate digital communication and meeting participation can reduce travel and printing, while retaining accessible alternatives for those who need them.

Health Bill Update

Council of Governors, 30 September 2026

1.0 Purpose of paper

1.1 This paper updates the Council of Governors on the Health Bill and the implications for St George's University Hospitals NHS Foundation Trust. It follows the initial overview considered on 25 June 2026 and brings together the parliamentary progress of the Bill, the next elections scheduled to the Council of Governors, and proposed preparation for future patient and community involvement.

2.0 Background

2.1 The Government's Health Bill was introduced in the House of Commons on 14 May 2026. It provides the legislative basis for major elements of the Government's NHS 10 Health Plan for England, including changes to how the NHS is organised, governed and held accountable. The Government's stated objectives are to reduce organisational duplication, clarify responsibility for NHS performance and give local organisations greater flexibility to respond to the needs of their populations.

2.2 The Bill proposes the abolition of NHS England, with its functions transferred to the Secretary of State, the Department of Health and Social Care and other NHS bodies, including integrated care boards. It also contains reforms to local commissioning and planning arrangements, changes to the oversight of NHS foundation trusts, and a legislative framework for a Single Patient Record. Further provisions would remove the existing statutory Healthwatch arrangements and transfer their functions, and transfer the functions of the Health Services Safety Investigations Body to the Care Quality Commission.

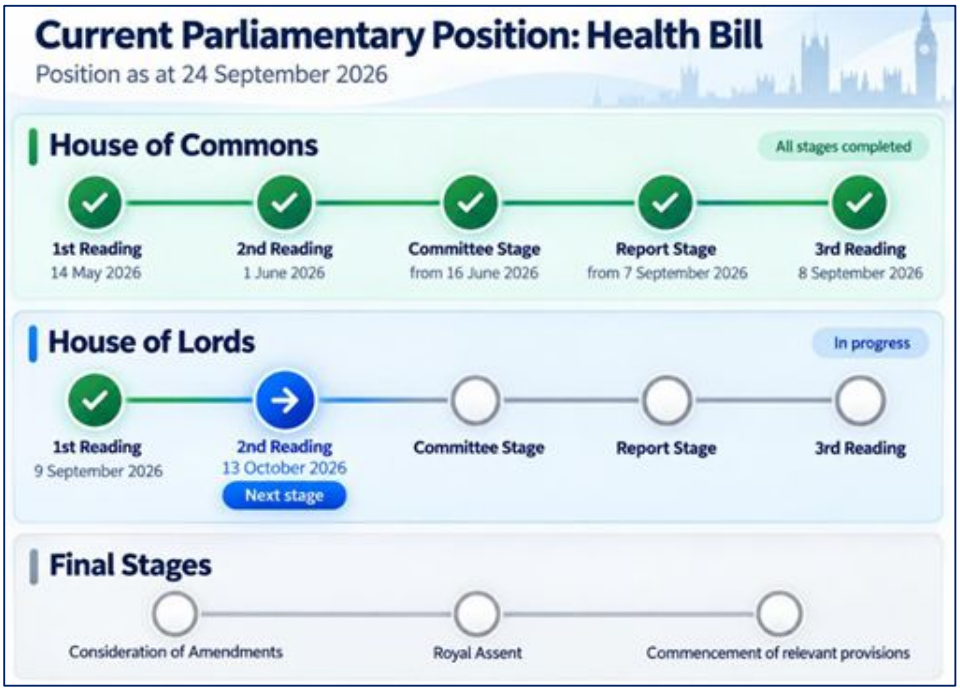
2.3 Of particular relevance to Governors, the Bill would remove the statutory requirement for foundation trusts to have members and a Council of Governors. Existing governor functions would either transfer elsewhere or cease, including the transfer of responsibility for appointing foundation trust Chairs and Non-Executive Directors to the Secretary of State. Government policy envisages trusts developing locally tailored arrangements for patient, staff and community involvement rather than retaining a nationally prescribed governor model.

3.0 Current Parliamentary Position

3.1 The Commons Committee Stage concluded on 16 July 2026. Report Stage took place on 7-8 September, followed by Third Reading on 8 September. The Bill received its First Reading in the House of Lords on 9 September; Second Reading is scheduled for 13 October. Substantive Lords scrutiny is therefore still ahead.

3.2 The Bill will undergo further scrutiny during its forthcoming House of Lords stages and remains subject to amendment. Second Reading, scheduled for 13 October 2026, will allow peers to debate its principles and identify provisions requiring further scrutiny. The subsequent Committee Stage will involve clause-by-clause examination and consideration of amendments, with all peers able to participate. During these stages, peers may seek ministerial assurances and propose revisions, with further amendments possible at Report Stage. For the Health Bill, there is already a specific indication of further Government consideration: on 8 September, Minister Karin Smyth committed to working with MPs and peers to review the Healthwatch provisions following concerns about independent scrutiny and patient voice. There are

indications that amendments to preserve an independent local patient voice are being considered, although their detail remains unresolved. These developments leave scope for changes to the eventual patient and public involvement arrangements. They should not, however, be interpreted as a commitment to retain Councils of Governors: the Government's published policy continues to provide for removal of their statutory role.



3.3 Royal Assent would not itself bring every reform into operation. Most provisions would commence on dates specified in regulations, with scope for transitional and saving arrangements. No fixed date for the end of Councils of Governors has been indicated by the Government at this stage.

4.0 The Wider Bill and Changes Since June 2026

4.1 The changes affecting Councils of Governors form part of a wider programme of legislative reform covering national NHS leadership, local commissioning and planning, provider governance and regulation, patient safety, and the use of health information. The Bill supports elements of the Government's 10 Year Health Plan for England, including its proposed shifts from hospital to community, analogue to digital, and sickness to prevention. The Government's stated intention is to reduce duplication in national oversight, clarify accountability and give local organisations greater flexibility to respond to their populations. NHS trusts, foundation trusts and integrated care boards would continue to exist, but their responsibilities, governance and relationships with the national centre would change.

4.2 The Bill combines the transfer of existing functions, particularly following the proposed abolition of NHS England, with new powers and changes to statutory duties. It also provides enabling powers under which further detail would be established through regulations. The legislation should therefore be distinguished from the wider policy and implementation arrangements that accompany it: not every proposed organisational or operational change is specified in the Bill itself.

4.3 During its Commons stages, amendments were made to aspects of board composition, partnership working, visiting and accompaniment, pharmaceutical services, and medicines and medical devices regulation. Ministers also announced further work on Healthwatch and maternity oversight. The table below summarises the principal provisions and developments, distinguishing provisions already included in the Bill from commitments to further consideration.

Principal provisions and key changes since June 2026	
Area	**Summary of proposals and developments**
National NHS leadership	The Bill would abolish NHS England, transferring its functions principally to the Secretary of State, the Department of Health and Social Care and integrated care boards (ICBs). This remains a central proposal.
Commissioning and local planning	ICBs would take direct responsibility for primary care and more specialised services. Statutory integrated care partnerships would be removed, with revised arrangements for neighbourhood health planning. Commons amendments restored the requirement for a local-authority-nominated ICB member.
Foundation trust governance	The statutory requirement for Councils of Governors and membership arrangements would be removed, with Chair and Non-Executive Director appointments transferring to the Secretary of State. No standard successor forum is prescribed. Commons amendments retained the requirement for medical/dental and nursing/midwifery executive representation on FT boards, subject to specified exceptions.
Provider oversight and finances	Provider regulation would transfer to the Secretary of State. The Bill would extend powers to limit FT spending to cover revenue as well as capital and allow an FT to be converted into an NHS trust in cases of serious failure.
Single Patient Record	The Bill would establish the legal framework for a Single Patient Record, connecting health and care information for patients and those providing their care. Detailed access, information-sharing and implementation arrangements would be developed through regulations and supporting work.
Patient safety	The functions of the Health Services Safety Investigations Body would transfer to CQC, with protections for confidential investigation material retained. The Bill would also extend the outer time limit for relevant CQC prosecutions from three to five years.
Healthwatch and patient voice	Existing statutory Healthwatch arrangements would be removed, with functions transferred principally to DHSC, ICBs and local authorities. Ministers have committed to reviewing these provisions during the Lords stages, following concerns about independent scrutiny and patient voice.
Visiting and involvement in care	New Commons provisions would require ICBs to promote appropriate visiting and accompaniment, and local authorities to consider visiting and the involvement of others in care decisions. These are duties to support involvement, rather than unrestricted visiting rights.
Pharmacy, medicines and medical devices	Commons amendments updated pharmaceutical-service and appeal arrangements and expanded provisions on medicines and medical devices regulation. These include powers to establish a future medical-device licensing scheme, with details to follow through regulations.
Maternity oversight	The Government has announced that it will propose a statutory maternity commissioner for England through amendments in the Lords. This is an announced intention, not a provision already included in the Bill passed by the Commons.

4.4 The Commons stages have therefore modified and expanded parts of the Bill, while retaining its principal proposals concerning NHS England, foundation trust governance and the allocation of patient-voice functions. These provisions remain subject to Lords scrutiny and any

subsequent parliamentary amendments. The specific implications for the Council of Governors, Healthwatch representation, forthcoming elections and future local engagement arrangements are considered in the following sections.

5.0 Implications for the Council's Statutory Role

5.1 Clause 30 and Schedule 3, as numbered in the Bill brought to the Lords, remove the statutory governor and membership model. This changes the legal basis of local accountability; it does not simply rename the Council. Governor functions would transfer elsewhere or cease:

Present governor function	Proposed change
Represent members and the public; hold non-executive directors (NEDs) to account	The statutory governor role ends. The policy expectation is for effective local engagement, alongside Board and national accountability.
Appoint and remove the Chair and NEDs	Appointment, removal and suspension powers sit with the Secretary of State under the revised framework.
Determine Chair and NED remuneration	Responsibility for determining Non-Executive Director remuneration transfers to the Secretary of State.
Approve the Chief Executive appointment	The requirement for governor approval is removed. Appointment of the Chief Executive remains a responsibility of the Non-Executive Directors under the revised arrangements.
Approve constitutional changes	The Trust would require Secretary of State approval to amend its constitution, replacing the current statutory approval arrangements involving the Board and Council, with member approval where applicable.
Approve significant transactions and statutory organisational changes	The governor approval role ends. The statutory concept of a "significant transaction" is repealed; merger and other statutory transaction approvals sit within the revised national framework.
Appoint the external auditor	The governor appointment role ends; revised audit arrangements apply under the Bill.

5.2 Amendments seeking to retain Councils of Governors were tabled during both Committee and Report Stages. They did not become part of the Bill:

Stage	Proposal	Recorded outcome
Commons Committee	Three amendments sought to retain the requirement for a Council of Governors.	Not moved / not called
Commons Report	Three amendments again sought to retain the requirement for a Council of Governors.	Not called
Related Report proposal	An amendment sought to place appointment decisions with civil servants rather than Ministers or special advisers. It was not a proposal for a successor governor body.	Not called

5.3 The Bill sent to the Lords therefore continues to propose the removal of the statutory Council of Governors and membership framework. No amendment adopted in the Commons establishes a statutory successor patient or community council. These matters can be reconsidered during the Lords stages, and any eventual change must be assessed against the final legislation rather than assumed now.

6.0 Patient and Community Voice: Healthwatch and Future Local Arrangements for FTs

Healthwatch: proposed changes and parliamentary scrutiny

6.1 The Bill proposes changes to both national and local arrangements for patient and public voice. The Bill in its current form would abolish Healthwatch England and remove the existing statutory local Healthwatch arrangements. National responsibilities would transfer to the Secretary of State, while local functions would become responsibilities principally of integrated care boards for health services and local authorities for social care and certain public health services. The Government's accompanying policy envisages a new Patient Experience Directorate within the Department of Health and Social Care, although its detailed structure and functions are not prescribed in the Bill.

6.2 The Government's stated intention is to bring patient and community insight more directly into commissioning, service planning and national policy decisions. Parliamentary scrutiny has, however, raised questions about how independent scrutiny and public confidence would be maintained. On 8 September 2026, Minister Karin Smyth committed to working with MPs and peers to review the Healthwatch provisions during the Lords stages. This is a commitment to further consideration, rather than an agreement to retain Healthwatch: the abolition provisions remain in the Bill and the final arrangements remain subject to parliamentary amendment.

6.3 These developments are particularly relevant to St George's because its Council includes appointed representatives of Healthwatch Wandsworth and Healthwatch Merton. The Trust will continue to monitor the proposals and maintain dialogue with these organisations as the national position develops. Their local relationships and experience of representing patients and communities can also inform consideration of the Trust's future engagement arrangements, without presuming the eventual form of Healthwatch locally.

Future patient and community engagement at Trust level

6.4 Alongside the Healthwatch proposals, the Government intends to replace the nationally prescribed foundation trust governor and membership model with more flexible, locally determined arrangements through which patient, staff and community insight informs providers' decisions. The DHSC provider factsheet, updated on 9 September 2026, envisages trusts tailoring their approach to their populations and retaining elements of existing engagement where these work well. The emphasis is on effective involvement and responsiveness to local needs, rather than requiring every trust to adopt the same structure.

6.5 The Bill does not establish or require a particular successor community council, patient forum or equivalent body. The Bill would remove the statutory governor and membership arrangements rather than replace them with another prescribed structure. The existing public involvement duty under section 242 of the NHS Act 2006 would continue, with the Bill making explicit the inclusion of carers alongside service users' representatives. A local forum would therefore be one possible component of the Trust's engagement arrangements, rather than a statutory body automatically inheriting the Council's powers or replacing Healthwatch's wider functions.

6.6 The Government states that the effectiveness of providers' engagement arrangements would be assessed through Provider Capability Assessments, CQC Well-led assessments and the assessment process for advanced foundation trust status. Local flexibility would therefore sit alongside an expectation that providers can demonstrate effective engagement and its contribution to their work.

6.7 To support preparation, it is proposed that the Trust establishes a small working group over the coming weeks, involving interested members of the Council of Governors and relevant patient, community and Trust participants. This would help explore what future arrangements should achieve and how they could best operate for St George's, while considering the wider Group and a potential future merger. The initial purpose would be to develop thinking and identify options, rather than determine a particular structure or its membership. Further information and proposals would be brought back to the Council and Board as this work progresses, taking account of parliamentary developments and any further national guidance.

7.0 Practical Implications: Governor Elections

7.1 Unless and until the Bill receives Royal Assent and the relevant provisions are brought into force, the existing statutory framework under the National Health Service Act 2006, as amended, remains in force. Foundation trusts and their Councils of Governors must continue to operate within that framework and their existing constitutions. Royal Assent alone would not abolish Councils of Governors: the relevant provisions would need to be commenced, taking account of any transitional arrangements made under the legislation.

7.2 Accordingly, the Council of Governors continues to exist, to meet and to exercise its full statutory responsibilities. These include representing the interests of members and the public, holding Non-Executive Directors to account for the performance of the Board, and exercising its existing appointment and approval functions. The proposed legislative changes do not suspend those responsibilities or the Trust's existing arrangements for electing governors.

7.3 No provision has been identified in the current legislation or the Trust's constitution that authorises St George's to postpone, defer or cancel its scheduled elections solely in anticipation of the Bill becoming law. The constitution requires elected governors to be chosen through elections conducted in accordance with the Model Election Rules. Its provisions for managing casual vacancies and specific disruption to an election do not provide a general power to suspend the scheduled election cycle because the Council may subsequently be abolished. Nor does anticipated legislative change authorise the extension of elected governors' terms beyond their permitted duration.

7.4 Some foundation trusts have taken a different approach. For example, one NHS foundation trust has announced a pause in its 2026 elections, following agreement by its Board and Council of Governors. That decision does not change the legal framework applicable to St George's or establish a corresponding power under this Trust's constitution. The proposed approach is therefore to proceed with the scheduled elections, while keeping the position under review should any legally effective transitional arrangements change the requirements before the election process is completed.

7.5 The Trust's next election round is due to take place later in 2026, with the process completed before the end of January 2027 and new terms commencing on 1 February 2027. The election schedule set out below comprises 12 seats: nine public and three staff. This includes the seats of eight public governors and two staff governors whose current terms expire on 31 January 2027, together with the existing Merton public governor vacancy and Allied Health Professionals and Other Clinical and Technical Staff vacancy. The final seat and term allocations will be confirmed with the Independent Returning Officer before the formal election notice is issued.

7.6 The tables below set out the seats included in the forthcoming election round. For serving governors, the service figures show the total period they will have served on the Council by 31 January 2027, assuming completion of their current terms. Existing vacancies are identified separately.

Public Governor Seats (9):

Constituency	Governor / vacancy	Council service began	Service at 31 January 2027
Wandsworth	John Hallmark	1 February 2018	9 years
Wandsworth	Augustine Odiadi	1 February 2024	3 years
Wandsworth	Jackie Parker	1 February 2024	3 years
Merton	Luisa Brown	1 February 2025	2 years
Merton	Hannibal Latuff	1 February 2025	2 years
Merton	Vacant – previously Chelliah Lohendran	Not applicable	Vacant
Rest of England	Ashok Bhat	1 February 2025	2 years
Rest of England	James Bourlet	1 February 2024	3 years
Rest of England	Xavier Fernandes	1 February 2026	1 year

Staff Governor Seats (3):

Constituency	Governor / vacancy	Council service began	Service at 31 January 2027
Nursing and Midwifery	Dympna Foran	1 February 2024	3 years
Medical and Dental	Abul Siddiky	1 February 2024	3 years
Allied Health Professionals and Other Clinical and Technical Staff	Vacant — previously Atif Mian	Not applicable	Vacant

Total seats to be filled (12):

Category	Expiring occupied terms	Existing vacancies	Total seats
Public	8	1	9
Staff	2	1	3
Total	**10**	**2**	**12**

7.7 The Trust is currently working with the Independent Returning Officer to agree the precise timetable for the forthcoming elections. Elections would ordinarily be completed in November or December, allowing newly elected Governors an opportunity to undertake induction and familiarise themselves with the Trust and their responsibilities during January, before commencing their terms of office on 1 February 2027. The detailed timetable, including nomination deadlines, voting dates and the declaration of results, will be communicated to Governors, members and staff once agreed in the coming weeks.

7.8 Under the Trust's constitution, elected governors may not serve more than nine consecutive years and must then have a break of at least one year before re-election. John Hallmark will complete nine consecutive years on 31 January 2027 and is therefore not eligible to serve a further consecutive term under the current arrangements. Other serving governors in the

proposed election round may seek re-election, subject to continuing to meet the applicable eligibility requirements.

7.9 Subject to confirmation of the final seat allocations, the proposed terms would run from 1 February 2027 to 31 January 2030. Election publicity and candidate information will explain that Parliament is considering legislation which would remove the statutory Council of Governors. If the relevant provisions are enacted and commenced during those terms, the governor role could end before January 2030. Prospective candidates will therefore be informed of both the current responsibilities of the role and the uncertainty about its future duration.

8.0 Recommendations

8.1 The Council of Governors is asked to:

a) **Note** the legislative update and continuing statutory responsibilities;
b) **Note** the proposed approach to the 12-seat election round; and
c) **Support** establishing a small working group over the coming weeks, with further information to return to the Council.

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NHS
St George's University Hospitals
NHS Foundation Trust

Council of Governors

Meeting in Public on Wednesday, 30 September 2026

Agenda Item	3.1	
Report Title	**Report from the Membership Engagement Committee**	
Governor Lead	Jackie Parker, Chair - Membership Engagement Committee	
Report Author(s)	Jackie Parker, Chair - Membership Engagement Committee Anna Missir, Governors and Membership Officer	
Previously considered by	n/a	-
Purpose	**For Noting**	

Executive Summary

The Membership Engagement Committee met on 10 September 2026 and reviewed progress against the 2026–2028 Membership Engagement Strategy, preparations for the Annual Members' Meeting (AMM), the developing programme of Member Talks, Connected, Meet Your Governor activity and targeted engagement.

The Committee supported a continued emphasis on meaningful engagement with existing members and local communities, with youth engagement remaining a strong priority. In light of proposed legislative changes affecting Foundation Trust membership and Councils of Governors, the Committee considered that recruitment activity should remain proportionate and targeted rather than focused solely on increasing numbers.

Since the Committee meeting, a Meet Your Governor event was held in the Grosvenor Wing on 15 September. Governors used agreed prompts to gather feedback from patients, visitors and members. The feedback was generally positive about staff, while also identifying themes around waiting times, communication, joined-up systems and appointments, and the range and affordability of food options.

This report also summarises feedback from Governor visits to Senior Health wards on 19 August, where delayed discharge and patient flow were recurring themes, alongside concerns raised by staff about bed capacity, space and heat on particular wards.

Action required by Council of Governors

The Council of Governors is asked to:

a) Note the report of the Membership Engagement Committee meeting held on 10 September 2026.

b) Note progress in delivering the 2026–2028 Membership Engagement Strategy and the Committee's continued emphasis on meaningful engagement, particularly with younger people.

c) Note the feedback arising from the Governor visits to Senior Health wards on 19 August 2026.

d) Note the feedback gathered at the Meet Your Governor event held on 15 September 2026.

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NHS
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Committee Assurance	
Committee	Not Applicable
Level of Assurance	Not Applicable

Appendices	
Appendix No.	**Appendix Name**
Appendix 1	Feedback from Governor Visits to Senior Health Wards – 19 August 2026
Appendix 2	Membership Engagement Strategy 2026–2028

Implications

Group Strategic Objectives

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

Risks

N/a

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

The Membership Engagement Strategy includes specific actions to improve engagement with younger people and members from global majority backgrounds to support a membership that is representative of the communities served by the Trust.

Environmental sustainability implications

N/A

Report from the Membership and Engagement Committee

Council of Governors, 30 September 2026

1.0 Purpose of paper

This report sets out the key matters considered by the Membership Engagement Committee at its meeting on 10 September 2026 and provides subsequent updates on Governor engagement activity.

2.0 Progress Report

2.1 Membership Engagement Committee – 10 September 2026

The Committee received updates on preparations for the Annual Members' Meeting (AMM), the Member Talk programme, Connected, Meet Your Governor activity and progress against the 2026–2028 Membership Engagement Strategy.

Communications advised that AMM promotion and registration were underway. The Committee supported a refreshed Lead Governor presentation which would explain Foundation Trust membership and the Governor role, highlight Governor activity and impact during the year, and promote opportunities for members to become involved. The Committee also emphasised the importance of clear signage and support for attendees at the AMM.

The first online Member Talk with Mat Shaw, Group Chief Executive Officer, was confirmed for 18 September. The session was designed to include a short introduction followed by questions from members, including questions submitted in advance. Registrations and advance questions were being captured through Microsoft Forms. A further Member Talk linked to 24 Hours in A&E was being explored for later in the year, and Communications agreed to consider an engagement opportunity relating to Addison's disease.

The Committee noted that work on Connected was nearing completion and supported a more regular and coordinated approach to member communications, including prominent promotion of forthcoming engagement opportunities.

The Committee considered the balance between membership recruitment and engagement in light of proposed legislative changes affecting Foundation Trust membership and Councils of Governors. Members agreed that the majority of current activity already focused on meaningful engagement with existing members and communities and should continue. Youth engagement remained a strong priority, with the Committee supporting continued relationship-building with younger people and links with City St George's.

Subject to a small wording adjustment to strengthen the emphasis on engagement with younger people, the Committee approved the proposed direction of the 2026–2028 Membership Engagement Strategy.

Steve Walters agreed to take forward the establishment of a central live calendar of Governor meetings and engagement events, to provide Governors with a single, up-to-date view of forthcoming opportunities and support attendance and planning. Initial enquiries have already been made and work is progressing to establish the most appropriate way of taking this forward. At the close of the meeting, Steve Walters reflected positively on the discussion and noted that wider Governor attendance at future meetings would provide greater opportunity for input. The

Committee also noted that attendance at this meeting had been affected by a late change of date, following a change to the Board meeting timetable, and that a number of Governors who had been available for the original date were unable to attend the rearranged meeting. Alfredo Benedicto asked that the wider point about encouraging Governor attendance at future meetings be captured and raised with the Council of Governors.

2.2 **Governor Visits to Senior Health Wards – 19 August 2026**

Governors Dympna Foran, Michelle Ellis, Afzal Ashraf and Augustine Odiadi visited Dalby, Caesar Hawkins and Amyand wards on 19 August 2026.

A recurring theme across the visits was delayed discharge. Staff described patients remaining on wards after they were medically ready to leave while appropriate community support, home-care arrangements or care-home placements were being secured. Governors noted the impact this can have on patient flow and bed availability and highlighted the importance of effective partnership working with local authorities, social care and voluntary-sector organisations.

At Dalby Ward, Governors also heard about support provided by RISE+, including practical assistance to help older patients settle at home following discharge. Staff raised concerns about reduced bed capacity and the potential impact on patient flow.

At Caesar Hawkins Ward, staff highlighted limited space, including the lack of a dedicated visitors' room, and concerns about high temperatures during hot weather, particularly for respiratory patients.

At Amyand Ward, Governors were advised that 18 of 20 beds were in use under a summer closure arrangement at the time of the visit. Staff raised concerns about the possible impact of reduced capacity on length of stay, bed availability and patient flow.

Governors suggested that appointed Local Authority Governors raise the delayed-discharge theme with their respective councils and explore opportunities for closer working between local authorities, the Trust and voluntary-sector partners.

2.3 **Meet Your Governor – 15 September 2026**

Following discussion at the September Committee meeting, Governors attending the Meet Your Governor event in the Grosvenor Wing on 15 September were provided with a short feedback template to support more focused conversations with patients, visitors and members. The questions asked what could improve people's experience, what they would like changed, what was working well and what messages they would like Governors to take back to the Board or Executive Team**.**

The written feedback received was mixed but generally positive about the attitude and helpfulness of staff. Several comments described staff as friendly, helpful or caring, and some respondents indicated that they were satisfied with their experience and wanted the Trust to continue what it was doing well.

Areas identified for improvement included waiting times and clearer communication, particularly where there are delays or changes to appointments. Feedback also raised the need for better joined-up systems and information, with concern that different systems do not always communicate effectively with one another.

Other comments included the importance of patients being able to obtain help and advice when needed, positive experience of support services such as PALS, and suggestions relating to the choice, affordability and availability of food, including options for different dietary needs.

The feedback will be used alongside other Governor engagement activity to help inform discussion at Council and to identify themes that may warrant further follow-up.

2.4 Next Steps

The immediate priorities are to deliver the September Member Talk and AMM, continue the programme of Meet Your Governor events, progress future Member Talks and maintain a regular approach to member communications through Connected and other channels. The Committee will also continue targeted engagement with younger people and local communities, while keeping the wider policy and legislative position under review. Steve Walters will also take forward the development of a central live calendar of Governor meetings and engagement events to support forward planning and participation.

3.0 Recommendations

3.1 The Council of Governors is asked to:

- Note the report of the Membership Engagement Committee meeting held on 10 September 2026.
- Note progress in delivering the 2026–2028 Membership Engagement Strategy and the Committee's continued emphasis on meaningful engagement, particularly with younger people.
- Note the feedback arising from the Governor visits to Senior Health wards on 19 August 2026.
- Note the feedback gathered at the Meet Your Governor event held on 15 September 2026.
- Note the Committee's reflection on supporting wider Governor attendance at future Membership Engagement Committee meetings, recognising that attendance on 10 September was affected by the late change of meeting date.