Public Board of Directors meeting

Wed 28 January 2026, 16:00 - 17:45

Robens Suite, Guy's Hospital and online via MS Teams

Guy's and St Thomas' NHS Foundation Trust

Agenda

16:00 - 16:02 (2 min)

1. Welcome and apologies

Verbal *Charles Alexander*

16:02 - 16:03 (1 min)

2. Declarations of interest

Verbal

16:03 - 16:05 (2 min)

3. Minutes of the previous meeting (22 October 2025) and review of actions

Paper

20251022 Public BoD Meeting Minutes vFinal.pdf (4 pages)

16:05 - 16:15 (10 min)

4. Chairman's report

Verbal *Charles Alexander*

16:15 - 16:45 (30 min)

5. Chief Executive's report

Paper *Amanda Pritchard*

Chief Executive Report - January 2026 Public Board vFinal.pdf (10 pages)

16:45 - 17:00 (15 min)

6. Resident doctors 10-point plan

Paper *Simon Steddon, Crystal Akass*

10 Point Plan - January Public Board - Final.pdf (6 pages)

17:00 - 17:15 (15 min)

7. Pharmacy update

Paper *Keith Thompson*

Pharmacy and Medicines Optimisation.pdf (6 pages)

17:15 - 17:25 (10 min)

8. Board Assurance Framework

Paper *Tendai Wileman*

Board Assurance Framework.pdf (3 pages)
Full BAF - 31 December 2025.pdf (31 pages)

17:25 - 17:40 (15 min)

9. Updates from chairs of Board committees

Verbal *Board committee chairs*

Papers for noting

17:40 - 17:40
0 min

10. Reports from Board committees:

10.1. Academic Committee in Common 21 October 2025

ACIC summary 21.10.2025.pdf (2 pages)

10.2. Audit & Risk Committee 12 November 2025

ARC summary 12.11.2025.pdf (2 pages)

10.3. Finance, Commercial & Investment Committee 29 October 2025

FCI summary 29.10.25.pdf (1 pages)

10.4. Financial Report Month 9

M09 Financial Performance.pdf (12 pages)

10.5. Quality & Performance Committee 15 October 2025

QP summary 15.10.2025.pdf (2 pages)

10.6. Integrated Performance Report November 2025

IPR November 2025.pdf (14 pages)

10.7. People, Culture & Education Committee 3 December 2025

PCE summary 03.12.2025.pdf (2 pages)

10.8. Transformation & Major Programmes Committee 19 November 2025

TMP summary 19.11.2025.pdf (1 pages)

17:40 - 17:40
0 min

11. Register of documents signed under seal

Documents Signed under Trust Seal - January 2026 Public Board - Updated.pdf (2 pages)

17:40 - 17:45
5 min

12. Any other business

Guy's and St Thomas' NHS Foundation Trust

BOARD OF DIRECTORS

Wednesday 22 October 2025, 4.00pm – 5.45pm
Robens Suite, Guy's Hospital

Members present:	Charles Alexander (Chair)	Jamie Heywood
	Crystal Akass	Deirdre Kelly
	Avey Bhatia	Mark Kinirons (for Louise Dark)
	Sarah Clarke	Graham Lord
	Steven Davies	Damien O'Brien
	Nilkunj Dodhia	James O'Brien (for Gubby Ayida)
	Jon Findlay	Pauline Philip
	Simon Friend	Amanda Pritchard
	Felicity Harvey (MS Teams)	Simon Steddon
In attendance:	Andrew Asbury	Nick Price (item 8)
	Edward Bradshaw (minutes)	Jackie Parrott
	Anita Knowles	Tendai Wileman
	Denis Lafitte	
	Members of the Council of Governors, members of the public and members of staff.	

1. Welcome and apologies

1.1. The Chair welcomed members of the Trust Board of Directors (the Board) and all staff, governors and members of the public in the room and online, and especially to Amanda Pritchard, who had returned to Guy's and St Thomas' in early September as the new Chief Executive.

1.2. Apologies had been received from Gubby Ayida, Miranda Brawn, Louise Dark, Richard Grocott-Mason, Ian Playford and Alison Wilcox.

2. Declarations of interests

2.1. There were no declarations of interest.

3. Minutes of the meeting held on 23 July 2025

3.1. The minutes of the previous meeting were agreed as an accurate record. There were no outstanding actions to follow up.

4. Chair's Update

4.1. The Chair reflected on the upcoming business planning round and noted that, unlike in recent years where trusts had been required to submit annual plans, from 2026/27 trusts would be required to submit three- to five-year plans plans. Once developed, the plan would underpin the implementation of the Trust's strategy to 2030 that had been published last September. Whilst no national planning guidance had yet been released, the Chair noted that development of the plan would be a key operational focus over the coming weeks.

5. Chief Executive's Update

5.1. The Chief Executive opened her report by thanking the Board for the warm welcome she had received since re-joining the Trust, and by acknowledging the legacy of her predecessor, Professor Ian Abbs. Since September she had been struck by the commitment and dedication of staff across the Trust, by

the breadth of the working being undertaken both strategically and operationally, and how the Trust had changed significantly to the one she had left in 2019.

5.2. The Board was informed that, since its previous meeting in July, NHS England had formally placed the Trust into segment one of the NHS Oversight Framework, ranking 15th out of 134 acute trusts. Whilst this was positive news, the Chief Executive recognised the Trust would have to continue to work hard to sustain its position. In addition, Lambeth and Southwark had been selected as pilot sites for the National Neighbourhood Health Implementation Programme. Guy's and St Thomas' was working in partnership with primary care colleagues to act as the 'Integrator' in both boroughs, leading the development of Integrated Neighbourhood Health Teams. This was a flagship initiative from NHS England and the Department of Health and Social Care to support the development of neighbourhood-based health services, a central component of the Government's 10-Year Health Plan.

5.3. The Trust was exceeding planned levels of elective care, with the total waiting list already below the March 2026 target. Elective care performance also continued to improve, with 64.8% of patients starting treatment within 18 weeks; again, this was already above the March 2026 target. However, there was a rising number of patients waiting over 65 weeks for treatment; whilst these patients represented a very small proportion of the overall waiting list, the Trust was working hard to treat them as quickly as possible and to reduce the number of such patients to zero by December 2025.

5.4. Diagnostic performance had dipped in August, in part due to new national guidance recognising the inclusion of audiology patients which had increased the number of patients waiting over six-weeks to 30.7%, above the 16.4% target. However, long waits over 13 weeks had reduced significantly during the year. Cancer care was improving, with the 28-day Faster Diagnosis Standard met at 83.3%, and 62-day performance reaching 61.1%: its highest in 2025/26. Whilst the Trust had consistently demonstrated strong comparative performance against the four-hour urgent and emergency care standard in the last few years, performance had dipped slightly since June and was just over 78% in July, August and September. Patients with mental health conditions attending the emergency department continued to represent a significant area of clinical risk. Board members queried how the Trust was working with colleagues at South London and Maudsley NHS Foundation Trust to ensure these patients were treated in the appropriate settings.

5.5. Board members discussed the transfer of pathology services to the Synnovis hub on Blackfriars Road. Performance had generally been good during the transition, with ongoing improvements noted in turnaround times; however, there had been delays in histopathology since that service had moved in September. Discussions were ongoing with colleagues from Synnovis to address this.

5.6. Winter planning had begun in the summer, with schemes designed to manage seasonal pressures by strengthening community service resilience and avoiding unnecessary admissions. An Equality Impact Assessment had been completed to ensure these schemes did not inadvertently disadvantage individuals or groups with protected characteristics. The Trust had responded well to five days of resident doctor industrial action in July; services across hospital and community sites had remained resilient, although business continuity plans had required the cancellation of a range of elective appointments to prioritise patients requiring urgent care.

5.7. One new patient safety incident investigation – relating to an incident in the Assisted Conception Unit – and one never event were reported in quarter two. The Quality and Performance Board Committee had continued to seek assurance about the steps being taken to reduce and learn from never events, including analysis of trends over the past 24 months. Mortality indicators remained stable, with improvements expected with improved data quality following the implementation of the Epic system. Responding to complaints within the Trust's policy timescales remained a challenge, though progress was reported as a result of strengthened capacity in both the central team and clinical groups.

5.8. Outbreaks of Candidozyma auris, MRSA, and VRE were being actively managed, with only one new acquisition of Candidozyma auris detected in September, indicating progress in reducing transmission. Water hygiene remained a risk area, with improvement work ongoing. The Trust's patient experience remained positive, with high Friends and Family Test scores and strong

performance in national surveys, including the Care Quality Commission's annual NHS inpatient survey 2024, which showed that the Trust had the best overall score amongst similar trusts in London, with particular strengths in kindness and compassion.

5.9. Uptake of the staff flu vaccination had reached 20% in the first three weeks of the vaccine being available; this compared well to other trusts in London and internal work was taking place to promote the importance of the vaccination for staff and patients. Clarification was sought about how the Trust was learning from other organisations to increase uptake still further; it was explained that through attendance at national and regional events the Trust had identified peer vaccinators as an important way to achieve this. The role of senior leaders in promoting the vaccine was also critical.

5.10. The Trust had reported a £24m deficit in the first half of the year. Whilst this was slightly better than plan, overall delivery of the cost improvement programme was behind target, prompting the Trust to implement tighter cost controls including around recruitment, procurement, and temporary staffing. The Productivity Programme was now in its delivery phase and aimed to drive greater financial sustainability through five primary workstreams. Capital expenditure to date was £28.1m, which was £29.4m lower than the phased plan.

5.11. The Trust continued to take pride in the wide range of events it holds to celebrate equality, diversity and inclusion, which include events such as Black History Month in October and religious festivals. The NHS Staff Survey 2025 had opened the previous month and would close on 28 November. Significant efforts were being made to boost participation as a means for staff to share their experiences of working at the Trust and help shape improvements. The latest General Medical Council National Training Survey had showed high trainee satisfaction but highlighted areas needing attention, such as burnout and education time. The Chief People Officer reported that the Trust's rate of annual performance development reviews for 2025 was 91.3%, which was a significant increase from the previous year.

5.12. Work was continuing at pace with the Trust's major capital programmes, including the relocation of the Principal Treatment Centre for very specialist children's cancer services serving south London and south east England, and the establishment of the Guy's Surgical Centre to increase capacity for elective care at Guy's Hospital. The Trust had marked the two-year anniversary of the go-live of the Epic electronic health record system with a showcase event, highlighting its impact on care delivery and patient engagement. Whilst the cumulative financial savings from the implementation of the Epic system were currently behind plan, the Trust was continuing to monitor this closely.

6. King's Health Partners (KHP) Annual Conference

6.1. The Trust's Chief Academic Officer and Chief Medical Officer provided an overview of the KHP Annual Conference that had taken place the previous week to showcase progress in delivering the recently launched KHP strategy, and collaboration between its partner organisations. The Conference had attracted a wide range of people from different organisations and countries; many had attended in person with even more online. Of particular interest had been the opportunity for attendees to see examples of the work underway to deliver KHP's three strategic priorities: delivering personalised health; accelerating digital health; and improving population health. Board members welcomed the update and emphasised the importance of KHP as a vehicle to work across organisational boundaries to improve health outcomes and drive innovation.

7. SC1 London Life Sciences Innovation District

7.1. The Board received an overview of the SC1 London Health and Life Sciences Innovation District, a collaborative initiative that united the Trust and a number of key partners across south central London to drive innovation in health and life sciences. In 2025, SC1 London had seen renewed strategic momentum with the formation of an interim partnership board, whilst a new team had been appointed to advance engagement and delivery. Key developments included planning progress on major infrastructure projects including the Snowsfields Quarter and Royal Street schemes, and the launch

of community-focused initiatives under the SC1 Skills and Employment Plan. SC1 London had also strengthened its role in regional and national strategies, being prominently featured in the London Growth Plan and the UK's Modern Industrial Strategy.

7.2. There was discussion about SC1's aim to position itself alongside other London innovation districts, such as Paddington Basin and the knowledge quarter around King's Cross, by fostering competition while building partnerships. Clarity was sought on how SC1 would differentiate itself and how it planned to attract further investment. Board members reaffirmed their commitment to SC1 and noted the upcoming SC1 Spotlight event on 20 November.

8. Infection prevention and control annual report 2024/25

8.1. The Board noted the infection prevention and control (IPC) annual report for 2024/25 which demonstrated strong performance across a range of key metrics. Despite exceeding national thresholds for C. difficile and E. coli infections, rates remained low compared to peer trusts. Innovations included AI-enabled dashboards, expanded surgical site infection surveillance, and antimicrobial stewardship improvements. The Trust had managed multiple outbreaks, including Candidozyma auris, which was described as very difficult to eliminate. As reported earlier in the meeting, the Trust's Candidozyma auris action plan was showing significant positive impact, and no patients had died or come to serious harm.

8.2. The IPC team had addressed environmental risks including water safety, for which there was an extensive improvement plan in place with regular reporting to the Quality and Performance Board Committee. Staff training compliance was high, and research outputs reinforced the Trust's academic leadership. Priorities for 2025/26 included stabilising Epic reporting, enhancing catheter care, and advancing national surgical site infection research.

8.3. Board members thanked the Joint Director of Infection, Prevention and Control for his hard work over the year and for a clear and comprehensive report. Questions were asked about the reasons why antimicrobial consumption had reduced and the clinical and non-clinical benefits of this. There was optimism that data quality improvements driven by Epic could lead to significant patient benefits, including an increase in the number of real-time interventions in clinical groups, although it was noted there remained some issues in extracting data from the system in the correct format.

8.4. There was discussion around the progress being made in addressing the Candidozyma auris outbreak and queries around the sustainability of the rapid diagnosis procedures that had led to the improvements, given the cost of these tests.

9. Reports from Board committees for noting

9.1. The non-executive chairs of the Trust Board committees summarised the key areas of discussion, the key risks noted, and the decisions made in the committee meetings held since the last public Board meeting in July.

10. Reports from Board committees for noting

10.1. The Board noted summary reports from meetings of its committees.

11. Register of documents signed under seal

11.1. The Board noted the record of documents signed under the Trust Seal.

12. Any other business

12.1. There was no other business. The next public meeting of the Board of Directors would be held on 28 January 2026.

BOARD OF DIRECTORS

WEDNESDAY 28 JANUARY 2026

Report title:	**Chief Executive's Report**
Executive sponsor:	Amanda Pritchard, Chief Executive Officer
Paper author:	Edward Bradshaw, Director of Corporate Governance and Trust Secretary
Purpose of paper:	For awareness/noting only
Main strategic priority:	All strategic priorities
Primary BAF risk:	All BAF risks
Key points of paper:	• This report provides the Board of Directors with an update about the Trust's overall performance, including quality of care, clinical operations and finance. • The report also includes updates on major and strategic programmes of work, where significant achievements have been made since the October 2025 Board meeting.
Paper previously presented at:	The content of this report has largely been discussed in other forums, including Board committees, but has been amalgamated for the first time in this report.
Recommendation(s):	The BOARD is asked to: 1. **Note** this paper.

1. Introduction

1.1. As we begin 2026, I would like to thank all our staff for their remarkable efforts over the previous 12 months. Since joining the Trust last September I have been continuously impressed by their dedication and commitment to delivering exceptional care to our patients. I would also particularly like to thank staff who worked over the holiday period, helping to ensure that our patients receive the care they need, including when this is urgent or an emergency, every day of the year.

1.2. We have taken steps to ensure we are as well-prepared as possible to cope with the exceptionally high demand for our services, which we anticipate being sustained throughout winter and beyond. The NHS will continue to face tough challenges in 2026, and as we approach the new financial year I am confident our collective talent, commitment and ingenuity will mean we are well-placed to respond in a way that keeps our patients and communities at the centre of what we do.

1.3. I would like to offer my congratulations to three colleagues from the Trust who were awarded honours in the King's New Years Honours List:

- Lorenzo Garagnani, consultant orthopaedic hand and wrist surgeon, who was made Member of the Order of the British Empire (MBE) for his service to children with hand and upper limb differences, including pioneering specialised, multidisciplinary clinics at the Trust;
- Major Neeraj Shah, a recently appointed consultant in the Lane Fox Unit at St Thomas' Hospital, who was awarded the King's Volunteer Reserve Medal; and
- Simon Friend, a Non-Executive Director on our Board, who has also been appointed a Member of the Order of the British Empire (MBE) in recognition of his years of service to charity.

On a personal note, I was hugely proud and deeply honoured to be made Dame Commander of the Order of the British Empire. This award really belongs to the extraordinary people across the NHS, past and present.

1.4. In recent months we have been please to host two notable visitors to the Trust. In December the Archbishop of Canterbury-elect, Sarah Mullally, visited us with a film crew from the BBC as part of a day of filming for her New Year message which was broadcast on New Year's Day. Bishop Sarah met staff and patients and visited Nightingale ward at St Thomas' Hospital, where she trained as a nurse, and took part in craft activities with children at Evelina London Children's Hospital. In early January we also welcomed the Secretary of State for Health and Social Care Wes Streeting to the Royal Brompton Hospital where I introduced him to our navigational bronchoscopy team. Watching them in action as they performed a robotic-assisted bronchoscopy was genuinely inspiring.

2. Significant developments since the previous public Board meeting

2.1. The Trust's overall performance is assessed by NHSE against a range of measures including quality of care, financial performance and waiting times. In quarter two (July to September 2025) the Trust remains in the highest-performing category (segment 1) of the National Oversight Framework. The Trust's position in the acute providers' league table improved from 15th in quarter one to 12th at the end of quarter two, reflecting sustained performance improvements and the continued hard work and commitment of our staff. Performance segmentation is reviewed quarterly, and maintaining this position will require the Trust to build on its achievements and continue to strengthen performance, financial management, quality of care and staff experience.

2.2. Since the last public Board meeting the Trust has been busy developing its operational plans for the coming years. Colleagues across the Trust have worked incredibly hard to balance longer-term operational, workforce and financial planning with maintaining high-quality care during the busiest time of the year. The Trust submitted an initial two-year plan – covering 2026/27 and 2027/28 – on 17 December 2025, and this is currently being reviewed by NHS England. We are in the process of developing our three-year operational plan which will incorporate 2028/29 and a five-year strategic plan, for submission on 12 February 2026.

2.3. The Trust continues to deliver the ambitions set out in our organisational strategy to deliver better, faster, fairer healthcare for all. At our Board away day in early December we spent time reflecting on the progress we have made against our five strategic priorities, whilst identifying areas for further focus over the coming year to ensure we have the required capacity and capability to deliver these. As the Board is aware, a key enabler of these strategic ambitions is our ability to work collaboratively and in partnership with individuals and organisations from across the health system and beyond. The Trust's scale and breadth of operations means this partnership landscape is complex. However, since returning to the Trust last year, my view is that we navigate it well. We are strengthening long-standing strategic partnerships, such as with King's Health Partners, and developing newer ones, for example to help support our aspirations for integrated neighbourhood services. We also host a large number of clinical and corporate services and programmes on behalf of the wider system, including the South London Health Innovation Network and the London Procurement Partnership, which demonstrates our commitment to shaping and supporting high-quality healthcare for all those who need it.

2.4. Earlier this month I wrote to the Board to share the news that Simon Steddon, our Chief Medical Officer, has been appointed as Medical Director at NHS England, London Region. In this new role, Simon will provide professional leadership to the capital's medical and Allied Health Professional (AHP) workforce whilst helping shape new models of care across the region. I would like to congratulate Simon on his new appointment – one that will enable patients and colleagues across the capital to benefit from his experience of improving and transforming healthcare delivery here at Guy's and St Thomas'. Simon will take up his new role on 1 April, and I will update the Board in due course about the interim arrangements to ensure continuity and a smooth transition.

2.5. I am delighted that the Trust has appointed Julian Kelly as Chief Strategy and Transformation Officer. This is a new role that will largely consist of the previous Deputy Chief Executive portfolio that Lawrence Tallon held prior to his departure, but with some important changes that are designed to increase vital capacity to drive forward our strategic ambitions and deliver the necessary transformation upon which this rests. Julian brings a wealth of experience, including expertise in leading complex strategic transformation at scale, and will be a fantastic addition to the Trust's executive team and Board when he starts on 1 February. Leadership oversight for the Trust's capital programme, along with our major programmes, private patient services and our productivity programme, will remain with Steven Davies as he moves into an expanded finance and investment role following a period as interim Deputy Chief Executive. Damien O'Brien, who has been covering the Chief Financial Officer role, will also take on an expanded role as Executive Director of Finance. Changes to executive portfolios will take effect from 1 April. I would like to thank Steven and Damien for their outstanding leadership of their interim portfolios, and I am confident that Julian's appointment alongside them will create even greater opportunity for success in the years to come.

3. Delivering healthcare across the Trust

3.1. A comprehensive Integrated Performance Report is included in the Board papers for this meeting which sets out how we are performing against the plans we have agreed with NHS England.

3.2. Activity: The Trust is working hard to safely treat as many patients as possible and continues to exceed activity targets agreed with NHS England. The total waiting list at the start of January 2026 was 110,655 which is already lower than the plan of 114,730 by 31 March 2026.

3.3. Access to elective care: The Trust has been placed into NHS England's tiering programme for elective care because of our distance from trajectory to eliminate all patients waiting over 65 weeks for treatment. At the end of December we predicted up to 40, but thanks to an incredible collective effort there were 25 such patients, mainly in vascular and urology, almost all of whom declined an appointment as they wished to wait until January. The Trust is, however, ahead of plan in the number of patients waiting over 52 weeks (1,235 versus the plan of 1,343), but whilst these patients represent a very small proportion of our overall waiting list, we are working hard to treat them as quickly as possible and prevent others waiting this long. Our overall referral to treatment performance, which measures waiting times against the national 18-week standard, is 65.5%; this exceeds our plan of 63.8% and compares favourably with other providers both regionally and nationally.

3.4. Diagnostics: After improvements earlier in 2025/26 diagnostic waits have risen over recent months and remain significantly higher than we would like, with performance of 35.4% compared to the planned 12.5%. The four most challenging modalities continue to be non-obstetric ultrasound; MRI; adult audiology; and paediatric echocardiogram. The Trust remains in the NHS England tiering programme for diagnostic performance, and this is helping to identify and implement a range of measures that will lead to sustainable improvement in our performance. The decision to support the development of a community diagnostic centre with £1m initial capital seed funding is a welcome and crucial enabler of longer-term improvement.

3.5. Cancer: Performance against the 28-Day Faster Diagnosis Standard (FDS) for patients with actual or suspected cancer reached 82.8% in October 2025 and indications are that this increased in November. This continues the Trust's strong performance during 2025/26. Improving our performance against the 62-day standard for patients to start cancer treatment following diagnosis remains our greatest operational challenge and we remain in the tiering programme. 62-day performance was 50.8% in October versus the plan of 67.0%, although our internal position was again significantly better at 68.5%. We have been stepping up the focus on improving 62-day cancer performance through initiatives including a revised approach to PTL management, and a backlog clearance plan for Q4. Specific "summits" are planned for our key services and issues around pathology turnaround times have been escalated. We would expect the cumulative impact of these measures to begin to show sustained improvement in performance from Q1.

3.6. Urgent and emergency care: The Trust's urgent and emergency care performance continues to be one of the strongest in the country and was 80.1% against the four-hour standard in November, which exceeded the month-end plan of 77.1%. A key operational objective is to sustain this performance through the winter months. Patients with mental health conditions attending our emergency department continue to represent a significant area of clinical risk and the Trust is continuing to work closely with South London and Maudsley NHS Foundation Trust to ensure these patients receive care as quickly as possible in the most appropriate settings.

3.7. Industrial action: Since the last public Board meeting resident doctors have undertaken two separate episodes of industrial action under a British Medical Association mandate in response to a national pay dispute: firstly between 14 and 19 November 2025 and secondly between 17 and 22 December. While services across our hospital and community sites remained resilient during both episodes of industrial action, business continuity plans required the cancellation of a range of elective appointments to prioritise urgent care. Based on average tariffs this resulted in a detrimental financial impact to the Trust of £885k and £2.1m respectively. The Trust continues to respect the right of staff to take industrial action but hopes that further negotiations will help avoid future disruption and minimise impact on patient care. Resident doctors are a vital part of our workforce, and we are committed to implementing NHS England's 10-point plan to improve resident doctors' working lives.

3.8. Quality of Care: The Trust remains committed to delivering safe, high-quality care to all our patients. Incident trends are monitored on a regular basis and a comprehensive quarterly review submitted and scrutinised by our Trust Risk and Assurance Committee. Incident reporting is encouraged by the Trust to ensure we learn from near miss events as well as any occasions where incidents have occurred. Our reporting rates remain consistent with circa 7,000 patient safety incidents reported in the last quarter, 97% of which were no or low harm. The most commonly reported incidents relate to medication, violence, and aggression to ward staff and delays in clinical care. The Trust continues with improvement work and programmes of work to address these areas. Patient administration related incidents have reduced from previous data, which is a positive sign that the processes within our new electronic patient record system are helping to drive quality improvements. Further work continues to improve experience for patients accessing appointments and contacting the Trust. In Quarter 3 (October – December 2025), three never events were reported, taking the total to nine for the financial year to date. All reported never events are investigated using an

appropriate learning response in line with the National Patient Safety Incident Response Framework (PSIRF) and the Trust held a collaborative learning event with clinical staff in early January to identify further actions, in addition to the existing improvement plan, to try and prevent these incidents occurring.

3.9. One Maternity and Newborn Safety Investigation (MNSI) was reported in Quarter 3 involving an unexpected admission to the Neonatal Intensive Care Unit. Three Ionising Radiation (Medical Exposure) Regulations (IRMER) incidents occurred involving increased exposure or incorrect imaging. All IRMER incidents were reported to the Care Quality Commission in line with the required process. Mortality indicators remain better than the national expected range, with the latest Summary Hospital-level Mortality Indicator (SHMI) 12 month rolling August 2024 to July 2025 (currently at 94.42 compared to 100 nationally) showing a positive trend compared with previous data. The Trust monitors this data monthly as part of its quality monitoring metrics and learning from deaths process.

3.10. Martha's Rule: The Trust continues to implement Martha's Rule. Component 1, the daily patient wellbeing check, has been trialled in the Evelina London Children's Hospital and on two adult inpatient wards. On our Evelina London children's wards, use of the 'carers concern' question within the National Paediatric Early Warning System Framework has improved significantly, rising from 21% to 50% completion, strengthening family engagement and early detection of concerns. The Trust is also part of the national Martha's Rule pilot in community settings. Components 2 and 3, regarding escalation to a different team if concerns persist, are fully operational across the Trust. Awareness materials have been distributed to all adult and paediatric wards, with additional translated resources in development.

3.11. Infection prevention and control: A relentless focus on infection prevention and control remains. The Trust has reported ten cases of healthcare-associated MRSA bloodstream infections in 2025/26 to date. Each case is investigated and the Director of Infection, Prevention and Control and the Chief Nurse or Chief Medical Officer meet the directorate management team to discuss any lapses in care, agree an action plan and identify any further Trust-wide learning. MRSA is frequently associated with vascular access devices and a Trust-wide improvement programme, *Every Device Journey Matters*, has been developed to address this. The *Candidozyma auris* (*C. auris*) outbreak at St Thomas' Hospital continues, although the number of new cases being identified has continued to reduce with 26 new detections in Q1 compared to 20 in Q2 and 14 in Q3. A new Trust-wide Cleaning Group has been established to further enhance cleaning effectiveness.

3.12. Flu: The staff flu vaccination campaign commenced on 1 October 2025 and will continue until 31 March 2026. The campaign has built on last year's successes and seen an increase in the number of peer vaccinators trained and actively delivering vaccines across the organisation. The Trust has successfully exceeded the NHS England external target to increase the end of season uptake for frontline staff by 5% (the target was set at 40.1%), with the current frontline staff uptake at 43.6% and a total of 9,950 vaccines delivered across all staff. The Trust is currently ranked eighth out of 32 London NHS providers for flu vaccine uptake amongst frontline staff.

3.13. Patient Experience: Overall patient experience remains positive. Friends and Family Test scores exceed 90% in most areas, with the Emergency Department rising to 88.0% in November and maternity services declining slightly to 85.5%, from 88.8% at the start of Quarter 3. With the exception of outpatients and admitted care, response volumes for all other areas improved slightly in November. Benchmarking results from the Care Quality Commission's annual NHS maternity survey 2025 showed that Guy's and St Thomas' had the joint second highest overall score when compared with a group of other teaching trusts in London. Women's experience of maternity care had improved in several areas including provision of information on where to give birth, women getting the help they needed during both the antenatal period and labour and birth, and the kindness and understanding staff showed women. There are opportunities for improvement relating to aspects of care during the antenatal period and during triage when women present in the early stages of labour. 'Staff caring for you' is a patient experience metric in the National Oversight Framework for 2025/26 with an improved Trust score since 2024.

3.14. Neurodiversity Strategy: In December the Trust launched its first Neurodiversity Strategy, *Our Neurodiverse Voices at the Heart of Care*, co-produced with neurodivergent individuals, families and staff to ensure lived experience underpins a clear vision for equitable, accessible and high-quality care. The strategy focuses on embedding lived experience and inclusive practice across the Trust so that care and employment are equitable, accessible and high quality for neurodivergent people. Delivery will be through six priorities: improving access to services (including flexible appointments and sensory friendly environments); enhancing recognition and understanding (including staff training and accessible information); tackling health inequalities; supporting families and networks; improving access for children and young people; and valuing and supporting neurodivergent staff (including inclusive recruitment, reasonable adjustments and manager education). Implementation will be phased over five years overseen by a dedicated governance structure with annual review and impact reporting.

4. Sustaining and improving the Trust's financial performance

4.1. So much of what we want to do as an organisation is dependent on us being financially sustainable; we are therefore continuing to take all reasonable steps to improve our financial position to enable us to deliver excellent care to our patients and create the best possible working environment for our staff. In the nine months to 31 December 2025, the Trust reported a year-to-date deficit of £25.1m, which is around £80k ahead of the planned position. We continue to anticipate meeting our planned breakeven position at the end of the year. The cash balance increased to £149.4m at month nine, whilst year-to-date capital expenditure was £85.2m, which is around £52m lower than the phased plan including additional public divided capital awards and donations. Several capital schemes have been brought forward to mitigate the slippage of in-year schemes to ensure we spend our full allocation for the year.

4.2. A key enabler of our future financial sustainability will be delivery of our savings plans which will reduce our costs to a level that is in line with the income we receive. In 2025/26 to date, we have identified around £83.8m (82%) of our full-year cost improvement savings target of £102.1m. Of this, we have delivered £53.4m, which is £6.3m behind plan. Last month we reported to the Board a series of actions that we were taking to control our costs in areas including temporary staff usage, recruitment and procurement. Whilst these controls have started to

take hold we fully recognise the need to increase the pace of implementation.

4.3. Our Trust-wide productivity programme continues to build momentum and is central to our organisational objectives in the coming years. The key objective of the programme is to identify opportunities to work more efficiently so we can spend more time delivering high-quality care to our patients, while ensuring we are financially stable. In recent months there has been particular focus on three workstreams in the programme:

- Administration: this workstream focuses on how we can make our corporate services and clinical administrative functions more effective and fit for the future. We are looking to modernise how we work, make better use of digital technology and improve the support we provide to clinical teams.
- Flow: improving 'patient flow' through our hospitals is vital to ensuring we can deliver safe, high-quality care to as many people as possible. 5 key principles have been developed which all wards and specialities should be following to help get patients home as soon as it is safe to do so; and
- Surgery: multi-disciplinary teams across the Trust are working together to improve the way we plan and deliver surgery. We are focused on treating more patients, making better use of our operating theatres, and creating a smoother experience for both patients and staff. This approach not only improves care but also ensures we are using our resources wisely.

5. Supporting our workforce

5.1. The Trust takes great pride in the wide range of events we hold to celebrate equality, diversity and inclusion at the Trust. As we reported at the last Board meeting, in October 2025 we celebrated Black History Month where a display honouring Kofoworola Abeni Pratt, the first Black nurse to work in the NHS, was unveiled at St Thomas' Hospital. In recent weeks we have also held events to recognise and celebrate several important religious and cultural events including Hanukkah and Christmas. The Trust's annual Love Admin awards were held on 15 January to recognise the outstanding contribution of our administrative and clerical teams whose work is so crucial to the efficient and effective delivery of high-quality care to our patients.

6. Transforming for the future

6.1. One of the Trust's major programmes is to relocate the Principal Treatment Centre for very specialist children's cancer services serving south London and south-east England from south-west London to the St Thomas' Hospital site. In November 2025, the programme reached a significant milestone with the approval of the full business case, confirming its affordability and deliverability. Whilst there are several high-level risks being actively managed, planning remains on course for the safe and sustainable transfer of services in March 2027.

6.2. The Trust's new Green Plan was launched early this month and sets out our priorities to 2028 which supports our commitment to protect the

environment, alongside the delivery of high-quality care for patients. The Trust is committed to incorporating sustainability into everything it does, which means treating patients in the most environmentally friendly way. It also means transforming green spaces, improving the air we all breathe, minimising waste and championing cleaner, greener ways of getting around. As well as creating a healthier local environment, these measures will improve the health and wellbeing of patients, staff and visitors. We marked this launch with a 'Green Week' between 12 to 16 January, which featured range of events taking place at our sites including drop-in stalls, garden volunteering and a wellbeing walk from Guy's Hospital to St Thomas' Hospital. I would like to extend my congratulations to the catering team at the Royal Brompton Hospital, which won the Health Service Journal (HSJ) 'Towards Net Zero' Award for their innovative approach to sustainable hospital food, including new plant-based menus and a bio-waste processor that turns food waste into compost on site.

7. Other news

7.1. At the end of October 2025, the Trust celebrated the 20th anniversary of the Evelina London Children's Hospital building. Over the last two decades the number of children we care for in the Evelina hospital has nearly tripled, whilst we have expanded our services to include more than 30 specialties, from cardiology to complex surgery. It has also become a hub for cutting-edge research and innovation and has achieved numerous clinical milestones including the development of robotic surgery and life-saving gene therapies.

7.2. The Trust is immensely proud of its Nightingale Academy for nurses and midwives which was established in 2017 to build on the legacy of Florence Nightingale, who opened her first School of Nursing at St Thomas' Hospital which helped define the profession and pushed forward the boundaries of nursing practice. In 2025 we celebrated a record number of Nightingale Award graduates, including our first nursing assistants and nurse associates. Phase 1 of the Positive Action Programmes – Evolve, Excel and Elevate – has been successfully completed and was marked by a Joint Graduation Ceremony in November. The event celebrated participants and reaffirmed our commitment to supporting Global Majority staff to progress with confidence and visibility. Early feedback shows increased confidence, leadership capability and career clarity, alongside a stronger sense of belonging. Cohort 2 is now onboarding, and 2026 will build on this success with continued focus on sexual safety, anti-racism and inclusion.

7.3. Finally, I would like to extend my congratulations to Royal Brompton Hospital's Rasleen (Ras) Kahai who was named HSJ Clinical Leader of the Year, becoming the first dietitian to receive the award. Ras was recognised for her pioneering research into nutrition for patients with lung disease and her leadership on accessibility and staff inclusion.

8. Consultant appointments (1 October 2025 – 31 December 2025)

8.1. The Board is asked to note the following consultant appointments made since the last report:

Post	Appointee	Post Type	Start date
Consultant in Neurological/Neuropsychiatric Sleep Medicine	Brent Elliot	Vacant Post	19/01/2026
Consultant in Paediatric Neuroimaging	Alexia Maria Egloff Collado	Vacant Post	05/01/2026
Consultant Radiologist with an interest in Head and Neck Imaging	Kyle Robert Scott Stephenson	Vacant Post	02/02/2026
Consultant Cardiologist in Heart Failure, Transplant & Mechanical Circulatory Support	Francesca Fiorelli	New Post	29/12/2025
Clinical Oncology posts x3: Consultant Clinical Oncology – Prostate, Breast and AOS	Khrishanthne Sambasivan	Vacant Post	09/02/2026
Clinical Oncology posts x3: Consultant Clinical Oncology – Breast / PRUH AOS	Robert Urwin	Vacant Post	09/02/2026
Clinical Oncology posts x3: Consultant Clinical Oncology – Head and Neck, Thyroid	Delali Adjogatse	Vacant Post	10/02/2026
Consultant in Pulmonary Hypertension	Heba Saman Nashat	Vacant Post	01/12/2025
Clinical Oncology post x2: Consultant in Clinical Oncology – Neuro Prostate	Pinelopi Gkogkou	Vacant Post	23/03/2025
Clinical Oncology post x2: Consultant Clinical Oncology – Urological and Prostate	Vishal Devkishen Manik	Vacant Post	09/02/2026
Consultant Neurologist with a specialist interest in movement disorders	Dilan Athauda	Vacant Post	01/12/2025
Consultant in Adult Cardiothoracic Anaesthesia and Critical Care	Rachel Gemma Li Liene Wong	New post	TBC
Consultant in Cardiothoracic Anaesthesia	Valentino Dammassa	New Post	01/12/2025
Consultant in Cardiology – Electrophysiology and Devices	Davide Fabbricatore	Vacant post	15/12/2025
Consultant in Adult Cardiac Surgery	Pouya Youssefi	New Post	02/01/2026
Consultant Radiologist with a special interest in Cardiothoracic Imaging	Carolyn Horst	Vacant post	01/05/2026
Consultant in Thoracic Surgery	Akshay Amar Jatin Patel	New Post	02/02/2026
Paediatric Ear, Nose and Throat	Sarah-Jayne Edmondson Lee	Vacant post	03/11/2025
Plastic Surgery Consultant with special interest in Head & Neck Cancer	Sarah Riadh Al-Himdani	New post	01/022025
Consultant in Radiologist in Breast Imaging	Charlotte Jane Marriott	Vacant post	02/02/2026
Consultant in Radiologist in Breast and Gynaecological Imaging	Stephan A Edey	Vacant post	23/03/2026
Consultant Vascular Surgeon	Mohamed Ahmed Abdelhalim	Vacant post	18/05/2026
Consultant Cardiac Surgeon	Yassir Hassan Iqbal	Vacant post	01/01/2026
Consultant in Adult Congenital Heart Disease	Sophie Anne Jenkins	Vacant post	06/07/2026
Consultant Clinical Oncology - Specialist Interest in Lung	Thomas Young	Vacant post	TBC

BOARD OF DIRECTORS

WEDNESDAY 28 JANUARY 2026

Report title:	**Implementing the NHS 10 Point Plan: Enhancing the Working Lives of Resident Doctors**
Executive sponsor:	Simon Steddon, Chief Medical Officer
Paper author:	Dorothy Kufeji, Guardian of Safe Working
Purpose of paper:	To provide assurance
Main strategic priority:	Valuing all of our people
Primary BAF risk:	Risk 10: High performing and future ready workforce
Key points of paper:	• The NHS 10 Point Plan (the Plan) seeks to address the longstanding challenges faced by resident doctors, with the aim of improving their working lives, supporting wellbeing, and ensuring the delivery of high-quality patient care. The Plan, which builds on previous national guidance and the NHS Long Term Workforce Plan, requires every NHS Trust to act across all ten areas within a defined timeframe and to report progress to their boards. • The Plan is closely aligned with national priorities, including the *'Making Working Lives Better'* programme and the implementation of the NHSE Sexual Safety Charter. Ongoing oversight and centrally coordinated support will be essential to maintain momentum, address remaining challenges, and ensure the Trust continues to meet national standards and expectations. • The Trust has made significant progress in implementing the keys actions set out in the Plan, including improvements to induction, rota management, payroll accuracy, wellbeing facilities, and support for International Medical Graduates and Locally Employed Doctors. These actions are, demonstrably, directly addressing longstanding challenges and enhancing the working lives of resident doctors.
Paper previously presented at:	Trust Executive Committee, 21 October 2025 People, Culture and Education Committee, 3 December 2025
Recommendation(s):	The BOARD is asked to **note** the progress the Trust has made against the actions set out in the Plan and to support its ongoing implementation.

1. Introduction

1.1. The NHS 10 Point Plan (the Plan) was formally launched on 29th August 2025. The plan seeks to address longstanding challenges faced by resident doctors, with the aim of improving their working lives, supporting wellbeing, and ensuring safety and the delivery of high-quality patient care. This report provides an overview of the Trust's progress in implementing the Plan, highlighting key achievements, ongoing challenges, and areas for further development.

2. Background

2.1. The 75,000 resident doctors working in the NHS are the backbone of the service, providing essential care across all specialties and settings. However, for a prolonged period of time, they have faced unfair and inconsistent working conditions - including payroll errors, poorly managed rotas, limited access to rest facilities and hot food, and the unnecessary repetition of statutory and mandatory training. These issues have contributed to dissatisfaction and burnout, ultimately impacting patient care and the effective running of the NHS.

2.2. In support of their commitment to staff under the 10 Year Health Plan for England, NHS England have described 10 ways in which they are improving resident doctors' working conditions. The plan, which builds on previous national guidance and the NHS Long Term Workforce Plan, requires every NHS Trust to act across all ten areas within a defined timeframe and to report progress to their boards. The Plans' focus is on 'getting the basics right' for resident doctors, with an emphasis on improving working conditions, ensuring fair and equitable access to leave, eliminating payroll errors, and reducing the administrative burden associated with rotations.

2.3. As stipulated by the Plan, the Trust has confirmed that the Chief Medical Officer is the named accountable lead for resident doctors at Board level. The Trust has appointed a substantive Resident Doctor Peer Lead, through an open competitive process.

2.4. The Trust is signed up to the NHS Sexual Safety Charter and has set up a dedicated group led by deputies from the CMO, CPO and CNO to work with colleagues across the organisation to implement the Charter. The Trust Sexual Safety Working Group is making progress with sexual safety risk assessment. In addition to collection and analysis of indirect and direct reporting, the group is launching a climate survey to be first piloted in a specific area and then rolled out across the Trust following feedback and analysis.

2.5. The Trust Sexual Safety Group are working closely with NHSE, The London Community of Practice and other Trusts within the region and nationally. We work closely with professional bodies such as the Medical Royal Colleges, regulatory bodies and other relevant agencies. Initial sexual safety awareness training is now available to all staff via the College of Healthcare (CoH). We are strengthening sexual safety training through a suite of coordinated programmes led by the Sexual Safety Group. These include sexual safety awareness for all staff, manager level training on receiving and processing a sexual safety concern and train the trainer programmes.

2.6. The Trust has actively participated in all nationally required processes, including surveys and data submissions. This has provided an opportunity to benchmark our current position, highlight areas of good practice, and identify priorities for further improvement. The feedback and data gathered have informed both our local action planning and our reporting to the Board. Our approach remains evidence-based and aligned with national expectations. We are committed to ongoing engagement with national reporting and assurance processes.

2.7. The Guardian of Safe Working has been engaging at national and regional levels with Trust Leads and NHSE. These meetings provide opportunity to share progress and examples of good work. These meetings provide an opportunity to share progress and examples of good work along with obtaining important information regarding the next steps and progress on updated guidance. As a specific requirement for the delivery for the 10 Point Plan our Associate Director for Workforce (Medical HR) attended the Payroll Processes Improvement Webinar.

2.8. In March 2025, the Resident Deal Implementation Group (NHS Employers and BMA representatives) agreed a new framework for Exception Reporting. This is based on the terms of the agreed pay offer of July 2024 and the subsequent changes to the Terms and Conditions of Service for NHS Doctors and Dentists in Training (England) 2016. Some of the underlying reasons for the reform are that the current system leads to under reporting and possible detriment of Resident Doctors for submitting exceptions reports.

2.9. There has been demonstrable and consistent improvement in the culture of exception reporting at GSTT over the last few years through openness and collaboration with senior clinicians across the Trust. The Guardian has been able to facilitate system changes to ensure safe working practices and enhance the experience of resident doctors.

2.10. A Trust-wide Exception Reporting Framework change implementation groups A Trust-wide implementation group has been set up (with stakeholders from all GSTT sites) to oversee this work with the Guardian as SRO, and Assistant Director of Medical Workforce as Project Manager. Resident Doctors are also part of this group.

3. Progress Update: NHS 10 Point Plan to Improve Resident Doctors' Working Lives

3.1. **Trusts should take action to Improve the working environment and wellbeing of resident doctors**:

- significant improvements have been made to induction processes – e.g the new exception reporting framework changes and sexual safety awareness.
- enhanced support for Locally Employed Doctors (including International Medical Graduates).
- wellbeing campaigns and staff psychology services have been actively promoted.
- the Trust's "Making Working Lives Better" programme has made good progress and closely overlaps with the objectives of the NHS 10 Point Plan. The programme takes a Trust-wide approach, with robust prioritisation and phased delivery of schemes to maximise impact within available resources.

- the refurbishment of staff rooms at St Thomas' Hospital and Guy's GCCU.
- the scoping of expanded breast milk facilities, all of which directly support improvements to the working environment and wellbeing of resident doctors.

3.2. **Resident doctors must receive work schedules and rota information in line with the Code of Practice:** The Trust remains compliant with the provision of generic work schedules; however, timely completion of *Personalised Work Schedules (PWS)* continues to be a risk, and we are not yet meeting the full Code of Practice requirements. This challenge is largely driven by the increasing number of Less-Than-Full-Time (LTFT) trainees, where the development of accurate PWS relies on close coordination between the resident doctor, clinical services, and Medical HR. Work is underway to streamline processes and improve system efficiency, supported by Trust wide discussions aimed at establishing a more consistent and sustainable approach.

3.3. **Resident doctors should be able to take annual leave in a fair and equitable way which enables wellbeing:** We are identifying areas where there is good practice across the Trust to inform further work on this through the Resident Doctors Steering Group, The Trust awaits NHSE's review of 'how annual leave should be managed' to further standardise practices.

3.4. **All NHS trust boards should appoint 2 named leads:** As reported above.

3.5. **Resident doctors should never experience payroll errors due to rotations:** A robust SOP and improved access to support teams have led to a significant reduction in payroll errors. This is an area that requires further ongoing support and work especially around generic work schedules.

3.6. **No resident doctor will unnecessarily repeat statutory and mandatory training when rotating:** Induction has been overhauled to prevent unnecessary repetition of training, with external certificates now accepted. Resident Doctors onboarding at GSTT can self-declare statman courses that they have already completed and in date.

3.7. **Resident doctors must be enabled and encouraged to Exception Report to better support doctors working beyond their contracted hours:** Exception reporting is encouraged and supported for all resident doctors across GSTT. The new Exception Reporting framework changes have required an update in software (DRS4 to DRS5) and a change in policy guidance and processes. The implementation date is 4th February 2026. The benefit for GSTT is that all resident doctors across all sites will exception reporting in the same way using the same software application. This strengthens our assurance as we will be able to identify trends and pattern right across the organisation.

3.8. **Resident doctors should receive reimbursement of course related expenses as soon as possible:** Study leave processes have been centralised, and instant reimbursement for mandatory courses is now available to all resident doctors, including locally employed doctors for approved courses.

3.9. **We will reduce the impact of rotations upon resident doctors' lives while maintaining service delivery:** Support services (HR, Payroll, Occupational Health and IT) are made available as part of induction to find immediate issues and minimise disruption.

3.10. **We will minimise the practical impact upon resident doctors of having to move employers when they rotate:** The Trust has expressed a keen interest in becoming a Lead Employer organisation to minimise the impact of employer changes during rotations. This process is in the early stages with further updates expected in the coming weeks.

4. National Reporting on 10 Point Plan

4.1. **10PPP Amenities Audit for our main sites**: This submission reflects the status of our core facilities and supports the request from NHSE to provide an updated overview of the amenities available for our resident doctors. Alongside this, we are conducting a more detailed audit of our local site-specific areas to gain a deeper understanding of the day-to-day environment and identify any areas needing improvement. This audit will include how we provide resident doctors the autonomy to complete portfolio and self-directed learning from an appropriate location for them. In parallel, we are developing an improvement plan that will outline the necessary actions to enhance our provision across all locations and areas. This plan is crucial for ensuring we continually improve our services and meet the needs of our resident doctors effectively.

4.2. **Local Amenities Audit**: Work on the local level amenities audit is now well advanced, led by the Resident Doctors' Forum Representatives through a structured data collection process across all specialties and clinical areas. Early analysis of the submissions has highlighted several consistent themes. Overall, feedback is positive, with staff confirming good access to *24/7 hot and cold food provision*, though some departments, particularly those located away from central facilities, reported challenges accessing food during night shifts. Secure storage remains variable: while many areas have adequate lockers, others report limited or no provision. Rest facilities remain a recurrent area of concern, with multiple departments reporting insufficient or poorly equipped overnight rest spaces, and requests for improved rest pods or lounge style seating. Departments have also provided information on local annual leave and study leave processes, which are generally functioning well, and a variety of local wellbeing initiatives.

4.3. The findings will directly inform a Trust wide improvement plan, with prioritisation to be aligned to the Making Working Lives Better (MWLB) workstream and funding pathway. A long list of potential improvements, such as expanded locker provision, upgrades to mess facilities, enhancements to out-of-hours rest areas, and improved vending options, is being developed for review by the MWLB Working Group at its February meeting.

4.4. This work complements the already completed main site Amenities Audit, submitted to NHS England, and ensures that local voices feed directly into organisational planning and investment decisions.

4.5. **NHSE Communications**: we have provided a case study of progress on the 10 Point Plan for NHSE public communications. This effort is part of their commitment to demonstrate that we are listening to resident doctors' concerns and working collectively across the NHS to address them. Our "Making Working Lives Better" programme update includes an overview of some of the work we have completed, particularly provision of 24/7 hot/cold food at night and rest areas.

4.6. **Trust Board and Resident Doctors engagement**: Our CEO and Chairman met with Resident Doctors and their Peer Lead, the CMO and the Guardian of Safe Working to seek their views and insights of the 10 Point Plan and co-develop future improvements. It is essential that actions are shaped in partnership with our Resident Doctors to ensure they reflect local needs and priorities. This in an ongoing area of priority for the Trust.

5. Recommendations

5.1. The Board is asked to acknowledge the significant progress achieved in implementing the NHS 10 Point Plan, including improvements to induction, rota management, payroll accuracy, wellbeing facilities, and support for Locally Employed Doctors (including International Medical Graduates).

5.2. The Board is asked to note the ongoing work to implement the NHSE Sexual Safety Charter, including the upcoming risk assessment and the reconvening of the Sexual Safety Group with dedicated resource.

5.3. The Board is asked to note that the forthcoming implementation of the new Exception Reporting Framework remains on track (4th February 2026).

6. Conclusion

6.1. The Trust has made significant progress in implementing the NHS 10 Point Plan to improve resident doctors' working lives, with notable achievements in induction, rota management, wellbeing facilities, and support for all doctors. The introduction and ongoing development of the new exception reporting framework will strengthen our promise to ensure safe working practices, transparency, and continuous improvement. In addition, our commitment to the 'Sexual Safety Charter' and the work that has been achieved so far shows our commitment to fostering a safe, supportive and inclusive environment to all.

BOARD OF DIRECTORS

WEDNESDAY 28 JANUARY 2026

Report title:	**Pharmacy and Medicines Optimisation Update**
Executive sponsor:	Louise Dark, Chief Executive, Integrated & Specialist Medicine Clinical Group
Paper author:	Keith Thompson, Chief Pharmacist & Clinical Director
Purpose of paper:	To provide assurance
Main strategic priority:	All strategic priorities
Primary BAF risk:	Risk 2: Quality of care and patient experience
Key points of paper:	• Pharmacy and Medicines Optimisation Services deliver safe, effective and resilient medicines services across all Trust and community sites. • Significant programmes of work are underway as part of our Strategy to 2030, to modernise infrastructure and service models, including aseptic transformation, outpatient pharmacy transformation, and readiness for the Evelina London Children's Cancer Principal Treatment Centre (PTC) Programme. • Medicines value, commercial pharmacy manufacturing activity and strong system partnerships continue to support Trust objectives, whilst also supporting change required to deliver the objectives of the NHS Long Term Plan. • Key updates aligned with Trust objectives are presented.
Paper previously presented at:	Trust Executive Committee, 4 November 2025
Recommendation(s):	The BOARD is asked to **note** the paper.

1. Introduction

1.1. This paper provides a general update to the Board on Pharmacy & Medicines Optimisation services, including progress against key objectives to support the Trust's strategic objectives. Pharmacy is a Trust-wide enabling service, integral to patient safety, clinical effectiveness, access to care and financial sustainability. The Pharmacy & Medicines Optimisation service operates across all sites and across multiple regulated environments, including areas licensed by the MHRA, NHS England Regional Pharmaceutical Quality Assurance, General Pharmaceutical Council, and Home Office.

2. Background

2.1. The Pharmacy & Medicines Optimisation Service supports all clinical services across the Trust and wider system. Our vision is to be a leader in pharmacy and medicines optimisation, enhancing the health of the populations we serve whilst also focusing on meeting individual patients' needs. The service is broadly comprised of:

- Medicines Supply Chain services: procurement function, inventory and distribution management, and direct to patient supply of medicines through inpatient dispensaries, outsourced outpatient partnership (Boots UK Ltd) and a number of third-party homecare providers
- Aseptic Preparation Services: preparation and supply of ready-to-administer chemotherapy, parenteral nutrition, and other high risk or complex intravenous medicines; alongside advanced therapies such as Zolgensma® and Hemgenix® and clinical trial medicines
- Clinical Pharmacy Services: provision of a range of interventions to optimise the use of medicines and improve medicines safety and patient experience, including prescribing and deprescribing support, inpatient pharmacist reviews (including medicines reconciliation on admission and discharge), patient counselling and monitoring. A residency and on-call service supports patients and staff out of hours.
- Clinical Pharmacy Support Services: including a medicines advice enquiry answering service for healthcare professionals; a patient medicines helpline; medicines formulary and governance support; digital pharmacy and analytics team; and medicines value and commissioning teams. A pharmaceutical quality assurance service is also available.
- Pharmacy Manufacturing: manufacture of a range of dosage forms, licensed by the MHRA, including sterile medicines (e.g. injections, eye-drops) and non-sterile medicines (e.g. tablets, capsules, creams) and investigational medicinal products for clinical trials. This service provides medicines which are used within the Trust and supplied across the UK.

2.2. We have a Pharmacy and Medicines Optimisation Strategy to 2030 which is aligned with the Trust strategy.

2.3. The Service continues to operate in a challenging environment with workforce pressures, increasing complexity of medicines, rising demand for aseptic services (including treatments for cancer; advanced therapies (including gene therapy); and clinical trials), and heightened

regulatory requirements. These challenges are being addressed through a combination of operational grip, targeted investment and strategic partnerships, and longer-term transformation programmes.

3. Key Updates

3.1. Delivering healthcare excellence

3.1.1. The outpatient pharmacy service delivered in partnership with Boots continues to demonstrate improved quality and patient experience compared with the previous provider, including reductions in dispensing errors, complaints and waiting times. The innovative model also offers greater patient choice: in addition to the two Boots pharmacies at Guy's Hospital and St. Thomas' Hospital, a new offsite location in Uxbridge enables both delivery to patients' homes and a local community collections service from around 50 Boots' branches across London, the South and Southeast.

3.1.2. Our Medicines Value Programme was established to support implementation of best value medicines, to ensure optimal use of medicines budgets. The programme is aligned with the SEL ICB Medicines Value Programme (Chaired by GSTT Chief Pharmacist) and oversees delivery of a number of workstreams including use of best value supply routes, and our biosimilar switch programme. Between April and December 2025, the programme has had oversight of a range of schemes which have collectively delivered over £10m of savings to the NHS. This has been achieved through biosimilar switches (ustekinumab, adalimumab); implementation of procurement frameworks (immunoglobulins); and therapeutic switches (e.g. the LMWH switch from dalteparin to enoxaparin).

3.1.3. In 2025, the Evelina London's pharmacy team won the 'Pharmacist Team of the Year Award' from global pharmaceutical company, Clinigen, beating 100 entries from 23 countries, for the vital role the team plays in ensuring safe, precise, and compassionate care for young patients, as well as its family-centric approach.

3.1.4. We monitor compliance with a broad range of regulatory standards and actively engage with our regulators. An internal audit programme is in place to provide assurance against standards for all our regulated areas. The pharmacy governance team also undertakes annual Trust-wide Safe and Secure Handling of Medicines audit (which complements the medicines domain of the ward accreditation process) and quarterly Controlled Drugs audits.

3.2. Improving the health of our populations

3.2.1. The Pharmacy and Medicines Optimisation Service hosts a number of posts and contributes to a range of projects designed to improve access to medicines and reduce healthcare inequalities through medicines use. We share a Lead Pharmacist for Population Health post with SEL ICB who is currently working on a range of projects for examples testing Written Medicine – a service which labels medicines and provides information in a patient's preferred language – with primary care and a community pharmacy pilot site; and supporting access to GLP1 inhibitors in under-served populations. Our Lead Pharmacist Children's Interface works directly with GP practices to support medicines safety in children and supports case finding of medicines optimisation opportunities in children in the community.

3.2.2. We are increasing our collaboration with primary care, including community pharmacy and our expert and consultant pharmacists – in key specialties including diabetes and endocine; cardiovascular; renal; and care of older people – are working on several projects to support population health and support the development of Integrated Neighbourhood Teams.

3.2.3. The pharmacy team have been involved in a range of projects to support reducing the environmental impact of medicines, from supporting reduction in volatile inhalational anaesthetics and decommissioning of nitrous oxide manifolds, to leading on an inhaler recycling scheme.

3.3. Valuing all of our people

3.3.1. Workforce sustainability and leadership capacity remain a core focus. Recent pharmacy operating model changes have strengthened leadership visibility and accountability, supporting both service delivery and capacity for transformation.

3.3.2. The Pharmacy Valuing Our People Committee – launched in 2025 – benefits from diverse and inclusive representation from across our directorate including pharmacists, pharmacy assistants, pharmacy technicians and healthcare scientists across all grade ranges and locations. In late 2025, the committee work focused on fair internal recruitment and career development pathways, and in 2026 will be supporting flexible working.

3.3.3. Work continues on expanding the role of pharmacists from registration, as we prepare for pharmacists being prescribers at point of registration for the first time later in 2026, with generic scope of practice agreed alongside a new training programme and supervision framework. Pharmacy Technician and Pharmacy Assistant role development also continues with good uptake of apprenticeship programmes particularly in procurement, data and analytics and quality improvement.

3.4. Innovating for a better future

3.4.1. Pharmacy plays a critical role in enabling the Trust's research and innovation ambitions. Activity continues to strengthen support for clinical trials to ensure delivery of the 150-day target, with review of pharmacy clinical trial capacity and capability underway, and improved performance metrics in development.

3.4.2. Progress continues to be made with Guy's and St. Thomas' Pharmaceuticals – our medicines manufacturing and consultancy service – with increased commercial income from manufacture of medicines and clinical trial products. Our team have also been developing new products and services, and exploring opportunities for strategic partnerships, under the oversight of a new Managing Director, Peter Wright. In 2025, the team formulated and manufactured Nasal PD solutions for the Cystic Fibrosis difficult diagnosis service at Royal Brompton; and they are currently working on a ready-to-use cardioplegia solution to improve safety, and a formulation of a product used in cysteinuria which would improve access to treatment and support financial sustainability.

3.4.3. A significant amount of work to maintain and improve the Electronic Prescribing and Medicines Administration component of Epic is progressing and a number of projects are active including the Pharmacy Clinician Builder Programme (UK first) with a number of Pharmacist SMEs now trained to undertake Epic build work – including for examples order panels (e.g. project to improve electrolyte prescribing safety) and medication profiles within order sets, and medicine preference lists – supporting across the ITCS Willow team and clinical teams. A project to deliver functionality to deploy Electronic Prescription Service within Epic is also being supported by the Pharmacy Digital Team, which will enable sending prescriptions direct to a patients' nominated community pharmacy in future.

3.5. Modernising our infrastructure

3.5.1. The Aseptic Transformation Programme remains a major strategic priority. Phase 1 delivery is progressing and will deliver a new Chemotherapy and Advanced Therapies Aseptic Suite at St. Thomas' hospital. This unit will facilitate delivery of Children's Cancer treatments when the PTC transfers to Evelina London; growth in adult cancer chemotherapy demand; and the medium-term pipeline of advanced therapies which are anticipated. It will also support capacity for Clinical Trials. Phase 2 development work continues to explore future licensed capacity options to meet forecast Trust demand beyond 2030 and system and/or regional demand for aseptic capacity.

3.5.2. In support of readiness for Children's Cancer PTC, pharmacy-related enabling workstreams are progressing well, including implementation of a dispensary automation (robot) within a redesigned Evelina London Pharmacy, to improve safety, efficiency and capacity.

3.5.3. A major refurbishment project for the STH Boots outpatient pharmacy is in progress, with outcome of BSA application awaited to facilitate full refurbishment of the footprint, including installation of a larger capacity dispending robot to support further improvements in safety and timely access, and reduced waiting times.

4. Recommendations

4.1. The Board of Directors is asked to note the update provided regarding Pharmacy & Medicines Optimisation Services and note that a full-year Annual Report on Pharmacy and Medicines Optimisation will be sent to the Quality and Performance Board Committee mid-2026, alongside the Annual Controlled Drug Accountable Officer Report.

Guy's and St Thomas' NHS Foundation Trust

BOARD OF DIRECTORS

WEDNESDAY 28 JANUARY 2026

Report title:	**Board Assurance Framework (Q3, 2025/26)**
Executive sponsor:	Tendai Wileman, Chief of Staff and Director of Organisational Change
Paper author:	Edward Bradshaw, Director of Corporate Governance and Trust Secretary
Purpose of paper:	To provide assurance
Main strategic priority:	All strategic priorities
Primary BAF risk:	Risk 11: Organisational excellence
Key points of paper:	• The Board Assurance Framework (BAF) is the primary means by which the Trust Board manages the principal strategic risks to its organisational objectives. • Per the Trust's risk management policy, the full Board should review the full BAF twice a year. This was last done in April 2025, when the Board made a number of suggestions about how the BAF risks should be refreshed to ensure they were aligned with the Trust's new organisational strategy to 2030. • The updated BAF at the end of quarter 3 (2025/26) is now presented to the Board for a further review, following the latest round of updates at Board committee meetings between October and December 2025. Some analysis has been provided to drawn Board members' attention to potential areas of consideration.
Paper previously presented at:	The content of this report has all been discussed in Board committees but has been amalgamated for the first time in this report.
Recommendation(s):	The BOARD is asked to: 1. **Note** this paper, including the Board Assurance Framework in Appendix 1, and the assurances provided 2. **Decide** whether an additional BAF risk on integrated neighbourhood services is required and, if so, when this should be added; and 3. **Highlight** any further changes that are needed.

1. Introduction

1.1. The Board Assurance Framework (BAF) contains the principal (also referred to as 'strategic') risks that are caused by or threaten the achievement of the Trust's strategic objectives, plus information on the existing and planned controls, and assurances that enable an assessment of whether the risks are being managed effectively.

1.2. Each BAF risk is 'owned' by a Board committee which reviews and updates the risks each quarter. Per the Trust's risk management policy the full BAF is reviewed by the full Board twice a year; this helps ensure that directors who do not attend certain committees can view and comment on the risks and also ensures that any interdependencies between BAF risks owned by different committees can be identified and managed. The efficacy of the BAF process is overseen by the Audit and Risk Committee and is subject to an annual internal audit.

1.3. At its meeting in April 2025 the Board reviewed the BAF and made a number of suggestions to refresh the document to ensure it was aligned with the Trust's new strategy to 2030. The Trust's latest BAF, which reflects the scoring, assurances and updates made during Board committee meetings in quarter three 2025/26 (October to December) is set out in Appendix 1 for the Board to review.

2. Analysis

2.1. In reviewing the BAF, the Board is asked to note the following:

- As shown in table 1 of Appendix 1, half of the 12 BAF risks have 'limited' assurance that they are being managed appropriately, and half have 'substantial' assurance. Since the start of the 2025/26 financial year, the assurance level for most risks has remained the same, with only two changes:
    - Risk 4: Resilience of digital infrastructure – in Q3 the level of assurance increased from 'limited' to 'substantial' as a result of the increased work led by the Trust's Chief Digital Information Officer to test the resilience of the Trust's digital systems to malicious external threats.
    - Risk 5: Epic benefits realisation – in Q2 the assurance level was decreased from 'substantial' to 'limited' due to the broader absence of assurance available to evidence the work being done to optimise use of the Trust's electronic health record system.

- Table 2 in Appendix 1 shows that there are four risks rated 'red'; these are as follows.
    - Risk 2: Quality of care and patient experience (risk score: 16)

  - Risk 3: Resilience of estates infrastructure (risk score: 16)
  - Risk 4: Resilience of digital infrastructure (risk score: 20)
  - Risk 7: Productivity (risk score: 20)

- Of the 12 risks on the BAF, only one has had its risk score changed during 2025/26: Risk 4: Resilience of digital infrastructure was increased from 15 to 20 as the likelihood of the risk materialising was judged to have increased from 3 to 5.

- Table 3 in Appendix 1 shows that nine of the risks continue to exceed their risk tolerance levels as per the Trust's risk appetite statement. Four of these – the same four that are red-rated for their score – exceed their tolerance by over 10 points:

  - Risk 2: Quality of care and patient experience (risk score 16 versus tolerance of 4)
  - Risk 3: Resilience of estates infrastructure (risk score 16 versus tolerance of 4)
  - Risk 4: Resilience of digital infrastructure (risk score 20 versus tolerance of 9)
  - Risk 7: Productivity (risk score 20 versus tolerance of 9)

- Risks have been identified to all five of the Trust's strategic priorities set out in GSTT 2030. However, it is arguable that of the five, risks to the priority around 'Improving the Health of Our Populations' are least well-represented. The NHS 10-year plan published in mid-2025 placed considerable emphasis on the establishment of integrated neighbourhood-based health services and the Trust is working in partnership with primary care colleagues to act as the 'Integrator' for Lambeth and Southwark to deliver more responsive, locally tailored care, particularly for residents facing the greatest health inequalities and barriers to good health. Whilst operational risks linked to this work are managed locally within the Trust, the Board is asked to consider whether a full BAF risk – either now or in the future as the Trust's work develops – provide a means through which the strategic risks linked to this work can be managed and mitigated.

3. Recommendations

3.1. The Board is asked to:

- **note** this paper, including the Board Assurance Framework in Appendix 1, and the assurances provided
- **decide** whether an additional BAF risk on integrated neighbourhood services is required and, if so, when this should be added; and
- **highlight** any further changes that are needed.

Board Assurance Framework
31 December 2025 (Q3, 2025/26)

The Board Assurance Framework (BAF) sets out the principal risks to the Trust's achievement of its strategic objectives, together with an assessment of the likelihood and severity of that risk materialising (shown as an overall risk score); a description of the key controls in place to mitigate the risk; and the key assurances the Board can take that the risk is being managed appropriately, towards its tolerance level (based on the risk appetite set by the Board).

Each principal risk on the BAF is owned by a Board committee and reviewed quarterly. The full Board reviews the full BAF twice a year. The effectiveness of the BAF process is overseen by the Audit and Risk Committee.

Definition of assurance

Assurance is 'an objective examination of evidence for the purpose of providing an independent assessment on governance, risk management, and control processes for the organisation'. Assurance can come from many sources. The *four tiers of assurance* model aids the identification and understanding of these sources and how they contribute to the overall level of assurance provided and how best they can be integrated and mutually supportive:

Definitions of tiers of assurance	
Tier 1	The way risks are managed and controlled day to day. Assurance comes **directly from those responsible** for delivering specific objectives or processes such as service or departmental teams.
Tier 2	The way the Trust oversees the controls so that it operates effectively. Assurance comes from **a second layer of review and validation within the organisation**, through functions such as oversight committees.
Tier 3	The way the Trust provides **objective and independent** assurance, although mainly still from within the organisation, through means such as internal audit or peer review (such as quality audits).
Tier 4	Assurance from **external, independent bodies** such as external auditors or regulatory bodies.

Assurance levels	
Full	There is significant evidence that the controls are effectively managing the risk in order to achieve the objective.
Substantial	No material issues have been identified with the effectiveness of the controls, although there are some gaps in the controls or evidence that could threaten achievement of the objective.
Limited	Controls generally ineffective in managing the risk, or significant gaps in available evidence to demonstrate their effectiveness.
Nil	No effective controls or evidence the controls are working.

Risk assessment matrix

Risk Score = Likelihood x Consequence scores after effectiveness of controls taken into account

Likelihood	Consequence: Insignificant (1)	Minor (2)	Moderate (3)	Major (4)	Catastrophic (5)
Almost certain (5)	Medium (5)	High (10)	High (15)	Very High (20)	Very High (25)
Likely (4)	Low (4)	Medium (8)	High (12)	Very High (16)	Very High (20)
Possible (3)	Low (3)	Medium (6)	Medium (9)	High (12)	High (15)
Unlikely (2)	Low (2)	Low (4)	Medium (6)	Medium (8)	High (10)
Rare (1)	Low (1)	Low (2)	Low (3)	Low (4)	Medium (5)

Board Assurance Framework
31 December 2025 (Q3, 2025/26)

1. Level of assurance over past 12 months

BAF risk	Summary risk title	Board Committee owner	Level of assurance (assessed quarterly)			
			Quarter 4 2024/25	Quarter 1 2025/26	Quarter 2 2025/26	Current Q3 2025/26
1	Operational performance and activity	Q&P	Limited	Limited	Limited	Limited
2	Quality of care and patient experience	Q&P	Limited	Substantial	Substantial	Substantial
3	Resilience of estates infrastructure (*previously risk 3a*)	Q&P	Limited	Substantial	Substantial	Substantial
4	Resilience of digital infrastructure (*previously risk 14*)	ARC	Limited	Limited	Limited	Substantial
5	Epic benefits realisation	TMP	Limited	Substantial	Limited	Limited
6	Organisational change and transformation (*NEW*)	TMP	N/A – new	Limited	Limited	Limited
7	Productivity (*NEW*)	TMP	N/A – new	Limited	Limited	Limited
8	Financial sustainability	FC&I	Limited	Limited	Limited	Limited
9	Capital expenditure investment	FC&I	Substantial	Substantial	Substantial	Substantial
10	High performing and future ready workforce (*NEW*)	PCE	N/A – new	Substantial	Substantial	Substantial
11	Organisational excellence	BiC	Substantial	Substantial	Substantial	Substantial
12	Research and academic ambitions (*previously risk 7*)	ACiC	Substantial	Limited	Limited	Limited

2. Risk score over past 12 months

BAF risk	Summary risk title	Risk score (assessed quarterly)				Tolerance level
		Quarter 4 2024/25	Quarter 1 2025/26	Quarter 2 2025/26	Current Q3 2025/26	
1	Operational performance and activity	**12**	**12**	**12**	**12**	Low (5 – 9)
2	Quality of care and patient experience	**16**	**16**	**16**	**16**	Very low (1 – 4)
3	Resilience of estates infrastructure	**16**	**16**	**16**	**16**	Very low (1 – 4)
4	Resilience of digital infrastructure	**15**	**15**	**15**	**20**	Low (5 – 9)
5	Epic benefits realisation	**12**	**12**	**12**	**12**	Low (5 – 9)
6	Organisational change and transformation	N/A – new	**12**	**12**	**12**	High (16+)

BAF risk	Summary risk title	Risk score (assessed quarterly)				Tolerance level
		Quarter 4 2024/25	Quarter 1 2025/26	Quarter 2 2025/26	Current Q3 2025/26	
7	Productivity	N/A – new	20	20	20	Low (5 – 9)
8	Financial sustainability	10	12	12	12	Very low (1 – 4)
9	Capital expenditure investment	8	8	8	8	Very low (1 – 4)
10	High performing and future ready workforce	N/A – new	12	12	12	Moderate (10 – 15)
11	Organisational excellence	12	12	12	12	Low (5 – 9)
12	Research and academic ambitions	4	12	12	12	High (16+)

3. ***Distance from risk tolerance level***

BAF risk	Summary risk title	*Target tolerance level:* ◆----------◆								*Current risk score:* ✖						*Distance to target**
		Very low				*Low*				*Moderate*			*High*			
		1	*2*	*3*	*4*	*5*	*6*	*8*	*9*	*10*	*12*	*15*	*16*	*20*	*25*	
1	Operational performance and activity					◆			◆		✖					+3
2	Quality of care and patient experience	◆			◆								✖			+12
3	Resilience of estates infrastructure	◆			◆								✖			+12
4	Resilience of digital infrastructure					◆			◆					✖		+11
5	Epic benefits realisation					◆			◆		✖					+3
6	Organisational change and transformation									✖			◆		◆	-6
7	Productivity					◆			◆					✖		+11
8	Financial sustainability	◆			◆						✖					+8
9	Capital expenditure investment	◆			◆			✖								+4
10	High performing and future ready workforce									◆	✖	◆				0
11	Organisational excellence					◆			◆		✖					+3
12	Research and academic ambitions										✖		◆		◆	-4

* *The distance to target is calculated by subtracting the current risk score from the highest tolerance level score*

Principal Risk 1: The Trust's activity levels may not be sufficient to meet the trajectories in our operating plan, resulting in patients being unable to access our services in a timely manner and lead to continued or increased regulatory intervention.

Summary risk title:	**Operational performance and activity**	**Date added to BAF**	Earlier versions of this risk from 2018
Board committee owner:	Quality & Performance Committee	**Risk tolerance level**	Low (5 – 9)
Executive committee lead:	Trust Operations Board	**Risk score (post-controls)**	12 (likelihood 3 x consequence 4)
Executive director lead:	Jon Findlay (Chief Operating Officer)	**Level of assurance**	Limited
Strategic priorities impacted:	Delivering healthcare excellence; Improving the health of our populations		

Potential causes and linked risks from the corporate risk register

- Key causes include: (1) increased demand on services including urgent and emergency and cancer care (2) capacity and demand mismatch in certain areas both locally and regionally / nationally (3) limitations around estate (including theatre and outpatient facilities) and equipment (4) temporary disruption of service due to business continuity incidents including possible future industrial action (5) changes to service delivery through Epic implementation and operating models (6) visibility of data to promote effective operational management and capturing of activity data (7) data quality agenda (8) challenging financial climate and reliance on unbudgeted additional capacity (e.g. IS) (9) lower levels of productivity compared with ambition (10) increasing acuity and the widening of the health inequality gap (11) structural changes to wider health economy and new oversight framework.

Linked risks from the corporate risk register are:

ID 4126	Safety of administrative processes relating to patient pathways	16
ID 4763	Delays to elective surgical pathway and use of independent sector	12
ID 4227	Insufficient theatre capacity to meet demand impacting on safe/timely patient care	15

Potential consequences (*if the risk was to materialise*)

- Compromised ability to meet the Trust's priority of delivering healthcare excellence.
- Continued focus on operational delivery takes time away from delivery of broader strategic initiatives as set out in GSTT2030.
- Compromised ability to reach the Trust's ambition of a breakeven financial position at the end of the year based on sustained or increasing spend on additional capacity and / or stagnant or deteriorating productivity levels. Similarly impacting on the Trust's need for long term sustainability.
- Impact on quality of care for patients including clinical deterioration whilst waiting for treatment and poor patient experience.
- Potential widening of the health inequality gap regarding access to healthcare services.
- If the risk to a number of areas were to materialise this would influence directly the segmentation/tiering status of the Trust in the new performance oversight framework, and this would bring additional scrutiny, autonomy implications and reputational risk.

Key controls (tier 1 – *controls already in place to manage/mitigate the risk*)

- Well embedded internal performance framework with clear and effective delivery structure aligned to the national performance oversight framework.
- New centralised elective access team formed responsible for the Trust's data quality agenda and elective access best practice. Focus in line with national ambition of reducing overall waiting list with the team and wider Trust engaging in "validation sprints" – supported by outsourcing.
- Sector working to understand and mitigate separate and common areas of risk in collaboration with a focus on transformation in particular in relation to ambulatory and pre-referral optimisation.
- Additional weekend working where possible, supporting increased utilisation of the estate, including across elective (HIT lists, etc) and emergency (SDEC etc).
- Continued use of independent sector working to mitigate risk to delivery across key areas.
- Trust-wide productivity programme revamped and being embedded in the Trust focusing on 5 key areas of opportunity and 4 enabling workstreams to support delivery.
- Supporting governance for health inequality agenda in place aligned to the regional agenda.

Gaps in controls (*further work required to manage risk to its tolerance level*)

- Additional premium capacity, including IS provision, carries significant cost and is not sustainable long term / viable in reaching the ambition of a breakeven finance position.
- Productivity programme aiming to deliver a sustainable solution long term where costs can be reduced. Needs to mature at pace in order to create capacity and release cost.
- Health inequality agenda needs to continue to develop and mature at pace.
- Increased oversight and accountability being introduced with a revised elective recovery board which will include clinical leadership supporting a drive to improve performance including through transformation.
- Further support required to influence referring providers on the 62 day pathway which represent an area of challenge for the Trust compromising the Trusts position.
- IPR is not currently considered useable by clinical groups with a key challenge relating to the timeliness of its data. Resolution possible with programme to be started.

Key assurances (*evidence that the controls are effective*)		Gaps in assurances (*further evidence required about effectiveness of controls*)

Tier 2 *(oversight of controls)*	• Clinical group governance framework (including executive committees and dedicated operational performance committees).
	• Clinical groups are held to account in quarterly performance review meetings with the Chief Executive and his corporate team.
	• Trust Operations Board meets fortnightly and is the primary executive committee with oversight of aggregate operational performance; this is reported into each meeting of the Trust Executive Committee.
	• Quality and Performance Committee reviews performance in depth on a quarterly basis; the Board in Committee also reviews performance at a higher level at each meeting.
		• Areas of poorer compliance for operational performance in the latest IPR / wider reporting are cancer 62 day, DM01 6 and 13 weeks and RTT 78 and 65 week waits. Cancer FDS has previously struggled but the position has seen sustained improvements over the year.
		  ○ Cancer 62 day: performance has been below plan across May, June and July with key risk areas remaining Urology surgical waits, thoracic surgical volumes and waits, and diagnostic waits on Breast, Gynae-Onc, H&N and Urology pathways. That said, the cancer recovery programme has garnered good improvements across its key priority areas and remains focused on delivering its priorities for 2025/26.
		  ○ DM01 6 and 13 weeks: Following success in the DM01 recovery programme the Trust's DM01 6 and 13 week position has deteriorated since July due t the inclusion of an additional cohort of Audiology that were previously excluding from reporting (change of guidance). Another key area of risk is Echo due to a mismatch in demand and capacity. The Trust is currently relooking at its key areas to understand the likelihood of meetings its planning trajectory in March 2026. Capital bids have been submitted externally to support improvements in key areas with consideration being given to internal funding.
		  ○ 78 and 65 week waits: the Trusts tracked well against its 2025/26 H1 65 week wait trajectory up until August when performance deteriorated. A revised trajectory has been submitted to NHSE with Groups committing to a position of 0 by November.
		• Additional areas of poor compliance are complaints, sickness and absence rate, A&E attendances per Emergency Consultant and incident management (overdue).
		• Limited view of contract monitoring data with monthly contract monitoring meeting rhythm being stood down following Epic implementation and the associated changes in recording and reporting.
		• The new performance oversight framework has been released and the Trust is currently in segment 1. The Trust performed well overall, noting that the financial override was not instigated due to the Trust's Q1 financial position, however there are areas of risk and the nature of the review process might see the Trust fluctuate between segments each quarter dependant on Trust performance and its relative position to other providers nationally. Tiering arrangements will remain in place but the intention is to close off the previous NOF exit criteria with NHSE.
		• IPR and internal performance reporting will need to reflect the new performance framework alongside other key national guidance including the Insightful Provider Board (IPB).
		• Productivity programme to continue maturing at pace, but targets have not yet been fully signed off alongside quantification and wider potential impact on performance and quality.

Tier 3 *(internal assurance)*	• Internal audit, clinical audit, peer reviews and benchmarking, monitoring of important performance and Epic operational metrics such as outcoming and day case errors, risk management processes, patient and staff feedback mechanisms and the management of data quality through the elective access team. • The latest IPR shows good levels of assurance across a range of metrics including risk management, mandatory training compliance, activity levels, cancer FDS, RTT waiting list and performance, and A&E 4 and 12 hours.	
Tier 4 *(external assurance)*	• Benchmarking through Model Hospital, working collaboratively via system and pan-London working (eg London OP Learning Improvement Network & GIRFT) and clinical networks. • The Trust are currently receiving additional support and scrutiny as a result of its NOF3 segmentation and tiering status for cancer and diagnostics. The Trust was able to demonstrate significant improvement to the end of March 2025 across diagnostics (+ 25.84 percentage points); Cancer FDS and 62 day (+10.3 and +15.7 percentage points respectively); internal 62 day (+19.7 percentage points). • The Trust was released from tiering for elective care in January 2025 following a period of significant improvement to the 65ww+ position from 1,494 in June to 47 in March. This has since deteriorated month-on-month amongst increasing national anxiety. Communication has been received from the national team that this will need to be cleared by December 2025, internally Groups have committed to 0 by November 2025. • FDS performance has remained strong in Q1 2025/26. 62 day overall has remained below plan with variation at TG level. DM01 has deteriorated and remains above plan. • The Trust benchmarks well for A&E 4 hour, FDS and RTT.	

		• Population health completeness levels in Epic low and needs focus in order to create actionable data and for the Trust to make more informed decisions around improving care.

Improvement actions/next steps (*include key actions to bring the risk to its tolerance level and how the gaps in assurance will be addressed over the next 3 months*)

Improvement action	*Lead/ owner*	*Timeframe*	*Latest update*
Work with regional and national colleagues alongside central and Clinical Group teams to understand the new performance framework (NPAF) at pace including the Trust's assigned segmentation and key areas of exposure / risk. Ambition for Trust is for operational excellence and in turn to reach segment 1.	Jon Findlay, COO	Q2 2025/26	**Status complete:** The Trust have been assigned segment 1 (high performing) for Q1 2025/26, ranking 15th position out of 134 acute NHS Trusts nationally. Work has been completed to assess the Trusts areas of exposure / risk, including what metrics have the ability to have a larger impact on the Trusts overall position should performance deteriorate. **Next steps:** Include creating an internal view broken down by Clinical Group to allow Groups to see their position and how this relates to the Trust's overall position and to incorporate this into the Trust reporting framework.
Under the existing performance framework continue to work on improving current areas of exposure including cancer 62 day and the emerging elective care risk (65 week waits).	Jo Johnson, DCOO	Q2 2025/26	**Status open:** Cancer 62 day remains the only planned area of non-compliance to the Trust's 2025/26 operational plan with an ambition to reach 80% internal and 70% overall by March 2026. Cancer recovery programme continues to focus on key areas to deliver this. Elective Recovery Board revamped as an assurance forum to support delivery of 65 week waits with clinical representation now included, target to clear 65ww+ with the latest revised trajectory aiming to deliver this by November. **Next steps:** Improvements to continue to be garnered as part of the cancer recovery programme and Clinical Groups to meet commitment of 0 65ww+ by November.
Work with corporate and Clinical Group stakeholders on a new IPR that will be informed by the new NPAF metrics, alongside other key national guidance, in order to offer a holistic view of performance that includes the new metrics in the NPAF when rolled out.	Jo Johnson, DCOO	Q2 2025/26	**Status open:** Post-Epic model developed and still being refined. New programme to be established that will outline scope / timeline for delivery / objectives / etc alongside a technical working group. Early engagement is beginning in September and this will form a key part of the Trusts reporting framework programme. **Next steps:** implement programme with key outputs and timeline in Q2 2025/26 and iterate over the remainder to the year.
Productivity programme and associated pillars to be fully embedded with clear quantified opportunities and associated delivery plans that consider performance / quality / health equity.	Steven Davies, DCEO	2025/26	**Status open:** Revamped governance which continues to mature at pace. Clinical senate established. **Next steps:** Work continues re identifying and quantifying opportunities and establishing targets.
Trust continue to work in collaboration with the ICB and other system partners on the health inequality agenda and have a particular focus currently on improving completeness levels in Epic in order to create actionable data for services and to improve informed strategic decision making in this area.	Jo Johnson, DCOO	2025/26	**Status open:** Jo Johnson assigned as SRO for protected characteristics workstream. Population health dashboard created and being socialised with staff. Dashboard monitors completeness of data which is now being reported through the Trust Operations Board. Training modules for staff being developed to drive improvements in this area. **Next steps:** Identify priorities and deliverables as part of multi-year planning.

Principal Risk 2: The Trust may fail to deliver safe, high-quality care to patients across all sites and services, whilst providing excellent standards of customer service that results in a high-quality patient experience.

Summary risk title:	**Quality of care and patient experience**	**Date added to BAF**	September 2020
Board committee owner:	Quality & Performance Committee	**Risk tolerance level**	Very low (1 – 4)
Executive committee lead:	Trust Risk & Assurance Committee	**Risk score (post-controls)**	16 (likelihood 4 x consequence 4)
Executive director leads:	Simon Steddon (CMO) and Avey Bhatia (CNO)	**Level of assurance**	Substantial
Strategic priorities impacted:	Delivering healthcare excellence		

Potential causes and linked risks from the corporate risk register

- Multiple patient safety, performance, and quality risks on the Trust risk register. Key causes include: Increasing demand on our services and the significant changes to service delivery and regulatory policy within CQC and NHSE.

Linked risks from the corporate risk register are:

RSK-1008	Suboptimal care and harm to mental health patients in the ED	20
RSK-023	Safety of administrative processes relating to patient pathways	16
RSK-017	Governance of Medical Equipment and devices safety	16
RSK-1059	Cross-site location of Paediatric Cardio-Respiratory & Intensive Care (CRIC) Services across RBH and Evelina sites.	**15**

Potential consequences (*if the risk was to materialise*)

- Patients are harmed or experience an extended stay in the hospital.
- Quality and efficiency of care are decreased, impacting patients and staff.
- Significant management time and operational pressures to respond to issues.
- Regulatory sanctions or improvement notices are applied with reputational and financial risk to Trust.

Key controls (tier 1 – *controls already in place to manage/mitigate the risk*)

- Quality Review Metrics and safety metrics in Integrated Performance Reports (IPR).
- Focused thematic reviews and working groups on key quality & safety themes, such as administration excellence and improving experience through 'contacting us' project.
- Implementation of PSIRF and learning responses into patient safety incidents.
- Localised response to patient feedback (complaints, PALS, experience).
- Clinical group day to day management controls on patient safety, risk and effectiveness.

Gaps in controls (*further work required to manage risk to its tolerance level*)

- Administration Safety remains a high clinical risk for the Trust, improvement programme has changed post-Epic and outcome measures improving.
- New highest risk in relation to mental health care in the ED; one newly reported PSII looking at the systems around MH-enhanced care under investigation.
- Review of complaints management processes and outcomes underway. Gaps remain in effective management and responding to patient feedback.
- Clinical Group Improvement areas identified aligned to PSIRF and will require local PSIRPs be formed in Q3, as part of the updated Trust PSIRP in Dec.

Key assurances (*evidence that the controls are effective*)

Tier 2 *(oversight of controls)*	• TRAC monthly meetings with delegated executive authority to oversee functions of clinical risk and assurance. • Clinical group governance meetings and Executive PRM meetings discuss quality, safety and patient experience. Improved assurance levels within 'safe' domain across clinical group assessments. • Learning for Improvement Group (LFIG) overseeing PSIRF learning and improvement across the Trust.
Tier 3 *(internal assurance)*	• Internal reviews and internal clinical audits, including Trust- wide quality priority audits. Pending group audit plans, some outstanding required for quality assurance readiness. • Quality Assessment Methods and improvement aligned to new CQC quality statements; Quality visit programme commenced in Q3.

Gaps in assurances (*further evidence required about effectiveness of controls*)

- Assurance is required from all Clinical Groups in relation to the quality of care, through completion of quality assessments for all services, in line with CQC quality statements. Quality visit programme commenced in Q3.
- Reduced assurance oversight and management of admin safety and patient pathway management; Apollo stabilisation and assurance on prioritisation required. Risk management processes within ITCS has been implemented. Assurance is required by Directorates that they have reviewed patient pathways and established checks on stages of the administration processes through reports and spot checks. Assurance framework renewed for administrative pathway safety and governance through TRAC and TOB. Risk score reduced in quarter 1 (down to Red 16) with improved assurances in place across admin excellence programme.

Tier 4 *(external assurance)*	• Maternity services CQC inspection on September 2022, rated 'good' overall but 'requires improvement' for safe. Out of date assurance. • CQC IRMER compliance inspection of Radiotherapy at Guys Jan 2025 and Harefield Cath Labs Apr 2025 positive, no issues identified. • HFEA follow up inspections underway with the ACU following a level 2 incidents; the event is also a PSII, with learning to come back to LFIG.	• Quarterly PSIRF Audits and Trust-wide priority audits underway for Duty of Candour and thematic learning from patient safety events. • PSIRF effectiveness of the framework will be reporting to TRAC post 18-month review. Revised PSIRPS being formulated to increase focus on high risk areas of quality and proportionate response to patient safety.

Improvement actions/next steps (*include key actions to bring the risk to its tolerance level and how the gaps in assurance will be addressed over the next 3 months*)

Improvement action	***Lead/owner***	***Timeframe***	***Status***	***Latest update***
Reduce overdue complaints to below 100 (first improvement target). Continuous reduction each month on length of time cases overdue.	Clinical Group Executives / CMO/ Corporate Departments	End of quarter 4 2025/26	Sustained improvement in reduction of overdue cases required On track for reduction in length of time overdue	The high number of overdue complaints have remained the same (not increased or decreased) whilst the significant structure changes are on-going. Recruitment to new posts within clinical groups will be completed by early November 2025 which will improve available resource and management processes. There are improvements in the length of time overdue with over 60 at 100 days plus in April to 16 over 100 days at end of August. Clear actions in place to further reduce length and number overdue that requires input from corporate departments and clinical groups.
Governance and oversight framework re-established for Administrative Excellence Programme.	Jon Findlay / COO's office	April 2026	On-track, with new timeframe for excellence	The Trust seen a reduction in incidents from delays in sending patient information and patients lost to follow-up within pathways, resulting in harm, as well as a sustained decrease in admin safety related incidents. No longer the Trust's highest corporate risk. Governance structure in place and new improvement timescales being overseen by the excellence programme within the COO's office and aligns to Epic benefit-realization.
Quality assessments and clinical group (internal) quality visits.	Clinical Group Executives / CMO	September 2025	On-track C&S / ISM / ELCH **Off-track in HLCC**	Desktop quality reviews commenced with ISM and C&S for planned quality visits led by clinical groups. ELCH and C&S quality assessment programme to recommence for annual review in Autumn 2025, with planned desktop reviews booked. HLCC yet to provide quality assessments in year and group-led quality visits not arranged, reported here as off track.
New and Updated Patient Safety Incident Response Plans (PSIRPs).	Clinical Group Executives / CMO	December 2025	On-track	PSIRF effectiveness review underway and completed with 2 out of 4 clinical groups; will be reporting to TRAC post 18-month review. Revised PSIRPs have been proposed and will be finalized with clinical groups in quarter 2. PSIRP and PSIRF policies will be formulated to increase focus on high risk areas of quality and proportionate response to patient safety. Plan to publish before 2-year anniversary of PSIRF and ensure updated on Trust website.
Formulation and Implementation of a new Trust-wide Quality Framework as required within the 2030 Strategy.	Chief of Staff / CEO and CMO offices	March 2026	On-track	First draft of framework completed that includes the planned steps to embed within the Trust. For submission to TEC in Q2 or early Q3 2025/26.

Principal Risk 3: The Trust's estates infrastructure may be insufficiently resilient to protect the Trust from current and emerging risks such as water, fire and ventilation, which may pose a risk to patient safety or negatively impact operational performance and patient outcomes.

Summary risk title:	**Resilience of estates infrastructure**	**Date added to BAF**	2024
Board committee owner:	Quality & Performance Committee	**Risk tolerance level**	Very low (1 – 4)
Executive committee lead:	Trust Risk & Assurance Committee	**Risk score (post-controls)**	16 (likelihood 4 x consequence 4)
Executive director lead:	Andrew Asbury (Managing Director, Essentia)	**Level of assurance**	Substantial
Strategic priorities impacted:	Delivering healthcare excellence; Modernising our infrastructure		

Potential causes and linked risks from the corporate risk register

- Increased frequency of failures associated with aging building fabric and estate infrastructure.
- Impact of climate change adding further pressure to our infrastructure assets across the estate.
- Insufficient investment (people and finance) to ensure appropriate planned preventative maintenance works are undertaken.
- Failure to deliver the agreed annual estate backlog investment plan, for which the level of investment has increased given the level of risk associated with the infrastructure.
- Limited access to undertake planned preventative maintenance works given pressures to restore and deliver clinical activity to pe-pandemic levels.
- Amendments to Health Technical Memorandum (HTM) and Building Safety Act (BSA) are adversely impacting on addressing key risks due to additional cost and time implications. A pragmatic approach, including the option to derogate where necessary from guidance/standards (assessed on clinical safety) needs to be agreed to ensure estate risks are managed/mitigated in a timely and safe manner. Compliance with statute will not and cannot be compromised.

Linked risks from the corporate risk register are:

ID 4728	Estate Backlog Infrastructure Risk	16
ID 6132	Water Safety Compliance (Legionella & Pseudomonas)	16
ID 4227	Insufficient theatre capacity to meet demand	15
ID 5110	Increased Risk of Fire	15
ID 4129	Business Continuity service level plans	12

Potential consequences (*if the risk was to materialise*)

- Patient and staff safety, and patient experience, could be compromised given the fragility of our estate particularly those assets associated with fire safety, ventilation, cooling, heating, electrical distribution and water safety.
- Estate challenges act as a constraint on increasing elective activity and operational productivity. This could increase patient waiting times – with associated clinical risks – and impair the financial stability of the Trust which is heavily dependent on clinical activity.
- Staff wellbeing is impacted due to infrastructure failures and its associated impact on clinical activity and the pressures that such events have on staff morale.
- Organisation reputational risk exists should there be a major and/or catastrophic impact to staff/patients/visitors related to the failure of any one or multiple assets.

Key controls (tier 1 – *controls already in place to manage/mitigate the risk*)

- **Annual planned preventative maintenance (PPM**) regime is in place across Trust sites to ensure critical assets are maintained at regular (recommended) intervals.
- **Infrastructure Health & Safety**: Following the chemical incident on the Guy's site during August 2025, steps are being taken across all GSTT sites to ensure appropriate processes and systems are in place to mitigate risks of injury to staff, patients and visitors. The incident itself is being investigated by the Trust's H&S team and the Health Safety Executive – the outcome of which is not known at the time of writing this report.
- **Water Safety**: a water safety plan is under way aiming to mitigate the risk of legionella and pseudomonas, but this does not treat the root cause of the proliferation of the bacteria. Progress and assurance is provided to the Water Safety & Ventilation Group. Establishment of a new Director of Water Safety role is in place, full review of processes and reporting underway,

Gaps in controls (*further work required to manage risk to its tolerance level*)

- Work underway to embed a culture within Essentia with an emphasis on "assurance" as opposed to "re-assurance".
- Assurance data is dependent on a number of different digital and paper-based systems with significant gaps and limited assurance being provided. Work is underway to migrate current CAFM system to a new platform which will aim to address a number of these risks/issues.
- Recruitment of required resources, with the appropriate skillset and knowledge to support management and mitigation of the known risks – there has been an increased level of reliance on external contractors to fill the skills shortage gap.

assessment of alternative means of secondary controls and external provider support has been secured following a tendering exercise, Key focus of the activity is addressing the recommendations from the 2024 audit, reduction in the number of point of use filters, developing improved dashboards to improve the level of reporting to increase assurance levels in relation to the necessary actions required to protect staff, patients and visitors. • **Risk assessed estate backlog maintenance plan** in place, with targeted investment requiring approval at IPB & TMPB (annually). Resources established to support delivery of annual £17m programme and for delivering the additional investment secured from NHSE of £22m (June 25). • **Estate backlog plan is refreshed annually** and managed by the Essentia Estate Board.	
Key assurances (*evidence that the controls are effective*)	**Gaps in assurances (*further evidence required about effectiveness of controls*)**
Tier 2 *(oversight of controls)* • Essentia Technical Assurance Committee (ETAC) meets monthly and seeks assurance on Asbestos, Confined Spaces, Electrical Systems, Fire Safety, Gas Safety, Medical Gas, Ventilation Systems and Water Management. • Trust Fire Safety Committee and the Water Safety & Ventilation Group, meet to provide oversight and seek assurance around specific areas of estates risk. • Investment Portfolio Board (IPB), overseeing progress on approved capital investment looking to address estate backlog risks/plans. • Trust Risk and Assurance Committee (TRAC) will receive updates from ETAC on estate related risks and progress on mitigating actions, escalations and assurance. • Quality and Performance Committee (Q&P) receives regular reports from Essentia, as necessary around the number of estates-related quality and safety issues that have arisen and patient experience reports linked to the estate.	• Evidence based assurance should be considered, to test effectiveness of controls and reporting progress on managing and mitigating risk. Support from Internal Audit may be required and Authorised Engineers. Agreeing a programme each year to forensically test effectiveness of controls and levels of assurances being provided across all high estate risks (namely fire safety, water safety, infrastructure including power, heating, cooling and ventilation). • No current mechanism for assessing whether capital investment is effectively reducing overall balance of risk for the Trust (e.g. whether we are effectively prioritising our improvement in Ventilation across wards vs. diagnostic rooms vs theatres).
Tier 3 *(internal assurance)* • Internal Audit have in the past undertaken forensic review of assurance controls, processes and systems in place, making recommendations as necessary for the Essentia management team to act on.	
Tier 4 *(external assurance)* • Independent assurance is sought from appointed Authorised Engineers (AE), acting as independent professional advisors for high risk engineering systems in line with Health Technical Memorandum (HTM) policies and principles. AE's provide advice to the Trust on whether infrastructure systems meet compliance standards and suggest actions where gaps are found in terms of HTM standards.	

Improvement actions/next steps (*include key actions to bring the risk to its tolerance level and how the gaps in assurance will be addressed over the next 3 months*)

Improvement action	*Lead/owner*	*Timeframe*	*Status*	*Latest update*
Progress the Essentia Digital Strategy to improve estate information.	Phil Mitchell	Being delivered in phases, expected go live for Phase 1 – Sep/Oct 25		Upgrade of the CAFM system underway which will strengthen processes associated in mitigating/managing the risks associated with our infrastructure – through enhanced reporting, increased level of assurance, real time updates, resource allocation etc. **Complete**
Terms of Reference (ToRs) for ETAC underway.	Noel James	Jul / Aug 25		The refresh of the ToRs for ETAC will further strengthen the level of assurances required on the management and maintenance of our infrastructure from a technical compliance perspective, considering the key risks and seeking assurances on the mitigation and management of the risks. **Due for completion in September 2025.**

Principal Risk 4: The Trust's digital infrastructure may be insufficiently resilient to protect the Trust from current and emerging risks, such as cyber threats, that may negatively impact operational performance and patient outcomes.

Summary risk title:	**Resilience of digital infrastructure**	**Date added to BAF**	September 2024
Board committee owner:	Audit and Risk Committee	**Risk tolerance level**	Low (5 – 9)
Executive committee lead:	Trust Risk & Assurance Committee	**Risk score (post-controls)**	20 (likelihood 4 x consequence 5)
Executive director lead:	Denis Lafitte (Chief Digital Information Officer / Senior Information Risk Owner)	**Level of assurance**	Substantial
Strategic priorities impacted:	Delivering healthcare excellence, Modernising our infrastructure		

Potential causes and linked risks from the corporate risk register

- Historic **underinvestment in infrastructure** resulting in technical debt including datacentres environmental measures, network, server and desktop estate leading to outdated technologies and legacy infrastructure no longer supported with security updates by vendors.
- **Changes in the cyber threat landscape** that require adjustments and improvements to cyber security measures to ensure new threats are countered and incidents are prevented and detected.
- **Supply chain security operational assurances** – Some assurances are not independent of supplier unless continuous monitoring, audit or penetration tested. Giving rise to disruptive cyber events.

Linked risks from the corporate risk register are:

RSK-022	Risk of loss of patient personal data and the provision of clinical services from cyber-attack.	20
RSK-844	Business Continuity service level plans	12

Potential consequences (*if the risk was to materialise*)

- Serious disruption to our Digital Services with a significant operational impact at scale on patient services and potential adverse patient outcomes.
- Regulatory Action against the Trust for failure to comply with legislative requirements for UK-GDPR and NIS2 regulations.
- Civil action from patients or affected parties.
- Financial losses as a result of reduction in operation throughput.

Key controls (tier 1 – *controls already in place to manage/mitigate the risk*)

- Cyber Resilience Strategy.
- Security Policy, Standards framework and Risk Management.
- Joiner, Mover and Leaver controls in place but currently lack full automation.
- Supplier Cyber Risk Management Process in place (Providing supplier incident alerting and continuous monitoring of key suppliers).
- GSTT Data Centre Improvements to Environmental Controls. Atos (Epic) Two data Centres resilient with failover tested every 6 months (next test Sept 25). Telefonica (Shared Clinical Systems) Two Data Centres with resilience.
- Backup As A Service (BAAS) implemented for infrastructure in Guys and St Thomas Data Centres.
- Server estate audited during August by InfoSec and supported estate found to be at 91% of the overall estate.
- Supported Desktop Estate currently maintained at 98% of the overall estate.
- Security patching of external (internet) facing assets and Internal facing client and server assets.
- Security review processes in place for digital solutions and cyber resilience measures.
- Threat intelligence monitoring in place. With intelligence and alerts acted upon.
- 24/7 Security Operations Centre (SoC) in place to respond to Cyber threats.
- Independent Penetration Testing by Crest Accredited supplier (June 2025).
- Secure authentication mechanisms deployed (including 2FA and MFA).
- Secure nhs.net email service implemented (June 2025).

Gaps in controls (*further work required to manage risk to its tolerance level*)

- Backup As A Service (BAAS) Scoping needs to be completed for implementation in RBH data centres. Improvements taking place for Disaster Recovery As A Service (DRAAS).
- Testing of failover capabilities at TT data centres is required.
- Completion of the Strategic Network Programme to deliver improved Network security and resilience.
- Decommission, Upgrade, Replacement of remaining 9% legacy server estate.
- Improvements required in the patching arrangements for internal facing server assets.
- Mitigation of risks associated with remainder of Windows 10 estate post 12th October 2025.
- Modernisation of Joiner, Mover, Leaver (JML) practices needed post nhs.net deployment. Practices are under review for RPA.
- Prioritisation and remediation of vulnerabilities identified by June 2025 BAU penetration testing.

Key assurances (*evidence that the controls are effective*)		Gaps in assurances (*further evidence required about effectiveness of controls)*
Tier 2 *(oversight of controls)*	1. TRAC Risk Updates (May 2025) 2. Audit Committee Updates (June 2025) 3. DT&I Risk Forum (Monthly) 4. Digital Governance Board (DGB) and Digital Operations Board (DOB) (Monthly) 5. Information Governance Steering Group (IGSG) (2 Monthly)	
Tier 3 *(internal assurance)*	1. DSPT 'Standards Met'. Reported against the new NCSC CAF DSPT Submission as 'Standards Met' Last DSPT Internal Audit review (June 2025) provided a substantial assurance rating. Placing low risk on our evidence collated and high confidence in the reported position. 2. Secure by Design – Information Security assessment of digital solutions and technology changes. In place for all new systems since 2021. (Daily BAU Activity) 3. Internal Vulnerability Assessment and remediation of vulnerabilities (Monthly) 4. Strategic Suppliers Performance Reports (Strategic Sourcing Team). (Quarterly) 5. Security operations centre (SoC) activity reports demonstrating rapid response to and handling of incidents. (Monthly) 6. IT Asset Management Report – Internal Audit provided a Limited assurance opinion. (May 2025)	
Tier 4 *(external assurance)*	1. Cyber Assessment Framework (CAF) Review. (Ernst and Young) confirming best practice are fully met in 31 of 39 areas of the assessment. (May 2024) 2. Independent Penetration Testing – Trust Infrastructure and Supplier Systems (CREST Accredited Pentester) (June 2025) 3. UpGuard Reports (continuous monitoring security posture scores for GSTT and critical suppliers) – Trust is currently scoring at the level B for its security posture. With scores increased owing to delivery of cyber improvements (Monthly) 4. Microsoft Security Scores and Assessment reports to identify improvement opportunities in our infrastructure. (April 2025) 5. External IT Audit covering cyber security carried out for year ending 31st March 2025. One minor finding relating to a supplier support account raised. Rated Green – IT controls relevant to the audit of financial statements judged to be effective at the level of testing and scope.	

Improvement actions/next steps (*include key actions to bring the risk to its tolerance level and how the gaps in assurance will be addressed over the next 3 months)*

Improvement action	*Lead/owner*	*Timeframe*	*Status*	*Latest update*
Resilience and Recovery – GSTT Data Centres Backup As A Service (BAAS) and Disaster Recovery As A Service (DRAAS).	Omar Perreira White	BAAS (30/06/2025 - Completed) DRAAS (TBC)		Systems onboarded to our new BAAS solution. Next stage of the programme is the DRAAS element of the solution. Further work is required with the business, on change management and cutover plans to ensure to failover for DR will work seamlessly.
Resilience and Recovery - Telefonica Tech (TT) data centre failover and recovery.	Caroline Bowring	31/12/2025		ITCS are working with TT to arrange testing on similar basis to the ATOS failover 6 monthly failover approach.
Internal Server Patching Improvements.	Omar Perreira White	30/10/2025		Working with ITCS colleagues and the business owners to agree downtime schedule for patching.
Decommission, Upgrade, Replacement of remaining 9% legacy server estate. Including forward planning for	Omar Perreira White	31/03/2026		Working with system owners to decommission, upgrade or replace infrastructure items. An InfoSec team audit of unsupported estate has

strategic replacement.				identified additional servers that require decommissioning. In addition, further work is ongoing on legacy email elements post migration of email to central tenant, retirement of internal unsupported Sharepoint services, and replacement of the aging and unsupported elements of the CITRIX environment.
Residual risks associated with remainder of Windows 11 estate post 12th October 2026.	Omar Perreira White	31/10/2025		EUT Manager planning for PAYG support for devices hosting applications that do not support Windows 11 at this time.
Improvements to Joiner, Mover, Leaver processes.	Omar Perreira White	01/03/2026		JML Processes requiring improvement and addressing of nhs.net email JML processes. An audit of leavers by Information Security has identified user accounts that required disablement. Initial short term improvements made and planning to automate with RPA.

Principal Risk 5: The Trust may not fully realise the opportunities to transform ways of working based on the EPIC EHR implementation and may not deliver the clinical, operational and financial benefits set out in the business case.

Summary risk title:	**Epic benefits realisation**	**Date added to BAF**	February 2023
Board committee owner:	Transformation and Major Programmes Committee	**Risk tolerance level**	Low (5 – 9)
Executive committee lead:	Trust Executive Committee	**Risk score (post-controls)**	12 (likelihood 3 x consequence 4)
Executive director lead:	Jon Findlay (Chief Operating Officer)	**Level of assurance**	Limited
Strategic priorities impacted:	Delivering healthcare excellence; Innovating for a better future; Modernising our infrastructure		

Potential causes and linked risks from the corporate risk register

- The Apollo Programme Board has highlighted the need to accelerate and assure the benefit realisation for the programme.
- The organisation has not historically been able to demonstrate the benefits of major capital IT programmes, and there is therefore risk that the structures and approach are not in place to realise or identify the realisation of these changes.
- As a major programme, the wide-ranging benefit delivery categories have several associated significant risks, including workforce change management, procurement and commercial risks, and IT delivery risks.
- A lack of local ownership of delivery and compliance to workflows will impact our ability to fully utilise Epic system capabilities and demonstrate high levels of adoption. Both are key fundamentals to transform ways of working.
- Lack of timely access to Epic data such as reports and dashboards that demonstrate the Economic (eg productivity metrics) and Quality (eg Patient safety metrics) Benefits outlined in the business case.

Linked risks from the corporate risk register are:

RSK-023	Safety of administrative processes relating to patient pathways	16

Potential consequences (*if the risk was to materialise*)

- The non-delivery of financial benefits of Epic would affect the overall trust financial position and the defined affordability of the electronic health record and associated products and services over the lifetime of the programme.
- In addition to the direct risk to trust finances, inability to deliver the benefits would lead to further cost reductions being required elsewhere. This could affect either clinical services or the ability to improve the software to meet changing needs over the lifetime of the programme.
- Inappropriate management of the changes associated with the benefits could add additional risk types, including quality, safety and reputational risks.
- Poor use and adoption of the system will inhibit our ability to fully optimise the system therefore not utilising its full capabilities (e.g Automation, AI).
- Inability to accurately track and monitor Economic and Quality benefits outlined in business case if Epic data is not available in a meaningful format.

Key controls (tier 1 – *controls already in place to manage/mitigate the risk*)

- Named Trust Epic Benefit lead, Senior Finance Lead and finance resource allocated to oversee Benefit Realisation for GSTT.
- Development of business case benefits based on experience from other Epic implementations that has been re baselined (Aug 24). This is based on previous financial assumptions unless there is updated information (e.g. legacy system decommissioning).
- Updated FBC baseline now includes an aggregate position (e.g includes RBH) which will support tracking across the Clinical Groups.
- Approach and resource to Benefit tracking that aligns to governance processes (both Apollo and GSTT) is in place including tracking of the financial benefits that are currently being delivered.
- Benefit Working groups to be established to scope, plan and validate benefits in the FBC that are currently not being delivered.
- Close working with UK Epic Benefits Lead to ensure that GSTT responds in a timely fashion to potential new and emerging benefits that could be realised.

Gaps in controls (*further work required to manage risk to its tolerance level*)

- Ongoing testing of the operational assumptions outlined in the original FBC is required with clinical groups.

Key assurances (*evidence that the controls are effective*)		Gaps in assurances (*further evidence required about effectiveness of controls*)
Tier 2 *(oversight of controls)*	• Monthly Benefit Delivery Group to track delivery progress. • Monthly Programme update and Year to date benefit realisation position to be reported to GSTT Apollo board. • Close alignment between Epic Benefit Delivery Group and Financial Improvement Group. • Monthly reporting to GSTT Apollo Board. • Quarterly reporting to Exec Level committee- Trust Executive Committee. • Quarterly reporting to Board Level committee- Transformation and Major Programmes. • Quarterly reporting to Joint Apollo Board (GSTT & KCH).	• None.
Tier 3 *(internal assurance)*	• Internal Audit of Epic Benefit Realisation (May 2025).	
Tier 4 *(external assurance)*	• Nothing currently.	

Improvement actions/next steps (*include key actions to bring the risk to its tolerance level and how the gaps in assurance will be addressed over the next 3 months*)

Improvement action	***Lead/owner***	***Timeframe***	***Status***	***Latest update***
Alignment across Trust productivity workstreams with Epic Benefit themes, as set out in the Epic FBC to ensure we are capturing and utilising Epic capabilities.	Georgina Charlton/ Victoria Fairhurst	31/12/25	In Progress	Ongoing as roadmaps, key deliverables and milestones for each productivity workstream are finalised.
Increase Epic Benefit Programme focus on non-financial benefits.	Georgina Charlton/ Simon Mendy	31/12/25	In Progress	
Review and adjust 2026/27 Epic benefit delivery phasing to include further financial saving opportunities e.g Clinical Directorate Admin remodelling above original FBC value.	Georgina Charlton/ Simon Mendy	30/01/26	To be completed in Q4	

Principal Risk 6: Failure to effectively deliver multiple large-scale and complex transformation programmes concurrently, due to limitations in capacity, capability, governance, or stakeholder engagement. This could result in delays, increased costs, reduced quality of outcomes, and failure to achieve strategic objectives, ultimately affecting patient care and organisational sustainability.

Summary risk title:	**Organisational change and transformation**	**Date added to BAF**	July 2025
Board committee owner:	Transformation and Major Programmes Committee	**Risk tolerance level**	High (16+)
Executive committee lead:	Trust Executive Committee	**Risk score (post-controls)**	12 (likelihood 3 x consequence 4)
Executive director lead:	Steven Davies (Deputy Chief Executive Officer)	**Level of assurance**	Limited
Strategic priorities impacted:	Delivering Healthcare Excellence, Improving the Health of our Populations, Modernising our Infrastructure		

Potential causes and linked risks from the corporate risk register	**Potential consequences (*if the risk was to materialise*)**
• Delivery models for large transformation programmes are not always consistent or wholly effective. There is some duplication between the roles of central corporate functions vs resources in the clinical groups. • The level of change in the overall change portfolio exceeds organisational bandwidth in terms of project resource, management time, and other resources. • Available resources are not allocated optimally to deliver on the Trust's strategic objectives. • The change assurance model does not always effectively escalate portfolio level risks and issues promptly. *There are no linked risks from the corporate risk register.*	• Key strategic priorities do not progress as they are under-resourced. • Reputational damage if the Trust does not deliver on commitments to partners. • A lack of 'organisational memory' where lessons learned in one programme are not always applied to other programmes. • There is duplication of effort in some areas, with resources from Clinical Groups and central corporate functions duplicating work on the same initiatives. • Risk and issues are escalated and resolved late, leading to lost time and effort. • Resources (people, money) are deployed to ineffective or low value initiatives.
Key controls (tier 1 – *controls already in place to manage/mitigate the risk*)	**Gaps in controls (*further work required to manage risk to its tolerance level*)**
• Named executive SROs for each major programme, with guidance provided to SROs by the Central Portfolio Office. • Established and well-understood programme governance structures through Programme Boards with terms of references and risk management processes, plus clear success criteria. • Strengthened Central Portfolio Office providing expert support and advice to teams undertaking transformation programmes. • Medium Term Capital Plan managed through the Investment Portfolio Board (IPB) that underpins the Trust's transformation agenda. • Increasing focus on benefits realisation of completed programmes.	• Requests to spend capital / CDEL are sometimes escalated or managed outside of IPB. • Lack of regular capacity planning to assess resource availability and constraints across different programmes, or flexible resourcing models to manage peak demand. • No centralised risk register for all transformation programmes, with regular reviews and mitigation planning. • Post-implementation reviews to capture lessons learned and inform future initiatives not carried out routinely for all major change programmes.
Key assurances (*evidence that the controls are effective*)	**Gaps in assurances (*further evidence required about effectiveness of controls*)**
Tier 2 *(oversight of controls)* • Transformation and Major Programmes Board Committee provides routine oversight of significant and major change programmes, ensuring alignment with strategic objectives and prioritisation of initiatives. • Central Portfolio Office portfolio reporting. • Rolling reports on delivery of each GSTT 2030 strategic priority to Trust Board. **Tier 3** *(internal assurance)* • Central Portfolio Office gateway reviews of Major Programmes at key points in the programme lifecycle. **Tier 4** *(external assurance)* • External gateway reviews at key business case stages for the most important major programmes.	• A lack of regular reporting on resource allocation across the change portfolio in order to highlight where key initiatives are under-resourced. • Gateway reviews are conducted inconsistently. • There is limited time in the executive governance meeting structure for dedicated major programme oversight. • Programme highlight reports that go from the programme boards through executive and Board governance can be very long (30pp+) and risk false assurance. • Benefits realisation reviews not always undertaken routinely for significant and major change programmes.

Improvement actions/next steps (*include key actions to bring the risk to its tolerance level and how the gaps in assurance will be addressed over the next 3 months)*				
Improvement action	***Lead/owner***	***Timeframe***	***Status***	***Latest update***
Strengthened Central portfolio office (CPO) with defined programme methodologies and tracking of risks.	Steven Davies / Tom Davies	November 2025		We have agreed SPOCs from the CPO for all major programmes. We have also agreed a support offer for Major Programmes, which was produced post discussions with SROs, PDs and delivery groups. Agreement and communication of Trust Delivery Methodology, has been rolled into the work of launching the new Project Delivery reporting/mgmt. tool (October 25).
Identify more executive time for portfolio management conversations to manage portfolio level risks and issues and to optimise resource allocation between programmes.	Ed Bradshaw	December 2025		To be considered more when the new CEO arrives into post.
Regular reporting on portfolio resourcing to identify where key initiatives are under-resourced or under-funded.	Jackie Parrott and Tom Davies	Ongoing		We are validating the number and responsibilities of all Project Delivery Resource across the Trust, with Clinical and Delivery Groups. Also working within the DCEO to identify resources that can be moved onto higher priority work, e.g. Productivity Programme.
Establish a 'standard delivery model' for large scale transformation / Major Programmes at GSTT, clarifying the roles and responsibilities of the central functions vs clinical group resources.	Steven Davies and Tom Davies	December 2025		Workshop took place on 9th September with Delivery Groups to review and refresh the Trust Delivery RACI agreed in 2024. Further engagement planned with Major Programmes and Clinical Groups.
Develop 'gateway review' offer in the Central Portfolio Office to be applied to all major strategic initiatives.	Tom Davies	Ongoing		A delivery assessment, in line with our approach for capital deliveries, was carried out on all major strategic initiatives by CPO and Strategy in September. CPO are also agreeing Assurance activity on the Trust's major programmes. A CPO health check review on GSC was completed in October.

Principal Risk 7: The Trust's productivity levels may be insufficient to enable it to balance delivery of both its operational and financial responsibilities and therefore may impact delivery of its strategic priorities.

Summary risk title:	**Productivity**	**Date added to BAF**	July 2025
Board committee owner:	Transformation and Major Programmes Committee	**Risk tolerance level**	Low (5 – 9)
Executive committee lead:	Trust Executive Committee	**Risk score (post-controls)**	20 (likelihood 5 x consequence 4)
Executive director lead:	Steven Davies (Deputy Chief Executive Officer)	**Level of assurance**	Limited
Strategic priorities impacted:	Delivering healthcare excellence; Improving the health of our populations; Valuing all of our people; Innovating for a better future; Modernising our infrastructure		

Potential causes and linked risks from the corporate risk register

- Increased workforce numbers and costs, but stable activity levels compared with 2019/20.
- Capped income and tighter public sector budgets expected to continue.
- Significant and increasing waiting lists across the NHS.
- Reduced opportunity going forwards to manage financial pressures with non-recurrent means.
- Block contracts during the Covid-19 pandemic removed the financial incentives to treat more patients quickly.

Linked risks from the corporate risk register are:

ID 4227	Insufficient theatre capacity to meet demand impacting on safe and timely patient care	15
ID 4763	Delays to the elective surgical pathway	12

Potential consequences (*if the risk was to materialise*)

- Operational impact: fewer patients treated than there would be if productivity was at a higher level, increased waiting lists and delaying access to care.
- Clinical impact: poorer clinical outcomes for those patients waiting longest for treatment.
- Financial impact: higher cost base than is sustainable.
- Regulatory impact: Increased scrutiny from NHS England, as productivity is a metric in the new draft National Performance Assessment Framework, so there is a potential impact of further regulatory intervention as a result.

Key controls (tier 1 – *controls already in place to manage/mitigate the risk*)

- Productivity programme designed to improve the trust's productivity focused on 5 areas of greatest opportunity (patient flow; surgical productivity; ambulatory; administration; and private patients) and with 4 enablers (data & analytics; workforce; digital, technology & innovation; and workforce).
- Productivity programme has a defined SRO (Deputy Chief Executive) and each of the 5 workstreams has an executive sponsor and a programme director.
- Surgical productivity and patient flow programmes have established trust-wide programmes set up (the focus and ambition is being tested and revised through the overarching productivity programme).

Gaps in controls (*further work required to manage risk to its tolerance level*)

- Productivity programme has recently been set up and needs to mature and start delivering tangible changes.
- Trust-wide programmes of work for administration, ambulatory and private patients are being set-up.
- Executive productivity report, including holistic dashboard covering finance and clinical operations to measure impact of programme in development – issues with data quality and refinement of format/content underway. This will include key KPIs associated with each workstream.
- Trust continues to benchmark relatively poorly for productivity (lowest quartile in London and third quartile nationally), indicating that the controls are not yet currently effective.

Key assurances (*evidence that the controls are effective*)		**Gaps in assurances (*further evidence required about effectiveness of controls*)**
Tier 2 *(oversight of controls)*	• Productivity Steering Group established, with terms of reference and supported by a dedicated PMO. The Group meets fortnightly and receives reports from each workstream. • The Productivity Steering Group reports on a fortnightly basis to the Trust Executive Committee. • Theatre productivity metrics including model hospital data is reported monthly.	• Currently no assurance at tier 3 or above except for TMP Board Committee. • The reporting dashboard for the programme has not yet been established to the extent that improvement and progress can be clearly demonstrated. Each workstream will have agreed KPIs to enable progress to be tracked. • An internal audit review of the productivity programme is planned in 2025/26.

Tier 3 *(internal assurance)*	• Board-level oversight from independent non-executive directors in the Transformation and Major Programmes Committee.	• An external consultancy [Moorhouse] has been appointed to provide expertise (including non-NHS experience) and advice to the administration workstream, to ensure we are learning from industry best practice.
Tier 4 *(external assurance)*	• Nothing currently.	

Improvement actions/next steps (*include key actions to bring the risk to its tolerance level and how the gaps in assurance will be addressed over the next 3 months*)

Improvement action	***Lead/owner***	***Timeframe***	***Status***	***Latest update***
Mobilisation of the productivity programme - Workstream leaders to review and further develop scopes of work, priorities, and resourcing. - Review through programme governance including Trust Executive Committee to ensure assessment against the mobilisation matrix has matured. - Complete initial engagement workshops/meetings of workstreams and enablers to establish asks of one another. - Prioritise areas of focus within and across workstreams in the programme recognising there may be multiple asks on services and individuals. - Develop roadmaps, key deliverables and milestones for each workstream and track progress against these.	Exec SROs for workstreams	Ongoing		Since the last TMPB in September, we have held a series of stocktakes with Programme Directors and SROs to review the activity required to agree in year targets underpinned by robust plans. We now have agreed targets for 25/26 and plans in place to deliver across the programme. Due to capacity constraints, we have refocused the Ambulatory programme's scope onto three priority areas: Digital Room Booking, Ambient Voice and Referral to first Appointment Optimisation, where we are planning to focus on one speciality in the short term to demonstrate approach before scaling the work.
Development and implementation of Trust-wide communications and engagement plan to ensure staff are aware of the pressures the trust is facing, where they can support and what actions to take.	Anita Knowles/ Steven Davies	Ongoing		Trust-wide comms to support the ward processes work in flow are being issued in early November – this includes patient comms. Future engagement and communications plans are being worked up for the Winter and New Year.
Data review (analytics, availability, access, quality) to ensure that we are using accurate data to effectively monitor performance, identify improvement action and assess impact of interventions.	Denis Lafitte / Simon Steddon	Ongoing		Updated dashboards published for flow, surgical and ambulatory as part of operational excellence. Continues focus on how we share data and insights from the programmes with operational and clinical teams. Redesign of the IQPR framework is underway and is planned to incorporate productivity metrics.
Technology opportunity review (inc Epic optimisation and other tools) to identify where technology optimisation and adoption can drive productivity improvement.	Denis Lafitte / Nadine Hachach-Haram	Ongoing		Outcomes of the prioritisation exercise are to be brought to the 4th November Productivity Steering Group. This will include identification of a small number of areas where we may wish to test and trial new technologies in addition to Epic to drive productivity.
Development of Executive Productivity Report including agreed KPIs for each programme.	Steve Davies/ Victoria Fairhurst	Ongoing		Monthly report is now being produced and shared at productivity steering group and trust executive committee (alongside the finance report). This includes NHSE headline productivity metrics and indicators and we are staring to include metrics linked to programme initiatives so we can see where we are having local impact that will ultimately improve overall productivity indicators – this will include metrics such as cases/list, DNA rates, average delays for medically ready patient discharge etc. We are working on the format, data quality and narrative within the report and continuing to iterate this as it develops.

				Monthly highlight reports from each programme are reviewed at productivity steering group and will include key programme metrics against targets now these have been agreed.
Stocktake of clinical and delivery group activity against Productivity objectives, outside scope of programme. To ensure that we are capturing all activity through wider group governance.	Victoria Fairhurst/Tom Davies	November 25		We are starting to incorporate reporting more formally into local and exec PRMs. We are also working with the clinical groups to bring together an aggregated view. Making further changes to the Exec PRM template to capture activity under admin, flow, ambulatory, admin, surgical productivity, private patients; would give us greater confidence that we have captured everything.

Principal Risk 8: The Trust may be unable to sustain sufficient efficiencies or secure sufficient income to deliver a sustainable financial position, which may result in regulatory intervention and impair its ability to deliver high quality care, provide timely access to services and fulfil its strategic agenda.

Summary risk title:	**Financial sustainability**	**Date added to BAF**	Pre-2019
Board committee owner:	Finance, Commercial and Investment Committee	**Risk tolerance level**	Very Low (1 – 4)
Executive committee lead:	Trust Executive Committee	**Risk score (post-controls)**	12 (likelihood 3 x consequence 4)
Executive director lead:	Damien O'Brien (Interim Chief Financial Officer)	**Level of assurance**	Limited
Strategic priorities impacted:	Delivering healthcare excellence; Improving the health of our populations; Valuing all of our people; Innovating for a better future; Modernising our infrastructure		

Potential causes and linked risks from the corporate risk register	**Potential consequences (*if the risk was to materialise*)**
• Insufficient identification and delivery of efficiencies, ineffective cost controls, or insufficient funding being secured and collected, leading to failure to deliver on financial targets and overall financial deficits. • Uncertainty of new financial regime and reduced income; particularly with current interpretation of 2025/26 Operational Planning Guidance and elective activity levels. • Delegation of NHSE Specialist Services commissioning and funding to ICBs, along with the move to 'fair share' allocations and changes to the operating model for commissioning post delegation. Number of commissioners GSTT contracts with adds to risks as commissioning income is increasingly widely distributed. • Ability to report activity delivery with values to commissioners to enable recovery of income with agreed timescales, whilst commissioner datasets post-Epic are completed. • Returns from commercial ambitions taking longer to materialise than required, notably recovery and expansion of private patient revenue streams. *There are no linked risks from the corporate risk register.*	• Regulatory intervention leading to a reduced ability to manage our own finances, to determine and to achieve our operational and strategic objectives. • Disruption to patient care, including delayed access and impaired quality of care, and potential for widening of existing inequalities. Fair shares allocations process increases the weighting for aging over deprivation leading to outflow of funding from SEL where deprivation rates are high. • A reduction in ambition and growth plans, and increase in strategic planning risks. Commercial ambitions & partnerships, and access to capital financing, could be threatened by overarching financial instability. • Reduced access to research and development funding. • Impact on ability to recruit, retain & support staff. • Core patient care income at risk until sufficient commissioner reporting capability from EPIC. • Reduction in cash holdings potentially impacting supplier payments and ability to progress capital programme.
Key controls (tier 1 – *controls already in place to manage/mitigate the risk*)	**Gaps in controls (*further work required to manage risk to its tolerance level*)**
• Clinical Group (CG) and Essentia annual business planning process for income (activity), expenditure and savings. • Group level finance boards to drive in year financial delivery including ongoing CIP identification. • Cross-cutting savings workstreams established to maximise identification and delivery of efficiency opportunities. • Non-pay review panels established in all clinical groups to increase scrutiny over purchasing. • Staff adherence to financial management policies and procedures especially procurement. Regular review & refinement of policies and controls to ensure their adequacy as the financial and regulatory environment evolves. • Processes for ensuring adequate cash operated by Finance team. • Trust wide vacancy control process introduced with enhanced controls over external recruitment introduced in July 2025. • Expanded availability of supporting data including drugs, clinical supplies and productivity dashboards in MIDAS. • Better Faster Fairer programme established to drive productivity improvements, including cash releasing opportunities. • Pursuit of further commercial opportunities including refreshed private patient strategy.	• Continuation of funding allocation convergence adjustments needs ongoing mitigations. • Continued inflationary impacts on revenue contracts and capital projects, either where fixed values may not have been agreed or the impact on suppliers continues to be assessed, but further funding unlikely. • Value of CIPs currently identified and their time-line for implementation needs to be both increased and accelerated. • Continued improvements to EPIC data required to ensure full recovery of commissioning income. • Improving accessibility of supporting data in forms and systems that enable efficient analytics and clear insight, to drive timely actions improving financial control. • High reliance on non-recurrent benefits within financial position impacts year-on-year sustainability.

• Leading role in system sustainability work and within the APC. • Strength of relationships with SEL ICB, universities and charities.		
Key assurances (*evidence that the controls are effective*)		**Gaps in assurances (*further evidence required about effectiveness of controls)***
Tier 2 *(oversight of controls)*	• Monthly Finance boards monitor progress against delivery of CIPs and challenge reviews of financial performance. • Oversight of PRM process and actions by Executive team. • Evidence based contract negotiation process overseen by Associate Director of Finance. • Process oversight by Director of Finance and Senior Management Team. • Board sub-committee established to focus on Finance, Commercial & Investment activity. • Financial Improvement Board stood back up from March 2025. • Effective and timely process for addressing commissioner challenges.	• Uncertainty around financial framework for 2025/26. • Lack of confirmed detail on move to 'needs based' specialised services financial allocation over future years. • Changes to the contracting arrangements with regard to specialist commissioning and the need to engage individually across a broad number of ICBs. • On-going review of revenue inflationary impacts within non-pay. • Internal processes around cash forecasting to be strengthened.
Tier 3 *(internal assurance)*	• Introduction of the Oversight Framework to assess performance against core domains. • Regular financial management reports. • Effectiveness of procurement controls and policy.	
Tier 4 *(external assurance)*	• CQC/NHSE Use of Resources ratings. • National Provider Assessment Framework scoring including external Implied Productivity assessment progress. • External auditor review of capacity for financial sustainability including assumptions of plans. • Model Hospital indicators. • Getting it Right First-Time reviews. • External audit of data quality for Quality Account – limited to 3 national waiting times indicators.	

Improvement actions/next steps (*include key actions to bring the risk to its tolerance level and how the gaps in assurance will be addressed over the next 3 months)*

Improvement action	***Lead/owner***	***Timeframe***	***Status***	***Latest update***
System discussions and lobbying on financial regime	Damien OBrien	Ongoing		
Continue to recover and grow non-NHS revenue streams, in particular private patients to mitigate core NHS funding constraints.	Damien OBrien	Ongoing		Private patient strategy coming to July FC&I committee. Risk that current incentive structures may hinder delivery of revenue & contribution growth in plans.
Continue development of programmatic approach to efficiency and improvement.	Damien OBrien	June 2025		Productivity programme established.
Focus on finance training for operational and clinical managers.	Hazel Childs	Ongoing		Programme set up to create on-demand finance training resources within College of Learning platform and collate existing resources in a single location. Internal prioritisation & protected capacity to ensure pace of progress given operational pressures.
Maximise value and minimise financial risk in contract offers to commissioners.	Clare Robinson	Closed		All contracts agreed – closed.

Principal Risk 9: The availability of CDEL and the Trust's ability to fund capital investments to both maintain existing infrastructure and deliver transformational programmes to deliver strategic objectives.			
Summary risk title:	**Capital expenditure investment**	**Date added to BAF**	February 2023
Board committee owner:	Finance, Commercial and Investment Committee	**Risk tolerance level**	Very Low (1 – 4)
Executive committee lead:	Investment Portfolio Board	**Risk score (post-controls)**	8 (likelihood 2 x consequence 4)
Executive director lead:	Damien O'Brien (Interim Chief Financial Officer)	**Level of assurance**	Substantial
Strategic priorities impacted:	Delivering healthcare excellence; Improving the health of our populations; Innovating for a better future; Modernising our infrastructure		

Potential causes and linked risks from the corporate risk register	**Potential consequences (*if the risk was to materialise*)**
• CDEL allocated to Guys and St Thomas' from South East London is insufficient to mitigate risk and delivery capital developments which support Trust Strategy. • Availability of cash to support delivery of Trust Capital plan. • Changes in capital guidance with CDEL no longer ringfenced for leases putting pressure on core capital. • Challenges in maintaining aged infrastructure (both physical and digital) whilst delivering on strategic objectives and Major Programmes. • Forecasting accuracy leading to underspending in year, impairing medium term planning and risking future year allocations. *There are no linked risks from the corporate risk register.*	• Risks planned to be mitigated through capital are not addressed leading to lack of compliance and unsafe environments for patients and staff. • Demand and capacity and strategic priorities addressed through capital programmes are unable to deliver fully. • Poor management and understanding of cash flow will lead to further reduction of cash levels.
Key controls (tier 1 – *controls already in place to manage/mitigate the risk*)	**Gaps in controls (*further work required to manage risk to its tolerance level*)**
• Medium Term Capital Plan engagement in place to prioritise use of capital over 5-year period. • Assessment of alternative funding sources e.g. leasing, charity, grants. • New Business Case Templates with greater financial transparency. • Centralised Project Management Office to drive consistent processes and controls • Updated Lease register for all Trust properties owned by Estates and shared with Finance • Involvement of procurement in project governance to ensure commercial rigour and control in place. • Regular discussion of capital finance issues across SEL trusts through the APC Capital Finance Group.	• Transparency to Investment Portfolio Board of Assets Under Construction. • Clear resourcing plans for capital programmes to ensure deliverability of risk related capital programmes. • Regular challenge of capital expenditure forecast delivery and CDEL mitigations. • Transparency of changes in prioritisation of backlog boards required through IPB.
Key assurances (*evidence that the controls are effective*)	**Gaps in assurances (*further evidence required about effectiveness of controls*)**
Tier 2 *(oversight of controls)*: • Oversight provided through Investment Portfolio Board and sub committees covering delivery portfolios. • Financial Management reporting of capital projects and portfolios monthly.	• Benchmarking of cost of delivery is required to ensure value for money. • Reviews of forecast accuracy to both test cashflow projections and also identify CDEL risks and opportunities.
Tier 3 *(internal assurance)*: • Internal Audit review of capital programmes. • Transformation and Major Programme Board oversight on large capital projects. • Central Portfolio Office review and health check on capital projects.	
Tier 4 *(external assurance)*: • CDEL is balanced not by Trusts but by ICS. SEL ICS maintain regular reporting on the Trust CDEL forecast and potential breaches. • Business Cases for major programmes require regulatory approval.	
Improvement actions/next steps (*include key actions to bring the risk to its tolerance level and how the gaps in assurance will be addressed over the next 3 months*)	

Improvement action	*Lead/owner*	*Timeframe*	*Status*	*Latest update*
Capital cash support application required in order to finance existing capital plan.	Catherine Eyre	July 2025		Cash support application submitted and outcome is being chased.
Lessons Learnt from 2025/26 accounts to be shared with IPB with actions to improve transparency of project delivery.	Tom Davies	May 2025		CLOSED
Review of National Funding approach and access to additional CDEL.	Tom Davies	July 2025		CLOSED
Challenge of capital expenditure forecast delivery and CDEL mitigations.	Catherine Eyre	November 2025		Actions are taking place in October's exceptional IPB.
Regular discussion of capital finance issues across SEL trusts through the APC Capital Finance Group including brokerage plans and capital allocations.	Catherine Eyre	March 2026		Consolidated MTCP update underway for end of October.

Principal Risk 10: Insufficient workforce enablement, development and transformation impairs the Trust's ability to achieve the right people capacity, capability and change-ready organisational culture to meet the demands of healthcare now and into the future - ensuring safe, efficient and optimal care for patients and a healthy, high performing, and inclusive working environment for colleagues who provide it.

Summary risk title:	**High performing and future ready workforce**	**Date added to BAF**	July 2025
Board committee owner:	People, Culture & Education Committee	**Risk tolerance level**	Moderate (10 – 15)
Executive committee lead:	Trust Operations Board	**Risk score (post-controls)**	12 (likelihood 3 x consequence 4)
Executive director lead:	Crystal Akass (Chief People Officer)	**Level of assurance**	Substantial
Strategic priorities impacted:	Valuing all of our people		

Potential causes and linked risks from the corporate risk register

- Significant shifts in the design and delivery of healthcare (from treatment to prevention, from hospital to community and from analogue to digital) require rapid and sustained workforce transformation, including the development of new capabilities, ways of working and digital enablement.
- The requirement to deliver sustained improvements to performance, while at the same time pursuing efficiency and cost reduction, requires optimised workforce deployment and ways of working that promote and sustain productivity.
- Day to day operational pressures sustain – including a prevalence of violence and aggression within the workplace as well as a slow pace of improvement in organisational health, wellbeing and equity measures.
- These pressures prevent significant uptake of education, learning and development in key, transformational topic areas including leadership, inclusion, digital and data literacy.
- Educational capacity (including educator time, relevant estate capacity, simulation environments and supporting technology) is constrained and insufficient.

Linked risks from the corporate risk register are:

ID 4113	Violence and aggression against staff	**15**

Potential consequences (*if the risk was to materialise*)

- Necessary organisational transformation is delayed or ineffective.
- Performance and financial objectives are not met – leading to enhanced oversight and intervention.
- We fail to create healthy, high performing and inclusive teams leading to decreased morale, motivation and delivery success.
- Poor colleague experience impacting our ability to attract, recruit and retain and develop the very best.

Key controls (tier 1 - *controls already in place to manage/mitigate the risk*)

- Valuing all of our people (Strategic priorities) Extraordinary, empowered and empowering leadership; supporting the development of highly skilled and enabled people; inspired to create and contribute to an Inclusive, high-performance and change-ready culture.
- Talent and succession strategy to build leadership and critical role pipelines.
- New PDR cycle embedding values, objectives, and career conversations.
- Continue to drive PMP completion for managers. Core completion requirements adjusted to reflect competing demands of managers and continued promotion of the programme.
- Health and wellbeing initiatives integrated into workforce strategy.
- Digital enablement programmes and investment in workforce systems.
- Inclusive leadership development and exploration of a leadership school and new L&D resources.
- A wide range of CPD opportunities, including apprenticeships, available to all staff groups and professions.

Gaps in controls (*further work required to manage risk to its tolerance level*)

- Enterprise capability analysis and strategic workforce planning aligned to service transformation and financial scenarios.
- Organisational appetite and preparedness for transformation.
- Over-reliance on charity funding to support and sustain key workstreams in both EDI and OHSWB, with immature plans to embed.
- Vacancy audits and redesign of hard-to-fill roles
- Line manager capacity and commitment to complete core training including PMP. Original PMP target of Sept 2025 (all managers) not met with current completion at 31%.
- All clinical groups and corporate areas will be required to forecast and commit to an improvement trajectory in terms of an uptake in participation for the forthcoming year.

Key assurances (*evidence that the controls are effective*)		**Gaps in assurances (*further evidence required about effectiveness of controls*)**
Tier 2 (oversight	• People & Capability Executive: Collective ownership and overall responsibility for the delivery of high-quality services provided across the people agenda.	

of controls)	• System of reporting at SWCAY Forum and SWCAY Executive Committees with comparison of uptake/engagement now reported directly against accurate workforce demographic data. • Workforce Portfolio Board: Monthly reporting on digital and workforce transformation programmes. • EDI Improvement Board: to drive the successful delivery of the Trust's EDI improvement programme. • Additional investment in leadership and talent function agreed to embed compassionate and culturally competent leadership across Trust. • Shared leadership of OD and ETD enables more joined up holistic, cross professional education and development offer. • Ongoing discussions and actions in progress regarding SWCAY programme redesign to mitigate funding reduction i.e. staff psychology service redesign & consultation. • Monthly reporting: Workforce metrics (turnover, vacancy rate, stability index, PDR & Stat/Man Training compliance.	• Modernising Recruitment - Analysis of the candidate experience around the recruitment process will provide insight to ensure equitable, inclusive attraction and hiring practices. • Revised workplace adjustments process in place. Oversight of performance against expected requests (based on number of disability disclosures) to be implemented for stronger assurance. • The completion of EQIAs in decision making papers, policies and procedures needs to be centrally monitored as a measure of fairness in service change.
Tier 3 (internal assurance)	• Internal audit reviews of key workforce and payroll processes including Freedom to Speak Up and Workplace Adjustments. • Clinical Grp, Delivery Grp and Corporate Services PRMs. • Staff Surveys inc action plans: NHS staff survey, Pulse survey (quarterly). • Excellence award for London Healthy Workplace Accreditation. • External evaluation and learning partner commissioned to review the elements of the Showing we care about you programme funded by GSTC. • WRES / WDES / Pay Gap – annual reporting.	
Tier 4 (external assurance)	• HEE quality visits and GMC, Friends and Family Test and comparators. • Assessment of health, wellbeing and benefits offer commenced against Wellbeing Framework diagnostic tool underway. • CQC inspections and reviews of statutory training and appraisal data. • Home Office inspection to assess compliance with visa requirements. • Externally commissioned evaluation of the health and wellbeing programme. • Occupational Health, Safety and Wellbeing Service SEQOHS reaccreditation.	

Improvement actions/next steps (*how the gaps in controls or assurance will be addressed over the next 3 months*)

Improvement action	***Lead/owner***	***Timeframe***	***Status***	***Latest update***
Work has commenced towards revising the Trust's end to end recruitment processes (through an anti-racism lens as well as inclusion), identifying areas for improvement to enhance the attraction and retention of talent and critical skills.	Andrea Williams-McKenzie	Autumn 2024		In progress: Recommendations have been received and are currently being reviewed. These will be presented at the next EDI Improvement Board, with an implementation plan to follow later in the year.
Defining Employee Value Proposition, positive pathways and leadership development programmes, through the EDI Improvement Programme, commissioning external learning partner to continue evaluation of the SWCAY programme.	Andrea Williams-McKenzie	Autumn 2024		In progress.
Policy review through EDI Lens to improve the sense of belonging and retention.	Andrea Williams-McKenzie	Ongoing		In progress.

Increased focus on anti-racism in Trust development offer, including Board, snr leadership and management development and a positive action programme that will be targeted at global majority staff.	Pav Ponnoosami/ Savita Rana	November 2025		In progress: Delivery delayed to ensure the right product, colleague engagement, and alignment with lessons from ARIA. Delivery scheduled to commence February 2026 - Focus on strengthening anti-racism within leadership and management for Global Majority staff.
27% reduction in funding for the SWCAY grant review of impact currently underway.	Helen Kay	January 2025		Paper detailing impact presented to DOPC, TEC and PCE committees. Further review planned with CPO.
Redesign/streamlining of staff wellbeing psychology service underway – consultation in progress.	Helen Kay	September 2025		Consultation closed on 05/11/25. New operating model to be implemented by 01 March 2026.
Revise and streamline the workplace adjustment process to establish a unified, Trust-wide approach that effectively supports staff wellbeing and ensures the continued delivery of services.	Sav Rana	September 2025		Improvement plan has been developed and will be presented to the EDI improvement board in November for endorsement - delivery to commence in November to implement recommendations for improvement

Principal Risk 11: If the Trust does not consistently optimise its ways of working, establish clear frameworks and standards, and ensure strong, visible leadership, organisational excellence will be compromised. This could undermine our ability to deliver high-quality patient care and achieve our strategic objectives.

Summary risk title:	**Organisational Excellence (framing of Well-led)**	**Date added to BAF**	September 2023
Board committee owner:	Board-in-Committee	**Risk tolerance level**	Low (5 – 9)
Executive committee lead:	Trust Executive Committee	**Risk score (post-controls)**	12 (likelihood 3 x consequence 4)
Executive director lead:	Amanda Pritchard (CEO), Tendai Wileman (Chief of Staff)	**Level of assurance**	Substantial
Strategic priorities impacted:	Delivering healthcare excellence/ Improving the health of our populations/ Valuing all of our people/ Innovating for a better future/ Modernising our infrastructure		

Potential causes and linked risks from the corporate risk register

- Considerable changes to the Trust's leadership and governance arrangements since the introduction of the new operating model continue to develop and embed.
- Post-merger system integration challenges including IT, workforce and financial systems inhibit the development of a shared culture.
- Other factors such as sustained operational pressures, industrial action and the IT major incidents in 2022 and 2024, have stretched senior management capacity to deliver the large number of commitments made in GSTT2030.
- The latest NHS Staff Survey results indicate there remains considerable work to create a truly inclusive organisation in which all our people feel valued and have equal opportunities.

Linked risks from the corporate risk register are:

ID 4129	Business Continuity service level plan	12

Potential consequences (*if the risk was to materialise*)

- The absence of organisational excellence in leadership and governance, which research demonstrates can correlate to substandard clinical service delivery; poor working environments; and an inability to fully deliver strategic priorities.
- Reputational consequence if the Trust is unable to sustain its position a leader in education, research, innovation and training.
- Potential regulatory consequences linked to a failure to maintain expected standards of leadership and governance required by the NHS provider licence.
- Clinical risks linked to poor governance of policies, procedures and guidelines.
- Negative impact on organisational culture.

Key controls (tier 1 – *controls already in place to manage/mitigate the risk*)

- Internal well-led programme established with cross-organisational representation. This coordinated self-assessments against the CQC well-led quality statements and developed improvement plans. Refresh of self-assessment, and progress against key areas, has been completed and a report is being submitted to Board-in-Committee on 17 December.
- The Trust is responding alongside Shelford Group colleagues to the CQC's most recent consultation on their single assessment framework to provide feedback from large, multi-site acute, community and tertiary providers.
- Learning has been collated from recent CQC inspections at Birmingham and St George's, in addition to direct engagement with KCH to understand their own experience of a recent Well-Led inspection in September 2025.
- New Trust strategy and values launched in September 2024 to give common vision and direction.
- Proactive and sustained engagement with the CQC, with a symposium held on 12 November 2024 to better understand the evolving single assessment framework, in addition to a subsequent session with Dr Prem Premachandran, CQC Medical Director, for senior leaders on 28 January 2025.
- Existing performance for all CQC domains reported via Executive-to-Executive Performance Review Meetings, the assessment criteria for which is kept under review. This now includes consistent reporting for each Clinical and Delivery Group against all Well-Led quality statements from June 2025 onwards.
- Increased Board visibility through a refreshed site visit programme, regular senior leader events (at corporate and clinical group level) and monthly all-staff briefings.

Gaps in controls (*further work required to manage risk to its tolerance level*)

- Further assurance needed that improvement actions are on track for delivery.
- Lack of an integrated document management system housing all corporate and clinical policies and guidance that is accessible to all staff.
- Lack of a universally-understood approach to quality improvement. A new Organisational Excellence model (incorporating a quality management system) is being developed by a range of teams.
- Following the review by Penny Dash, the Well-Led quality statements are being updated by the CQC so it remains unclear to what extent we will need to re-review our evidence base. The new quality statements are expected to be published by the end of 2025, subject to a formal consultation.
- Uptake of Board site visit programme is very limited.

• Accountability and Performance Framework and Scheme of Delegation will updated in early 2026 to accurately reflect current processes and systems, following the implementation of the wider review into Board-level and Executive-level governance within the Trust.		
Key assurances (*evidence that the controls are effective*)		**Gaps in assurances (*further evidence required about effectiveness of controls*)**
Tier 2 *(oversight of controls)*	• Periodic update papers to executive and Board governance forums to give visibility of issues and risks, and ongoing improvement work. • Evidence base drafted to capture our current strengths, areas of improvement, and supporting documentation to demonstrate our well-led performance. • The People Board Committee oversees the FTSU process and the work of the EDI improvement board. • Green Plan Delivery Board being stood up to oversee and manage the Trust's sustainability commitments. • Well-Led assessments included in quarterly PRMs to ensure that actions taken to address these gaps have been completed.	• Absence of measurable data to support the provision of objective assurance regarding the Trust's well-led status across a number of key domains. • Limited capacity within partner organisations to provide a peer review of well-led performance. • Additional engagement is required to ensure that staff feedback on the Trust's leadership and governance arrangements is collated and any issues mitigated. • Exit interviews or 360 feedback for managers is not applied universally across the Trust to capture feedback. • Challenges have been reported with the Trust's quality indicators, such as freedom of information requests and appraisal compliance. • Not all demographic data is available from Epic, restricting the ability of the Trust to fully understand its impact on health inequalities. • Limited current oversight at Board level of the Trust's progress in delivering its Green Plan and environmental sustainability commitments.
Tier 3 *(internal assurance)*	• Internal audit review in autumn 2024 found the Deloitte recommendations had been implemented appropriately and Board governance changes made in 2023 had led to an improvement (albeit were still being embedded). • Internal audit review in 2025 concluded there was 'substantial' assurance around the robustness of the Board Assurance Framework process. • Internal executive governance effectiveness review undertaken in spring 2024 found significant evidence of good governance practice, with improvements identified. • For 2024, the Trust recorded organisation-wide increases in performance against each of the seven, core people promises.	
Tier 4 *(external assurance)*	• External review by Deloitte in November 2022 concluded the Trust was well-led and well-governed. Recommendations arising from the review have been implemented where necessary. • Regular meetings held between the CQC and the relevant leads at GSTT to support knowledge transfer and aid understanding.	

Improvement actions/next steps (*include key actions to bring the risk to its tolerance level and how the gaps in assurance will be addressed over the next 3 months*)

Improvement action	***Lead/owner***	***Timeframe***	***Status***	***Latest update***
Ongoing work to complete well-led action plans in a timely manner to address the areas of improvement identified, and to iterate evidence bases and collation of documents to demonstrate Well-Led performance.	Harry Richardson	Ongoing – up to notification of CQC inspection		In progress with onward escalations to TEC as needed.
Procurement of a document management system to host policies, guidelines, etc. that can more easily evidence our Well-Led performance.	Tendai Wileman, San Chaudhuri	5 months		Procurement process was successful and contract negotiations are underway. A go-live date of April 2026 is expected.
Development and deployment of an organisational excellence model within the Trust.	Simone Akuffo-Akoto, Ashley Parrott, Ronny Cheung, Laura Gudefin	2 months		Model has been socialised with TEC and senior leaders and further work is ongoing to communicate this in a simple, effective way to the organisation at large.

Principal Risk 12: The Trust may fail to fully deliver on its clinical academic research ambitions as set out on the strategy.			
Summary risk title:	**Research and academic ambitions**	**Date added to the BAF**	Earlier versions of this risk from 2018/19
Board committee owner:	Academic Committee-in-Common	**Risk tolerance level**	High (16+)
Executive committee lead:	Trust Executive Committee, via R&D Board	**Risk score (post-controls)**	12 (likelihood 3 x impact 4)
Executive director lead:	Simon Steddon, (Chief Medical Officer)	**Level of assurance**	Limited
Strategic priorities impacted:	Delivering healthcare excellence; Improving the health of our populations; Innovating for a better future		

Potential causes and linked risks from the corporate risk register	**Potential consequences (*if the risk was to materialise*)**
• Failure to work collaboratively with the other organisations that make up King's Health Partners (KHP) including possible misalignment of strategic ambition, priority areas of focus and ways of working. • Remaining areas of integration still to complete following the merger with Royal Brompton & Harefield and the existence of dual internal operating models for research. • Limited benchmarking and key performance measures to drive improvement and deliver on the ambitions of the organisation. • Reduced national research funding/ funding constraints due to competing organisational priorities. • Inadequate research infrastructure or digital capabilities and limited time for clinicians to engage meaningfully in research. • Local management of grant and commercial research funding within directorates is uncoordinated and not prioritised leading to risk of not spending research funds appropriately/IFRS15. *There are no linked risks from the corporate risk register.*	• A detrimental impact upon the reputation of Guy's and St Thomas' as a national and international leader in this field, with the Trust consequently unable to attract and retain fewer high-quality research active clinical staff • The Trust's contribution to improving patient outcomes, both at the present time and in the future, may be impaired. • Failure to use R&D to contribute or acknowledge R&D contribution to the Trust's work to address health inequalities and improve population health. • A reduction in the level of research funding (RDN, RCF, NIHR infrastructure funding, commercial income from research) impacting the Trust's financial sustainability for research; change in the Trust's current financial commitment to research (Centre for Translational Medicine). • Risk that the Trust is not re-designated as an NIHR biomedical research centre when the next applications are considered in 2028.
Key controls (tier 1 – *controls already in place to manage/mitigate the risk*)	**Gaps in controls (*further work required to manage risk to its tolerance level*)**
• The Trust's strategy to 2030 sets out a clear ambition to be a local, national and international leader in clinical care, education, research and innovation. • The new KHP Strategy was published in June 2025 and joins the strategic visions of the partner organisations. R&D strategic framework exists for the Trust – research values are being established • Joint initiatives in place including a Joint Research Office with KCL and the Centre for Translational Medicine (CTM). • Establishment of a Chief Academic Officer role working across the Trust, King's College Hospital (KCH) and King's College London (KCL) with a mandate to drive innovation, collaboration and improved outcomes across the health and care system in south east London and beyond. • Improved patient data from the Epic system at both the Trust and KCH could support improved opportunities for R&D such as enhanced recruitment to studies via a data driven approach and expanding opportunities for health data research. • Strong research management of research exists within the Trust via the R&D Directorate which has responsibility for the regulatory compliance and legal aspects of setting up and delivering research across the organisation – as well as supporting staff. • ACORN (A Centre of Research for Nurses and Midwives) will be expanded to include allied health professionals and healthcare scientists.	• The Trust lacks a number of relevant Board-approved strategies (data and analytics, AI, innovation) to support and underpin further advancements in research. • Greater clarity and definition needed in the next iteration of the Scheme of Delegation about the R&D responsibilities that will be delegated to clinical groups and the responsibilities that will remain within the central R&D function.

• The R&D Directorate proactively seek infrastructure funding (CRDC, HRC, capital infrastructure, GMP) /funding opportunities in order to stay ahead in research and supporting new government initiatives and the wider research agenda (eg advanced therapies).		
Key assurances (*evidence that the controls are effective*)		**Gaps in assurances (*further evidence required about effectiveness of controls)***
Tier 2 *(oversight of controls)*	• The Research Delivery Committee monitors R&D performance on a monthly basis. • R&D Governance and Risk Committee to oversee all R&D associated risk and incidents chaired by Director of R&D including hosted services and joint functions including CTO. This committee reports into TRAC on 6-monthly basis and R&D are core members • Finance controls via monthly R&D Finance Performance Review meetings – with Associate Director of Finance and R&D Director. • The R&D Board sits within the Trust's executive governance framework and reports into the Trust Executive Committee (TEC). All R&D functions/operations including clinical groups report to the R&D Board on a quarterly basis. • A joint Academic Committee in Common between the Trust, KCH and KCL drives delivery of strategic objectives and further promote partnership working.	• A schedule for R&D and the R&D Board reporting to TEC and Trust Board has been established on a quarterly basis for TEC and six-monthly basis for Trust Board. R&D Board minutes submitted to TEC in July 2025 and full R&D update is scheduled for October TEC. • Incoming performance metrics from the DHSC and NIHR will provide the backbone for what is reported to the Board and TEC; and will be a small component of the NIHR Research Delivery Network's new funding model under the performance category.
Tier 3 *(internal assurance)*	• R&D has an established quality assurance function relating to all R&D activity and especially the Clinical Research Facility, through the Head of R&D Quality Assurance, R&D Quality Assurance Manager and a newly appointed post of R&D Compliance and Audit Manager.	
Tier 4 *(external assurance)*	• Regular regulatory inspections from Medicines & Healthcare products Regulatory Authority – in capacity of Good Clinical Practice, sponsor responsibilities and infrastructure such as the Advanced Therapies Manufacturing (GMP) Unit licences. • Regular performance reviews take place with the NIHR Regional Research Delivery Network in South London. • External peer-review of e.g. organisational NIHR infrastructure applications such as CRF, CRDC and HealthTech Research Centre. Submission of annual reports on activity and financial management on these awards.	

Improvement actions/next steps (*include key actions to bring the risk to its tolerance level and how the gaps in assurance will be addressed over the next 3 months)*

Improvement action	***Lead/owner***	***Timeframe***	***Status***	***Latest update***
Ongoing focus on the role of the ACIC to unlock new opportunities and strengthen partnership working across the Trust, KCH and KCL.	Simon Steddon	Ongoing		First meeting of ACIC held on 22 May; the Committee will meet again in July 2025 and on a quarterly basis thereafter.
Data and Analytics Strategy is in development and will be brought to the Trust Board in the coming months.	Simon Steddon	Ongoing		Timescales for bringing the strategy through executive and Board governance remain unknown.
Proposals for the £4m NIHR BRC funding with Imperial were submitted to the DHSC.	Kate Blake	Ongoing		Questions were raised around the focus on Imperial as the sole collaborator. Further work has been undertaken to expand working to include the Manchester BRC and revised proposals are now being peer reviewed via the NIHR Selection panel. The centre has been advised that any funding will be backdated to 1 April 2025 – DHSC review is slow and is still ongoing. Funding has been agreed (September 2025) with DHSC and will be routed via the Imperial and Manchester BRCs for activity until March 2028.

Committee name	Academic Committee in Common
Date, time	Tuesday 21 October 2025, 9am – 12pm
Venue	Dulwich room, Hambleden Wing, King's College Hospital, Denmark Hill
Chair	Graham Lord

Review of action log: The Committee reviewed progress against outstanding actions. Key updates included the unsuccessful Applied Research Collaboration (ARC) South London bid and the launch of a new pan-London competition, outcomes from the National Institute of Health and Care Research (NIHR) training programme and NIHR Internship Scheme outcomes, and the CQC's well-led inspection at King's College Hospital (KCH) NHS Foundation Trust. Partners emphasised the need for clear governance, coordinated engagement, and alignment across organisations.

Clinical academic workforce: Clinical academics were noted as being integral to delivering the NHS Long Term Plan and the Life Sciences Sector Plan. Discussion focused on declining clinical academic numbers and the need for coordinated action. Work was underway to map the workforce and improve data. The Committee approved recommendations for taking forward a Memorandum of Understanding to outline shared principles for supporting clinical academics. Partners recognised the value of a multidisciplinary clinical academic workforce and stressed the importance of clear communication and joint accountability.

Honorary, Adjunct & Professors of Practice: The Committee received proposals to harmonise honorary, adjunct, and Professor of Practice appointment schemes across faculties. Recommendations included clearer processes, improved transparency, and creation of a central repository. The Committee noted varying faculty practices, potential applicant concerns, and the opportunity to strengthen partnerships and enhance visibility of NHS colleagues. The Committee agreed to develop a more consistent approach to the schemes, to conduct a data review to validate current appointees across all health faculties, and to improve the information available publicly about these appointment schemes.

Measures of Success/Impact Framework: The Committee noted the four domains previously agreed to enable measurement of its impact: innovation access, clinical academic careers, curricula enhancement, and economic benefit. An additional metric on health inequalities and equitable trial access was proposed. Committee members emphasised timely data provision from partners and the need for clarity on actions required to strengthen academic strategy delivery.

Trial Setup at King's Health Partners (KHP): The Committee noted the new UK Government mandate requiring clinical trials to move from regulatory submission to first patient recruitment within 150 days. KHP would apply this consistently across all studies, aiming for <99 days. Recommendations included sole sponsorship, streamlined contracting, parallel capacity assessments, and early participant identification. The Committee noted capacity challenges, investment needs, and the requirement for aligned reporting and rapid implementation planning.

Biomedical Research Centre (BRC) Planning and Approach: The NIHR BRC competition would launch in early 2027, with funding from 2028. The Committee received a report outlining KHP's strong research outputs, the need for clearer synergy, and five guiding principles, including NHS-first and digital readiness. Planning would focus on interdisciplinary themes, wider delivery, and population-level outcomes. Workshops and leadership calls were underway.

Financial Position and Research and Development (R&D) Summary: Finance leads reported aligned governance and consistent reporting across partners. Discussion covered capital access, optimising resources, and ensuring joint activity improves patient outcomes. Risks were noted, including Dental cost improvement pressures linked to the educational offer. KCL's continued research growth, particularly for the Institute of Psychiatry, Psychology & Neuroscience, was highlighted.

Governance and Risk Management: The Committee reviewed progress on developing a unified approach to risk management across Guy's and St Thomas', KCH and KCL. Work was underway to align frameworks, jointly identify and assess shared risks, and establish a Committee risk register. Key risks

included clinical trial timelines, research infrastructure alignment, clinical academic workforce challenges, curriculum pressures, and financial sustainability. A full paper would return in January.

KCL Council Pre-Read Oct 2025: The Committee noted the strength and scale of health and life sciences at KCL and the strategic value of being part of KHP. The report provided a clear, data-driven overview of achievements, partnership benefits, and future development opportunities. Members welcomed the clarity of purpose, noting strong reception by KCL Council and recognising the importance of a shared data strategy for future alignment.

Committee name	Audit and Risk Committee
Date, time	Wednesday 12 November 2025, 1pm – 4pm
Venue	Boardroom, Chelsea Wing, Royal Brompton Hospital
Chair	Nilkunj Dodhia

Review of action log: The Committee reviewed the actions and received updates noting rising counter fraud referrals in line with national trends and the need for strengthened oversight of overdue internal audit actions. The Committee agreed to develop clearer principles and a decision tree for approving advisory internal audits and requested early sight of the 2026/27 internal audit plan alongside a longer-term plan.

External audit: The Committee received planning assumptions for the 2025/26 external audit, noting that timelines remained consistent with previous years. External auditors were exploring use of AI to support efficiency, and members asked about implications for audit hours, fees and sector wide Value for Money benchmarking. Auditors remained confident in the Trust's core financial data but highlighted wider financial sustainability pressures. Most 2024/25 external audit recommendations had been addressed, though recurrent savings and financial planning continued as priorities.

Internal audit report: The Committee received an update on delivery of the internal audit plan, noting six audits were in progress and two awaited final executive sign-off. Some plan items would potentially be deferred due to resourcing pressures. Significant progress had been made in closing overdue recommendations, though Committee members noted challenges with management response times and agreement of recommendations. The Committee agreed that a formal framework should be developed to set clear expectations for timely responses, including defined timelines, monitoring and escalation.

Internal audit progress report: planned maintenance at Trust sites: The Committee noted improvements in procurement compliance, contract unification and strengthened financial controls, alongside work to improve operational structures. Members discussed the need to reduce reliance on waivers and embed stronger supplier performance evaluation. Intentional breaches of Standing Financial Instructions would continue to be managed under the Disciplinary Policy. A further update with targeted closure dates would be provided in February 2026.

Counter fraud report: The Committee received an update showing that fraud referrals had doubled, with 56 open investigations, and 14 cases closed, including seven with confirmed fraud or irregularity. Members discussed delays in disciplinary processes, proportionality of investigative effort and ongoing preventative activity, including Fraud Awareness Week. The Committee noted the Trust did not currently hold cyber insurance and agreed that options for this should be explored.

Corporate Risk Register report: The Committee received a quarterly update on the Corporate Risk Register (CRR) noting 16 significant organisational risks, including increased scores for chemotherapy supply distribution, which rose from 12 to 15 due to ongoing commercial constraints, and for cyber-attack, which increased from 15 to 20 in response to heightened threat levels. The Committee discussed the chemotherapy supply risk, noting a mixed model of in-house and external manufacturing and that a paper on meeting full in-house requirements was progressing through governance. Committee members also noted improved engagement from executives and risk owners, with individual risk updates now reported to executive committees. An annual review of progress against the risk strategy would be presented in February 2026.

Information governance update – FOI compliance: Despite recent improvements, overall performance remained below the 90% standard, with October compliance at 69.4% for clinical groups and 80% for corporate services. A cultural shift, supported by stronger senior level messaging, was agreed to be required. Options considered included low-level automation, improved triage and greater centralisation of FOI responsibilities.

Data centre resilience – update on physical security measures: The Committee reviewed physical and technical controls including biometric and PIN based access, multi-factor authentication (MFA), alarms and CCTV, with PINs refreshed every 90 days. Weaknesses in removing access for leavers were noted,

with organisational integration work due by Q2 2026/27. Fire and heat resilience were strong, though flood risk remained at the St Thomas' site. Plans to relocate data centres were progressing, with a tender expected by Q4 2025/26 and scoping in Q1 2026/27, alongside plans for a third data centre.

Cyber security update: The Committee noted improvement of the Data Security Protection Toolkit rating to a green 'B', with work underway to achieve an 'A' by year end. Progress included NHS Mail migration, Backup as a Service, expanded MFA and strengthened privileged access controls. Penetration testing showed minor issues and incident response times had improved. Growing risks relating to medical devices and the need to confirm Pen Testing contractual requirements were highlighted. The Committee agreed to scope options for a full review of cyber security activities.

Board Assurance Framework Risk – resilience of digital infrastructure: The Committee approved updates to the resilience of digital infrastructure risk on the Board Assurance Framework, including an increase in the risk score from 15 to 20 to mirror the related corporate risk.

Waiver report: The Committee noted the progress made in reducing the number of waivers since the previous report. It was agreed that adding a timeline to future waiver reports would be helpful for tracking progress. It was further agreed that the wording of retrospective breach waivers and waivers by directorates would be revised to provide greater clarity.

Guy's and St Thomas'
NHS Foundation Trust

Committee name	Finance, Commercial and Investment Committee
Date, time	Wednesday 29 October 2025, 1pm – 4pm
Venue	Burfoot Court, Counting House, Guy's Hospital
Chair	Simon Friend

Financial update: The Committee reviewed the Trust's financial position at the end of the first half of the 2025/26 financial year, noting the year-to-date deficit was slightly ahead of plan, but that the Trust was fining it challenging to both identify and deliver cost improvement programmes (CIPs) in line with its target. Capital expenditure was £28.1m, £29.4m below the phased plan, and assurance was sought about how the Trust was preparing to mitigate this slippage to ensure its full capital allocation was used.

Financial Forecast and Recovery: A financial forecast for 2025/26 was presented, showing a range of scenarios from worst-case to best-case. Achieving breakeven would be dependent on delivering CIP savings and additional central control measures including temporary staffing reductions, vacancy controls, and tighter purchase management. If progress towards breakeven was not seen by the end of October, it was recognised that further measures may need to be implemented which could potentially impact performance. Rising numbers of referrals from outside SE London was increasing demand for several services including imaging, and the Trust was seeking additional funding from Integrated Care Boards to ameliorate the impact of this. The Committee discussed the need for clear messaging to staff about the financial position and the savings needed.

Private Patient Productivity Workstream & Strategy Development: An update was provided on the development of a Private Patient Strategy, focusing on estates, workforce, and international themes. The Committee agreed that understanding market viability and the competitive landscape would be essential and that enhancing access to theatres and beds, and establishing a dedicated private patient estate, would be critical for long-term sustainability of the Private Patient income stream.

Queen Mary's Hospital Sidcup (QMS) Surgical Hub Exit Plan: The Committee discussed the implications of withdrawing from the QMS Surgical Hub. The Trust did not currently have sufficient theatre capacity to repatriate all work and was consideration the possibility of acquiring a standalone mobile theatre unit. Feasibility work on potential sites was being undertaken by Essentia and was likely to be complete by the end of the year, whilst a mobile unit would be in place by the summer 2026. The provision of a mobile unit would not only enable the repatriation of all QMS surgical lists but also provide additional capacity to the wider surgical group at a cost saving to the Trust.

Contract Awards: The Committee reviewed and approved a report recommending the award of the contract for the provision of Home Haemodialysis Replacement Therapies Services. The Committee also agreed to recommend to the Board that the Trust enter into a contract for the delivery of Cardiac Rhythm Management and Percutaneous Coronary Intervention services as part of a collaborative procurement exercise covering seven NHS Trusts.

Board Assurance Framework (BAF) risks: The Committee reviewed and approved updates to the two BAF risks it owned on behalf of the Board.

BOARD OF DIRECTORS

WEDNESDAY 28 JANUARY 2026

Report title:	**Finance Report for the nine months to 31st December 2025**
Executive sponsor:	Damien O'Brien, Interim Chief Financial Officer
Paper author:	Hazel Childs, Associate Director of Finance – Financial Management
Purpose of paper:	For awareness/noting only
Main strategic priority:	All strategic priorities
Primary BAF risk:	Risk 8: Financial sustainability
Key points of paper:	• The reported financial performance to 31st December is a deficit of £25.1m, following an in month surplus of £3.9m. This takes the YTD position to £0.1M ahead of plan • There has been minimal movement in CIP identification in month, though YTD delivery CIP delivery has increased to £53.4m including £12.4m for the sale of Lexica recognised earlier in the year. • The cash balance at 31st December 2025 stands at £149.4m, a reduction of £41.3m since the start of the year. • Capital spend stands at £85.2m against a plan of £137.2m YTD and £182.9m for the full year.
Paper previously presented at:	Trust Operations Board, 20th January 2026 Finance, Commercial and Investment Committee, 21st January 2026
Recommendation(s):	The BOARD is asked to: 1. **Note** the content of this report.

1. Summary

1.1. This paper updates the Board on the headline financial performance of the Trust for the nine months to 31st December 2025.

2. Financial Performance Summary

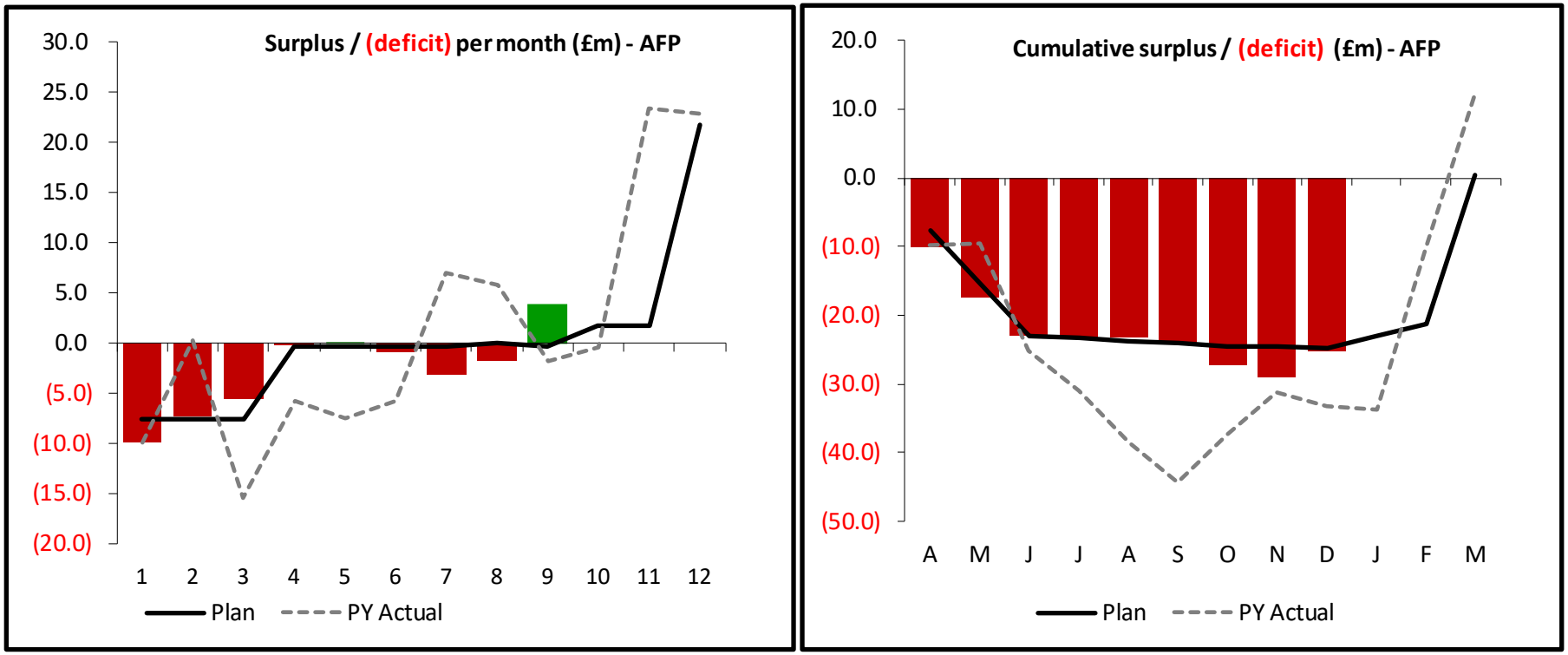
2.1. The Trust has agreed a breakeven plan for 2025/26, based on achieving £102.1m in cost improvement savings over the year. The rate of CIP delivery is expected to increase over the course of the year and the plan has been phased to take this into account, with a planned deficit for the first quarter, and a planned surplus in quarter four.

2.2. In the nine months to 31st December 2025 the Trust has reported a deficit of £25.1m. This follows a £3.9m surplus in month and puts the YTD position marginally ahead of plan.

Table 1: Trust I&E Summary at 31st December 2025.

Income and Expenditure £,m	Budget Mth	Actual Mth	Variance Mth	Budget YTD	Actual YTD	Variance YTD	Annual Plan
Income	250.0	276.1	26.1	2,264.2	2,307.5	43.2	3,019.9
Pay	(148.4)	(149.2)	(0.9)	(1,338.2)	(1,336.8)	1.3	(1,784.1)
Non Pay	(102.0)	(122.9)	(20.9)	(951.2)	(995.7)	(44.5)	(1,235.8)
Surplus / (Deficit) - Adjusted Financial Position (AFP)	**(0.4)**	**3.9**	**4.3**	**(25.2)**	**(25.1)**	**0.1**	**(0.0)**
DODA	(1.1)	(1.1)	0.1	(10.3)	(9.8)	0.5	(13.7)
Capital Donations	0.4	0.2	(0.2)	3.8	0.8	(2.9)	5.0
Technical Adjustments	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Surplus / (Deficit) - Excl Fin Adj's	**(1.1)**	**3.1**	**4.1**	**(31.7)**	**(34.1)**	**(2.4)**	**(8.7)**

Figure 1: In Month and Cumulative Surplus / (Deficit) Trend



2.3. The main drivers of the reported financial position are:

- The in-month position includes a number of non-recurrent or backdated benefits including:
  - £4.2m in funding for Industrial Action from NHSE covering the November and December strike impacts. This was a key factor in recovering the adverse YTD variance to plan reported in M08.
  - A further £3.5m in month reflecting overperformance (extrapolated from the reported Q1 position)
  - £2.1m in prior year accruals released.

  - There was a deterioration in the run rate spend on Clinical Supplies of £6.2M caused primarily by an understatement of costs in prior periods and a catch up in invoicing for supplies. Further investigations are ongoing into the root causes of these issues.

- Pay spend was £0.8m above trend in month, primarily driven by increased costs within Medical staffing (£0.8M). The increase was mainly contained within temporary staffing costs and predominately reflects industrial action costs. It should be noted that December is a 5 week month for weekly payroll so we have seen a rise in bank costs across other staff groups, but not outside of weekly trends excluding industrial action costs. Agency costs were £0.7m below trend in month at £0.5m compared to a M1-8 average of £1.2m, however this likely to be partly reflective of the activity levels and staffing plans over the Christmas period.

- Year to date, pay is £1.3m better than planned. Within this Medical pay is £9.8m overspent, of which industrial action accounts for c£1.8m. All clinical groups are overspent on medical pay in excess of industrial action costs, with the greatest pressures seen in resident doctors. This is offset by underspends in A&C pay of £17.7m YTD, of which £9.7m is within Hosted Services and is in turn offset in operating income.

- Private patient income is £4.0m behind plan YTD. The run rate is £0.8m/month ahead of the monthly average achieved last year, with £59.8m in income achieved to date. December's income, was below the previously noted trend in the YTD by £1.7M reflecting reduced demand during the Christmas period

- Purchase of healthcare, including independent sector, insourced and outsourced services, is £5.0m overspent YTD.

- Drugs are £23.7m overspent, partially offset by additional income, with the in-year net position being £6.3m worse than planned, further offset by £3.5m in prior year benefits.

- Clinical supplies are £20.8m overspent, and remain £10.9m overspent once current year high cost device income is accounted for. This reflects a continuation of high levels of expenditure as experienced in Q4 of 2024/25. The areas of greatest overspend are:

  - Pathology, £3.7m overspent to date driven under accrued prior year costs due to refreshed data from Synnovis, including Dermatology costs recognised in September, and increased month-on-month test volumes. These are only partially offset by the £2.0m credit for overstated prior year costs under the RBH contract, which was recognised earlier in the year.

  - Clinical groups are £19.2m overspent to date, though this reduces to £11.5m once high cost device income is accounted for. Net overspends are distributed across all four clinical groups, though highest in HLCC at £5.3m overspent at M09.

- The variances above are partly offset by the £9m plan phasing adjustment that balances to the £25.2m planned deficit YTD. This phasing adjustment is reducing month on month. The continuation of the above overspends along with CIP delivery falling behind target is therefore becoming visible in both the deficit and the variance to plan.

- The underlying performance remains a deficit in excess of £7.5m/month with an increase seen in M09 following the above trend clinical supplies expenditure. Overall, the position includes £53.5m in non-recurrent benefits YTD. It is critical therefore that underlying costs are materially reduced every month going forwards if the organisation is to deliver its planned break-even position. Further it is imperative that this is achieved through recurrent measures in order that the Trust can go into 2026/27 in a financially sustainable position.

3. CIPs

3.1. The externally reported CIP target for 2025/26 is £102.1m. This includes a 2% efficiency target on controllable costs, unbudgeted items offset by agreed funding, carry-forward of unmet 2024/25 CIP, and growth-related adjustments.

3.2. At the end of December identified CIPs stood at £83.8m, including £22.2m of central schemes, against the Trust target of £102.1m. This is a small increase compared to November, though a £20.6m improvement since the start of the year, and still leaves £18.3m unidentified.

3.3. Of planned group savings: 40% (£24.4m) are pay, 44% (£27.1m) non-pay, and 16% (£10.1m) income. The Trust's planning submission includes a WTE reduction of 1,535. As of month 7, the CIP tracker shows a planned reduction of 462 WTE.

3.4. PWR data for M08 shows that the trust total WTE has grown by 0.87% since M1, reaching 24,487 WTE in total. (M09 PWR data is not available at the point of reporting), meaning any headcount reductions from CIP schemes have been more than offset by other increases.

3.5. Year to date CIP delivery at month nine totalled £53.4m. This includes £12.4m in relation to the sale of Lexica which was planned to be achieved in M12. If the Lexica sale is excluded, YTD delivery is £3.9m behind the phased plan of £50.0m for identified schemes and £20m behind an evenly phased target.

3.6. This equates to a delivery rate of 91.3% against identified schemes, comparable with the reported month 8 position. If including unidentified schemes, and measured against an evenly phased plan, the delivery (excluding Lexica) falls to 68.7% however, underlining the need for both further identification of schemes and an increased pace of delivery as a priority.

4. Cash & Capital

4.1. **Cash** - The cash balance at 31st December 2025 stood at £149.4m, a £41.3m reduction compared to the opening position for the year of £191m but a £42.2m improvement in month.

4.2. **Capital** - The Trust was initially allocated a CDEL limit of £110m for 2025/26. In year CDEL and PDC awards have added to the annual capital plan, including £22m for backlog maintenance and £25m for the Children's Hospital Programme and the Paediatric Cancer PTC. Including donations of £5m, this gives a total capital plan for 2025/26 of £182.9m. Year-to-date the trust has spent £85.2m on capital schemes, which is £52.0m lower than the phased plan for the year including in year CDEL awards, additional PDC awards and donations. IPB is overseeing a review of options for ensuring all capital allowances are fully utilised in year including scope to bring forward spend from future years to offset slippage in year.

5. Risk of Non-Delivery Assessment (RoNDA) and Draft Internal Oversight Framework

5.1. From July 2025 the financial performance of NHS organisations is being assessed using the Risk of Non-Delivery Assessment (RoNDA) framework, with organisations put into one of four segments based on the RoNDA scores. The segmentation determines the level of external intervention or additional operating freedoms organisations will face. The framework considers the organisation's financial position and efficiency delivery, with an additional metric around cash performance still to be added. The initial assessment by NHSE using June results put GSTT in segment 2.

5.2. Table 4 below gives our internal assessment of our RoNDA scores using December results. It also includes performance thresholds for moving up or down a tier for each metric, to put performance in context and provide visibility of the degree of risk and opportunity within the segmentation scoring.

5.3. A number of assumptions have had to be made where metrics utilise national data, notably it has been assumed that annual national allocations remain unchanged from M3 and the national average planned efficiency % for M9 has been extrapolated from M3 (M3 + 5/9 of the remaining plan for the year).

5.4. The estimated assessment indicates the Trust would place in segment 2 using December figures, unchanged from November.

5.5. It should be noted that under the separate NPAF framework, any underperformance from plan at the quarter end assessments (i.e. at M9 and M12) would cap the Trust at segment 3 regardless of operational performance. This would have material consequences, notably loss of capital freedoms and likely regulatory interventions, alongside reputational impacts.

5.6. The Internal Group Oversight Framework was refreshed in August to align this to RoNDA as far as possible and taken through governance routes in September.

5.7. There are a number of RoNDA metrics which can only be calculated at trust level which are therefore excluded, notably the cash metric, YTD surplus/deficit & efficiency delivery vs national plan average. The financial discipline metric looking at the % services adverse to plan has been retained from the previous iteration of the framework. Controllable expenditure has been used as the denominator for a number of metrics rather than turnover to ensure comparability across all groups.

5.8. Each metric is scored 1 to 4, with the % thresholds for each score and the weighting for metrics matched to those used in the Trust RoNDA assessment. The overall score calculation is now a weighted average, again aligned to the RoNDA approach giving a final score between 1 & 4 for each group.

5.9. The draft group results under this framework are given in Table 5 below.

6. Recommendations

6.1. The Board is asked to:

- Note the YTD deficit of £25.1m at month 9, following a £3.9m surplus in month, taking the trust to £0.1m ahead of plan
- Note the small improvement in identified CIPs at M09 compared to M08, with £18.3m yet to be identified, and 91.3% delivery against identified plans.
- Note the current cash balance of £149.4m at 31st December 2025 and £41.3m reduction in cash since the start of the year
- Note the capital spend of £85.2m against a plan of £137.2m YTD and £182.9m full year.

Table 2: Trend in actual income

£m	2024/25 YTD Ave	2024/25 FY Ave	YTD ave	Last Six Months: Jul	Aug	Sep	Oct	Nov	Dec	YTD Total Plan	Actual	Variance
Income From Activities												
NHSE	79.98	80.90	18.74	19.58	17.23	18.38	18.54	18.82	23.10	160.26	168.70	**8.43**
SEL ICB	62.85	70.34	92.61	89.41	91.10	92.20	91.45	91.38	103.95	819.86	833.48	**13.61**
Other ICBs	37.52	38.14	72.04	60.99	71.01	77.71	72.20	71.75	76.19	650.09	648.39	**(1.71)**
High Cost Devices Income	5.71	6.13	6.37	6.97	6.03	5.21	5.77	9.14	7.30	49.96	57.33	**7.37**
High Cost Drugs Income	26.35	23.52	28.27	41.98	27.86	22.48	27.77	23.54	31.95	233.52	254.47	**20.95**
Private Patients	5.86	5.82	6.65	7.92	6.07	8.13	7.74	6.86	5.13	63.79	59.81	**(3.98)**
All Other Income from Activities	3.73	3.72	4.23	5.94	4.44	4.52	4.41	4.26	2.97	43.80	38.06	**(5.74)**
Total Income From Activities	**222.00**	**228.56**	**228.91**	**232.79**	**223.73**	**228.63**	**227.90**	**225.74**	**250.59**	**2,021.29**	**2,060.23**	**38.94**
Operating Income												
Research and Development	6.22	6.90	7.07	7.48	8.35	6.45	4.91	9.02	6.27	56.55	63.64	**7.09**
Education and Training	6.68	7.26	7.56	7.88	6.95	7.32	10.84	7.21	7.72	60.91	68.00	**7.09**
Non patient care services to other bodies	2.97	3.41	2.70	1.94	2.95	1.39	2.37	4.98	2.18	25.21	24.33	**(0.87)**
Income for Clinical Services	1.35	1.41	1.81	1.94	1.51	1.61	1.80	1.82	2.17	15.65	16.30	**0.65**
All Other Operating Income	8.06	8.52	8.33	9.30	5.09	9.12	8.98	9.21	7.18	84.62	74.97	**(9.65)**
Total Operating Income	**25.29**	**27.50**	**27.47**	**28.55**	**24.85**	**25.89**	**28.91**	**32.24**	**25.52**	**242.94**	**247.24**	**4.31**
Total Income	**247.29**	**256.06**	**256.39**	**261.34**	**248.58**	**254.52**	**256.81**	**257.99**	**276.11**	**2,264.23**	**2,307.47**	**43.25**

Table 3: Trend in actual spend

£m	2024/25 YTD Ave	2024/25 FY Ave	YTD ave	Last Six Months: Jul	Aug	Sep	Oct	Nov	Dec	YTD Total Plan	Actual	Variance
Pay												
Medical Staff	(38.99)	(38.90)	(40.97)	(39.27)	(47.04)	(41.20)	(40.71)	(41.80)	(41.72)	(358.97)	(368.74)	(9.77)
Nursing Staff	(46.19)	(46.49)	(48.76)	(47.82)	(54.38)	(49.01)	(48.32)	(48.50)	(49.19)	(440.30)	(438.83)	1.47
PAMs	(9.56)	(9.61)	(10.46)	(10.12)	(11.77)	(10.61)	(10.68)	(10.54)	(10.39)	(93.02)	(94.14)	(1.13)
Professional & Technical (PTB)	(5.59)	(5.55)	(5.96)	(5.87)	(6.69)	(5.99)	(5.96)	(5.94)	(5.87)	(56.07)	(53.65)	2.43
Admin & Clerical	(26.69)	(26.67)	(27.68)	(27.96)	(30.59)	(28.40)	(27.14)	(28.10)	(27.16)	(266.75)	(249.10)	17.65
Estate and Facilities Staff	(4.60)	(4.77)	(5.65)	(5.62)	(5.90)	(5.61)	(5.56)	(5.54)	(5.67)	(47.00)	(50.81)	(3.81)
All Other Staff	(8.35)	(8.55)	(9.06)	(8.54)	(10.13)	(9.20)	(9.35)	(9.32)	(9.25)	(76.04)	(81.56)	(5.52)
Total Pay	**(139.96)**	**(140.54)**	**(148.54)**	**(145.19)**	**(166.51)**	**(150.03)**	**(147.71)**	**(149.74)**	**(149.24)**	**(1,338.15)**	**(1,336.83)**	**1.32**
Non-Pay												
Drug Costs	(32.80)	(33.20)	(32.80)	(33.33)	(32.20)	(32.26)	(34.76)	(26.40)	(36.23)	(271.54)	(295.23)	(23.69)
Clinical Supplies	(33.37)	(34.83)	(36.43)	(34.20)	(36.77)	(29.18)	(36.19)	(38.14)	(41.95)	(307.08)	(327.87)	(20.79)
Premises Costs	(15.05)	(15.07)	(13.06)	(10.94)	(12.71)	(10.20)	(13.26)	(15.25)	(12.91)	(121.78)	(117.54)	4.24
Purchase of Healthcare (non-NHS)	(4.47)	(4.51)	(4.33)	(5.38)	(4.74)	(3.00)	(4.80)	(6.60)	(2.30)	(35.90)	(39.01)	(3.12)
Establishment Costs	(2.48)	(2.78)	(3.32)	(6.20)	(2.33)	(4.71)	(2.51)	(3.03)	(3.20)	(23.17)	(29.86)	(6.69)
Depreciation	(6.61)	(6.99)	(6.49)	(6.46)	(6.47)	(6.47)	(7.32)	(6.48)	(6.40)	(54.46)	(58.43)	(3.97)
Amortisation	(1.52)	(1.67)	(1.49)	(1.61)	(1.36)	(2.31)	(1.36)	(1.37)	(1.77)	(13.57)	(13.44)	0.13
Clinical Negligence	(3.13)	(3.13)	(3.17)	(3.11)	(3.21)	(3.21)	(3.16)	(2.85)	(3.24)	(29.15)	(28.49)	0.66
Movement in Bad Debt Provisions	(0.16)	(0.28)	0.72	(0.45)	0.22	(0.89)	2.60	(0.05)	(0.11)	(3.74)	6.50	10.24
Other Non-Pay Costs	(8.12)	(8.77)	(8.67)	(6.93)	(9.37)	(9.79)	(9.99)	(6.53)	(11.64)	(70.17)	(78.03)	(7.86)
Total Non-Pay	**(107.71)**	**(111.23)**	**(109.04)**	**(108.61)**	**(108.94)**	**(102.02)**	**(110.75)**	**(106.70)**	**(119.75)**	**(930.56)**	**(981.40)**	**(50.84)**

Table 4: 2025/26 CIP Plan Trust Summary

2025/26 CIP Plan Trust Summary *9th January 2026*	Target	Planning Status				(Unweighted)			Delivery Performance		
		Opportunity	Plans in Progress	Fully Developed - delivery not yet started	Fully Developed - in delivery	Total Plan	Unidentif'd CIPs	Progress (%) RAG	Fully Developed Full Yr Plan	Fully Developed FOT	Variance
		25%	50%	75%	100%						
Clinical Groups / Delivery Group / Corporates											
C&S	***15,557***	641	576	35	12,274	**13,526**	-2,031	86.9%	12,309	11,085	-1,224
Evelina	***8,994***	1,377	981	849	4,051	**7,258**	-1,736	80.7%	4,900	6,287	1,387
HLCC	***16,048***	44	95	1,541	14,087	**15,768**	-280	98.3%	15,629	14,013	-1,616
ISM	***14,033***	2,112	243	17	8,153	**10,525**	-3,508	75.0%	8,170	8,220	50
Essentia	***4,066***	0	188	0	4,050	**4,238**	172	104.2%	4,050	4,050	0
Pathology	***10,546***	0	0	0	164	**164**	-10,381	1.6%	164	164	0
Corporate	***10,678***	0	0	0	10,132	**10,132**	-546	94.9%	10,132	10,203	71
Total Allocated CIP	**79,921**	**4,173**	**2,084**	**2,443**	**52,911**	**61,611**	**-18,310**	77.1%	**55,354**	**54,023**	**-1,331**
Central	***20,000***	0	7,569	0	12,431	**20,000**	0	100.0%	12,431	12,431	0
Unallocated	***2,206***	2,206	0	0	0	**2,206**	0	100.0%	0	0	0
Total CIP	**102,127**	**6,380**	**9,653**	**2,443**	**65,342**	**83,817**	**-18,310**	82.1%	**67,785**	**66,454**	**-1,331**

Table 5: Month 9 Actual CIP Delivery against CIP plans and targets

2025/26 CIP Plan Trust Summary *9th January 2026*	M9 YTD Performance				M9 YTD Performance			
	Plan	Actual	Variance to Plan	Progress (%) RAG	Target*	Actual	Variance to Target	Progress (%) RAG
Clinical Groups / Delivery Group / Corporates								
C&S	**10,382**	**8,436**	**-1,946**	81.3%	**11,668**	**8,436**	**-3,232**	72.3%
Evelina	**5,344**	**4,992**	**-352**	93.4%	**6,809**	**4,992**	**-1,817**	73.3%
HLCC	**10,294**	**9,923**	**-371**	96.4%	**11,690**	**9,923**	**-1,767**	84.9%
ISM	**7,608**	**6,437**	**-1,171**	84.6%	**10,541**	**6,437**	**-4,105**	61.1%
Essentia	**3,423**	**3,320**	**-103**	97.0%	**3,050**	**3,320**	**270**	108.9%
Pathology	**123**	**123**	**0**	100.0%	**7,909**	**123**	**-7,786**	1.6%
Corporate	**7,688**	**7,749**	**61**	100.8%	**8,009**	**7,749**	**-259**	96.8%
Total Allocated CIP	**44,862**	**40,979**	**-3,883**	91.3%	**59,676**	**40,979**	**-18,696**	68.7%
Central	**0**	**12,431**	**12,431**	100.0%	**0**	**12,431**	**12,431**	100.0%
Unallocated	**0**	**0**	**0**	0.0%	**0**	**0**	**0**	0.0%
Total CIP	**44,862**	**53,410**	**8,548**	119.1%	**59,676**	**53,410**	**-6,265**	89.5%

Table 6: RoNDA internal assessment M09

Metrics	Metric Name	Metric Description	Current Performance	Metric Score	Weighting	Weighted Score	Threshold to move up £m	Threshold to move down £m	Prior Month Metric Score	Movement in month
Financial Position	YTD Variance	Surplus / Deficit YTD variance to plan as a percentage of YTD turnover	£0.08	1	2.00	0.19	n/a	£0.00	2	1.00
	YTD Actual Surplus / Deficit	YTD actual (surplus / deficit) as a percentage of national total of system allocation (pro rata)	(£25.07)	2	2.00	0.38	£0.00	(£80.23)	2	0.00
	YTD Pay Variance	Provider pay expenditure YTD variance to plan as a percentage of YTD Plan for Pay	£1.32	1	2.00	0.19	n/a	£0.00	1	0.00
	Forecast Outturn + Total Risk	FOT (surplus / deficit) variance to plan + unidentified mitigations + other risks) as percentage of FOT Turnover	£3.00	2	2.00	0.38	£0.00	£31.11	2	0.00
Efficiency	Efficiency Variance YTD	Efficiency YTD variance to plan as a percentage of YTD plan	£8.55	1	1.00	0.10	n/a	£0.00	1	0.00
	Efficiency delivery vs. National average	Difference between YTD actual delivery as a % FY efficiency plan and expected delivery based on national average plan profile	£53.41	4	1.00	0.38	£68.59	n/a	4	0.00
	Efficiency Variance FOT	Efficiency FOT variance to plan as a percentage of Full Year Efficiency Plan	£0.00	1	0.50	0.05	n/a	£0.00	1	0.00
Cash	Year to date operational cashflow compared to breakeven	TBC			0.00	0.00				
Trust Score					10.5	2			2	0.00

Table 7: Internal Group Financial Oversight Framework M09

Domain	Metric	Basis	Weighting		C & S	Evelina London	HLCC	ISM	Essentia	Corporate	Other
Financial Discipline	# Services NOT under Control	No. of services with an adverse variance as % of total number of services	0.5	Performance	26	26	20	27	29	37	11
				Metric result	-55.3%	-45.6%	-48.8%	-41.5%	-50.0%	-43.0%	-37.9%
				Score	3	2	2	2	2	2	2
Financial Position	I&E Variance	Total YTD Variance (all income and expenditure) v YTD Expenditure Plan as %, at CG level	2	Performance	-£11,667	£2,740	-£17,701	-£10,423	£2,577	-£1,150	£35,704
				Metric result	-3.0%	0.9%	-3.6%	-2.5%	1.4%	-0.4%	18.4%
				Score	4	1	4	4	1	2	1
	Pay Variance	Total YTD Pay Variance v YTD Pay Plan, at CG level	2	Performance	-£3,783	£3,122	-£5,564	-£4,617	-£927	£14,458	-£1,364
				Metric result	-1.5%	1.3%	-1.9%	-1.5%	-1.1%	8.6%	-167.2%
				Score	3	1	3	3	3	1	4
	FOT + Risk	FOT Variance (Likely Case) v FY Expenditure Plan, at CG level	2	Performance	-£15,908	£1,812	-£23,076	-£12,718	£1,927	-£5,738	£21,846
				Metric result	-3.1%	0.4%	-3.5%	-2.3%	0.8%	-1.4%	10.3%
				Score	4	1	4	4	1	4	1
Efficiency	CIP Variance	CIP YTD Variance v YTD Plan for 25-26	1	Performance	-£1,946	-£352	-£371	-£1,171	-£103	£61	£12,431
				Metric result	-18.7%	-6.6%	-3.6%	-15.4%	-3.0%	0.8%	10086.0%
				Score	4	3	2	4	2	1	1
	CIP FOT Variance	CIP FOT Variance v Total Target for 25-26	0.5	Performance	-£3,483	-£1,672	-£2,018	-£5,688	£19	-£473	-£12,617
				Metric result	-23.4%	-18.7%	-12.6%	-38.5%	0.5%	-4.4%	-38.5%
				Score	4	4	3	4	1	2	4
	Overall score				**4**	**2**	**3**	**4**	**2**	**2**	**2**

Committee name	Quality and Performance Committee
Date, time	Wednesday 15 October 2025, 1.30pm – 5.00pm
Venue	16th Floor, Tower Wing, Guy's Hospital
Chair	Pauline Philip

Feedback from Trust Site Visits: Feedback was received from non-executive directors and governors from recent clinical service visits, highlighting the challenges faced by community midwives and issues such as staff car parking fines. The Committee discussed improving the use of site visit reporting forms and considered ways to facilitate more clinical staff visits to the pathology hub.

Quality and Safety: The significant reduction in overdue complaints was noted, though timely responses remained challenging. Recruitment to support complaints management was underway. The Committee reviewed significant events under the Patient Safety Incident Response Framework, including never events, and discussed ongoing Trust-wide initiatives to strengthen surgical safety. The Committee also reviewed mortality surveillance, clinical audit progress, and infection prevention efforts, and received positive feedback on patient experience and safeguarding work.

Mortuary Assurance Report: The Committee noted progress in implementing recommendations from the Fuller Inquiry and integrating mortuary governance under the Cancer & Surgery Clinical Group. Delays in the mortuary office estates project were discussed, and an interim solution was requested.

Operational Performance and Activity: The Trust maintained high national performance rankings, with strong operational results despite the impact of industrial action. Key risks included long waits and underperformance against cancer and diagnostic standards, with robust plans in place to address these. The Committee requested enhancements to the operational performance summary for greater clarity.

Synnovis 90 Improvement Plan: The Committee was pleased with improvements from the 90-day plan, especially in dermatopathology and haemato-histopathology. Concerns remained about histopathology turnaround times and staffing gaps. The Committee agreed to reinforce contractual obligations with Synnovis to ensure performance standards were met.

Internal Audit Recommendations Update: Progress was reported on implementing recommendations from two internal audit reports escalated from the Audit and Risk Committee due to limited assurance. It was evident that good progress was being made and the Committee was assured that the work being done would mitigate the identified risks.

Patient Story: A patient shared their positive experience with the Trust's @home community service, which supported their recovery and mental health. The Committee discussed embedding this model into medical job plans and increasing clinical engagement to encourage referrals.

Infrastructure Updates: Data, Technology & Information (DT\&I) and Estates: Updates were provided on IT resilience, cyber security, and digital infrastructure improvements, including progress on recommendations from the 2022 data centre incident. Estates updates covered water and fire safety improvements, chemical incident response, and ongoing estates projects.

Clinical Group Assurance Reports: Each clinical group provided an exception report about relevant quality and operational performance issues and risks in their groups, including cardiac surgical service configuration, MRSA outbreaks, and equipment replacement needs.

Maternity Quarterly Report: The Committee received updates on maternity risks, compliance, and staffing, including challenges with laboratory testing and theatre capacity. Actions were proposed to address these issues, and progress was noted in reducing health inequities.

Board Assurance Framework – Quality and Performance Risks: The Committee reviewed and approved the three strategic risks on the Board Assurance Framework, noting current risk scores and recent improvements in assurance and control levels.

Statutory and Regulatory Reports: The Committee noted a range of statutory and regulatory reports, most of which had been discussed earlier in the meeting.

Any Other Business: The Committee noted a new government ambition to reduce clinical trial set-up times and discussed the upcoming workshop for Non-Executive Directors on quality, safety, and clinical governance.

Integrated Performance Report Public Board

Guy's and St Thomas' NHS Foundation Trust

December 2025

we are **Caring** | **Ambitious** | **Inclusive**

NHS
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Highlight Report Contents

Guy's and St Thomas' NHS Foundation Trust

Domain	Theme	Indicator	Latest Actual
Responsive	4.1 A&E access	A&E stays less than 4 hours (type 1 2 3)	79.0%
Responsive	4.1 A&E access	Number of patients spending >12 hours in A&E from decision to admit (DTA)	60
Responsive	4.2 Elective treatment access - referral to tre...	RTT - Total incomplete pathways	108,495
Responsive	4.3 Cancer access	Cancer - 62 day all referral types (total)	54.6%
Responsive	4.3 Cancer access	Cancer - FDS	85.2%
Responsive	4.4 Diagnostic access	Diagnostic waits - % over 6 weeks	40.2%
Responsive	4.9 Recovery	Elective DC & IP vs 25/26 Operational Plan	99.8%
Responsive	4.9 Recovery	Number of 65 Week Waiters	25
Responsive	4.9 Recovery	Number of 78 Week Waiters	4
Responsive	4.9 Recovery	Outpatient New & FU vs 25/26 Operational Plan	90.1%

Executive summary

Accident and Emergency

- The percentage of emergency patients admitted, transferred or discharged within 4 hours in December 2025 was 79%, with the Trust ranking 13th out of 121 general hospital Trusts nationally (top quartile).
- The number of patients waiting in the emergency department for greater than 12 hours from Decision-To-Admit (DTA) was 60.

Referral to Treatment

- The total number of Referral to Treatment (RTT) patients waiting for treatment at the Trust in December was 108,495 and 66.3% of patients were waiting 18 weeks or less for their elective treatment.
- A total of 25 patients were waiting longer than 65 weeks for their routine treatment in December, with 4 of these patients having waited longer than 78 weeks.
- The Trust remains committed to clearing these long waiting patients with an ambition of reaching as close to zero patients waiting longer than 65 weeks by the end of January 2026 and to maintain a position of zero from February 2026 onwards.
- A total of 1,075 patients were reported as waiting longer than 52 weeks for their treatment in December, representing 1.0% of the total waiting list.

Cancer

- The Faster Diagnosis Standard position reached 85.2% in November demonstrating continued improvement in-year with this strong performance expected to continue for the remainder of 2025/26.
- The percentage of patients treated for cancer within 62 days of referral (overall) for November was 54.6%, demonstrating an improvement of 3.8 percentage points compared with October. This position remains challenged and continues to be an area of focus for the Trust with a comprehensive recovery programme in place to improve this position.

Diagnostics

- In December the Trust reported 40.2% of patients waiting longer than 6 weeks for their routine diagnostic procedure, with 12.2% of patients waiting longer than 13 weeks. This remains another area of risk to the Trust who are working to improve this position in quarter 4 of 2025/26.

Activity

- The Trust reached a position of 90.1% of outpatient activity (new and follow up) for December and 99.8% for elective activity (elective overnight and day case).

Responsive

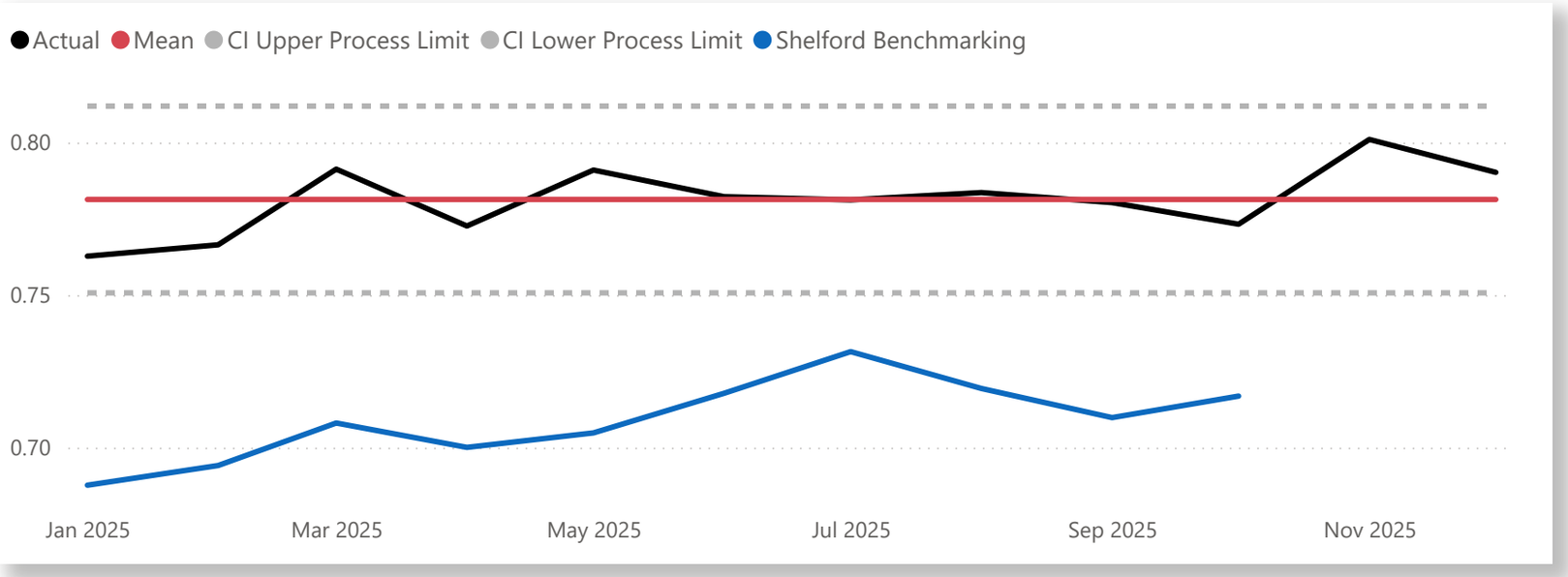
Guy's and St Thomas'
NHS Foundation Trust

December 2025
79.0%

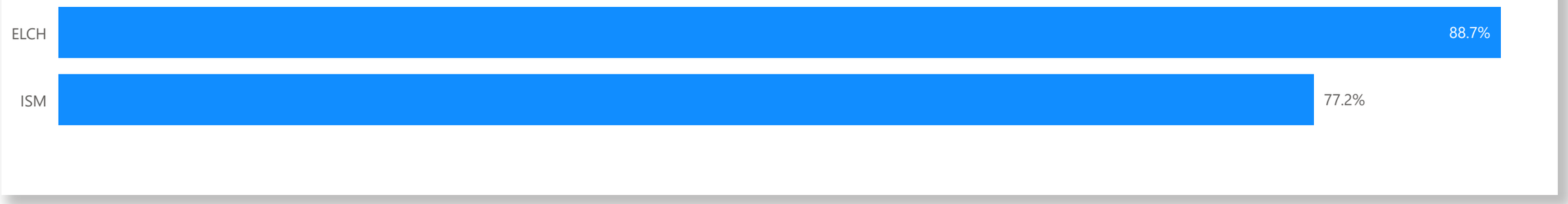
SPC

This indicator is showing common cause variation

A&E stays less than 4 hours (type 1 2 3)



Clinical Group Overview



Responsive

Guy's and St Thomas'
NHS Foundation Trust

December 2025
60

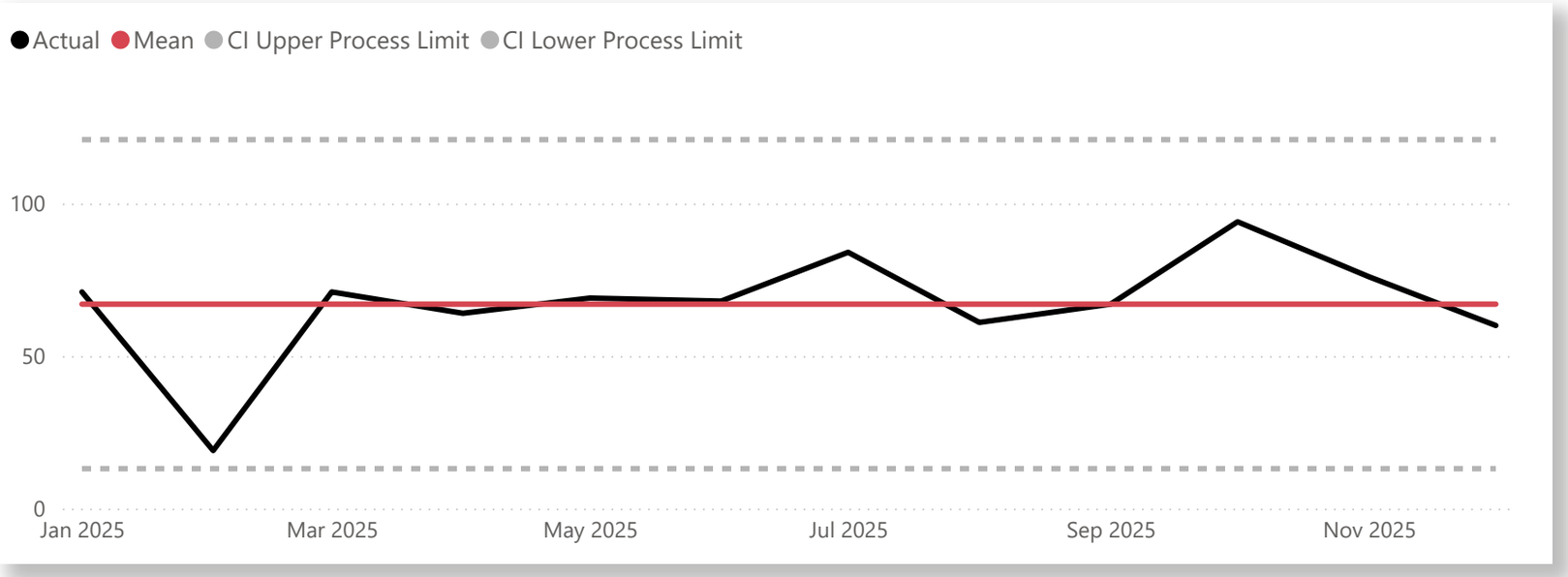
SPC

This indicator is showing common cause variation

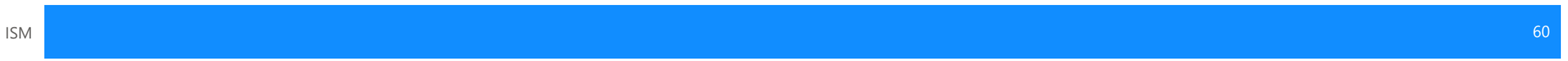
Caveat

A&E data represents a combined position including Adults and Paediatrics, work is underway to ensure that the data maps correctly to the appropriate Clinical Groups for future reporting.

Number of patients spending >12 hours in A&E from decision to admit (DTA)



Clinical Group Overview



Responsive

Guy's and St Thomas'
NHS Foundation Trust

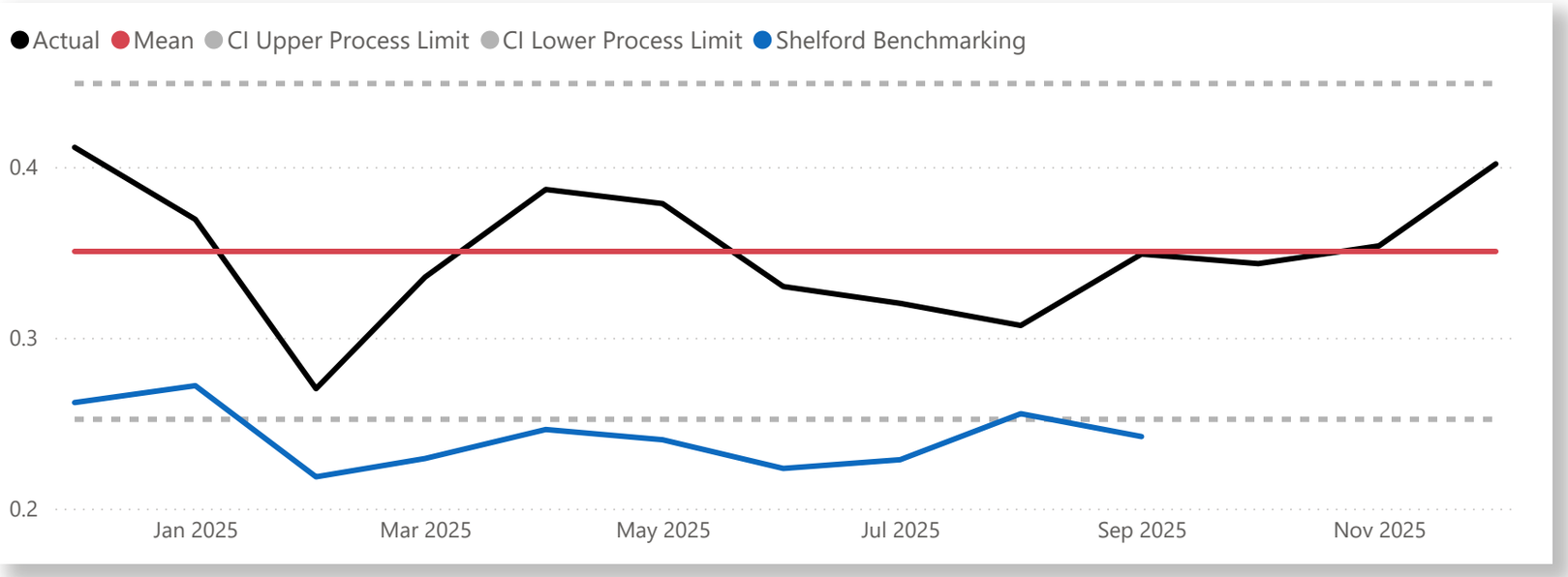
December 2025

40.2%

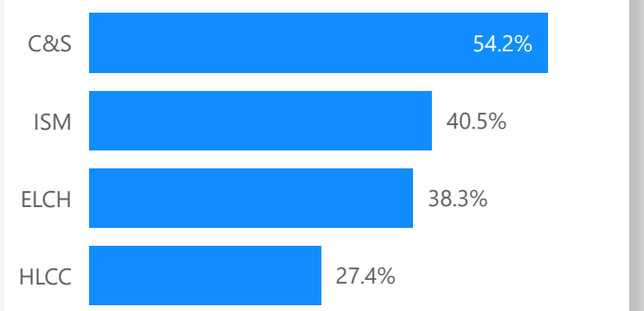
SPC

This indicator is showing common cause variation

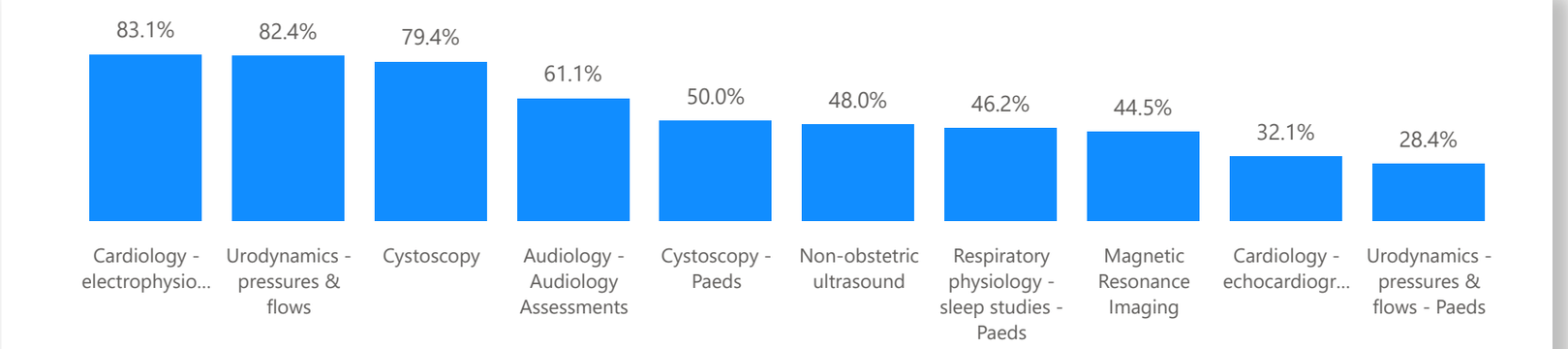
Diagnostic waits - % over 6 weeks



Clinical Group Overview



Bottom 10 Modalities



Responsive

Guy's and St Thomas'
NHS Foundation Trust

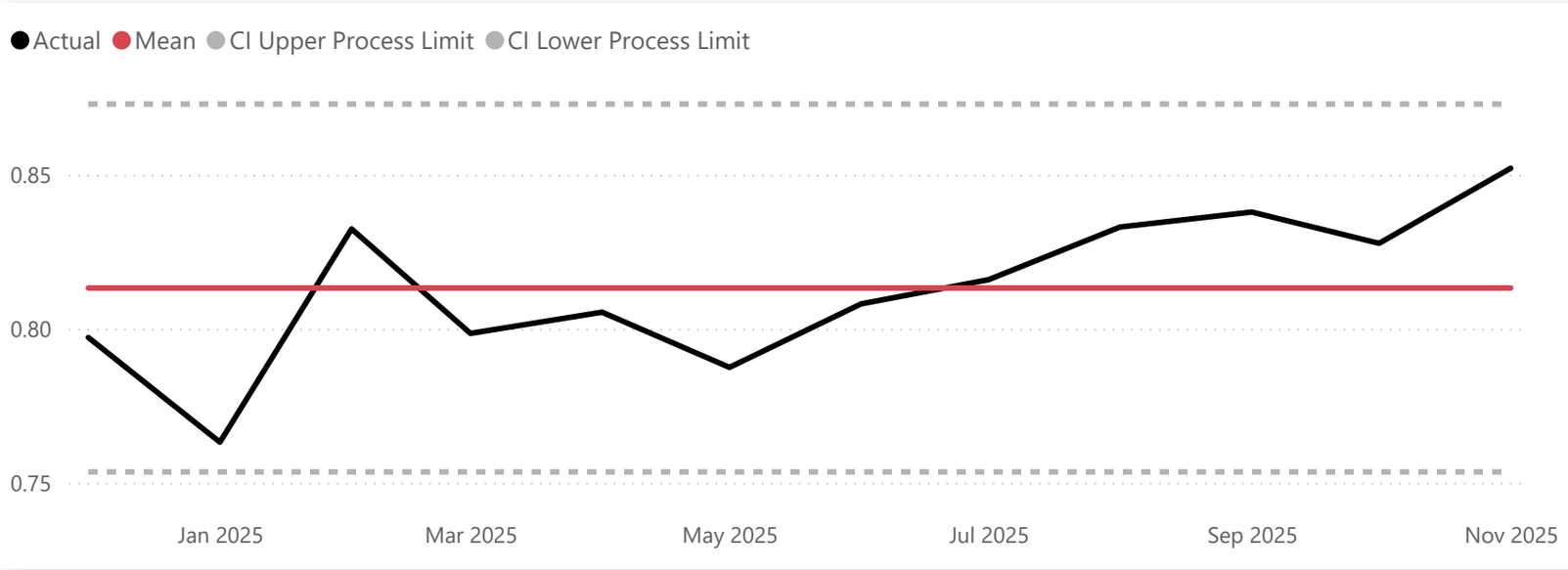
November 2025

85.2%

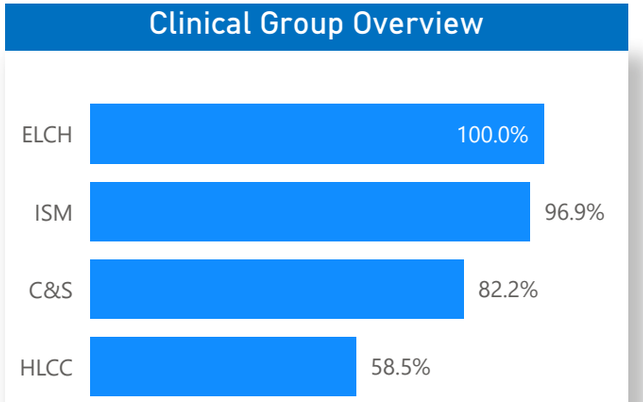
SPC

This indicator is showing common cause variation

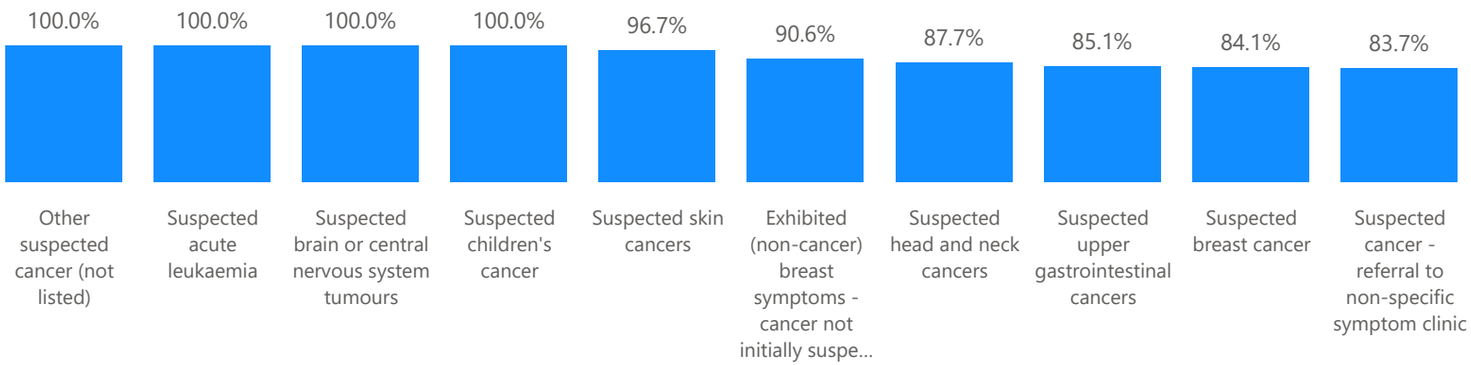
Cancer - FDS



Clinical Group Overview



Top 10 Tumour Groups



Responsive

Guy's and St Thomas'
NHS Foundation Trust

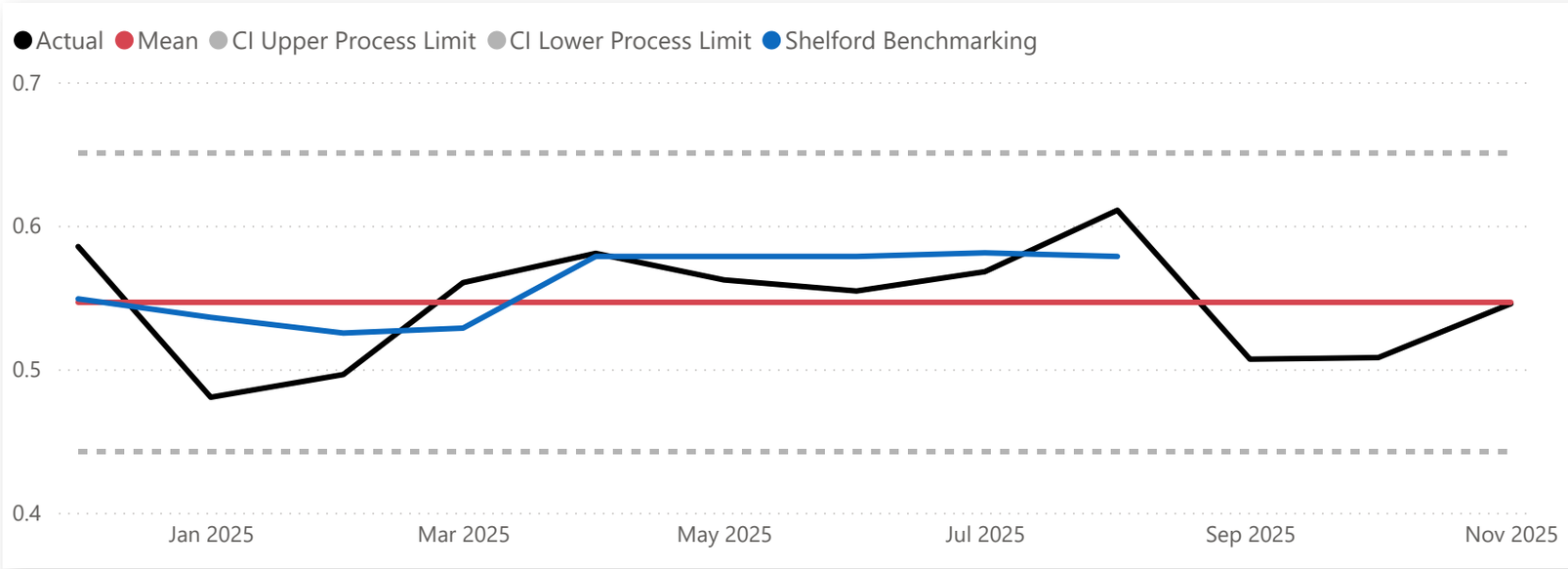
November 2025

54.6%

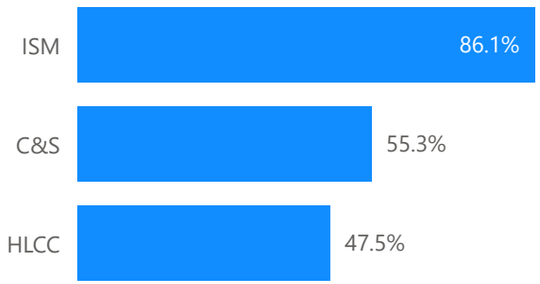
SPC

This indicator is showing common cause variation

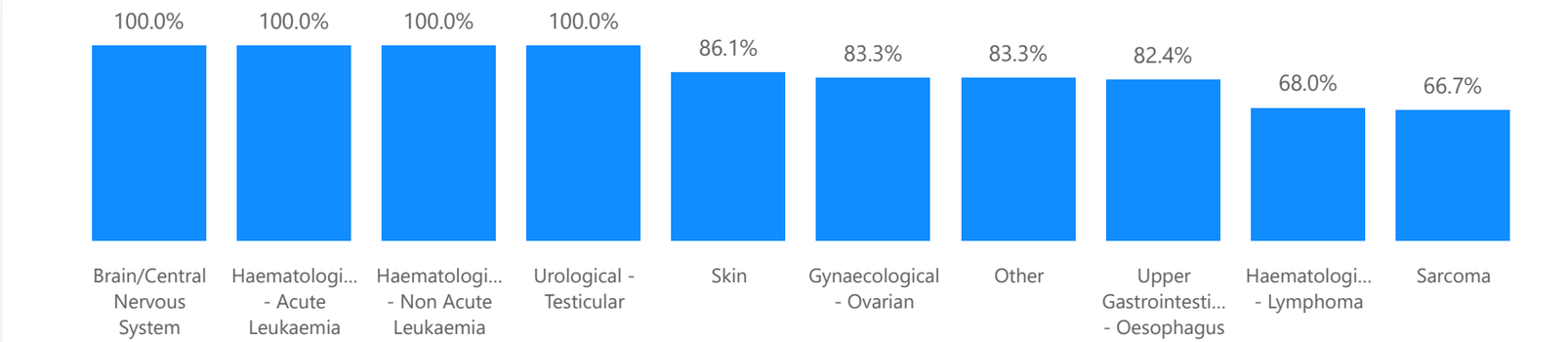
Cancer - 62 day all referral types (total)



Clinical Group Overview



Top 10 Tumour Groups



Responsive

Guy's and St Thomas'
NHS Foundation Trust

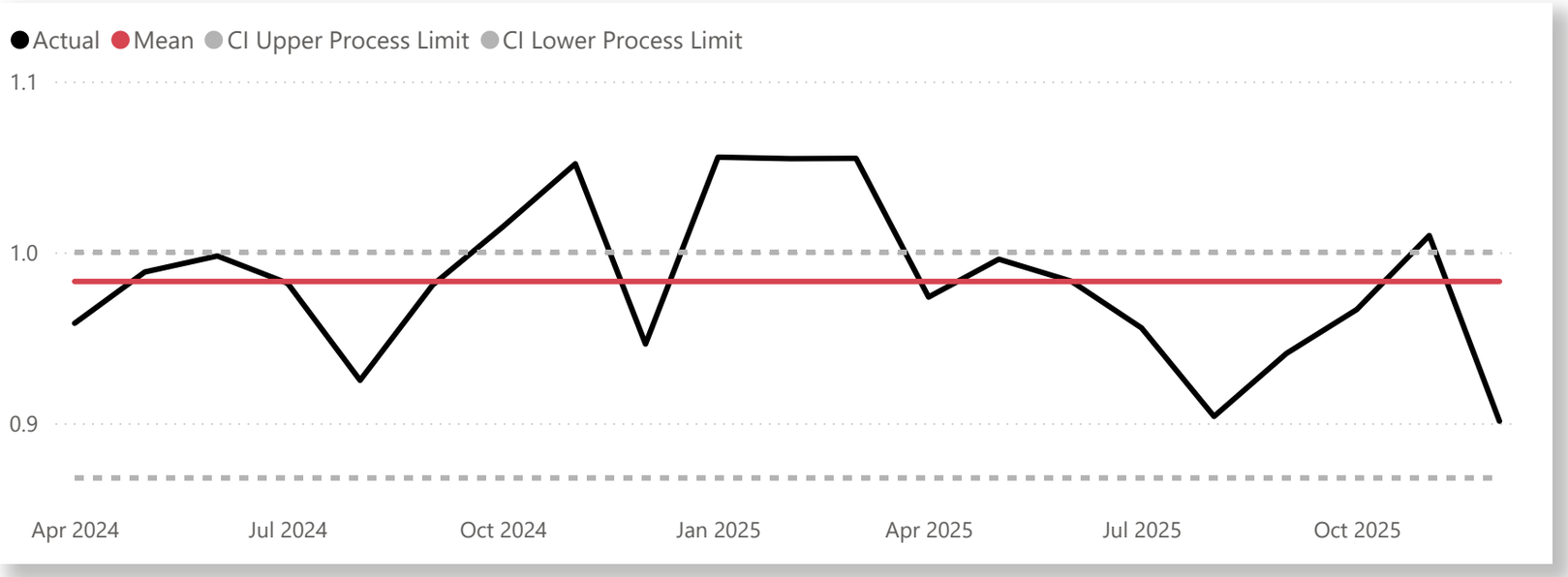
December 2025

90.1%

SPC

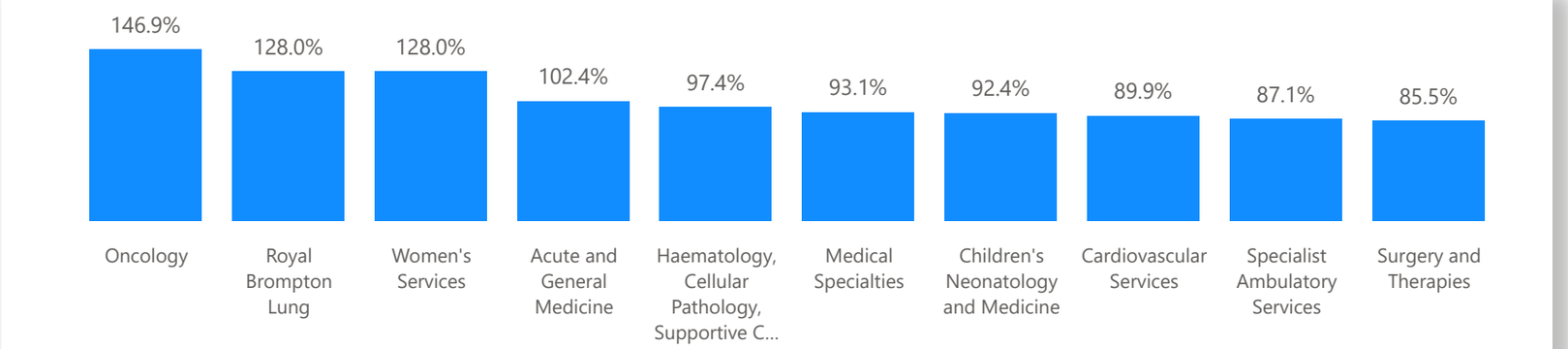
This indicator is showing common cause variation

Outpatient New & FU vs 25/26 Operational Plan



Clinical Group Overview

Top 10 Directorates



Responsive

Guy's and St Thomas'
NHS Foundation Trust

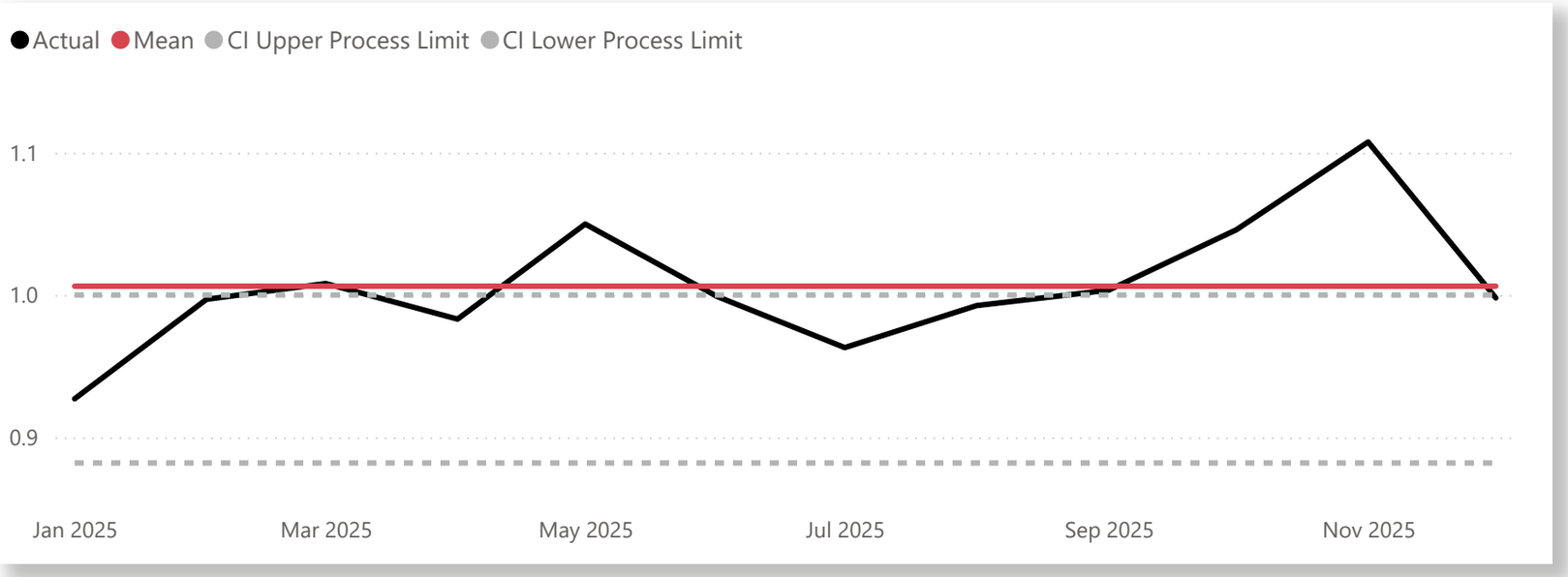
December 2025

99.8%

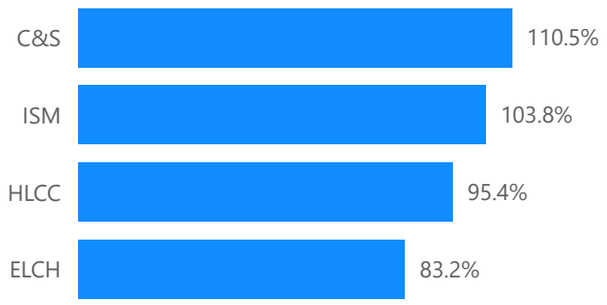
SPC

This indicator is showing common cause variation

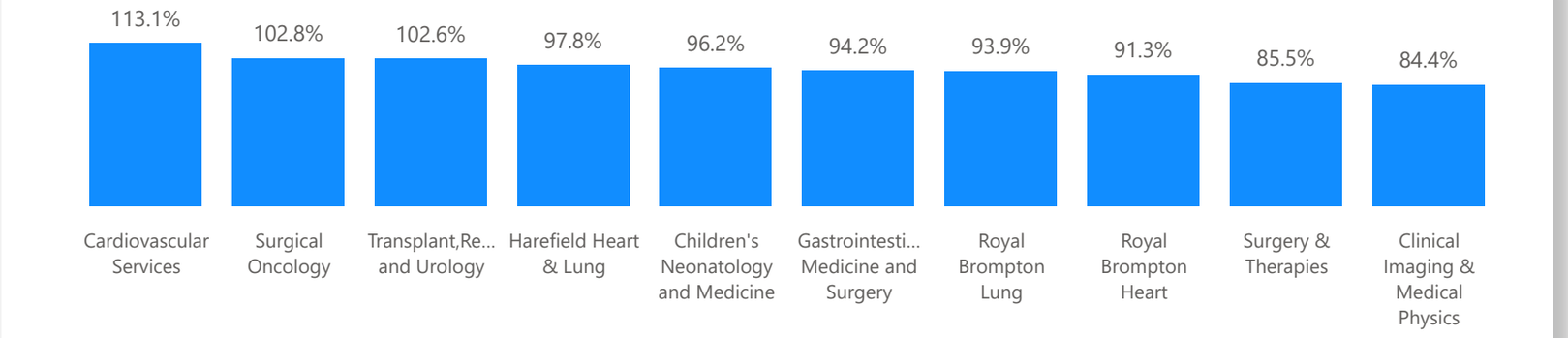
Elective DC & IP vs 25/26 Operational Plan



Clinical Group Overview



Top 10 Directorates



Responsive

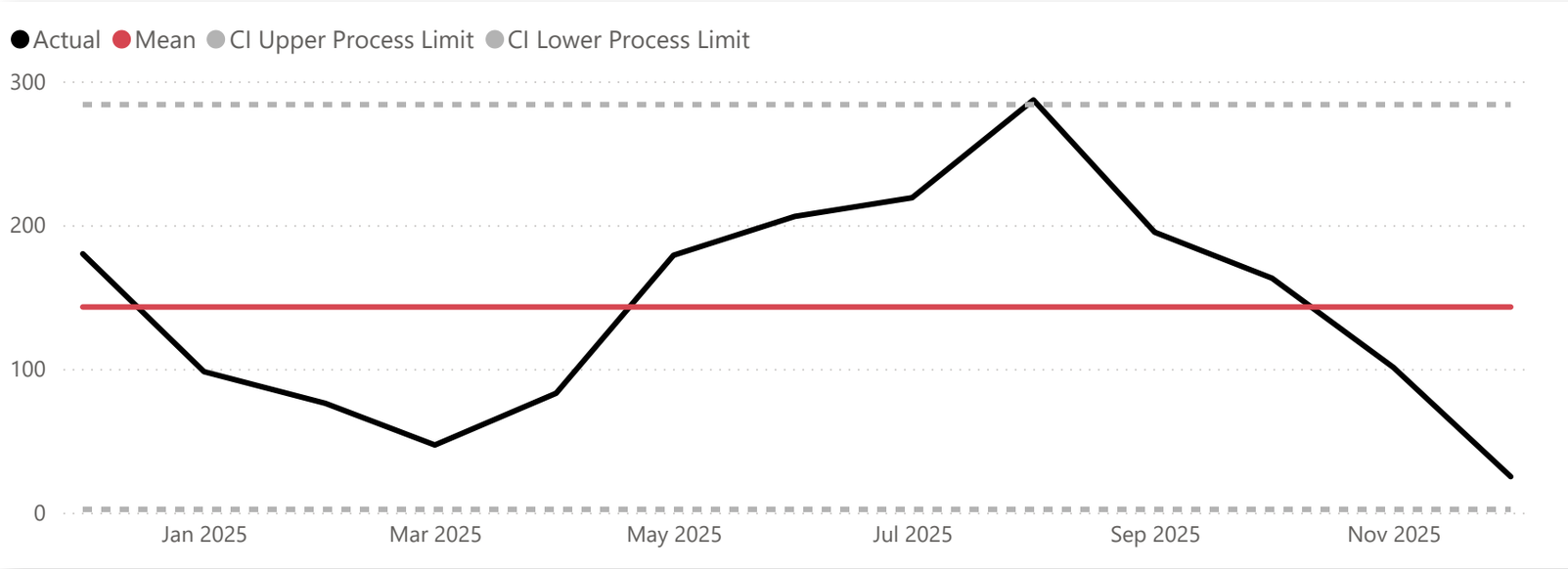
Guy's and St Thomas' NHS Foundation Trust

December 2025
25

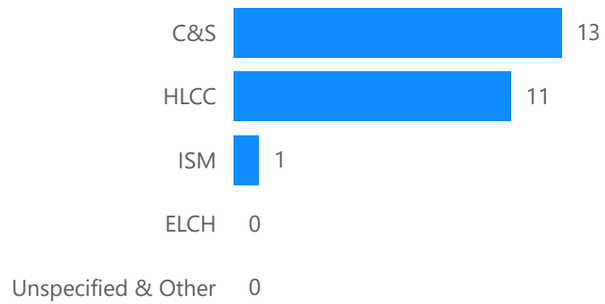
SPC

This indicator is showing common cause variation

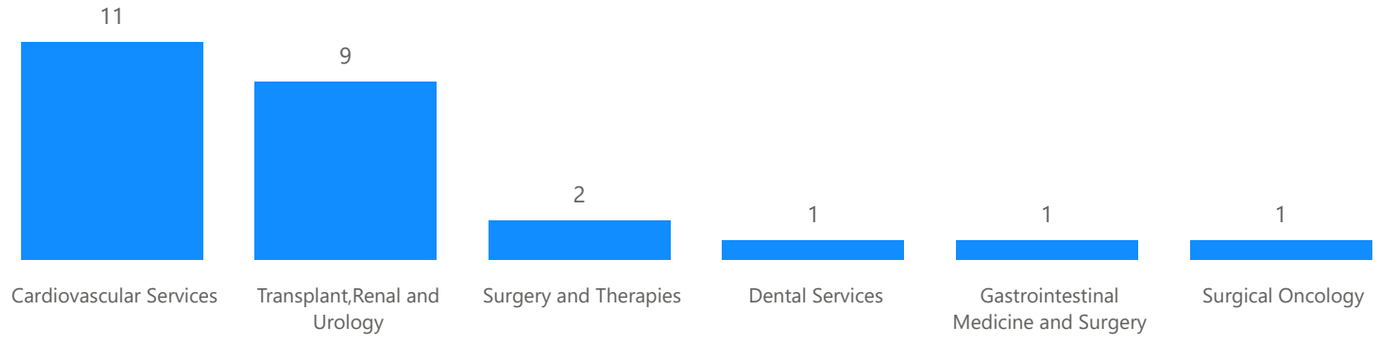
Number of 65 Week Waiters



Clinical Group Overview



Directorate Overview



Responsive

Guy's and St Thomas'
NHS Foundation Trust

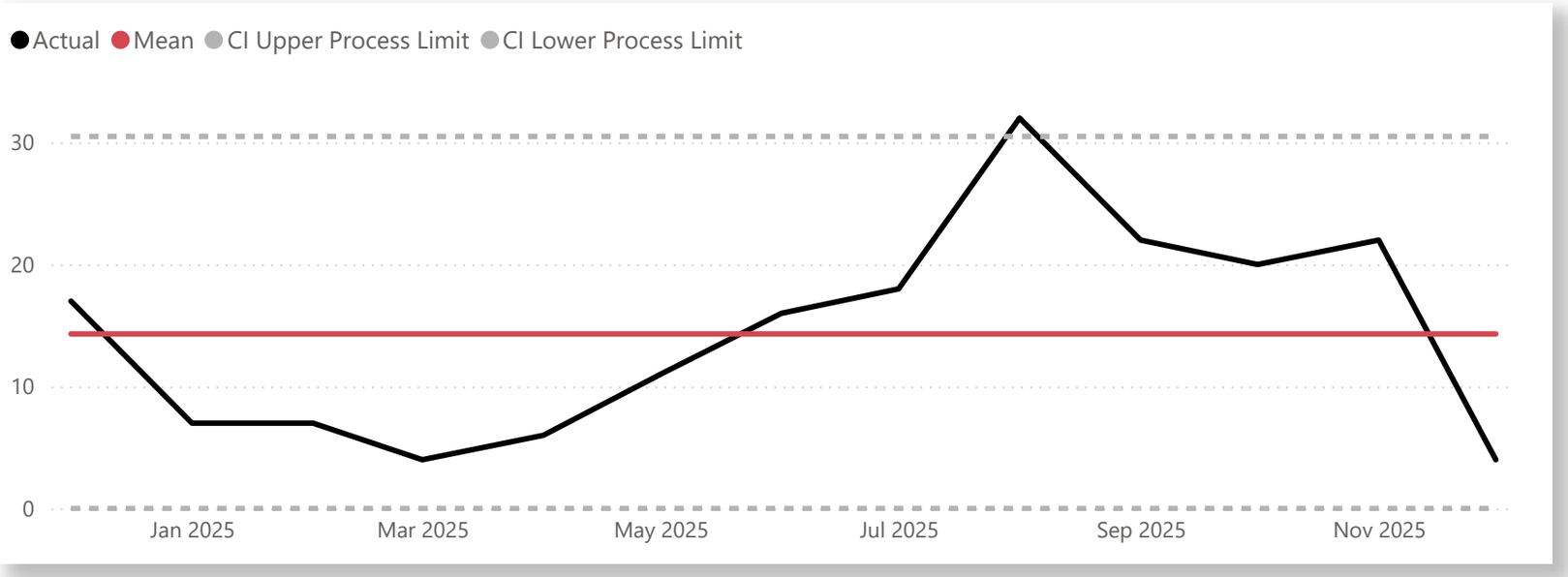
December 2025

4

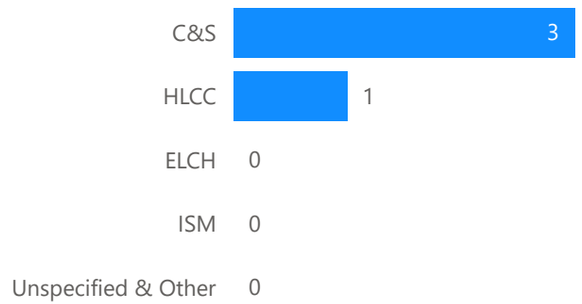
SPC

This indicator is showing common cause variation

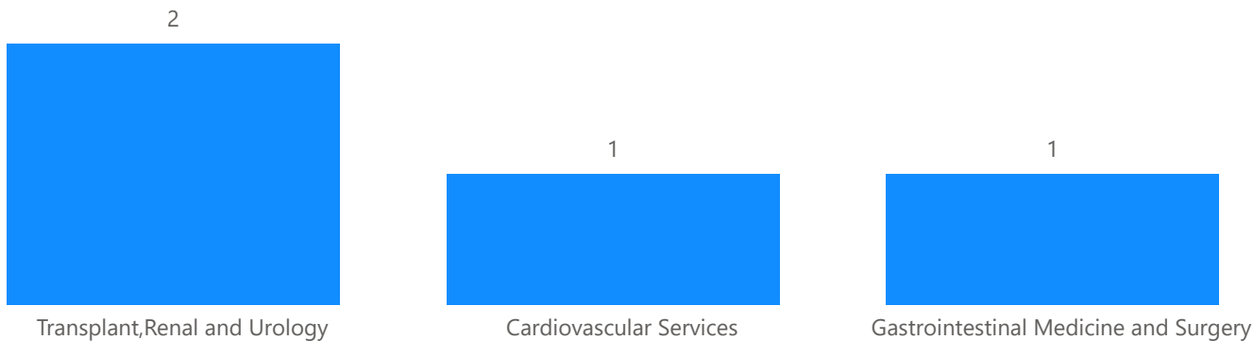
Number of 78 Week Waiters



Clinical Group Overview



Directorate Overview



Responsive

Guy's and St Thomas' NHS Foundation Trust

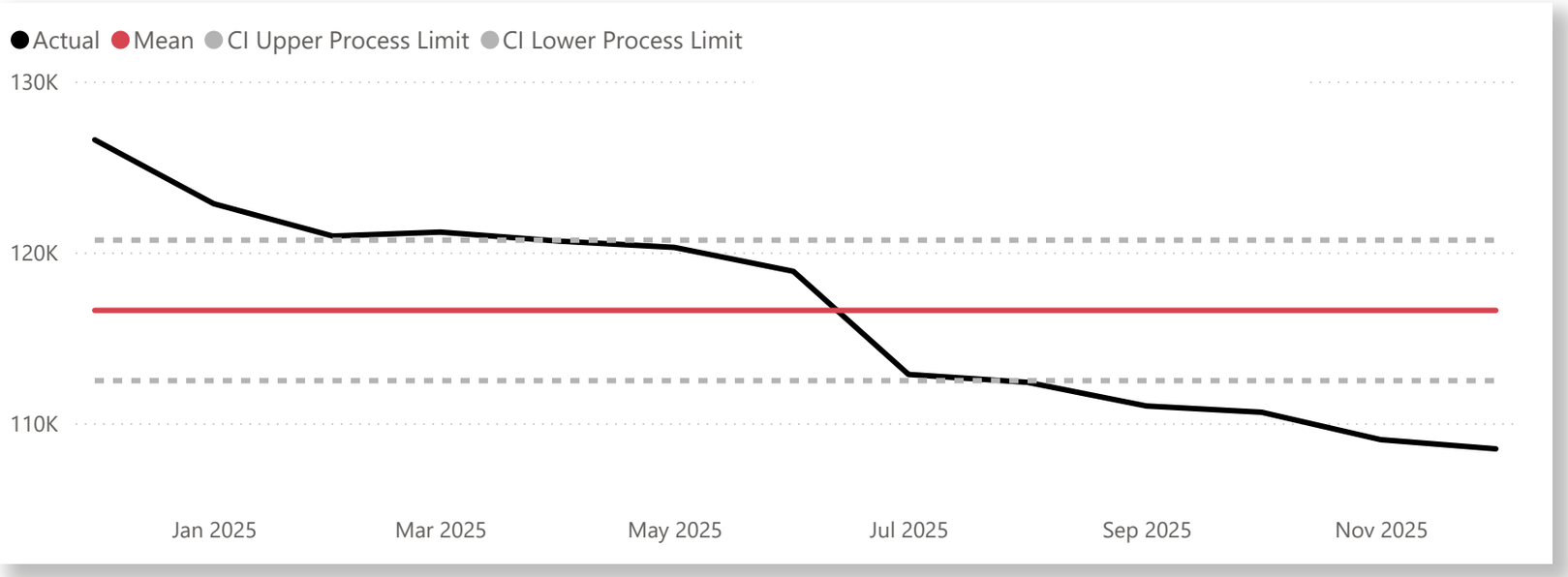
December 2025

108,495

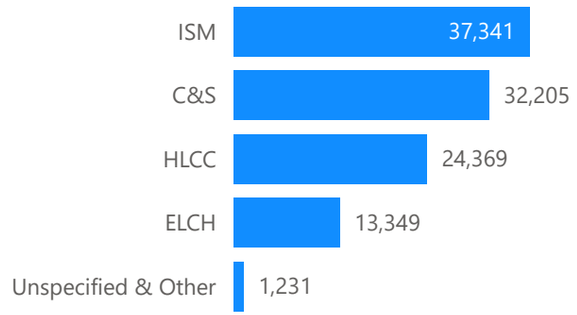
SPC

This indicator is showing special cause variation - Single Point (Positive)

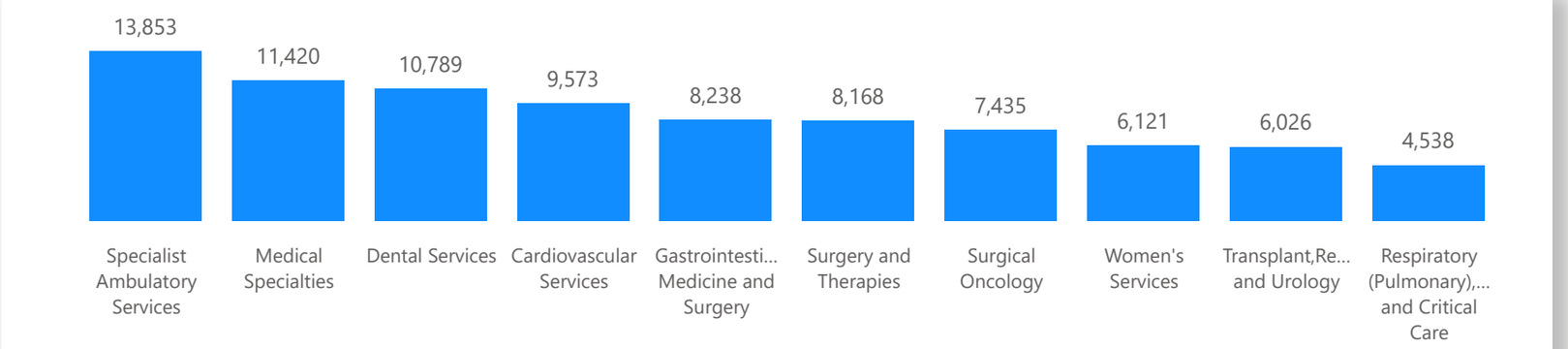
RTT - Total incomplete pathways



Clinical Group Overview



Top 10 Directorates



Supporting Information

SPC definitions

Guy's and St Thomas' NHS Foundation Trust

Statistical Process Control (SPC) charts allow you to identified statistically significant changes in data. The SPC confidence (or process) limits represent the expected range for data points if variation is within the expected limits. A number of rules have been applied in line with the NHSE SPC approach to identify when indicators are showing special variation. Each rule is calculated using the latest month values.

Common cause variation

Indicator has not triggered any SPC rules for current month

Special cause variation – single point

A single point outside the SPC confidence limits (mean +/- 3 sigma)

Special cause variation – trend/shift

A run of 7 points above or below the mean (a shift), or a run of 7 points consecutively ascending/descending (a trend)

Special cause variation – moving range

There is a large change in the moving range (greater than 3.27 & average moving range)

Special cause variation – 2 of 3

2 out of 3 points are within 1 sigma of the upper or lower confidence limit

Committee name	People, Culture and Education Committee
Date, time	Wednesday 3 December 2025, 1pm – 4pm
Venue	Boardroom, Chelsea Wing, Royal Brompton Hospital
Chair	Miranda Brawn

Chief People Officer's update: The Committee noted the successful but challenging restructuring of the staff wellbeing psychology service, ongoing evaluation of the new model, and development of a long-term action plan. The Committee also noted the upcoming five-day resident doctors' strike and open Unite ballot, with recent meetings identifying opportunities for compromise. Good progress was reported on productivity initiatives, including a long-term sickness absence taskforce and administrative service transformation, with risks and union engagement discussed. Recruitment to the Director of People Strategy and Transformation had concluded, the People Hub was nationally recognised, and annual appraisal completion rates exceeded 90%.

Consultant Job Planning Process: The Committee noted that job planning compliance was around 80%, with some areas performing strongly and others needing improvement. Current figures excluded Royal Brompton and Harefield sites, but a new consultant job planning process launching in January 2026 aimed to bring all clinical groups onto a single electronic platform, enhancing consistency, fairness, and efficiency. The Committee discussed the need for coordinated training to address cultural differences and anticipated that the new approach would require challenging conversations, especially for demand-led job plans. The process was expected to address internal audit findings, reduce pay gaps, improve oversight and value for consultant pay, and support career development, with a professional fulfilment paper to follow at the next meeting.

Occupational Health Deep Dive: The Committee received a comprehensive overview of the Occupational Health, Safety and Wellbeing (OHSWB) Service, noting its multidisciplinary model, national recognition, and independent accreditation. While performance had dipped over the past year, recent improvements were observed, with key performance indicators expected to return to target by March 2026. The Committee discussed the need for ongoing external evaluation, alignment with national and local priorities, and redesign of the service due to financial constraints. The OHSWB team was commended for supporting sickness absence reduction, and further work was planned to improve referrals and manager engagement through the People Managers Programme.

GSTT People Policies Review: The Committee received an update on the harmonisation of People-owned policies following the merger with Royal Brompton and Harefield. Most policies had been harmonised and were up to date, except for a small number which were still being reconciled, with drafts scheduled for ratification at upcoming forums. All policies were accessible to staff via the intranet a new Document Management System was being procured to consolidate Trust-wide policies. The Committee discussed the need for an excess travel policy and opportunities to review and update content on the external website.

The Brawn Review: The Brawn Review was a comprehensive, independent initiative focused on improving sustainability, inclusion, and governance in boardrooms, highlighting ongoing gaps in diversity and the positive impact of inclusive cultures on performance and innovation. The report following the review had set out 50 practical recommendations, such as broadening board recruitment, supporting women's health, championing neurodiversity and disability inclusion, and fostering open dialogue on race and class. The Committee discussed the importance of these recommendations, acknowledged that some had already been adopted by the Trust, and agreed to continue exploring further actions.

Sexual Safety Update: The Committee noted that the Trust had formally adopted the NHS England Sexual Safety Charter and established a Sexual Safety Group with dedicated EDI leadership. The Trust was actively engaged with the NHS Sexual Safety Community of Practice, and its sexual safety work spanned all business areas and professional groups. A comprehensive risk assessment framework, including anonymous surveys and staff interviews, was being piloted to inform tailored action plans and would be extended Trust-wide. The Committee agreed on the need for regular reporting to the EDI Improvement Board, further communication of commitments, improved staff awareness, and collective

training to address unwanted behaviours, supporting a culture of safety, dignity, and respect across the organisation.

Implementing the NHS 10 Point Plan: The Committee received an update on the implementation of the NHS 10 Point Plan, noting significant progress in improving the working lives of resident doctors, supported by the "Making Working Lives Better" programme and the NHSE Sexual Safety Charter. Compliance with timely delivery of work schedules had reached 100%, payroll errors had reduced, and work was ongoing to streamline onboarding processes. The Trust aspired to be at the forefront of national efforts and recognised the importance of continuous improvement and best practice sharing.

Operational People Metrics: The Committee reviewed the latest people operational metrics, noting an increase in Trust headcount, with the most significant growth in Essentia due to the insourcing of patient transport drivers. The rise in administrative and clerical roles was noted as surprising, given ongoing reviews in this area. Recruitment controls were in place, with all administrative and clerical bank work paused unless approved by the vacancy control panel. The Committee discussed the need to review backfill and recruitment policies in light of rising workforce numbers and noted that financial return on investment figures would be reported in the new year.

People, Culture & Education Board Assurance Framework (BAF) Risk: The Committee approved the current position of the "high performing and future ready workforce" BAF risk.

Internal Audit Improvement Plans: The Committee reviewed audits of People Directorate services over the past 18 months, noting substantial assurance for payroll, pensions, and temporary staffing, while consultant job planning, workplace adjustments, and lone working required stronger guidance, oversight, and system improvements. Actions to address limited assurance findings were underway, with oversight of audit outcomes and performance in resolving actions to be routed through the Committee to strengthen governance and ensure timely implementation of recommendations.

Committee name	Transformation and Major Programmes Board Committee
Date, time	Wednesday 19 November 2025, 3pm – 6pm
Venue	Governors Hall, St Thomas' Hospital
Chair	Ian Playford

Guy's and St Thomas' (GSTT) Green Plan to 2028: The Committee approved the refreshed Green Plan to 2028. The Plan include 53 objectives and 119 KPIs across 10 focus areas to achieve net zero emissions by 2040/2045. Progress had been made in reducing carbon emissions, implementing environmentally friendly practices, and engaging staff on green programmes. There would be regular monitoring and reporting on key metrics to ensure the Trust's environmental objectives were being met.

Project Dovetail and NHS App Integration Update: The Committee discussed the project's scope, technical challenges, and dependencies, noting its strategic importance in enhancing digital interoperability and integrating the NHS App across South East London for the benefit of our patients. The Committee emphasised the need to accelerate information governance approvals and secure adequate technical resources, expressing concerns over the incremental integration strategy adopted by NHSE and actively advocating for a more effective approach. Overall, the Committee expressed strong support for Project Dovetail's direction and its potential to deliver significant benefits to patients and staff.

Central Portfolio Office Major Programme Report: The Committee noted that most major programmes were progressing according to plan and while an increase in the overall cost base was anticipated, this highlighted the need for careful programme prioritisation. The Guy's Surgical Centre full business case (FBC) was not ready for presentation but was not expected to delay overall timelines. Progress on productivity workstreams was being expedited, and pre-flight programmes such as the District Energy Network and Brompton Campus were on track. The Committee also discussed the forthcoming transformation of the medium-term capital plan and the restructuring of fund management, with a continued focus on resource management and the effective delivery of major programmes.

Productivity Programme: Stocktake Update: The programme was transitioning from planning to delivery, with robust governance and a focus on measurable outcomes. Financial opportunities had been identified, and the Trust was actively working to realise these through targeted transformation and efficiency initiatives.

Children's Hospital Programme (CHP) Update: The CHP was progressing according to plan, with design, procurement, and enabling works underway. Challenges such as cost pressures and timeline adjustments were being managed through contingency planning and stakeholder engagement, maintaining the overall delivery trajectory for the hospital's development.

Children's Day Treatment Centre (CDTC) six-month update: Over the past six months, the Children's Day Surgery Unit within the CDTC had demonstrated steady growth in patient throughput and service delivery. The update reflected improvements in patient flow, staff recruitment, and operational efficiency, while noting areas for further enhancement in scheduling and capacity management.

Children's Cancer Principal Treatment Centre (PTC) Full Business Case: The PTC FBC was reviewed and approved by the Committee. The FBC outlined the clinical, financial, and operational case for the PTC. The next steps would focus on implementation planning and engagement with relevant stakeholders to ensure smooth mobilisation.

Guy's Surgical Centre (GSC) Programme Update: The GSC programme had achieved significant milestones, including the completion of infrastructure works and the commencement of service reconfiguration. The update noted successful risk mitigation, positive feedback from clinical teams, and early benefits in surgical capacity and patient care pathways.

Board Assurance Framework: The Committee approved the proposed changes to the Trust's principal strategic risks on the Board Assurance Framework owned by the Committee.

NHS
Guy's and St Thomas'
NHS Foundation Trust

BOARD OF DIRECTORS

WEDNESDAY 28 JANUARY 2026

Report title:	**Documents Signed under Trust Seal, 16 October 2025 to 21 January 2026**
Sponsor:	Charles Alexander, Chairman and Amanda Pritchard, Chief Executive
Paper author:	Joshua Roles, Senior Business Manager
Purpose of paper:	For awareness/noting only
Main strategic priority:	All strategic priorities
Primary BAF risk:	All BAF risks
Key points of paper:	• In line with the Trust's Standing Financial Instructions, the Chairman, Charles Alexander and Amanda Pritchard, Chief Executive are required to sign contract documents on behalf of the Trust, under the Foundation Trust's Seal.
Paper previously presented at:	N/a
Recommendation(s):	The BOARD is asked to: 1. **Note** the record of documents signed under Trust Seal.

1. Introduction

1.1. In line with the Trust's Standing Financial Instructions, Amanda Pritchard, Chief Executive and Charles Alexander, Chairman signed document numbers 1113 to 1114 under the Foundation Trust's Seal during 16 October 2025 to 21 January 2026.

2. Recommendations

2.1. The Board is asked to note the record of documents signed under the Trust's Seal:

Number	Description	Date
1113	Signing and Sealing of the lease between (1) Guy's and St Thomas' NHS Foundation Trust and (2) Cell Therapy Catapult Limited for the renewal of two leases pertaining to the (part) 10th floor of Tower Wing, Guy's Hospital.	21 January 2026
1114	Signing and Sealing of the underlease between (1) Guy's and St Thomas' NHS Foundnation Trust and (2) Cedars-Sinai UK Ltd pertaining to the engrossment of the underlease within Part of 3rd Floor at 79 Wimpole Street, London W1.	21 January 2026