GSTT Public Board of Directors meeting (inc. Trust CARE Awards)

Wednesday 21 October 2026, 15:45 - 17:45

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

Guy's and St Thomas' NHS Foundation Trust

Agenda

15:45 - 16:00 (15 min) ***Trust CARE Awards***

16:00 - 16:05 (5 min) **1. Welcome and apologies**

Charles Alexander

16:05 - 16:05 (0 min) **2. Declarations of Interest**

16:05 - 16:05 (0 min) **3. Minutes of the previous meeting (22 July 2026) and matters arising**

- 20260722 Public BoD Meeting Minutes v1.0.pdf (5 pages)

16:05 - 16:15 (10 min) **4. Chairman's report**

Verbal *Charles Alexander*

16:15 - 16:30 (15 min) **5. Chief Executive's report**

Amanda Pritchard

- Chief Executive Report - Oct 2026 Public Board.pdf (12 pages)

16:30 - 16:50 (20 min) **6. Thirlwall Inquiry Report and Recommendations**

Gubby Ayida, Sara Hanna

- Thirlwall Inquiry Update to Public Board - Oct 2026.pdf (8 pages)
- Annex 1 - Thirlwall Inquiry Recommendations.pdf (9 pages)
- Annex 2 - Letter from NHSE CNO & COO.pdf (4 pages)

16:50 - 17:05 (15 min) **7. Apollo: Maximising the value of Epic and delivering the next phase**

Jon Findlay, Denis Lafitte

- Apollo Update - October 2026.pdf (7 pages)

17:05 - 17:20 (15 min) **8. Board Assurance Framework**

Avey Bhatia, Tendai Wileman

- Board Assurance Framework Report v1.0.pdf (6 pages)
- Full BAF - 30 September 2026.pdf (32 pages)

17:20 - 17:40
20 min

9. Updates from chairs of Board committees

Board committee chairs

Papers for noting

17:40 - 17:40
0 min

10. Reports from Board Committee

10.1. Academic Committee in Common 8 July & 6 October 2026

Verbal

ACiC Summary 08.07.26 and 06.10.26 .pdf (1 pages)

10.2. Quality & Performance Committee 15 July 2026

Q&P summary 15.07.2026 v1.0.pdf (2 pages)

10.3. Finance, Commercial & Investment Committee 19 July 2026

FC&I Cttee Summary 29 July 2026 v1.0.pdf (1 pages)

10.4. People, Culture & Education Committee 2 September 2026

PCE summary 02.09.2026 v1.0.pdf (2 pages)

10.5. Transformation & Major Programmes Committee 9 September 2026

TMPB summary 09.09.2026 v1.0.pdf (2 pages)

10.6. Audit & Risk Committee 16 September 2026

ARC summary 16.09.2026 v1.0.pdf (2 pages)

10.7. Finance Report at Month 6 (2026/27)

M06 Financial Performance.pdf (8 pages)

10.8. Integrated Performance Report September 2026

Public Board IPR 21.10.2026 Final.pdf (14 pages)

17:40 - 17:40
0 min

11. Register of documents signed under seal

Amanda Pritchard

Documents Signed under Trust Seal, 16 July 2026 to 14 October 2026 vFinal.pdf (2 pages)

17:40 - 17:45
5 min

12. Any other business

NHS
Guy's and St Thomas'
NHS Foundation Trust

BOARD OF DIRECTORS

Wednesday 22 July 2026, 4.00pm – 5.45pm
Robens Suite, Guy's Hospital and MS Teams

Members present:	Charles Alexander (Chair)	Felicity Harvey
	Ian Abbs	Jamie Heywood
	Gubby Ayida	Deirdre Kelly
	Avey Bhatia	Julian Kelly
	Miranda Brawn	Mark Kinirons (for Louise Dark)
	Sarah Clarke	Graham Lord
	Steven Davies	Pauline Philip
	Nilkunj Dodhia	Ian Playford
	Jon Findlay	Amanda Pritchard
	Simon Friend	Kate Tilley (for Crystal Akass)
	Richard Grocott-Mason	Alison Wilcox
In attendance:	Eve Bignell (to item 6)	Damien O'Brien
	Edward Bradshaw (minutes)	Jackie Parrott
	Amal Idris (to item 6)	Sam Strudwick
	Denis Lafitte	Tendai Wileman
	Bobby Juniper (to item 6)	
	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. Apologies had been received from Crystal Akass and Louise Dark.

2. Declarations of interests

2.1. There were no declarations of interest.

3. Minutes of the meeting held on 29 April 2026

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 highlighted the recent visits to the Trust by His Majesty The King and Her Royal Highness The Princess of Wales, noting that both visits had showcased the Trust's clinical excellence, research capability and commitment to patient care. The Board noted that the visits had provided an opportunity to celebrate the 300th anniversary of Guy's Hospital and the Trust's wider strategic developments, including the Children's Hospital Programme and the future Children's Principal Treatment Centre for cancer.

4.2. The Chair also reflected on recent national political developments, including that a new Prime Minister had taken office, and the implications for both the Trust and the wider NHS. It was noted that the Trust was well placed to contribute to emerging national priorities, including healthcare innovation, advanced therapeutics, neighbourhood health services and social care integration, and would continue to work constructively with government and system partners.

4.3. The Chair recorded the Board's appreciation for the contribution of the Director of Corporate Governance and Trust Secretary who would shortly leave the Trust after almost six years of service.

5. Chief Executive's Update

5.1. The Chief Executive reported that the Trust had again been assessed as within segment 1 of the NHS Oversight Framework and had been ranked twelfth out of 134 acute trusts nationally at the end of Quarter 4 2025/26. Members noted that a revised NHS Oversight Framework would apply during 2026/27, increasing the number of metrics used to assess providers from approximately 23 to around 33. Work was underway to understand the new Framework and its implications for the Trust.

5.2. The Board welcomed publication of the Care Quality Commission's findings following inspections of urgent and emergency care services. Services at St Thomas' Hospital had retained an overall rating of 'Outstanding', whilst Guy's Hospital Urgent Care Centre had retained a rating of 'Good'. Members were particularly encouraged that both sites had improved from 'Good' to 'Outstanding' in the 'Caring' domain. The Board also noted the safe completion of the temporary relocation of children's cardio-respiratory and intensive care services from Royal Brompton Hospital to the St Thomas' Hospital site, and discussed the implications of the recently published national maternity reviews. The Board noted the intention to undertake further detailed review of maternity services against the recommendations arising from those reports.

5.3. Members discussed what had been a particularly challenging quarter operationally due to the prolonged periods of extreme heat experienced during June and July. The Board recognised the significant efforts of staff in maintaining services and minimising disruption to patients despite difficult conditions across most hospital and community settings.

5.4. The Board noted and discussed growing demand pressures across a range of services. Growth in referrals for elective treatment had reached 7.9% in Quarter 1, compared with planned growth of 2%, which had led to increases in the Trust's waiting list. Clinical specialties with particularly high growth included dental and dermatology services. Members explored the extent to which this reflected wider NHS trends and were advised that, whilst demand growth was being seen nationally, the scale of increase experienced by the Trust was not being replicated elsewhere. Assurance was provided that the increase had been validated by system partners and that management actions were underway to address the resulting increase in waiting times.

5.5. The Board noted that almost 112,000 patients were waiting for treatment at the end of May, compared with a planned position of 107,248. Despite these pressures, Referral to Treatment performance remained above plan at 69.1% against a target of 67.6%, whilst performance against the cancer 62-day standard had improved to 69.4%, exceeding plan. Members also discussed continuing challenges within diagnostics and urgent and emergency care, and noted the detailed improvement plans in place to support recovery.

5.6. In considering quality of care, the Board noted continued progress in complaints management, implementation of Martha's Rule and infection prevention and control. Members welcomed the fact that no healthcare-associated MRSA bloodstream infections had been recorded during the financial year to date, alongside a significant reduction in Candida auris cases, reflecting the impact of targeted improvement work across the Trust.

5.7. The Board noted the Trust's financial position at Quarter 1 remained in line with its plan, albeit against a challenging financial backdrop requiring delivery of £115 million of efficiencies during 2026/27.

5.8. A new collaboration agreement had been established with the Trust's staff networks and members concurred that, at a time of significant pressure and change across the NHS, maintaining strong relationships with staff networks and listening carefully to staff feedback was particularly important.

The agreement was recognised as strengthening partnership working between the Trust and its staff networks and supporting the Trust's ability to implement change collaboratively and in a way that reflected the views and experiences of staff.

6. Freedom to speak up annual report

6.1. The Board received the annual Freedom to Speak Up report covering activity, themes and outcomes arising from the speaking up service during 2025/26. Members noted that the service had managed 384 cases during the reporting period and that 2025 NHS Staff Survey results – in which the Trust had recorded the fourth highest score nationally for the question "we each have a voice that counts" – indicated increasing levels of confidence amongst staff in raising concerns and confidence that concerns would be addressed appropriately.

6.2. The Board discussed the implications of the abolition of the National Guardian's Office and noted the increased responsibility placed upon Trust boards of directors to ensure that effective speaking up arrangements remained in place. Assurance was provided that the Trust's leadership, governance arrangements and organisational culture continued to support staff in raising concerns.

6.3. Through discussion, Board members explored the importance of focusing not only on speaking up structures and processes but also on demonstrable outcomes and learning arising from concerns raised by staff. Board members discussed trends relating to anonymous concerns, staff groups using the service and protected characteristics including ethnicity. The challenges associated with interpreting relatively small data sets where individual cases could significantly influence overall trends were also noted.

6.4. The Board welcomed examples of improvements delivered through speaking up concerns, including changes to clinical systems and support provided to colleagues raising operational concerns. Members also noted encouraging progress in establishing a growing network of Speaking Up Ambassadors across the organisation.

6.5. The Board thanked the Freedom to Speak Up Guardian and wider team for their contribution and reiterated its commitment to promoting an open, inclusive and learning culture across the Trust.

7. Future Ready update

7.1. The Board received an update on the Trust's Future Ready campaign, which had been launched earlier in 2026 to bring together the Trust's improvement, productivity, quality and transformation initiatives under a single organisational framework.

7.2. It was reported that the campaign had already established a strong foundation through extensive engagement, communications activity, staff recognition schemes and development of supporting resources. The Board noted that Future Ready sought not only to support operational and financial improvement – although the campaign was both distinct from and separate to the Trust's cost efficiency programme – but also to reinforce a culture of innovation, collective ownership and continuous quality improvement across the organisation.

7.3. Board members heard examples from across clinical groups of quality improvement, digital innovation and service redesign projects that were contributing to improved patient care, productivity and staff experience. It was agreed this provided clear evidence that the campaign was building momentum. Discussion emphasised the importance of spreading learning across the organisation and ensuring that staff understood how existing improvement activity aligned under the Future Ready banner.

7.4. The Board welcomed the level of ambition shown by the campaign and supported plans to further embed it within organisational processes, including performance development reviews, management development and staff engagement activities. Members recognised the importance of celebrating

success whilst also promoting learning from initiatives that had not delivered the intended outcomes. Overall, the Board agreed that Future Ready was a critical enabler of the Trust's long-term transformation ambitions and financial sustainability objectives.

8. System partnerships update

8.1. The Board received an overview of the Trust's extensive partnership arrangements and hosted services. Members noted that partnership working was fundamental to delivery of the Trust's clinical, research, academic, educational and strategic objectives, and reaffirmed the Trust's commitment to collaborating with organisations across healthcare, research, education and innovation for the benefit of patients and populations. The Board noted that the organisation was involved in a broad range of local, regional and national partnerships and collaborations.

8.2. The Board discussed the Trust's work with integrated care systems, universities, research partners, clinical networks, charities and industry partners. Particular emphasis was placed on the role of partnerships in supporting integrated care, reducing health inequalities, enhancing research capability, improving patient pathways and facilitating innovation. Members noted the breadth and depth of the Trust's partnership activity and were assured that the Trust continued to be an active and valued partner across local, regional and national systems. Members also noted the significant contribution made by hosted services and clinical networks that operated under the Trust's sponsorship.

8.3. During discussion Board members highlighted the importance of maintaining oversight of partnership effectiveness, governance arrangements and future opportunities for collaboration. It was suggested that future reporting could consider how partnership performance and impact might best be evaluated. The Board was assured that the Trust continued to navigate an increasingly complex healthcare environment effectively through its partnership arrangements, whilst maintaining a strong focus on delivering benefits for patients, staff and the wider health and care system. The Board welcomed the breadth of collaborative activity taking place across the organisation and noted the paper.

9. Patient and Public Engagement annual report

9.1. The Board received the annual report on patient and public engagement and sought assurance regarding delivery of the Trust's patient and public engagement strategy and compliance with relevant statutory duties.

9.2. The report highlighted continued progress in embedding the patient voice within strategic planning, service redesign and decision-making processes across the Trust. Members noted several examples demonstrating meaningful involvement of patients, service users and communities in shaping services and organisational priorities. It was also confirmed that statutory consultation requirements had been met where applicable.

9.3. The Board recognised the significant volume of engagement activity taking place across clinical groups and major programmes and discussed the importance of continuing to strengthen patient involvement, equality impact assessment processes and approaches to addressing health inequalities. Board members welcomed the positive progress reported and noted the continuing opportunities arising from wider legislative and policy developments relating to patient and public engagement.

10. Reports from Board committees for noting

10.1. The Board received and noted reports from the non-executive chairs of its standing committees and received updates on key areas of work undertaken since the previous public Board meeting.

10.2. There had been significant progress in relation to the Trust's academic and research agenda, including achievement of the national 150-day clinical trials target, establishment of the London Applied Research Collaboration, and preparatory work associated with the forthcoming Biomedical Research Centre funding application. The Board also noted the increasing alignment between research, education and population health initiatives.

10.3. The focus of the Audit and Risk Committee had been on overseeing completion of the Trust's Annual Report and Accounts process, continued scrutiny of internal audit findings and ongoing oversight of cyber security risks.

10.4. The Board noted that the Finance, Commercial and Investment Committee was continuing to focus on the Trust's delivery of its ambitious cost efficiency programme, the Trust's cash position, capital investment plans, financial benefits arising from Epic and development of the private patient strategy.

10.5. The Chair of the Quality and Performance Committee reported continued scrutiny of operational performance, including elective care, cancer and urgent and emergency care performance. Committee members had also reviewed patient safety incidents, associated learning, progress in reducing overdue complaints, infection prevention and control performance, and preparations for a dedicated review of maternity services in response to recent national reports.

10.6. The People, Culture and Education Committee had discussed development of the Trust's People Strategy, and equality, diversity and inclusion priorities. The Committee had agreed to develop a smaller number of focused equality, diversity and inclusion priorities, supported by improved measures of success and organisational oversight.

10.7. The Transformation and Major Programmes Committee had reviewed progress across the Trust's major capital and transformation programmes, including the Children's Hospital programme, the Children's Principal Treatment Centre for cancer, and the Guy's Surgical Centre. Board members noted continued progress despite wider challenges relating to programme complexity, affordability and delivery timescales. The Committee had also begun considering how transformation activity could be more closely integrated with oversight of major programmes and strategic risks.

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 21 October 2026.

BOARD OF DIRECTORS
WEDNESDAY 21 OCTOBER 2026

Report title:	**Chief Executive's Report**
Executive sponsor:	Amanda Pritchard, Chief Executive Officer
Report author:	Stephanie Calvert & Lucy Yasin, Director of Corporate Governance and Trust Secretary (interim)
Purpose of report:	For awareness/noting only
	To provide the Board with a comprehensive overview of matters arising over the past three months.
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.
Key points of report:	• 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 July 2026 Board meeting.
Primary BAF risk:	All BAF risks
Supporting material:	N/a
Recommendation(s):	The BOARD is asked to: 1. **Note** this paper.

1. Significant developments since the previous public Board meeting

1.1. At national level the focus on patient safety and organisational culture has intensified following publication of the Thirlwall Inquiry Report and the response from the Department of Health and Social Care and NHS England to its recommendations. The response sets out a programme of work to strengthen safeguarding, improve accountability, support speaking up, and enhance oversight of maternity and neonatal services across the NHS. The Trust recognises the importance of this work and will carefully consider the recommendations and take forward any further action required locally. While our maternity and neonatal services are performing well and feedback from women and families is positive, we recognise that there is always more to learn and will reflect carefully on the national findings as we continue to strengthen openness and effective escalation, and maintain robust Board oversight of quality and patient safety. A separate paper on the Thirlwall Report and its recommendations will follow this report on the agenda. The Board also had a dedicated session on maternity services on 16 October 2026.

1.2. A further national development has been the announcement of a National Cancer Board to drive improvement in cancer outcomes, support innovation and strengthen national oversight of cancer services. We welcome this national focus, which reflects the scale and importance of the challenge across the NHS. At the Trust, we recognise that our cancer performance, particularly against the 62-day treatment standard, is not yet where it needs to be, and delivering sustained improvement remains one of our top priorities. We will engage closely with the National Cancer Board and emerging national priorities, alongside continued delivery of our cancer recovery plan, to improve waiting times and outcomes for our patients. This focus on improvement comes as we mark the tenth anniversary of Guy's Cancer Centre, which since opening has brought many of our cancer services together in one place and provided a strong foundation on which to build further progress.

1.3. The Trust recently welcomed Ian Peters, Chair of NHS England London Region, for a wide-ranging visit highlighting the Trust's pioneering research, healthcare innovation, and paediatric transformation plans. During his visit Ian met with some of the Trust's leading clinical academics to hear about their work across a range of areas and how we are working in partnership to drive innovation. Ian also toured Evelina London and heard more about our ambitious plans to expand our children's services. Following his visit Ian noted the Trust's strong commitment to conducting research that reflects the diverse populations we serve and the measurable impact of our children's community services.

1.4. Last month we celebrated National Inclusion Week which provided us with a valuable opportunity to reflect on the importance of being a genuinely inclusive organisation, as well as the links between inclusion and improvement. We recognise that whatever we are doing, we get the best results when diverse voices are involved, barriers are understood and people feel safe to speak up. This year's theme was 'Build Trust. Navigate Change' recognising that creating an inclusive culture requires trust, open conversations and a commitment to understanding and valuing different experiences. We also launched our new Equality, Diversity and Inclusion Plan to 2030 which sets out our shared vision for creating a fairer and more inclusive trust, improving staff experience and opportunity, and supporting our commitment to deliver better,

faster, fairer healthcare for our patients and communities.

1.5. NHS England published their Quarter 1 2026/27 National Oversight Framework (NOF) results in September. This followed the publication of an updated Framework in June 2026, which included a significant expansion in metrics against which acute trusts would be measured. Whilst the Trust continues to be rated amongst the highest-performing trusts in the country it has moved from segment one to segment two (remaining above average) and is now 25 out of 134 acute trusts. We continue to work hard to build on the substantial performance improvements that we have made.

1.6. As part of our drive to improve performance we also hosted a Flow Summit on 8 September to launch our new 'Flow Manual' which brings together standards, principles, practical guidance and tools to help teams deliver timely, safe and well-coordinated care. This was followed by our 'Perfect Week' which commenced on 28 September and provided the opportunity for teams to test new approaches and ways of working to improve flow through our hospitals.

2. Delivering healthcare across the Trust

2.1. 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.

2.2. Access to elective care: Whilst the Trust continues to work hard to provide timely access to elective care, our waiting list is higher than planned at this point in the year. At the end of August, almost 109,320 patients were waiting for treatment, compared with our planned position of 104,831. Much of this is driven by far higher levels of demand than anticipated. A range of actions are underway to address this, including increased focus on validation as well as additional activity. This has impacted the Trust performance against national waiting time standards. Referral to Treatment performance, which measures the proportion of our patients seen within 18 weeks of their referral, was 67.7% in August, slightly below the planned performance of 69.4%. The main contributing services are Gynaecology, Cardiology, Plastic Surgery and Urology. The number of patients waiting more than 52 weeks has also fallen behind plan and activity is underway to address this.

2.3. The Trust continues to make good progress with its ambulatory transformation programme, which aims to improve outpatient and ambulatory care through redesigned patient pathways, reduced unnecessary follow-up appointments, improved use of clinical capacity and a better patient experience. The programme brings together pathway redesign, patient self-scheduling, optimisation of the electronic patient record and improved referral management within a single coordinated approach. Delivery is being supported by dedicated clinical, operational, digital and transformation teams, with a focus on improving access, productivity and outcomes.

2.4. Diagnostics: The proportion of patients waiting more than six weeks for a diagnostic test remains consistently ahead of plan since May, with performance at 26.3% for August 2026 against the 27% plan. Medical imaging continues to present the greatest challenge. Progress on the development of a new Community Diagnostic Centre in South East London is welcome; however, the benefits will not be realised immediately, and further improvement will be required and is planned to achieve our ambition of reducing long waits to 14% by March 2027.

2.5. Cancer: Performance against the 28-Day Faster Diagnosis Standard for patients with actual or suspected cancer reached 86.7% in August ahead of the planned 80%. Our performance against the 62-day standard for patients to start cancer treatment following diagnosis remains challenged, however the performance of 65.8% in August was ahead against the planned position of 63.4%. Improving cancer performance remains one of our top three priorities. We continue to deliver our cancer recovery plan and remain focused on reducing waiting times, including by prioritising patients who have waited longest for treatment.

2.6. Urgent and emergency care: Following consistently strong performance throughout 2025, urgent and emergency care performance has been more challenging during 2026. Performance against the standard that all patients are admitted or discharged within four hours of their arrival was 75.44% in September against a planned performance of 82%, and the number of patients waiting more than 12 hours for admission or discharge increased from 150 in May to 160 in September. We continue to work hard to deliver our improvement plan and meet the revised trajectory agreed with NHS England and are confident that the actions set out in the plan will lead to improvement in performance, in part because of strong ownership and engagement from the urgent and emergency care team, as well as from colleagues across the Trust.

2.7. Winter planning: The Lambeth and Southwark Integrated Winter Plan 2026/27 has been developed with system partners and sets out five funded schemes to strengthen capacity, urgent and emergency care, vaccination and patient flow, supported by a comprehensive set of impact measures which will be monitored through the Trust Operations Board. The plan reflects the Trust's continued focus on reducing length of stay for planned and emergency care and flexible use of additional winter ward beds. Additional measures include influenza vaccinations and rapid respiratory infection testing, with learning from the regional stress test and equality impact assessments incorporated as appropriate.

2.8. Quality of care: The Trust continues to strengthen the quality and safety of patient care, with focused action under way following an increase in procedure related Never Events. Seven Never Events were reported in Quarter 2, all involving wrong-site surgery or retained foreign objects. Although none resulted in severe harm, an action plan is being developed to ensure that lessons are learned and improvements are embedded in clinical practice. The Trust is strengthening accountability, safety culture and the consistent application of safety checks. Key actions include introducing a revised WHO Surgical Safety Checklist; reinforcing learning and leadership expectations across clinical teams; strengthening safety arrangements for procedures undertaken outside theatre environments; expanding simulation and human factors training; and improving the sharing of learning from Never Events to support continuous improvement.

2.9. Complaints management continues to improve. However, at the end of September, 125 complaints were overdue, including 24 overdue by between 20 and 43 days. Further improvement remains a priority, alongside managing increased complaint volumes. The main themes remain clinical care, communication and information, waiting times, staff attitude and behaviour, and follow-up appointments, with action under way to address them. The latest 12-month rolling Summary Hospital-level Mortality Indicator (SHMI), covering May 2025 to April 2026, was 93.29 against the national benchmark of 100. The Hospital Standardised Mortality Ratio (HSMR) also remains below the expected range. Work continues to improve coding and the accuracy of patient activity classification. All inpatient deaths continue to be reviewed by the Trust's independent medical examiner service and through the Trust's learning from deaths processes.

2.10. Martha's rule: Martha's Rule has been successfully implemented across maternity, adult acute and community inpatient services, and children's services. A working group is considering its extension to the Emergency Department in line with NHS England requirements. Call data is now routinely reported to clinical groups, enabling learning from feedback to inform service improvement.

2.11. Infection prevention and control: The Trust continues to demonstrate strong infection prevention and control performance. There have been no healthcare-associated MRSA bloodstream infections in 2026/07 reflecting sustained focus on prevention, vascular access safety, screening and learning. Although the Trust has the lowest rates of healthcare-associated *C. difficile* infection and *E. coli* bloodstream infection within the Shelford Group, its position within the national framework is less favourable because performance is benchmarked against organisations with lower levels of complexity. Targeted improvement work is focused on urinary catheter management, optimisation of broad-spectrum antibiotic use, and enhanced risk stratification.

2.12. Management of *Candidozyma auris* remains a key priority. An outbreak involving four patients in Harefield Hospital was contained with no onward transmission or infection, while new detections remain low despite some diagnostic uncertainty following the move to PCR testing. Outbreaks of COVID-19, influenza, parainfluenza and Carapenenase-Producing Enterobacterales (CPE) were managed during the period, with no evidence of widespread or sustained transmission. Work continues to address diagnostic (turnaround times) environmental cleanliness and service disruption, alongside improvements in cleaning, water safety, surveillance, assurance and preparation for an internal IPC audit.

2.13. Patient experience: Overall patient experience remains positive. Friends and Family Test scores exceed 90% in most areas, with the Emergency Department rising from 83.4% to 86.7% although maternity services declined slightly from 92.4 % to 86.8%. Excluding the Emergency Department, response volumes for all other areas fell slightly in August, similar to the pattern seen in the same month in 2025. Scores for the Emergency Department compare well with national and regional averages.

2.14. Benchmarking results from the Care Quality Commission's annual NHS adult inpatient survey showed that Guy's and St Thomas' had the joint highest overall score with Sheffield Teaching Hospitals NHS Foundation Trust when compared with Shelford Group peers and first place when compared with a small group of other teaching trusts in London. Areas of strength included confidence and trust in doctors and nurses

treating patients, reduced noise at night, patients getting sufficient food and drink and not waiting too long for a bed on a ward, good communication between staff, patients and families and responsiveness. Opportunities for improvement were identified in meeting patients' individual language needs and discussions with patients regarding equipment and adaptations needed once they returned home from hospital.

2.15. The Trust received results for the 2025 National Cancer Patient Experience Survey. The Trust's overall care rating for this survey had increased from 8.8 to 9. Compared with similar trusts, fewer questions were below the expected range or declining than in 2024, indicating improvement. Over four years, scores improved significantly for offering support at diagnosis, involving families and carers in treatment decisions, providing support information and enabling relatives to speak to the care team. However, privacy when receiving test results declined. Among Shelford Group peers, the Trust ranked sixth for average question score and fourth for overall care; among London peers, it ranked fourth and third respectively.

2.16. The PALS service has remained extremely busy across all hospital sites during July and August. Key themes emerging from enquiries include patient challenges when trying to contact departments by telephone, book a first appointment or cancel an appointment. Patient contacting PALS also cited lengthy waits to receive appointments and/or treatment. A detailed analysis of concerns raised, emerging themes and trends will be provided in the quarter 2 PALS report.

2.17. Safeguarding: During Quarter 2, safeguarding training compliance continued to improve across both adult and children's services, although some areas remain below target. Adult safeguarding referrals showed an increase compared with the previous quarter, as did domestic abuse. Self-neglect remains the most common safeguarding concern, particularly where patients have complex care needs. Learning disability and dementia referrals have remained largely in line with previous quarters. Mental health pressures persist, with increased referrals and ongoing delays in admission and transfer for some patients, and we continue to work closely with local mental health providers to address this. Safeguarding concerns relating to Trust services increased slightly, primarily involving concerns related to care received and unsafe discharge.

2.18. Children's safeguarding activity remains significant, with more than 500 cases recorded each month across the hospital sites. High levels of vulnerability continue, particularly in relation to recreational drug and alcohol use among young people, alongside a continuing increase in domestic abuse referrals. Mental health presentations to the Emergency Department remain complex, with a considerable increase in length of stay. Arrangements for children looked after continue to be closely scrutinised. Four cases are currently subject to learning reviews, including two relating to the deaths of young people. The team also continues to address the 'did not attend' rate, which is concentrated within a particular age group. Routine collection of feedback from children looked after about their experience of the service has commenced and will inform future patient experience reporting.

2.19. Sustainability: The delivery of the Trust's Green Plan to 2028 continues to progress with significant data-centre energy savings, operational solar installations, publication of the Climate Change Adaptation Plan, progress on reusable products and lower use of high-carbon inhalers.

Reduced capacity within the Sustainability Team, and changes to the shared-service arrangements with King's College Hospital, has meant that some initiatives are not yet operational and a revised operating model, with greater accountability for delivery embedded across clinical, corporate and delivery groups is being designed.

2.20. A new Board Assurance Framework risk recognising the impact of climate change and the need to mitigate and adapt has been approved, alongside strengthened performance reporting and governance arrangements.

3. Sustaining and improving the Trust's financial performance

3.1. A financial performance report is included in the Board papers for this meeting which sets out how we are performing against the plan we have agreed with NHS England. The headlines are that the Trust continues to work hard to improve its financial position and take steps to deliver sustainable, high-quality, responsive care within available funding. In the six months to 30 September 2026 the Trust reported a year-to-date deficit of £36.4m, which is slightly ahead of the planned £36.5m deficit. Partly as a result of the deficit, the Trusts cash balance has been impacted, and was £102.7m at month six, which is £66.2m lower than at the start of the year. Capital expenditure to date was £35.6m, which is £54.1m lower than the phased plan including additional public divided capital (PDC) awards and donations. The Trust is taking steps to meet its full capital allocation for the year.

3.2. We have fully identified around 53.6% of full-year cost improvement savings target [of £115m], with delivery of these identified schemes £3.8m behind plan. Full delivery is essential to achieving a sustainable financial position going forward. The Trust has taken decisive steps to implement a series of corporate measures to control our costs, including a vacancy freeze from 1 September to 31 December 2026; line by line budget reviews; measures to reduce what we spend on temporary staffing; and additional controls on the procurement of goods and services.

4. Transformation

4.1. The Trust is finalising a Transformation Plan to support its ambition to deliver better, faster and fairer healthcare, while improving productivity and financial sustainability. The Plan brings together existing transformation activity with the longer-term changes needed to improve patient access, experience and outcomes; make better use of capacity and resources; and deliver more proactive, integrated care. The Plan sets out a phased roadmap over the next three to five years, recognising the need to "get the basics right", standardise ways of working and make better use of existing capabilities, while progressively scaling and embedding more fundamental changes to care delivery, ultimately moving towards an integrated learning health system.

4.2. Four priorities are proposed for focused delivery over the next 12 months: ambulatory care transformation, to improve access and streamline outpatient pathways; integrated neighbourhood care, to develop more proactive and joined-up care through Integrated Neighbourhood Teams (INTs); Smart Hospital, bringing together existing initiatives and piloting new technologies to improve hospital productivity and patient flow; and process redesign and automation, including AI-enabled workflows and AI features in Epic, to simplify processes and release staff time.

4.3. A substantial proportion of this activity is being delivered through the Trust's 'Future Ready' Programme. This includes the ambulatory care transformation programme which was launched in June 2026 across 12 specialties, including the aim of introducing a single point of access and advice and guidance (A&G) model this quarter. Other examples include the clinical administration programme, which is centralising referral management and new patient scheduling while retaining the majority of administrative staff within local services, with changes coming into effect from 1 December 2026.

5. Supporting our workforce

5.1. NHS Staff Survey: The NHS Staff Survey 2026 opened on 28 September and will close on 27 November. The Trust performed strongly in the 2025 survey, achieving a response rate of 49% which was above the national average of 47% for our category and the second highest level of participation ever. We also achieved scores above the national average across all seven NHS People Promise areas as well as for staff engagement and morale themes and 93% of respondents said that they were proud to work for the Trust. A comprehensive range of initiatives, including a launch event on 6 October and roadshows have been arranged, to encourage all staff to complete this year's survey and provide honest feedback on what the Trust is doing well and where further improvements are needed. Staff input is essential to shape a positive working environment and drive continuous improvement. As a result of previous feedback, the Trust developed and is continuing to deliver a multi-year action plan focused on investing in leadership; diversifying and being representative of the communities we serve; promoting and developing healthy workplaces; leading in healthcare, education, learning and development; and embracing and enabling flexibility.

5.2. EDI Plan to 2030: As set out earlier in the report we launched our Equality Diversity and Inclusion Plan to 2030 in National Inclusion Week. This Plan has been developed to support a more sustainable, outcomes-led organisational approach. Informed by workforce equality data, Staff Survey findings, independent evaluation, engagement with Staff Networks and colleagues, discussions through the EDI Programme Board, and engagement with Executive and operational leaders, the Plan is structured around six outcome areas, focused on delivering measurable improvement in:

1. staff feeling valued, safe, included and supported to thrive
2. fair access to recruitment, development and progression
3. timely and effective workplace adjustments and accessible support
4. concerns about discrimination, bullying, harassment or exclusion being listened to, acted on and fed back

5. staff diversity being reflected across roles, professions, pay bands and leadership levels
6. widening participation into employment and workforce pathways for local and underrepresented communities

5.3. The Trust also published its annual Workforce Race and Disability Equality Standard reports in September. The majority of indicators had improved and particular progress had been made in supporting reasonable adjustments for disabled staff. However, the Trust is not complacent and recognises that more work needs to be done as set out in its EDI Plan to 2030 outlined above.

5.4. PDR completion: Performance and Development Reviews (PDRs) play a vital role in supporting staff development, enabling meaningful conversations about achievements, objectives, wellbeing and career aspirations. They help ensure that colleagues receive constructive feedback, identify opportunities for learning and development, and understand how their contribution supports the Trust's strategic objectives and values. We are therefore pleased to have exceeded our target of 90% PDR completion, reflecting the commitment of both managers and staff to fostering a culture of continuous development, engagement and high performance across the Trust.

5.5. General Medical Council (GMC) Training Survey 2026: The 2026 GMC National Training Survey demonstrates notable improvement in the quality of postgraduate medical training at the Trust across the previous 3 years. The Trust improved from 4th to 2nd in the Shelford Group, with improvement across 15 of 18 indicators and a substantial reduction in areas requiring improvement. Resident doctor participation increased significantly in 2026 from 77.02 % to 92.5%, supported by a coordinated Trust-wide engagement approach. This provides greater confidence that the results are representative of resident doctor experience and has been recognised by NHS England as an example of good practice. Educational governance has strengthened, including improved Local Faculty Group compliance and consistently high Educational Supervisor compliance. Areas requiring further improvement are subject to targeted action and monitoring through established educational governance processes.

5.6. Management of organisational change: In support of our transformation agenda, consultation with colleagues and their staff side representatives has been undertaken (and / or is ongoing) in a number of corporate and clinical administrative service areas where re-design and refinement of team structures is needed to improve ways of working, efficiency and quality. Regular engagement and active dialogue is an essential part of this process, it enables us to identify and act upon areas of concern and ensures that our proposals for change are informed by those closest to it. Relationships with our Staff Side remain positive, and we seek to resolve areas of disagreement through negotiation where possible. This includes with Unite, which has pursued an active mandate for industrial action within the Essentia organisation. While many of the issues raised as part of this mandate relate to the application of national terms and conditions, not within the Trust's control, we remain committed to solving problems wherever local solutions exist and to bringing this action to a successful end.

5.7. The Trust also takes great pride in the wide range of events we hold to celebrate equality, diversity and inclusion as well as the achievements of specific staffing groups. During Quarter 2 we have marked, amongst other events, National Inclusion Week and World Mental Health Day, as well as several religious and cultural events. We also held a launch event for Black History month on 2 October and have events planned throughout the month, aimed at celebrating the contributions of Black colleagues and communities, increasing understanding of lived experiences, promoting allyship and inclusion, and providing opportunities for learning, reflection and engagement across the Trust.

6. Other news

6.1. The annual St Thomas' Abseil charity event arranged by the Guy's and St Thomas' Foundation took place on 25 and 26 September. The event brought together staff, patients, supporters and members of the local community, all united in their commitment to improving care and supporting our hospitals. I would like to thank everyone who took part, donated, volunteered or helped organise the event. Their enthusiasm, generosity and willingness to take on this unique challenge were instrumental in making the event such a success.

6.2. I am delighted to report that the Day of Surgery Admission Team at Harefield Hospital won Cardiac Team of the Year at the Society for Cardiothoracic Surgery in Great Britain and Ireland for their commitment to improving how patients are admitted for cardiac surgery. Approximately 90% of cardiac surgery patients are now admitted through the DOSA pathway, giving Harefield one of the highest DOSA admission rates in the country.

6.3. The Trust welcomed colleagues from the Department of Health and Social Care who visited Guy's hospital to film our robots in action with Professor Ben Challacombe. The Trust currently has a fleet of 11 surgical robots and three diagnostic robots. This makes Guy's and St Thomas' not only the largest centre for robotic surgery in the United Kingdom, but one of the biggest in Europe.

6.4. A new documentary about experimental cancer medicine trials at Guy's Hospital was broadcast on BBC Radio 4 in September 2026 called 'Floor 15'. The documentary goes behind the scenes of the National Institute for Health and Care Research (NIHR) Clinical Research Facility's Phase One Unit telling the stories of four patients, their families and the staff caring for them whilst they participate in cutting edge clinical research trials.

6.5. An annual showcase bringing together staff and researchers from across the Trust to share the latest advances in heart, lung and critical care research marked its 20th anniversary in the Summer. The milestone event showcased the depth and diversity of research taking place, with a wide range of posters presenting innovative projects designed to improve patient outcomes and experience. The judging panel praised the high quality of submissions and the strong focus on improving outcomes and experiences for patients. Congratulations to the winners.

6.6. Lambeth Together has produced a film showcasing the @home service which provides urgent care for people in their own homes, preventing hospital admissions and helping to free up hospital beds at the Trust and at King's College Hospital.

7. Consultant appointments (1 July 2026 – 30 September 2026)

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

Post	Appointee	Start date
Consultant in Restorative Dentistry	Kajal Bhupendra Patel	03/11/2026
Consultant Histopathologist	Ildikó Krencz	14/09/2026
Consultant in Genitourinary and General Internal Medicine	Julia Aleksandra Bilinska	01/10/2026
Consultant in Lower Gastrointestinal Paediatric Surgery	Jessica Kate Burns	04/01/2027
Consultant in Medical Oncology (with an interest in Breast Cancers)	Uzma Saddia Asghar	17/09/2026
Consultant in Rheumatology and Lupus	Gagandeep Sukhija	01/12/2026
Consultant in Rheumatology and Lupus	Kristina Elizabeth Neergaard Clark	17/11/2026
Consultant Urologist - GSTT / UHL (Shared service posts with Lewisham) X3 posts	Clarissa Martyn-Hemphill	05/10/2026
Consultant Urologist - GSTT / UHL (Shared service posts with Lewisham) X3 posts	Thomas Harry Reid	14/12/2026
Consultant Urologist - GSTT / UHL (Shared service posts with Lewisham) X3 posts	Eric Edison	05/10/2026
Consultant in Interventional Cardiology	Alexander Philip Peter Tindale	To be confirmed
Consultant ENT Surgeon - Otology	Fiona McClenaghan	To be confirmed
Consultant in Cardiothoracic Anaesthesia	Laura Daley Ashton-Edwards	01/11/2026
Consultant in Cardiothoracic Anaesthesia	Leyda Alejandra Ceballos Salazar	01/11/2026
Consultant in orthopaedic	Emma Zohra Fossett	01/09/2027
Consultant Gynaecological Oncologist	Jessica Lim Hui Cheah	01/03/2027
Consultant Gynaecologist (Special Interest in Gynaecological Oncology)	Mansi Tiwari	04/01/2027
Consultant obstetrician x 2 WTE	Melanie Nana	To be confirmed
Consultant obstetrician x 2 WTE	Alexandra Rideout	To be confirmed

Post	Appointee	Start date
Consultant Ophthalmologist in Vitreoretina	Luke Michaels	01/11/2026
Consultant in Paediatric Dentistry	Rakhee Jayprakash Udhdeo	01/12/2026
Consultant in Cardiovascular Magnetic Resonance & Adult Congenital Heart Disease	Miriam Conway	01/10/2026
Consultant Cardiologist in Heart Failure	Lukas Stoiber	01/10/2026
Consultant in Endodontic	Eleni Machmouridou	To be confirmed
Consultant in Critical Care Medicine	Barbara Ficial	To be confirmed
Consultant Cardiologist with expertise in Electrophysiology	Irum Kotadia	To be confirmed

BOARD OF DIRECTORS

WEDNESDAY 21 OCTOBER 2026

Report title:	**Thirlwall Inquiry Report and Recommendations, and Implications for GSTT Maternity & Neonatal Services**
Executive sponsor:	Gubby Ayida, Chief Executive Evelina London Women's & Children's Clinical Group
Report author(s):	Sara Hanna (Clinical Group MD and Deputy CMO), Janet Powell (Clinical Group Director of Nursing) and Charlotte Dunn (Chief of Staff)
Purpose of report:	To provide assurance
	To ensure the Board is aware of the key findings of the Thirlwall Inquiry and recommended actions, the implications for neonatal services including our Trust staff, and assurance that we are compliant with the two urgent actions.
Previously presented at:	This paper has not been presented previously. The Trust Board received written notification on 28 September 2026 of compliance with one of the two urgent actions (the second urgent action is to bring this update to the Public Board), and a 2hr deep dive session on our maternity and neonatal services is scheduled for 16 October 2026.
Key points of report:	• Six main findings - including failures of hospital leadership and governance - and associated recommendations for action by the clinical group, Trust and wider system / partner organisations. • Confirmation that the Trust is compliant with the two immediate and urgent actions outlined in the final report.
Primary BAF risk:	Risk 2: Quality of care and patient experience
Supporting material:	• Annex A: Thirlwall Inquiry recommendations. • Annex B: Letter from NHSE on Thirlwall Inquiry report and recommendations.
Recommendation(s):	The BOARD is asked to: • **Note** compliance with the two urgent actions, and plans for addressing the other actions relevant to the Trust. • **Note** the Secretary of State is committed to implementing a series of actions, while the Government considers the Inquiry's recommendations in full. • **Reflect on** the findings of the Inquiry and its implications for services at the Trust. • **Understand** the specific implication for our neonatal service and the support needed to address any areas of improvement.

1. Background and introduction

1.1. The Thirlwall (public) Inquiry was commissioned by the then Health Secretary in September 2023 to investigate events at the Countess of Chester hospital between 2015 and 2018. This followed the conviction of neonatal nurse Lucy Letby for the murder of seven babies and the attempted murder of a further six babies. The Inquiry described the increase in neonatal deaths in 2015 and 2016 at the hospital, the concerns about the possibility of deliberate harm that were raised by clinicians at an early stage, and the repeated failures of organisations and individuals to act.

1.2. The Inquiry focussed on the experiences of the parents of the babies named in the indictment, the conduct of those working at the Countess of Chester hospital, including whether action should have been taken earlier, and the effectiveness of NHS management, governance, scrutiny and regulation in keeping babies in hospital safe. The final report and recommendations were published on 15 September 2026, and the current Secretary of State delivered a statement in Parliament that committed to implementing a series of actions, while the Government considers the Inquiry's recommendations in full.

1.3. The purpose of this paper is to outline the main findings of the Inquiry, the recommendations for action that Trusts are expected to take in the next 6-12 months, and specifically to report on progress in implementing the two most urgent actions within the specified deadlines. This report should be considered in the context of 2026 and in particular, important system wide and Trust changes since the time frame of the failure to detect and prevent the deaths of these babies.

2. Main findings of the inquiry

2.1. The central conclusion of the Inquiry was that the events were not simply the result of one individual's actions. Failures in hospital leadership, safeguarding, professional communication and external oversight meant that warning signs were not acted upon effectively. The report emphasised that patient safety must take priority over institutional reputation, that concerns raised by clinicians must be taken seriously, and that suspected deliberate harm must be escalated promptly.

2.2. There were several key findings grouped together into the following main themes:

- **Failure to act on doctors' concerns** - Hospital leaders failed to respond adequately to these concerns.
- **Serious failures in safeguarding -** failure to apply safeguarding procedures when deliberate harm was suspected, and staff and managers did not recognise that suspicion alone was sufficient to trigger safeguarding action.

- **Failures of hospital leadership and governance -** repeated failures of accountability, transparency and professional responsibility. The hospital's management was dysfunctional, with a significant divide between senior leaders and frontline clinicians, and managers failed to prioritise the safety of babies over organisational reputation and internal disputes.
- **Failure to communicate honestly with parents** - these failures added to the distress experienced by bereaved and affected families.
- **Failures by external organisations** - regulators and professional organisations failed to identify, investigate or escalate concerns effectively including the Care Quality Commission (CQC).
- **Earlier intervention could have prevented further harm** - serious, missed opportunities to protect babies on the neonatal unit. The inquiry concluded that some babies would have been saved if action had been taken earlier.

3. Recommendations and compliance with immediate actions

3.1. Lady Justice Thirlwall made 17 recommendations on what needs to be done to keep babies safe, and the full list of actions is listed below (see Appendix on slides 5-8). The Trust was required to progress two of these actions immediately:

- To urgently communicate to all relevant staff and the Board that the Sudden and Unexpected Death In Children (SUDIC) process applies to our maternity and neonatal services - by no later than 28 September 2026.
- To review the Thirlwall report and consider its findings at the next available Public Board meeting (on 21 October 2026).

3.2. The SUDIC protocol is applicable for every death (or collapse leading to death) of an infant or child under the age of 18 which would not have been reasonably expected to occur 24 hours previously and in whom no pre-existing medical cause of death is apparent, irrespective of the place of death. All Trusts with a neonatal unit therefore were to communicate to all relevant staff and the Board that the SUDIC process applies and runs alongside their own internal reporting processes. **The Trust Board received written notification on 28 September 2026 of our compliance with this action.** The Clinical Group MD emailed all Evelina staff on the SUDIC process, and our communications team urgently updated the relevant pages and links on the intranet. It was also raised at our Executive Committee and Senior Leaders Forum, both held in September.

3.3. To note, the guidance, first published in 2004 following the wrongful conviction of mothers for the deaths of their babies, and extensively updated in 2016 was intended for use primarily when babies or children are brought into hospital following unexpected death at home and was aimed at ensuring proper, consistent process and support for families in these tragic circumstances. However, the guidance has formed the basis of our response to unexpected death, and we have worked closely with our local coroner to ensure there is clear guidance for the consistent management of all neonatal and child deaths occurring in the Trust.

3.4. In response to the Inquiry's findings, the second immediate action was for every Trust to review the report and consider its findings at the next available public meeting. Boards are asked to reflect on whether it would have been possible for similar events to occur at their own organisation and seek assurance that sufficient measures are in place to keep the babies and children in their care safe, no matter what setting. Central to this is a culture of professional curiosity, where both Board members and staff feel empowered, supported, and confident to speak up, challenge concerns, and raise issues without fear. **Compliance with the second urgent action is to bring this written update to the Public Board on 21 October 2026.**

3.5. The table in the appendix below shows all 17 recommendations, who is responsible for implementation (and when), and what steps we are taking as a Trust – where appropriate - to ensure we are fully assured. Evelina London Clinical Group has reviewed the recommendations and commenced actions, as have Synnovis and the Trust's Medicines Safety Committee. A Task & Finish Group is being established to bring all the actions together which will require input from other parts of the Trust including workforce and security.

4. Recommendations

4.1. The Board is asked to:

- Note our compliance with the two urgent actions, and plans for addressing the other actions relevant to the Trust.
- Reflect on the findings of the Inquiry and its relevance to the Trust's maternity and neonatal services.
- Support the need for Trust wide implementation of a number of actions.
- Continue to support our neonatal service as they address any areas of improvement.

4.2. There is much in these actions which lie outside the Trust to enact, although when eventually implemented will have implications for the Trust. We understand that NHSE will be working with the Department of Health and Social Care (DHSC) and partner organisations to review the recommendations and implications for maternity and neonatal services and the wider NHS. The DHSC led Maternity & Neonatal Taskforce is also developing a comprehensive National Action Plan, which is expected to be published at the end of 2026 which will bring together the findings and actions from a number of reports.

Appendix: Thirlwall Inquiry - Table of Recommendations

	Recommendation	Deadline	Action / Comments
1	**CCTV & Monitoring** • All cots and incubators in all neonatal units should be fitted with baby monitors (in-cot cameras with livestreaming video), so that parents can observe their baby remotely at any time. The funding for this should be centrally managed and ring-fenced, to ensure consistency and implementation across all neonatal units at speed.	31 March 2027 - NHSE to set out road map for implementation	**Action for NHSE – with implications for GSTT**
2	**Insulin** • Digital devices should be used to restrict access of insulin to authorised people and record access to insulin storage units. • Until access to insulin requires the provision of biometric data, each Trust should install CCTV cameras focused on storage fridges, cupboards or units and the cameras should store recordings for at least 28 days. • The GIRFT Laboratory Handling of Insulin Requests in the Investigation of Hypoglycaemia guidance for the testing and reporting of insulin and C-peptide results, issued in October 2025, must be made mandatory and of national application.	31 March 2027 - All neonatal units must meet the expected requirements for access control and storage of insulin set out in *GIRFT Neonatology Guide to safe insulin use.*	**Action for GSTT / Synnovis** • Trust Medicine Safety Team taking forward consideration of the timescale of introduction of biometric access or if interim CCTV will be required. This is a Trust wide action not confined to NICU. • The laboratory recommendation has been shared with Synnovis. Gap analysis has been undertaken. Planning on implementing requires changes by end 2026.
3	**Bereavement Care** • The National Bereavement Care Pathway for pregnancy loss, stillbirth and neonatal death should be implemented nationally.	31 August 2027	• This is on the next Evelina London End of Life Care meeting agenda and is with the relevant teams to report on how they will enact the implementation of this and what is already implemented.
4	**Safeguarding & contracts of employment** • All Trusts must provide safeguarding training to all staff (appropriate to their role and expertise) and Board members, including NEDs. This training should include how to deal with concerns and suspicions about deliberate harm caused by staff. • By March 2027, every existing contract of employment for work in an NHS hospital must be amended to include an obligation on the employee to follow all relevant safeguarding guidance, including the Suspicion of Deliberate Harm Protocol (at Recommendation 9), for dealing with concerns and suspicions about	March 2027	**Action for GSTT** • All current child protection training at each level demonstrates what staff should do if they have concerns or suspicions regarding deliberate harm. There is new national intercollegiate training guidance, and GSTT's new training strategy was ratified at the Vulnerable Person's Committee on 30 September 2026.

	deliberate harm. Agency and bank staff contracts and all new contracts of employment must include the same obligation.		• A clear Allegations process and policy has been in place since 2016; it was updated this year and will be reviewed again considering the Inquiry findings and recommendations. • The Evelina London Director of Nursing has delegated responsibility (from the Chief Nurse) for Children's Safeguarding and oversees all allegations related to children (N.B. The Countess of Chester Hospital did not have an Allegations process in place).
5	**Operating Systems** • NHSE must provide, by 31 March 2027, a clear and timed route to ensuring that computer systems are harmonised across the NHS by December 2028. Work on the development of a mandatory information standard with requirements for interoperability between systems should be taken forward and implemented as soon as possible. This should mean that data relating to babies and neonates in hospital may be entered on a single occasion, be reviewed in a timely manner and facilitate continuous monitoring.	31 March 2027	**Action for NHSE – with implications for GSTT**
6	**Monitoring deaths in hospitals** • By 31 March 2027, all hospital Trusts must have in place effective mechanisms for Board level monitoring of all deaths of children and babies. • By 31 March 2027, all hospital Trusts must have in place a clear and predetermined route to senior management for the escalation of concerning data trends or patterns.	31 March 2027	**Action for Evelina London/GSTT** • Immediate action to map current Trust processes and guidance regarding the reporting and monitoring of the deaths of babies and children and escalation of concerns to ensure there are no gaps.
7	**Data reporting** • All hospitals with a neonatal unit should name a 'lead reporter' with responsibility for inputting data regularly (at least weekly) and reviewing real-time data viewers on neonatal and maternity units in the MBRRACE system • Save where data requires immediate action, in which case a report should be made to the Medical Director and the Board immediately, the lead reporter should report to Trust Boards at least every six months and advise whether any alerts or a need for investigation have arisen, and the investigation or action plan in place.		**Action for Evelina London/GSTT** • 'Lead Reporter' already in place. • Action to implement direct reporting to Board on a 6 monthly basis.
8	**SUDIC guidelines**	28 Sept 2026	**Action for Evelina London – completed** **Action for DHSC**

	• NHSE must immediately inform all Trusts with a neonatal unit that the SUDIC process applies to the sudden and unexpected deaths of babies who have never left hospital, and direct all Trusts that they must, within seven days, draw this information to the attention of all relevant staff and the Board. • DHSC must complete its review and revision of the SUDIC guidelines and ensure the revised guidelines are distributed to all Trusts by no later than 31 March 2027.	31 March 2027	
9	**Suspicion of deliberate harm** • NHSE must produce and distribute a one-page protocol setting out the steps to be taken by managers when concerns or suspicions are raised that a healthcare professional may have deliberately harmed a patient. Guidance of no more than two pages should accompany the protocol. • Trusts must embed the Suspicion of Deliberate Harm Protocol and guidance within their hospital.	31 March 2027	**Action for NHSE – with implications for GSTT** • Trust Policy on the Management of Allegations against Trust Staff Involving a Vulnerable Adult or a Child to be reviewed in light of the report and updated as required.
10	**Panel of experts** • Serious consideration should be given by DHSC to the setting up of a panel of independent experts from all specialties to be called upon in situations where there are emerging concerns about an individual and harm to a patient or patients.	No date given	**Action for DHSC**
11	**Medical examiners** • The National Medical Examiner should, by 31 March 2027, prepare and distribute a one-page document setting out all the steps to be taken by a medical examiner when dealing with the death of a neonate. • The revised SUDIC guidelines (see Recommendation 8 above) should be set out within the good practice guidelines for medical examiners, not merely signposted.	31 March 2027	**Action for national medical examiners** • To note: Trust ME reviews all child deaths including neonates and determines the need for coroner's referral following the review which includes account of parental and clinician concerns.
12	**Paediatric & perinatal pathologists** • DHSC and NHSE must ensure that, by June 2033, there are 37 doctors in training posts as paediatric and perinatal pathologists, in line with the workforce requirement set out by the Royal College of Pathologists in the November 2025 Paediatric and Perinatal Pathology Workforce Report.	June 2033	**Action for DHCS and NHSE** • GSTT currently has 2 of 4 paediatric and perinatal pathologists in post and is undertaking all efforts to appoint to the 2 vacant posts.
13	**Accountability & regulation of managers** • DHSC and NHS England must develop and put in place a barring system for all managers (clinical and non-clinical) by September 2027. It should be reviewed in 2030 with a view to moving to a full statutory regulation system by Sept 2032.	Sept 2027	**Action for NHSE – with implications for GSTT**

	• In addition to the statutory duty for organisations, all managers must be subject to an individual duty of candour to all patients and colleagues. This should be included in the code of conduct and in the contract of employment for all managers. • The NHS Leadership and Management Framework Code, a code of conduct for NHS managers published in July 2026, must be amended urgently to set out, at the beginning, the uncontroversial duty of every manager to put patients first.		
14	**Care Quality Commission (CQC)** • CQC should conduct without-notice inspections of hospital departments. Inspection teams should include at least two current practising experts in the relevant field (in this case paediatrics/neonatology).	No date given	**Action for CQC – with implications for GSTT**
15	**Assessment of the performance of the CQC** • There must be a rigorous and consistent review and assessment of the performance of CQC by the Health and Social Care Committee, initially once a year.	No date given	**Action for the Parliamentary select committee**
16	**Parliamentary & Health Service Ombudsman (PHSO)** • The functions of the National Guardian's Office should be taken over by the PHSO in England. The Ombudsman's powers must be increased to include investigating complaints that whistleblowing in the NHS has not been dealt with adequately and assisting whistleblowers by referring their concerns to the relevant NHS bodies and overseeing the response.	No date given	**Action for the PHSO**
17	**Implementation of recommendations** • A new responsibility for auditing the implementation of the recommendations of statutory inquiries into NHS bodies should be given to the National Audit Office. Funding for appropriate additional staffing should be made available so that it may begin its work by September 2027.	Sept 2027	**Action for National Audit Office**

Recommendations

My recommendations are set out below. The reasons for each are explained in the relevant chapters of this report.

The long-standing underfunding of hospital services for babies and children is well recognised and requires action. The drive to increase the provision of health services in the community should not obscure or undermine the urgent need for adequate and enduring funding for hospital services for babies and children. I trust that the government will give this issue the urgent attention it requires.

CCTV and monitoring

Recommendation 1

All cots and incubators in all neonatal units should be fitted with baby monitors (in-cot cameras with livestreaming video), so that parents can observe their baby remotely at any time. The funding for this should be centrally managed and ring-fenced, to ensure consistency and implementation across all neonatal units at speed. By 31 March 2027, NHS England should set out a roadmap for how this will be implemented.

Chapter 33

Insulin

Recommendation 2

i. Digital devices should be used to restrict access of insulin to authorised people and record access to insulin storage units. I acknowledge that steps are being taken to achieve this. By 31 March 2027, all neonatal units must meet the expected requirements for access control and storage of insulin set out in the NHS England Getting It Right First Time guide, *GIRFT Neonatology: Guide to safe insulin use*.

ii. Until access to insulin requires the provision of biometric data, each Trust should install CCTV cameras focused on storage fridges, cupboards or units. The cameras should store recordings for at least 28 days.

iii. The GIRFT *Laboratory Handling of Insulin Requests in the Investigation of Hypoglycaemia* guidance for the testing and reporting of insulin and C-peptide results, issued in October 2025, must be made mandatory and of national application.

Chapter 34

Bereavement care

Recommendation 3

The National Bereavement Care Pathway for neonatal death should be implemented nationally and in all Trusts by 31 August 2027.

Chapter 29

Safeguarding and contracts of employment

Recommendation 4

i. All Trusts must provide safeguarding training to all staff (appropriate to their role and expertise) and Board members, including Non-Executive Directors. This training should include how to deal with concerns and suspicions about deliberate harm caused by staff.

ii. By March 2027, every existing contract of employment for work in an NHS hospital must be amended to include an obligation on the employee to follow all relevant safeguarding guidance, including the Suspicion of Deliberate Harm Protocol (at Recommendation 9), for dealing with concerns and suspicions about deliberate harm. Agency and bank staff contracts and all new contracts of employment must include the same obligation.

Chapter 41

Operating systems (interoperability)

Recommendation 5

NHS England must provide, by 31 March 2027, a clear and timed route to ensuring that computer systems are harmonised across the NHS by December 2028. Work on the development of a mandatory information standard with requirements for interoperability between systems should be taken forward and implemented as soon as possible. This should mean that data relating to babies and neonates in hospital may be entered on a single occasion, be reviewed in a timely manner and facilitate continuous monitoring.[1]

Chapter 35

Monitoring deaths in hospitals

Recommendation 6

i. By 31 March 2027, all hospital Trusts must have in place effective mechanisms for Board-level monitoring of all deaths of children and babies.

ii. By 31 March 2027, all hospital Trusts must have in place a clear and predetermined route to senior management for the escalation of concerning data trends or patterns.

Chapter 35

Data reporting

Recommendation 7

i. All hospitals with a neonatal unit should name a 'lead reporter' with responsibility for inputting data regularly (at least weekly) and reviewing real-time data viewers on neonatal and maternity units in the MBRRACE system. Whilst the lead reporter does not necessarily need to be a clinician, they must be trained to understand and interpret the available data and able to explain and discuss it with clinicians.

ii. Save where data requires immediate action, in which case a report should be made to the Medical Director and the Board immediately, the lead reporter should report to Trust Boards at least every six months and advise:

    a. whether any alerts or a need for investigation have arisen

    b. the investigation or action plan in place.

Chapter 35

Sudden Unexpected Death in Infancy and Childhood (SUDIC)

Recommendation 8

i. NHS England must:

    a. Immediately inform all Trusts with a neonatal unit that the SUDIC process applies to the sudden and unexpected deaths of babies who have never left hospital.

    b. Direct all Trusts that they must, within seven days, draw this information to the attention of all relevant staff and the Board.

ii. DHSC must complete its review and revision of the SUDIC guidelines and ensure the revised guidelines are distributed to all Trusts by no later than 31 March 2027. The guidelines must include a clear statement that SUDIC applies to sudden and unexpected deaths of babies who have never left hospital.

iii. SUDIC forms must be redesigned and shortened to keep bureaucracy to a minimum. The focus should be on what it is essential to know.

Chapters 12 and 28

Suspicion of Deliberate Harm Protocol and guidance

Recommendation 9

Protocol

i. By 31 March 2027, NHS England must produce and distribute a one-page protocol setting out the steps to be taken by managers when concerns or suspicions are raised that a healthcare professional may have deliberately harmed a patient. The Suspicion of Deliberate Harm Protocol must make explicit that:

   a. It is irrelevant whether the person to whom the concerns have been expressed does or does not believe they are true, as is the fact that the person raising the concern is not sure.

   b. Where concerns or suspicions of deliberate harm are being raised in good faith, they must be acted upon immediately.

   c. Only in cases where the concerns are obviously irrational or malicious (which assessment must be recorded) will no further action be justified.

   d. Pending investigation of a member of staff, action to protect patients by moving the person suspected of causing harm is likely to be the first step.

   e. The moving of a person suspected of causing harm and the investigation into suspicions and concerns about a member of staff is a neutral act.

   f. Safeguarding steps must be followed, as a result of which the police will become involved.

Guidance

ii. Guidance of no more than two pages should accompany the protocol. It must set out the factors to be considered when assessing the nature of the concerns and suspicions. The reader should be directed to guard against their own biases, loyalties and prejudices. The guidance should explain what should be said and when to those who are or who may be involved with any investigation (such as patients, parents and staff). This must include that patient safety comes first, and investigation is required. The guidance should also explain that failure to follow the protocol will be a breach of contract by an employee, as well as a breach of the relevant code of conduct.

Implementation

iii. Trusts must embed the Suspicion of Deliberate Harm Protocol and guidance within their hospital.

Chapter 41

Panel of experts

Recommendation 10

Serious consideration should be given by DHSC to the setting up of a panel of independent experts from all specialties to be called upon in situations where there are emerging concerns about an individual and harm to a patient or patients. A team from any specialty or combination of specialties would be drawn from the panel to conduct a swift, technical investigation into the concerns raised. This may most often be necessary where there are concerns that harm is being or has been caused inadvertently.

The precise make-up of the panel should be determined by DHSC but could include, for example:

a. two doctors and two nurses from each clinical specialty

b. four senior managers

c. four pathologists including paediatric and perinatal pathologists

d. other experts as decided by DHSC.

Where necessary, a small team (always including clinicians from the relevant specialty/ specialties) would be drawn from the panel to carry out an independent investigation into clinical concerns. Such investigations should always include safeguarding considerations (including contacting the police). In addition to reporting their findings to the Trust and DHSC, the experts would be available to be called as witnesses in any proceedings that may follow.[2]

Chapter 41

Medical examiners

Recommendation 11

i. The National Medical Examiner should, by 31 March 2027, prepare and distribute a one-page document setting out all the steps to be taken by a medical examiner when dealing with the death of a neonate.

ii. The revised SUDIC guidelines (see Recommendation 8 above) should be set out within the good practice guidelines for medical examiners, not merely signposted.

iii. Medical examiners should ask direct questions of the attending practitioner as to whether there is a concern that a child has been harmed or some other safeguarding concern. Where there may be such a concern, the medical examiner should ensure that there is a record made that day of the contact details of every doctor or nurse who attended to the baby during life.

iv. There should be a pool of neonatologists who can assist medical examiners with their work until such time as it is possible to appoint the appropriate number of regional neonatologist medical examiners. Ring-fenced funding should be provided for this purpose.

v. The medical examiner system should be reviewed again in 2027 by DHSC. The review should include the adequacy of funding for medical examiners and their support staff and offices. In particular, the question of whether the funding should be ring-fenced must be addressed. Thereafter, reviews should be as directed by DHSC and NHS England.

Chapter 32

Paediatric and perinatal pathologists

Recommendation 12

DHSC and NHS England must ensure that, by June 2033, there are 37 doctors in training posts as paediatric and perinatal pathologists, in line with the workforce requirement set out by the Royal College of Pathologists in the November 2025 *Paediatric and Perinatal Pathology Workforce Report*. The incentive scheme should remain in place and funded until at least 37 doctors are in training posts as paediatric and perinatal pathologists.

Chapter 28

Accountability and regulation of managers

Recommendation 13

i. DHSC and NHS England must develop and put in place a barring system for all managers (clinical and non-clinical) by September 2027. It should be reviewed in 2030 with a view to moving to a full statutory regulation system by September 2032.

ii. NHS England must require any Trust seeking approval for the movement of a senior manager to another Trust to demonstrate that:

    a. The move is not proposed because of the manager's lack of capability or misconduct.

    b. The manager meets the fit and proper person test.

    NHS England must not grant approval, and Trusts must not seek approval, unless they are able to demonstrate the matters at a. and b. above.

iii. In addition to the statutory duty for organisations, all managers must be subject to an individual duty of candour to all patients and colleagues. This should be included in the code of conduct and in the contract of employment for all managers.

iv. The NHS Leadership and Management Framework Code, a code of conduct for NHS managers published in July 2026, must be amended urgently to set out, at the beginning, the uncontroversial duty of every manager to put patients first. I suggest the following wording, with thanks to Mr Jarrold: 'I will make the care and safety of patients my first concern and act to protect them from risk.' What matters is that patients come first.

v. In the Leadership and Management Framework Standards, the competency 'delivering across healthcare' should be first (it is currently third). The first and fundamental competency under this heading is, rightly: "*I put patients first and report safety concerns and incidents.*"

Chapter 37

Care Quality Commission (CQC)

Recommendation 14

i. CQC should conduct without-notice inspections of hospital departments. Inspection teams should include at least two current practising experts in the relevant field (in this case paediatrics/neonatology).

ii. Inspectors should investigate what is happening in hospital departments and not accept what they are told at face value. Where processes are being inspected, questions must be asked to elicit the effectiveness of those processes.[3]

iii. Training should make explicit that CQC is responsible for ensuring the safety of patients in hospitals and not just for checking there are processes in place which, if implemented, should ensure patient safety. Inspectors and team leaders must always approach an inspection of neonatal services not as a box-ticking exercise but as a way to determine that babies in hospital are safe.

Chapter 42

Assessment of the performance of CQC

Recommendation 15

There must be a rigorous and consistent review and assessment of the performance of CQC by the Health and Social Care Committee, initially once a year and, once the committee is satisfied, once every three years, or such other frequency to be determined by the select committee.

Chapter 42

Parliamentary and Health Service Ombudsman

Recommendation 16

The functions of the National Guardian's Office should be taken over by the Parliamentary and Health Service Ombudsman in England. The Ombudsman's powers must be increased to include:

a. investigating complaints that whistleblowing in the NHS has not been dealt with adequately

b. assisting whistleblowers by referring their concerns to the relevant NHS bodies and overseeing the response.

Chapter 31

Implementation of recommendations

Recommendation 17

A new responsibility for auditing the implementation of the recommendations of statutory inquiries into NHS bodies should be given to the National Audit Office. Funding for appropriate additional staffing should be made available so that it may begin its work by September 2027.

Chapter 31

Endnotes

1 Baroness Amos's final report from the National Maternity and Neonatal Investigation recommends DHSC/NHSE must deliver estates and digital systems that are fit for modern maternity and neonatal care with 12-month, 5-year and 10-year investment commitments and implementation deadlines. The importance of interoperable digital systems is a common theme in both our reports and should be treated as a priority. The Rt Hon. the Baroness Valerie Amos LG CH, *Independent Investigation into Maternity and Neonatal Services in England: Final report and recommendations*, June 2026 (**https://www.matneoinv.org.uk/wp-content/uploads/2026/08/NMNI-Final-Report-and-Recommendations.pdf**)

2 Baroness Amos's final report recommends that NHS England, DHSC and CQC "*put in place a specialist regulatory unit, with a sufficiently sensitive methodology, to provide regulatory assessment for maternity and neonatal services*" within nine months. This must include clinicians so that "*the most recent clinical perspectives are fully integrated into the regulatory function*". This recommendation aligns with my recommendation and should be taken forward with urgency. The Rt Hon. the Baroness Valerie Amos LG CH, *Independent Investigation into Maternity and Neonatal Services in England: Final report and recommendations*, June 2026, page 20 (**https://www.matneoinv.org.uk/wp-content/uploads/2026/08/NMNI-Final-Report-and-Recommendations.pdf #page=20**)

3 Baroness Amos's final report recommends that DHSC, NHS England and CQC must drive improvement within 12 months in the quality, transparency, oversight and accountability of their investigations, and ensure that learning is captured and acted upon when things go wrong. Our recommendations regarding CQC should be taken forward with urgency. The Rt Hon. the Baroness Valerie Amos LG CH, *Independent Investigation into Maternity and Neonatal Services in England: Final report and recommendations*, June 2026, page 16 (**https://www.matneoinv.org.uk/wp-content/uploads/2026/08/NMNI-Final-Report-and-Recommendations.pdf#page=16**)

To: NHS trusts and integrated care boards:

- chief executives
- chief operating officers
- chief nursing officers
- chairs
- medical directors

cc. NHSE regional teams:

- regional directors
- chief nursing officers
- medical directors

NHS England
Wellington House
133-155 Waterloo Road
London
SE1 8UG

21 September 2026

Thirlwall Inquiry report and recommendations

Dear colleagues,

Lady Justice Thirlwall's report is a sobering moment for all of us working in the NHS. From the devasting failure, both of individuals and the system, to act quickly enough to safeguard babies, to the questions it poses about the NHS culture that prevented this – the need for change goes beyond the walls of a single hospital ward. We must address these together now.

Our thoughts remain very much with the families affected who have experienced unimaginable loss and pain, and the NHS repeatedly failed them. The care, safety, and safeguarding of all patients is the principal duty of all of us, and this is why we must all act with the urgency, curiosity, and openness to ensure that the learning from this Inquiry is translated into clear action.

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This is not just a matter for Trusts with neonatal services. It is a matter for every single Trust and ICB Board to consider, and for every member of staff across the NHS.

Recommendations

On Tuesday, the Secretary of State delivered a statement in Parliament that committed to commencing a series of actions recommended in the final report, while the Government considers the Inquiry's recommendations in full.

Specifically:

- Urgently work to develop plans for all cots and incubators in all neonatal units to be fitted with baby monitors (in-cot cameras with livestreaming video), so that parents can observe their baby remotely at any time. Taking learning from places where this is already used, we will develop a national approach to support neonatal units to implement this;
- Go further on new guidance on the safe use and storage of insulin and strengthened guidance for medical examiners reviewing neonatal death;
- Undertake a review of the 'Working Together to Safeguard Children' (April 2026) and safeguarding training nationally;
- Work through plans to regulate NHS managers through a barring scheme for senior leaders who fail in their responsibilities;
- Continue rollout of the National Bereavement Care Pathway for families experiencing neonatal loss.

Actions needed now

Trusts should immediately progress the following actions in response to the Inquiry's findings:

- **Every Trust and ICB Board to review the Thirlwall report and to consider its findings at the next available public Board meeting:** Boards should reflect on whether it would have been possible for similar events to occur at their own organisation and seek assurance that sufficient measures are in place to keep the babies and children in their care safe, no matter what setting. Central to this is a culture of professional curiosity, where both Board members and staff feel empowered, supported, and confident to speak up, challenge concerns, and raise issues without fear. Any risks to this must be urgently discussed with the regional team.
- **Sudden and Unexpected Death In Children** (SUDIC): The Inquiry rightly made clear that no member of staff should ever assert that they did not know what to do in response to a sudden and unexplained death. The SUDIC protocol is applicable for every death (or collapse leading to death) of an infant or child under the age of 18 which would not have been reasonably

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expected to occur 24 hours previously and in whom no pre-existing medical cause of death is apparent, irrespective of the place of death**.** This includes sudden and unexpected deaths within neonatal units. **All Trusts with a neonatal unit must urgently communicate to all relevant staff and the Board that the SUDIC process applies as set out above. This must be completed by no later than Monday 28 September 2026.** It is important to note that SUDIC reporting runs alongside your own internal reporting processes.

- **National Bereavement Care Pathway for stillbirth and neonatal death:** ICBs and providers should take immediate action to improve care of the bereaved as has already been set out in the NHS Medium Term Planning Framework (October 2025).

- **Insulin**: By 31st March 2027, all neonatal units must meet requirements for access control and storage of insulin as set out in the GIRFT neonatology Guide to safe insulin use. Until access to insulin requires the provision of biometric data, each Trust should urgently install CCTV cameras in neonatal units focused on storage fridges, cupboards or units by 30 November 2026 at the latest. The cameras should store recordings for at least 28 days.

- **Safeguarding:** Trusts and ICBs should ensure that all staff and Board members are compliant with safeguarding training requirements at the appropriate level and confirm that staff know who to raise and escalate concerns to. Boards must assure themselves that the safeguarding of babies and children is given the level of prominence required.

In addition, Trusts are reminded that the Insightful Provider Board guide is intended to help Boards identify the information they need and the cultures, behaviours and governance required to ensure that information is used effectively.

Health and wellbeing

We are mindful that the findings of this Inquiry may impact the confidence of parents and families whose babies are currently receiving neonatal care. We would urge you to consider what steps can be taken locally to provide parents with assurance of the care being given and support that is required during the care of their baby.

We also recognise that caring for very sick babies can be psychologically difficult for staff and this is an opportunity to review the support mechanisms in place for staff working in these services.

Next steps

The report firmly underlines why the urgent work we are doing through the Maternity and Neonatal Care 10-Point Plan must be a top priority for the NHS. As the Secretary of State has clearly set out, the safety, safeguarding and wellbeing of mothers and babies must never be treated as a side issue and must be a central priority for NHS boards.

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The findings of this crucial report will be a key focus of our next CEO leadership event tomorrow**.** It is important that we challenge each other when we meet on whether we are all doing enough to ensure that babies and children are protected, no staff member is ignored when they raise concerns, and that we are consistently acting to the highest standards of governance and leadership.

Yours sincerely,





Duncan Burton

Chief Nursing Officer for England

Sarah-Jane Marsh

NHS England Chief Operating Officer

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BOARD OF DIRECTORS

WEDNESDAY 21 OCTOBER 2026

Report title:	**Apollo: Maximising the Value of Epic and Delivering the Next Phase**
Executive sponsor:	Jon Findlay, Chief Operating Officer (Apollo SRO) & Denis Lafitte, Chief Digital Information Officer
Report author:	India Brummitt-Nevin, Director of Apollo & Clinical Systems & Georgina Charlton, Associate Director of Delivery – Epic Benefits Realisation
Purpose of report:	For awareness/noting only This report provides the Board with its periodic update on progress, benefits delivery and key priorities for the Apollo Programme.
Previously presented at:	Transformation and Major Programmes Board Committee, 9 September 2026
Key points of report:	• Epic has established the digital foundation for more connected care across GSTT and South East London (SEL), enabling a shared record, common workflows and greater collaboration across organisational boundaries. • Apollo continues to deliver measurable benefits for patients, staff and the organisation, with strong progress in digital access, safety, productivity and financial performance. • Future priorities focus on accelerating adoption, automation and artificial intelligence, while extending the value of a shared record across SEL.
Primary BAF risk:	Risk 5: Epic benefits realisation
Supporting material:	• N/a
Recommendation(s):	The BOARD is asked to: 1. **Note** this update.

1. Introduction

1.1. A new, integrated Electronic Health Record, Epic, was launched at Guy's and St Thomas' NHS Foundation Trust and King's College Hospital NHS Foundation Trust on 5 October 2023. It also includes our pathology partner, Synnovis.

1.2. This is a major strategic investment in a leading digital technology, to improve patient care. It was the largest single-instance Epic deployment undertaken anywhere in the world at that time, with over 40,000 staff trained and ready to use the system on the first day.

1.3. In the three years since, GSTT has moved from stabilising the system to a focus on continually improving Epic as its core clinical and operational platform. The first year established the essential foundations for our staff and patients before the transition towards sustained optimisation and transformation.

1.4. The achievement is broader than the implementation of a new EHR system. In partnership with KCH, GSTT has established a single integrated record across its services, more consistent clinical and administrative workflows, and workforce capability required to improve the platform continuously. The integrated patient app, MyChart, has enabled over 1 million GSTT and KCH patients to have greater control of their own healthcare, including their letters, test results, questionnaires and messages.

1.5. The Apollo Programme now provides a key digital foundation for delivering the GSTT 2030 Strategy, including more connected and personalised care, smarter and more productive services, and greater use of data, automation and artificial intelligence.

1.6. This foundation also aligns with the NHS 10 Year Health Plan and its three shifts from hospital to community, analogue to digital, and sickness to prevention. A shared record, digital patient services and common workflows create the practical infrastructure needed to connect care across organisational boundaries, support more care outside hospital and make better use of technology and data.

1.7. Our collective use of Epic has become a strategic asset for SEL. The shared platform and governance established through Apollo provide the basis for additional acute and community partners to join the record, adopt shared standards and reuse improvements rather than develop separate solutions to common challenges. The next phase is focused on using this foundation more consistently and ambitiously through adoption, standardisation and service redesign, while preparing for more connected care across SEL.

2. Apollo programme progress

2.1. Apollo is the name of the transformation and improvement programme which aims to make best use of our Epic system across the trusts.

2.2. Apollo continues to focus on three connected areas: Capability and Adoption, Transformation and Benefits, and Collaboration and Convergence. Together, these support the Trust's ambition to maximise value from Apollo and use digital capabilities to improve patient care, staff experience and organisational performance.

Capability and adoption

2.3. As the programme has matured, the emphasis has shifted from system implementation towards capability building, adoption and optimisation. Training and support continue to evolve beyond traditional classroom-based approaches, with greater focus on practical, service-based support that helps teams use Epic more effectively day to day.

2.4. Digital Squads continue to support staff capability and adoption across services. Combining clinical, operational, training and technical expertise, they work alongside teams to improve workflows, support local priorities and embed best practice. This is complemented by wider investment in digital skills through local digital leadership, SmartUser development, Clinician Builder programmes and quality improvement approaches that help services sustain improvement over time.

2.5. Successful adoption increasingly depends on a partnership between Apollo and operational services. Apollo provides the training framework, specialist support, data and improvement expertise, while Clinical Groups identify local digital leaders, release staff for development and embed effective use of Apollo within routine operational management.

2.6. Examples of this approach are already demonstrating measurable improvements. Across Midwifery, the combination of data analysis, leadership engagement and at-the-elbow support has enabled the development of departmental preference lists and shared profiles that can be adopted by other staff. This has reduced the time taken to complete targeted order forms by 22 seconds, equating to approximately 122 hours of clinical time returned to patient care annually.

Transformation and benefits

2.7. Epic is increasingly being used as a platform for service transformation and redesigned ways of working. Aligned to the GSTT Strategy, priorities include enhanced digital patient communications, pathway redesign, native clinical decision support, automation and the adoption of emerging technologies.

2.8. MyChart remains a key component of the Trust's digital front door, supporting patient communications, self-service, remote engagement and digital access to care. Over 1 million patients have registered since the system was launched in late 2023, and more services are launching patient self-booking tools to enable more convenient access to care for patients. Extensive outreach and co-design work with patients and local communities underpins this work, aiming to improve accessibility and reduce digital inequalities. Delivery continues to focus on expanding self-scheduling, digital communications, remote clinical review and patient engagement capabilities, while preparing for further SEL onboarding and ensuring compliance with emerging national requirements.

2.9. A clinically led review of test result release rules, aligned to NHS England guidance, is underway. This is expected to simplify existing release rules, improve consistency and support wider digital access to information, whilst maintaining appropriate clinical and safety controls.

2.10. Within outpatient services, activity has been aligned to ambulatory transformation priorities including personalisation, automation, artificial intelligence tools and Ambient Voice Technology (AVT). The Trust has begun rolling out AVT across services to support clinical documentation, with early experience indicating significant potential to reduce administrative burden and improve the clinical user experience.

2.11. Embedded clinical decision support tools within Epic continue to support safer and more effective care by providing information, guidance and alerts at the point of care. Changes implemented have seen increased completion of falls risk assessments in Emergency Departments and reducing duplicate imaging investigations and blood tests.

Collaboration and convergence

2.12. Regional collaboration remains a significant focus for the programme. Apollo was established as a shared platform across GSTT and King's and continues to provide the foundation for a more connected digital ecosystem across SEL.

3. Epic benefits delivery and Honor Roll status

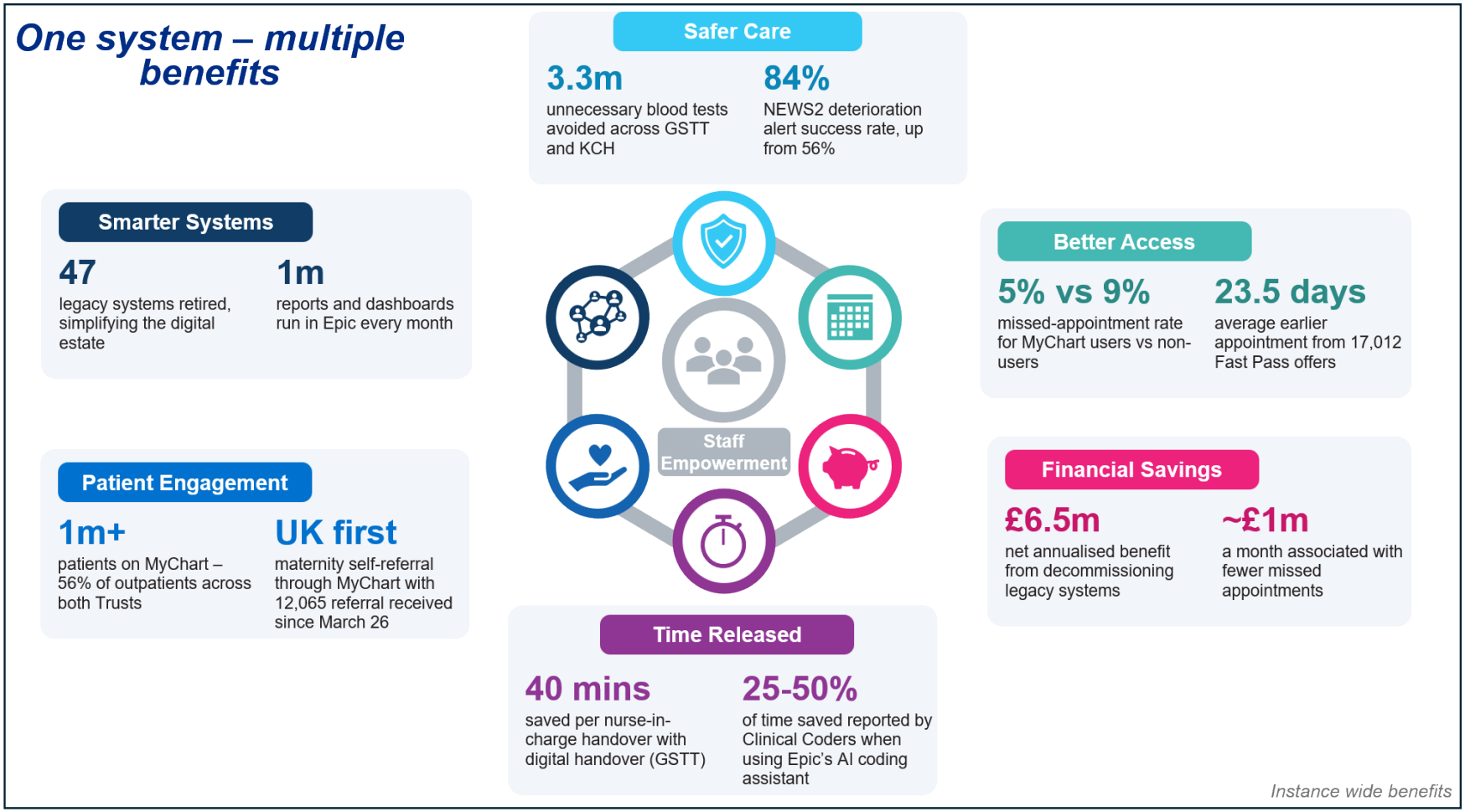
3.1. Epic has enabled a chance to standardise care pathways and change how care is delivered, rather than simply moving old processes onto a new system which has brought tangible benefits across GSTT and KCH. The benefits fall under six linked themes: Safer Care, Better Access, Financial Savings, Time Released, Patient Engagement and Smarter Systems. Because the themes overlap, one improvement often creates value in several places at once.

3.2. For safer care, clinicians now see one transparent record within and across organisations, supported by decision-support alerts that follow local and national policy. Clinicians can also see which tests a patient has already had at either Trust, so patients avoid repeat tests and unnecessary hospital visits. For access, digital tools such as the MyChart patient portal are helping patients get seen sooner and cutting missed appointments. Patient-led scheduling and the ability to take up last-minute cancellations will build on this further.

3.3. Patients are increasingly active partners in their own care. Over a quarter of a million test results are released to patients every month, and 1,800 patients are benefitting from automatic offers of earlier appointments at short notice. Missed appointment rates for patients with MyChart are consistently lower than the overall rate for the organisation. For staff, the system gives time back for patient care and supports their wellbeing, including finishing work on time.

3.4. Staff point to four key benefit themes in their feedback: a complete care record in one place, including the London Care Record; efficiency from automation and personalised Epic tools; secure messaging that bridges acute and community teams; and real-time clinical data, such as vital signs, on mobile devices.

3.5. At Month 5, the Epic Benefits Programme continues to perform strongly, with financial benefits remaining ahead of target. Key contributors include Clinical Directorate Administration Team remodelling, reduction in pathology testing, and reduced drug spend (antimicrobials). A funding grant was awarded by NHS England in October 2026 to accelerate the adoption of digital tools for antimicrobial stewardship across GSTT and KCH and produce reusable Epic build specifications and an implementation playbook that could support wider NHS adoption.



3.6. In parallel, progress towards the Epic Honor Roll programme continues. Honour Roll is an Epic programme which recognises excellent implementation and benefits delivery from best use of the Epic system. Currently, we pass 52 of 82 requirements (63%), representing a 23% improvement over the last six months. Main delivery risks to Honor Roll that require local ownership and clinical leadership are:

- Personalisation – Current Trust Personalisation rate is 60% against a target of 80%. We must complete all the eligibility requirements (which personalisation full under) to formally proceed with submitting for Honor Roll. Essential personalisation

monthly trend is 1% increase. Completion of personalisation will also facilitate prompt issuing of available AI tools such as AVT and therefore positively impact roll out pace of these tools.

- Barcode Medication Administration (BCMA) - For level 1 areas in the BCMA target is 80%, current performance (self-reported) for GSTT is 56.3% for adult inpatients.

4. Looking ahead: transforming care through digital, automation, and AI

4.1. The core digital foundations are in place to support a growing programme of automation and artificial intelligence. Trust-wide standardisation of clinical administration and wider processes is helping preparing services for further transformation, alongside standardisation of clinical practice to enable effective use of emerging AI tools.

4.2. Standardisation of practice, and high levels of staff proficiency in using Epic's processes and workflows are essential in enabling automation at scale. Our Digital Squad support to the organisation, and wider efforts led by Clinical Groups to support staff in these best practices are essential building blocks for the automation and transformation ahead.

4.3. Automation - we are focused on enabling automation across pathways wherever possible. This often means using existing functionality better, reducing clicks or automating steps across processes to improve the experience of giving and receiving care for our staff and patients.

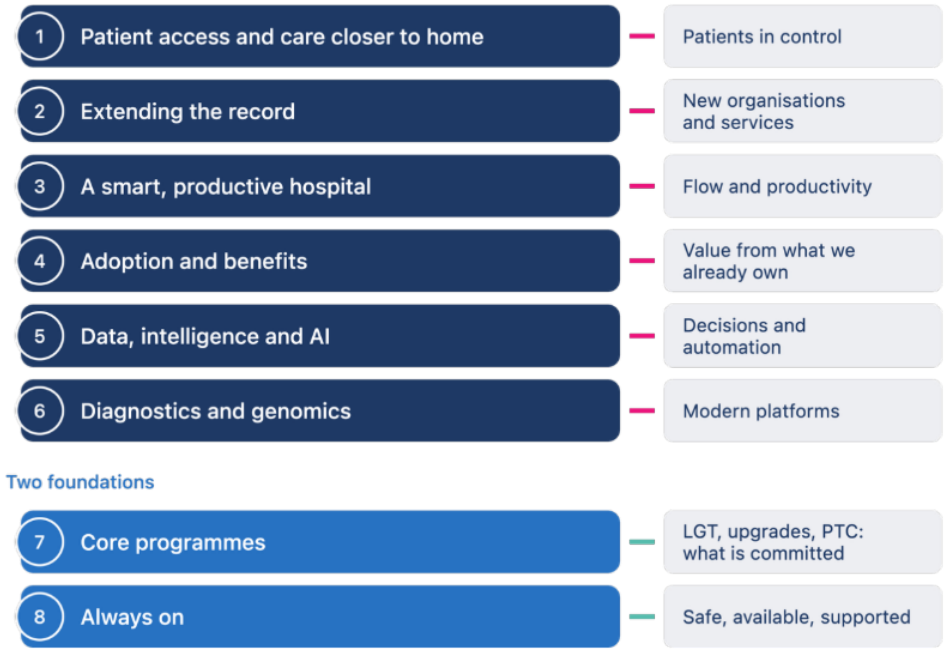
4.4. Making the most of what we have - we are working to assess the impact and use of the existing functionality of Epic. This will help us identify the opportunities for improving the experience of giving and receiving care at GSTT.

4.5. Leveraging automation and workforce transformation to reduce workflow friction - beyond what is already available for end users, further opportunities exist to reduce friction and increase automation to ensure there is time to care released.

5. Strategic priorities and focus for the next phase

5.1. These themes reflect where Apollo can make the greatest contribution to Trust objectives, including improving patient access, supporting productivity and flow, extending the reach of the shared record, increasing value from capabilities already available within Epic, and enabling more effective use of data, intelligence and automation. They sit alongside two foundations: delivery of committed core programmes and maintaining a safe, reliable and supported service.

5.2. As the programme matures, it is timely to review how demand enters and moves through the Apollo governance and prioritisation structure.



6. Collaboration and convergence

6.1. During 2027, convergence with SEL partners onto Apollo will create the foundation for operating from a shared record, with common data, workflows and approaches. This means patients undergoing care under different providers can have a more seamless experience, and clinical teams can collaborate more effectively between organisations and neighbourhoods.

6.2. Our increased digital maturity also changes how improvement spreads: an approach proven in one organisation can be evaluated, adapted and adopted elsewhere rather than rediscovered. Where organisations face the same operational or clinical challenge, there is no good reason to build separate workflows, governance, training materials and technical solutions. A shared platform lets us do things once, learn from each other, and draw on international comparators running the same system. Value increases when change is designed once for shared pathways and applied across organisational boundaries.

6.3. This matters most for care that crosses boundaries. Integrated Neighbourhood Teams and SEL complex discharge pathways both depend on community, acute, specialist and partner services working from the same information.

7. Recommendations

7.1. The Board is asked to note this update.

BOARD OF DIRECTORS

WEDNESDAY 21 OCTOBER 2026

Report title:	**Board Assurance Framework (Q2 2026/27)**
Executive sponsor:	Tendai Wileman, Chief of Staff and Executive Director Corporate Development Avey Bhatia, Chief Nurse
Report author:	Stephanie Calvert/Lucy Yasin, Director of Corporate Governance (interim) Adeola Ogunlaja, Corporate Governance Manager
Purpose of report:	To seek approval In accordance with the Trust's risk management policy, the full Board should review the BAF in full twice a year. It last did so in April 2026, when it proposed a number of changes to ensure that the BAF risks reflected the Trust's current strategic risk profile.
Key points of report:	• The Board Assurance Framework (BAF) is the primary means by which the Trust Board manages the principal strategic risks to its organisational objectives. • The updated BAF at the end of quarter 2 (2026/27) is now presented to the Board for a further review, following the latest round of updates at Board committee meetings between April and September 2026. • There are currently 13 principal risks, including the introduction of a climate-change risk which was approved by the Board in Committee on 23 September 2026. Future BAF risks with respect to health inequalities and strategic capital and infrastructure delivery are also under development and will raise the number of risks to 14, following the merger of risks six (organisational change and transformation) and seven (productivity).
Primary BAF risk:	Risk 11: Organisational excellence
Supporting material:	The full Board Assurance Framework is attached to this paper as Annex 1.
Recommendation(s):	The BOARD is asked to: 1. **Note** the full Board Assurance Framework as at the end of Q2, including the amendments made since the April review and the assurances provided. 2. **Consider** whether the BAF, taken as a whole, provides a coherent, complete and proportionate articulation of the Trust's principal strategic risks.

3. **Identify** any risks which may be missing, or where there may be opportunities for consolidation, reframing or rationalisation.
4. **Approve** the proposed format for future reporting of the full Board Assurance Framework as set out in section five, to strengthen the Board's shared understanding of strategic risks and improve the consistency of assurance.

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. In accordance with 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 the dedicated BAF session in April 2026 the Board reviewed the BAF and made a number of suggestions amendments to ensure it reflected the Trust's current strategic profile. These amendments have been considered by the relevant Board committees and the Trust's latest BAF, reflecting the scoring, assurances and updates made during Board committee meetings in quarter two 2026/27 (April to September) is set out in Annex 1 for the Board to review. An overview of the changes is set out in section three of the paper.

2. Background

2.1. On 29 April 2026 the Board met to undertake a comprehensive review of the BAF to achieve the following objectives:

2.1.1. review each BAF risk and agree whether it should be **retained, reworded** or **removed** to ensure that the BAF reflected the Trust's principal strategic risks, aligned with external expectations and supported effective Board assurance;
2.1.2. highlight BAF risks where the scoring or level of assurance needed further consideration; and
2.1.3. agree if there were any other risks that should be added to the BAF.

2.2. Following detailed discussion of objectives one and two, there was insufficient time for the full Board to complete the third objective of considering whether any additional risks should be included in the BAF. Notwithstanding this, consideration of potential additional risks continued at Board committees and is brought together in this paper for the Board's review, alongside an assessment of the coherence and completeness of the BAF as presented.

2.3. The outcome of discussions on objectives one and two was that the overall BAF structure was considered appropriate, but the Board identified the need for clearer and more consistent risk descriptions, stronger alignment between risk scores and assurance levels and better recognition of the constraints affecting delivery of the Trust's strategy.

2.4. The review also resulted in several substantive changes. Highlights were as follows:

2.4.1. Digital infrastructure remained the highest-rated organisational risk, with greater emphasis placed on cyber threats, geopolitical instability and artificial intelligence.
2.4.2. Financial sustainability and capital investment risk scores were increased, while the estates risk was retained separately and strengthened to reflect the potential impact of major infrastructure failure.
2.4.3. The transformation (risk six) and productivity (risk seven) risks should be rationalised and risks relating to operational performance, quality of care, Epic benefits realisation, sustainability and research should be refined.
2.4.4. Additional risks covering health inequalities and adapting to climate change were identified for inclusion.

2.5. This work was led by the BAF coordinators for the individual risks and reported through the subsequent round of Board committees.

2.6. The risk on climate change impact and the Trust's ability to meet net zero requirements was approved at the Board in Committee meeting on 23 September and has been included in the BAF as Risk 13. The risk in respect of failing to deliver and embed population health and a health equity approach is at an advanced stage of development and expected to come for approval soon. A further risk regarding strategic capital delivery and infrastructure is also under consideration.

2.7. The Board agreed to review the future reporting model for the full BAF to strengthen collective understanding, consistency and assurance and a proposal for future reporting is included for consideration in this report.

3. Update on changes to the BAF in Quarter 2

3.1. The quarter two 2026/27 BAF has been compared with the quarter one position and the requests arising from the Board BAF review session held in April 2026. This identified four material movements in risk score or assurance levels, together with substantive changes to a number

of principal risks, most notably quality of care and digital infrastructure. These movements are included in the table below along with the wider picture:

Principal risk	Q1 risk score/ assurance level	Q2 risk score/ assurance level	Risk increase/ decrease	Summary of update and status
Risk 6 - Organisational change and transformation	Score 12 Limited	Score 12 Substantial	↓	Assurance improved following progress in portfolio resourcing, capital governance and project-delivery productivity. Capacity planning, portfolio-wide risk management, gateway reviews, executive oversight and benefits realisation remain gaps.
Risk 9 - Capital expenditure investment	Score 12 Substantial	Score 12 Limited	↑	Assurance reduced due to pressures linked to the revenue position and the lack of material headroom in the medium term capital plan.
Risk 10 - High performing and future ready workforce	Score 12 Substantial	Score 16 Substantial	↑	The risk score increased above the moderate tolerance range of 10–15, reflecting the ongoing impact of financial constraint as well as wide reaching workforce transformation, likelihood of change fatigue and risk of industrial action.
Risk 11 - Organisational excellence	Score 12 Substantial	Score 9 Substantial	↓	The risk score reduced reflecting progress with the governance and operating model review, mock inspections, CQC preparedness and Advanced Foundation Trust activity.
Other principal risks	Scores and assurance as reported in Q1	Unchanged	↔	Digital infrastructure remains the highest rated risk at 20. Quality of care, estates infrastructure, productivity, financial sustainability and workforce are each scored at 16.
NEW Risk 13 - Climate change/net zero	N/A	Score 12 Limited	N/A	The Board approved its introduction and is subject to further Board consideration within the wider BAF profile.

3.2. The quarter two review demonstrated mixed progress against the Board's recommendations from April. Significant progress was made in relation to the quality of care and digital infrastructure risks, both of which were substantially revised in response to Board feedback. The operational performance, estates infrastructure and Epic benefits realisation risks were partially updated, although their principal risk descriptions remained largely unchanged.

3.3. A small number of the Board's recommendations remain in progress. The proposed rationalisation of the transformation and productivity risks and the potential increase in the Epic likelihood score were not reflected in the quarter two BAF, while further review of the research and academic ambitions risk will need to be undertaken as part of a future update.

3.4. The transformation and productivity risks remain separate in the quarter two BAF. However, at its meeting on 9 September 2026, the Transformation and Major Programmes Board Committee considered merging them into a single risk covering transformation, organisational change and culture, and creating a new strategic capital and infrastructure delivery risk. Both proposals require further consideration alongside the wider BAF but are expected to progress.

3.5. The climate change impact/net zero risk has been added as risk 13 and two further risks are under development for potential future inclusion as outlined in paragraph 2.7.

4. Next steps

4.1. The quarter two BAF contains 13 principal risks. The Board is invited to confirm whether these collectively remain an appropriate and proportionate articulation of the Trust's principal strategic risk profile, noting the two further risks under development and the work underway to merge organisational change and transformation (Risk 6) and productivity (Risk 7), and the interdependencies between estates, digital infrastructure and capital investment.

4.2. No specific proposals for further rationalisation are presented for approval at this stage. The Board is, however, invited to consider whether there are opportunities to simplify and rationalise the BAF, including through the merger, reframing, addition or removal of risks, while ensuring that material strategic exposures remain visible and clear committee ownership is maintained. The Board's discussion will inform a more structured review of the BAF and development of any subsequent proposals.

4.3. If Risks 6 and 7 are merged and the new strategic capital and infrastructure delivery and health inequalities risks are added, the BAF would contain 14 principal risks. This total may change following future Board decisions on their scope, wording, ownership, scoring and tolerance.

5. Future reporting

5.1. The full BAF should continue to be presented to the Board at least twice each year, consistent with the risk management policy, with an additional review where there is a material change in the strategic risk profile. Each full review should provide a concise summary of movements in scores and assurance, risks outside tolerance, progress against Board requests, new or emerging risks and proposals to merge, add or remove risks.

5.2. Board committees should continue to review their allocated principal risks quarterly, challenge the adequacy of controls and assurances, monitor delivery of mitigating actions and escalate material movements, cross-cutting dependencies and emerging risks to the Board. Risk appetite and tolerance should be reviewed periodically and whenever the Trust's strategy or external operating environment changes materially, to ensure that thresholds remain meaningful and aligned with Board priorities.

6. Recommendations

6.1. The Board is asked to:

6.1.1. **Note** the full Board Assurance Framework as at the end of Q2, including the amendments made since the April review and the assurances provided.
6.1.2. **Consider** whether the BAF, taken as a whole, provides a coherent, complete and proportionate articulation of the Trust's principal strategic risks.
6.1.3. **Identify** any risks which may be missing, or where there may be opportunities for consolidation, reframing or rationalisation.
6.1.4. **Approve** the proposed format for future reporting of the full Board Assurance Framework as set out in section five, to strengthen the Board's shared understanding of strategic risks and improve the consistency of assurance.

Guy's and St Thomas' NHS Foundation Trust

Board Assurance Framework
30 September 2026 (Q2, 2026/27)

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
30 September 2026 (Q2, 2026/27)

1. *Level of assurance over past 12 months*

BAF risk	Summary risk title	Board Committee owner	Level of assurance (assessed quarterly)			
			Quarter 3 2025/26	Quarter 4 2025/26	Quarter 1 2026/27	Current Q2 2026/27
1	Operational performance and activity	Q&P	Limited	Limited	Limited	Limited
2	Quality (safe, effective, experience) of care	Q&P	Substantial	Substantial	Substantial	Substantial
3	Resilience of estates infrastructure	Q&P	Substantial	Substantial	Substantial	Substantial
4	Resilience of digital infrastructure	ARC	Substantial	Substantial	Substantial	Substantial
5	Epic benefits realisation	TMP	Limited	Limited	Limited	Limited
6	Organisational change and transformation	TMP	Limited	Limited	Limited	Substantial
7	Productivity	TMP	Limited	Limited	Substantial	Substantial
8	Financial sustainability	FC&I	Limited	Limited	Limited	Limited
9	Capital expenditure investment	FC&I	Substantial	Substantial	Substantial	Limited
10	High performing and future ready workforce	PCE	Substantial	Substantial	Substantial	Substantial
11	Organisational excellence	BiC	Substantial	Substantial	Substantial	Substantial
12	Research and academic ambitions	BiC	Limited	Limited	Limited	Limited
13	Climate change mitigation and adaption *(NEW)*	BiC	N/A – new	N/A – new	N/A – new	Limited

2. *Risk score over past 12 months*

BAF risk	Summary risk title	Risk score (assessed quarterly)				Tolerance level
		Quarter 3 2025/26	Quarter 4 2025/26	Quarter 1 2026/27	Current Q2 2026/27	
1	Operational performance and activity	12	12	12	12	Low (5 – 9)
2	Quality (safe, effective, experience) of care	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	20	20	20	20	Low (5 – 9)
5	Epic benefits realisation	12	12	12	12	Low (5 – 9)
6	Organisational change and transformation	12	12	12	12	High (16+)
7	Productivity	20	20	20	16	Low (5 – 9)

BAF risk	Summary risk title	Risk score (assessed quarterly)				Tolerance level
		Quarter 3 2025/26	Quarter 4 2025/26	Quarter 1 2026/27	Current Q2 2026/27	
8	Financial sustainability	12	12	16	16	Very low (1 – 4)
9	Capital expenditure investment	8	8	12	12	Very low (1 – 4)
10	High performing and future ready workforce	12	12	12	16	Moderate (10 – 15)
11	Organisational excellence	12	12	12	9	Low (5 – 9)
12	Research and academic ambitions	12	12	12	12	High (16+)
13	Climate change mitigation and adaption *(NEW)*	N/A – new	N/A – new	N/A – new	12	Very low (1 – 4)

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 (safe, effective, experience) of care	◆---------◆											✖			+12
3	Resilience of estates infrastructure	◆---------◆											✖			+12
4	Resilience of digital infrastructure					◆---------◆								✖		+11
5	Epic benefits realisation					◆---------◆					✖					+3
6	Organisational change and transformation										✖		◆---------◆			-4
7	Productivity					◆---------◆							✖			+7
8	Financial sustainability	◆---------◆											✖			+12
9	Capital expenditure investment	◆---------◆									✖					+8
10	High performing and future ready workforce									◆---------◆			✖			+1
11	Organisational excellence					◆---------✖										+0
12	Research and academic ambitions										✖		◆---------◆			-4
13	Climate change mitigation and adaption *(NEW)*	◆---------◆									✖					+8

* *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 (2) C&D mismatch (3) estate limitations (4) temporary disruption of service due to business continuity incidents (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 (8) challenging financial climate and reliance on unbudgeted additional capacity (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.

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 operational and strategic priorities.
- Downgrade from segment 1 in NOF.
- Reduced Board capability rating.
- Reduced scoring under new London Performance Management Framework (LPMF)
- Inability to meet financial plan. Under revised regime this will result in inability to reach above segment 3 which attracts significant intervention from NHSE and limitations to financial freedoms.
- 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.
- Reputational risk.

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

- Embedded performance framework with clear and effective delivery structure aligned to NOF.
- Centralised elective access team responsible for the Trust's data quality agenda and elective access best practice / training. Trust engaging in RTT "sprints" to support performance.
- Productivity programmes in place to support the most effective use of resources and the need to transform in order to meet strategic priorities. Ambulatory to feature as a key trust priority in 2025/26 and beyond.
- Sector working to support joined up approach to risk management and delivery.
- Additional weekend working where possible, supporting increased utilisation of the estate, including across elective (HIT lists, etc) and emergency (SDEC etc).
- Continued use of ISP working to mitigate risk to delivery across key areas.
- Supporting governance for health inequality agenda aligned to the regional agenda.

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

- Trust maintained segment 1 status for Q4 and ambition to maintain in 2026/27 under the new regime. Financial position high risk to future segmentation.
- Estate limitation remains.
- Additional premium capacity, including IS provision, carries significant cost and is not sustainable long term. Discussions ongoing about best approach moving forwards.
- Productivity programme needs to mature at pace in order to create capacity and release cost. CIP (particularly recurrent) identification and delivery a significant challenge.
- Health inequality agenda needs to continue to develop and mature at pace.
- Further support required to influence referring providers on the 62-day pathway which represent an area of challenge for the Trust. Cancer position fragile.
- A&E 4-hour performance challenged in Q4 25/26 and Q1 26/27.
- Need to revise IPR to ensure it is fit for purpose and aligns to Insightful Provider Board.

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

Tier 2 *(oversight of controls)*

- CG governance framework (including exec committees).
- Quarterly Exec-Exec Performance Review Meetings.
- Fortnightly Trust Operations Board as primary executive committee with oversight for operational performance.
- Quality and Performance Board Committee reviews performance in depth on a quarterly basis. Board in Committee review monthly.

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

- Contract monitoring infrastructure remains a challenge.
- Counting and coding.
- Financial ask and in turn risk increasing as outlined in planning process.
- Internal tiering status in place for RTT, diagnostics and cancer.
- Areas of non-compliance and in turn risk as identified in planning: ambulance handovers, community waiting list and long waits, cancer 62 day.

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. • Internal tiering introduced in RTT. • IPR reported quarterly to Exec-Exec PRMs. Holistic view of performance.	• IPR and internal performance reporting will need to reflect the new performance framework alongside other key national guidance. • Productivity programme to continue maturing at pace, targets to be signed off alongside quantification and wider potential impact on performance and quality. • Population health completeness levels in Epic low and needs focus to create actionable data so the Trust can make more informed decisions to improve care. • Areas struggling to deliver priorities: DM01 6 and 13 weeks, RTT waiting list, A&E 4-hour and community long waits. Cancer delivering plan but remains risk. • New NOF metrics proposed for 26/27+ which could impact the Trusts position.
Tier 4 *(external assurance)*	• Benchmarking through Model Hospital, working collaboratively via system and pan-London working (eg Learning Improvement Network & GIRFT) and clinical networks. • Segment one under National Operating Framework (quarterly review). Tier one status for Cancer, Diagnostics and RTT (bi-weekly meetings). • ICB monthly performance meetings. Contract monitoring board.	

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***
Set Q4 25/26: Assessment against new NOF metrics to understand potential impact for the Trust.	**JF / JJ (Q2 26/27)** 26/27 NOF guidance alongside the **draft** technical annex. Indicative assessment made against new NOF metrics with an overview due to be reviewed at TEC on 14 July and Q&P on 15 July.
Set 25/26: Revise IPR to ensure it is fit for purpose.	**JJ (Q2 26/27)** new reporting framework being constructed. Metric layer nearing completion, first output will be for the new NOF (Jul-26). Next key output that will mirror this structure will be the IPR. IPR metric review complete with domain leads in the wider context of the Insightful Provider Board guidance. Timelines to be provided in next update. Will be structured in new power BI premium environment.
Set Q4 25/26: Revise internal tiering / recovery programme where required across challenged areas proportional to risk.	**JF / JJ / SC (Q2 26/27)** delivery plans were drawn up and discussed in Q1 26/27, identifying the gap in meeting the Trusts operational planning commitments across all performance domains. Due to be presented with proposed mitigations at TEC / Q&P in Jul. Internal tiering arrangement remains in place for DM01, Cancer and RTT.
Set Q4 25/26: Install all operational planning targets, including activity, in all performance dashboards.	**JF / JJ (Q2 26/27) n**earing completion, majority of plans available to operational teams on Midas. Plan will also be embedded in new reporting framework (IPR etc).
Set 25/26: Launch of revised Future Ready to support the Trust reaching a sustainable position for the future.	**SD / VF/ DOB / JF (26/27)** FR to serve as an enabler to supporting the Trust in reaching its goal of returning to constitutional standards whilst delivering high quality care in a financially sustainable way. Productivity programmes to support required transformation and wider scheme to support in identification and delivery of recurrent savings.
Set 25/26: Trust continue to work in collaboration with the ICB and other system partners on the health inequality agenda.	**JJ (26/27+)** new programme of work developed under JK with a clear newly proposed governance structure (inc BAF risk) and an outlined approach to data infrastructure and performance and capabilities and training. Ambition to align to Trust strategy and operational and strategic priorities and ensure the Trust meets its commitments in a fair and equitable way.

Principal Risk 2: Due to variation in the consistency of quality governance, clinical effectiveness, and safety management systems, the Trust may not consistently deliver safe, effective and high-quality care across all pathways and services, resulting in avoidable harm, suboptimal clinical outcomes, poor patient experience and regulatory challenge.

Summary risk title:	**Quality (safe, effective, experience) of Care**	**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 (TRAC)	**Risk score, post-controls**	16 (Likelihood 4 x Consequence 4)
Executive director lead:	Avey Bhatia (Chief Nurse)	**Assurance level**	Substantial
Strategic objective(s) impacted:	Delivering Healthcare Excellence		

Potential causes and linked risks from the corporate risk register

- Variation in clinical effectiveness, safety monitoring and communication for patients across services and Clinical Groups.
- Gaps in delivering on improvements from learning events and proactive safety improvement activity aligned to Patient Safety Response Plan.
- Ineffective or inconsistent use of patient feedback and delays to responding to complaints as drivers of improvement.
- Insufficient oversight and mitigation of high-risk quality areas (e.g. mental health, infection prevention and control, device safety).

Linked risks from the Corporate Risk Register are:

RSK-1008	Suboptimal care and harm to mental health patients in the ED	**Red 20 ↔**
RSK-222	Insufficient Obstetric Theatre Capacity	**Red 16 ↓**
RSK-017	Governance of Medical Equipment and devices safety	**Red 16 ↔**
RSK-1059	Cross-site location of Paediatric Cardio-Respiratory & Intensive Care (CRIC) Services across RBH and Evelina sites.	**Orange 15 ↔**

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

- Avoidable patient harm and deterioration in outcomes.
- Reduced effectiveness and reliability of care delivery.
- Poor patient experience and increased complaints.
- Reputational and financial impact from regulatory action, enforcement or adverse inspection outcomes.

Key controls (tier 1 and 2 - *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.
- Patient Safety Incident Response Framework in place (reporting, investigations, sharing findings/learning and action delivery).
- Safeguarding and Infection Prevention and Control systems in place
- Patient feedback systems (complaints, PALS, experience) with response processes.
- Clinical Group governance systems and PRMs overseeing patient safety, effectiveness and experience, such as day-to-day incident and complaint management.
- Learning for Improvement Group (LFIG) overseeing PSIRF learning and improvement across the Trust. TRAC monthly meetings with delegated executive authority to oversee functions of clinical risk and assurance.

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

- Compliance with administrative pathway management on Epic (e.g. unsigned visits, untriaged referrals)
- Limited systematic prioritisation across clinical groups of highest-risk patient safety themes identified in Patient Safety Incident Response Plan.
- Timely completion and embedding of learning response actions
- Compliance with responding to complainants within Trust set timescales (these are within regulatory timescale of six months).

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

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

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; CQC Mock Inspection programme commenced in Q4, common themes around IPC, cleanliness and medicines safety. • Ward Accreditation programme in place with increasing number of wards gold and silver rated.	• Improved compliance on consistent basis to common themes identified through ward accreditation visits, mock inspections and quality assessments. • Reduction required to hospital acquired infections. • Gaps in sharing learning across clinical groups. • Amendments to PSIRP and Incident management policy approved by TRAC in Q4. Assurance on patient safety improvement relevant to Clinical group priorities. Gaps of improvement impact and sustainability in clinical groups. • Dependence on future CQC inspection outcomes for external validation.
Tier 4 (external assurance)	• Maternity services CQC inspection September 2022 rated 'good' overall but 'requires improvement' for safe. • 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. • CQC Inspection for UEC STH (Outstanding) and Guys (Good) in March 2026. Strong assurance for UEC and the Trust. • National patient surveys continue to be positive for GSTT.	

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 length of overdue complaints to below 30 days overdue by end of June 2026100 (first improvement target).	Clinical Group Executives / Q&A/ CNO / Corporate Departments			There are improvements in the length of time overdue with over 60 at 100 days plus in April 2025 to 6 over 40 days overdue as of June 2026.
Improve compliance measures for clinical guidelines in date, overdue learning response actions, duty of candour.	Clinical Group Executives / Q&A/ CNO / Corporate Departments			Improvements to clinical guidance compliance, duty of candour compliance and reduction in overdue actions continues. Requires continued effort and chasing to deliver on compliance.
Strengthen incident process to ensure executive oversight and ownership within clinical groups for escalation and delivery of learning response actions.	Q&A/ Clinical Group Executives / CNO			Incident pathway flowchart in progress and will be included within the revised policy. Learning for Improvement Group includes executive membership from each clinical group.
Strengthen improvement monitoring for Patient Safety Incident Response Plan priorities across the clinical groups.	Clinical Group Executives / CNO / Director of Quality			Improvement plan for PSIRP reporting and assurance into LFIG and across clinical groups.
Improve compliance to administrative patient pathway workflows.	COO's Office and Clinical Group Executives			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.

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 is set at £12m for 26/27, thus increasing 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. Limited decant facilities compound this risk.
- 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.
- Potential future enforcement notices from London Fire Brigade linked to funding constraints to undertake required fire remedial works to Borough Wing at Guy's.

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 has been investigated by the Trust's H&S team and the Health Safety Executive (HSE). The review led by HR is also nearing completion, with lessons identified to date informing the current Essentia Operational Services review.
- **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. 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

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.

necessary actions required to protect staff, patients and visitors. Project with support from clinical and IPC colleagues, has commenced to change Borough Wing to a water lite design by removing 110 sinks to reduce the bacteria risk to patients. • **Risk assessed estate backlog maintenance plan** in place, with targeted investment requiring approval at IPB & TMPB (annually). Resources established to support delivery of annual £12m programme. • **Estate backlog plan is refreshed annually** and managed by the Essentia Estate Board. • Works have commenced to **improve the standby power resilience at the Harefield Hospital** site and ensuring that the site has N+1 generators. Expected to complete Qtr1 2026.	

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 vs power resilience – as examples). However, review of risk ID 4728 is underway to create more granular site and system-based risks that will aide prioritisation of investment.
Tier 3 *(internal assurance)*	• Internal Audit has 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***
Review of the subcategories and assets of the Trust Estate Infrastructure risk is being reviewed by the teams.	Jonathan Forsyth	End of Q2 2026/27		A line by line review is underway on the subcategories and assets which contribute to the Trust's Estate Infrastructure risk. Over the last month, 8 risks have been closed out, with a further 9 due to be closed out during Q2 of 2026/27. Process for updating the infrastructure risk following investment either through the annual estate backlog fund and wider capital projects is being developed to provide a real time view of this Trust risk.

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 including** These include geopolitical risks, healthcare as a high consequence target, and emerging AI and zero-day threats 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.
Preventative Controls

- Secure authentication mechanisms (2FA/MFA) and NHS.net email service to prevent unauthorised access.
- Perimeter and data centre firewalls in place.
- Security patching of external and internal assets, plus supported desktop/server estate maintenance.
- Security review processes for digital solutions and cyber resilience measures.
- Supplier Cyber Risk Management to reduce third-party vulnerabilities.

Detective Controls

- Threat intelligence monitoring with actionable alerts.
- 24/7 Security Operations Centre (SOC) for continuous threat detection.
- Independent penetration testing by a CREST-accredited supplier.
- Server estate audits and continuous monitoring of key suppliers.

Corrective Controls

- Backup-as-a-Service (BAAS) for infrastructure recovery.
- Resilient dual data centres with failover of ATOS/EPIC tested every six months.
- Environmental improvements in GSTT Data Centres to maintain operational continuity.
- EPRR EPIC Ransomware exercise completed (Jan 2026)

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

- Backup As A Service (BAAS) in place. Issues with running low on backup credits with supplier. Contract re-negotiation underway. Improvements required for Disaster Recovery As A Service (DRAAS) or selection of a cost effective alternative.
- EPIC DR improvements (IRE) and testing of failover capabilities at TT data centres is required.
- Completion of programmes including the Strategic Network Programme (SNP) to deliver improved Network security work now in BAU for GST networks. RBH network infrastructure requires attention alongside resilience measures.
- Bedding in and tuning of firewall security monitoring for zero day and AI threats.
- Work progressing with decommissioning, Upgrade, Replacement of remaining, reduced from 6.6% to 3.6% legacy server estate. Note Items going out of support will increase our unsupported estate over the next quarter.
- Upgrade of Windows 11 23H2 to 25H2 pilot complete and rollout underway for November 2026 completion.

	• Improvements made in the automation of patching and scheduled reboots for internal facing DT&I Infrastructure server assets. Further work underway for legacy clinical servers. • Updated scanning tool procured and modernisation and Improvements to internal vulnerability scanning and remediation prioritisation underway. • Modernisation of Joiner, Mover, Leaver (JML) practices needed post nhs.net deployment. Practices are under review for RPA. • Scheduling of ATOS/EPIC Penetration test.- Post April EPIC Upgrade (MyChart April 2026/ EPIC Components Oct/Nov 2026).
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, 2. Audit Committee Updates, 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 25/26 'Standards Met' (June 2026) substantial assurance rating, **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, 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. Independent Penetration Testing** – Trust Infrastructure and Supplier Systems (CREST Accredited Pentester) (July 2026) **2**. **UpGuard Reports** (continuous monitoring security posture scores for GSTT and critical suppliers) – Trust is now scoring an **A grade** for its security posture. **3.** Microsoft Security Scores (Medium Cyber Security Exposure) and Assessment reports to identify improvement opportunities in our infrastructure. (July 2026) **4. External IT Audit** covering cyber security carried out for year ending 31st March 2025. Rated Green – IT controls relevant to the audit of financial statements judged to be effective at the level of testing and scope**. 5. Evelina ICO Audit -** An independent review of by the ICO of our Cyber Security Management was completed in February 2026 as part of a review of the Evelina – The report provided High assurance on the cyber controls in place. **6. External HIMSS INFRAM assessment** (July 2026) assessed the Trust as meeting maturity Level 6.

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***
Recovery and Operational Resilience (Sub Actions – DRAAS, Cyber Incident Exercises).	Omar Perreira-White	**DRAAS:** 31/12/2026 **Incident Testing:** 31/03/2027		Systems onboarded to our new BAAS solution. Contract re-negotiation underway. Next stage of the programme identifying the DRAAS element / or financially viable alternative of the solution. One test has been held in 2026 further Cyber Incident response testing for this financial year being arranged.
Recovery and Operational Resilience (Sub Actions TT Failover and EPIC IRE).	India Brummitt / Ben Fidler	**IRE:** 31/03/2027 **TT Failover:** 31/12/2026		Awaiting decision on IRE environment for EPIC. ITCS are working with TT to arrange data centre switch over testing with to give assurance on the availability of shared clinical applications at. This will be on similar basis to the ATOS 6 monthly failover approach. This is currently not in the TT contract and discussions are underway between ITCS and TT to progress.

Legacy Technical Debt (AD GST/RBH Integration, Unsupported Servers, Legacy email retirement, Citrix retirement, Windows Desktop refresh).	Omar Perreira-White	**Legacy Servers <= Win 2012:** 31/10/2026 **Windows 2016:** 31/12/2026 **Mail forwarding and Citrix:** 31/12/2026 **Windows 11 25H2:** 10/11/2026		Current Status: Working with system owners within Trust financial constraints to decommission, upgrade or replace infrastructure items. **All Servers: 1,606** of which total **Legacy Servers: 514 (32.0%).** **Legacy Breakdown** **Pre Windows 2012 Out of Support : 58** (3.6 % of all servers | 11.2% of legacy servers). **Windows 2012: 190** (11.8 % of all servers | 37% of legacy servers). **Windows 2016: 266** (16.6% of all servers | 51.8% of legacy servers). In addition, further work is ongoing on legacy email elements post migration of email to central tenant, retirement of internal unsupported servers, and replacement of the aging and unsupported elements of the CITRIX environment during this quarter. Desktop/Laptop refresh to Windows 2011 25H2 is currently in progress for completion by November 2026. **Total Devices: 27,098** • Upgraded: 7,697 (28.4%). • Exempted: 1,500+ (5.5%+ Known software compatibility issues). • Under investigation: 2,500+ (9.2%+ H/W and other S/W incompatibility). • Remaining (In Progress): 15,401 (56.9%) ex*cluding exempted and devices under investigation.*
Vulnerability Management modernisation (VM Group, Vulnerability Risk based prioritisation).	Paul Merison	31/10/2026		Terms of Reference for a new Vulnerability Management Group have been drafted. Cyber Operations and Infrastructure teams have built the new Vulnerability management platform, and this is being populated with data and system priority ratings. This will enable us to focus remediation resources to the most critical areas and assets.
Identity and Access Security (Privileged Access Management (PAM) Solution and Joiner, Mover, Leaver (JML) Processes).	Omar Perreira-White	**PAM:** 31/12/2026 **JML:** 31/03/2027		PAM platform has been built. Testing is underway ahead of deployment by Infrastructure team this quarter. Service Desk JML Processes requiring improvement and addressing of nhs.net email JML processes. Initial short term improvements completed. Planning underway to automate with RPA.
Firewall Advanced IPS/IDS Monitoring (Zero Day and AI Threats).	Omar Perreira-White	31/08/2026		New Firewall functionality implemented, tuning underway and data under review. This is a key activity to drive risk reduction this quarter.
Medical Device and Clinical Infra Security (Validation of network segmentation and remote device access).	Omar Perreira-White	30/09/2026		Under review to obtain assurance that clinical device networks are segmented and monitored, with approved remote access only.
Supplier and Third-Party Risk (Cyber Risk Integration with Supplier performance, supplier continuous monitoring).	Paul Merison	31/10/2026		QBR Meetings attended and additional assurance data sought on supplier patching and vulnerability management. Continuous monitoring in place.
Board Level Assurance (Cyber Resilience Dashboard DSPT/CAF).	Paul Merison	31/12/2026		Currently reviewing opportunities to further improve board assurance data for Digital Governance Board and Digital Operations Board using data from our new security features and toolsets.

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 (e.g. productivity metrics) and Quality (e.g. 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*)

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

Tier 2 *(oversight of controls)*	• Monthly Benefit Delivery Group to track delivery progress.

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

- None

	• Monthly Programme update and Year to date benefit realisation position reported to GSTT Apollo board. • Close alignment between Epic Benefit Delivery Group and Financial Improvement Group. • 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).	
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***
Increase Epic Benefit Programme focus on non-financial benefits.	Georgina Charlton/ Simon Mendy	31/12/26	In Progress	Aug 26- Review of Economic FBC benefits in partnership with Trust performance team.

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:	Julian Kelly (Chief Strategy and Transformation Officer)	**Level of assurance**	Substantial
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.	• 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.
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.	

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***

Regular reporting on portfolio resourcing to identify where key initiatives are under-resourced or under-funded.	Tom Davies	Ongoing	In Progress	Update paper taken to TAAG to set out the benefits of this exercise and the support required. A project 'kick-off' meeting has taken place to engage stakeholders from delivery teams and to begin the process of collecting data.
Review of Capital Governance.	Tom Davies	September	In Progress	An update is going to IPB in September to assess the effectiveness of capital governance. The analysis undertaken shows the effectiveness of governance in place and highlights the risks of expedited governance where undertaken. Outcome of this paper will determine next steps and governance changes required.
Delivery Project Delivery productivity workstream.	Tom Davies	November	In Progress	This workstream of the productivity programme is now in delivery phase having been through Design Authority. In the coming month new structures and ways of working will be implemented. This will enhance controls providing a dedicated support to each clinical group, independence and consistency in treatment of Major Programmes and oversight of project delivery.

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)**	16 (likelihood 4 x consequence 4)
Executive director lead:	Steven Davies (Chief Financial and Investment Officer)	**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

- 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:

RSK-015	Insufficient theatre capacity to meet demand impacting on safe and timely patient care	15
RSK-011	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 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 (the trust's CFO) and each of the 5 workstrands has an executive sponsor and a programme director.
- All programmes workstrands have established trust-wide programmes set up and are starting to deliver tangible change.
- Executive productivity report, including holistic dashboard covering finance and clinical operations to measure impact of programme has been shared with Execs and will be reviewed at TEC and Productivity Steering Group on a regular basis.

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

- Productivity programme workstrands need to continue to mature and set out roadmaps for the next phase of their delivery.
- In recent months the Trust has benchmarked well for productivity Model Hospital reports +8.0% at M12 25/26 compared with +3.3% for peer organisations. However, we are -8.1% below 19/20 levels (M12 25/26 data) and controls are not yet fully effective. Our cost base remains c.14% higher than peers (NCC data).
- Work is ongoing to set out the trust's transformation plan of which productivity programme activities will be a key part; a first draft is due later this calendar year.

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 workstrand. It reports to the Trust Executive Committee. • Theatre and flow productivity metrics including model hospital data is reported monthly. • Board-level oversight from independent non-executive directors in the Transformation and Major Programmes Committee.	• The reporting dashboard for the programme has been established and needs to evolve and mature to clearly demonstrate improvement and progress for all workstrands. • An external consultancy provided expertise (including non-NHS experience) and advice to the administration workstrand, to ensure we learn from industry best practice. • Consultancy support was also being provided to the private patient workstrand to provide external expertise to support development of the strategy and understanding of the opportunity.

Tier 3 *(internal assurance)*	• An internal audit review of the Flow Programme has recently completed focused on delays to discharge and alignment with programme focus.	
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***
Maturing the productivity programme - Finalise roadmaps, key deliverables and milestones for all workstrands and track progress against these. - Workstrand level governance to mature (e.g. ambulatory board to started in early 26/27, private patient forum to be established). - Overall programme governance to mature with regular reporting on progress including KPIs via highlight reports to take place for all workstrands. - Continued review of the ambition and pace of delivery within workstrands.	Exec SROs for workstrands	October 26		All workstrands are mobilised with identified areas of focus, key deliverables and core KPIs. **Ambulatory** has held kick off meetings with services to start work across 12 specialties as wave 1 of the ambulatory transformation plan. The **Admin** Design Authority has approved models for a number of areas and consultation with relevant staff has started in clinical admin and some corporate areas. Following an extensive strategic review, a new **Private Patients** strategy has been approved by the board and is moving to implementation. **Flow** continues to focus on length of stay reduction, a GSTT Flow Manual, establishing a Trust-wide framework for consistent inpatient flow has been developed and will be launched in September. .
Sustaining Trust-wide engagement in Future Ready to ensure staff understand the choices and decisions the trust has to make and are aware how they can support and what actions to take.	Anita Knowles/ Steven Davies	Q4 26/27		Staff recognition scheme launched in May to encourage ideas and improvement activity across the trust. Improvement activity across the trust has been brought under the Future Ready campaign banner and is being championed locally as well as through trust wide channels. Colleagues are expected to include a Future Ready objective in their PDR conversations.
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	Q1 26/27		Targets and directional indicators have been added to the executive productivity report which provides a monthly overview of key productivity metrics at trust and clinical group level and is themed by the productivity programmes.
Reflecting and aligning the productivity programme activities within the trust-wide transformation plan (due later in 2026).	Julian Kelly	Q3 26/27		Productivity programmes have been reflected in initial mapping for the transformation plan and there is ongoing work to align and include these where appropriate in the development of Trust-wide transformation priorities and goals.

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)**	16 (likelihood 4 x consequence 4)
Executive director lead:	Damien O'Brien (Executive Director of Finance)	**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 2026/27 commissioner contract status, alongside operational performance recovery expectations. • 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. • Allowance for commissioners to 'deconstruct block contracts' further exacerbates core income risk. • 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, now progressed to Trust-wide 'Future Ready' programme. • Pursuit of further commercial opportunities including refreshed private patient strategy. • Leading role in system sustainability work and within the APC.	• 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. • Continued instability and pace of change within commissioner organisations • Uncertainty over commissioning of specialised services and disparate / differential approach to the commissioning of specialised services across England.

• Commencement of APC 'Acute Services Review' led by Carnall Farrar. • Strength of relationships with SEL ICB, universities and charities. • Additional external consultancy support commissioned to support acceleration of identification, development and delivery of CIPs. • Initiation of run-rate reduction exercise in July and August.		
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 2026/27. • 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 O'Brien	Ongoing		
Continue to recover and grow non-NHS revenue streams, in particular private patients to mitigate core NHS funding constraints.	Damien O'Brien	Ongoing		Private patient strategy on FCI agendas.
Continue development of programmatic approach to efficiency and improvement.	Damien O'Brien	June 2025		Productivity programme established / additional external consultancy support commissioned.
Focus on finance training for operational and clinical managers.	Hazel Childs / Catherine Eyre	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.

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)**	12 (likelihood 3 x consequence 4)
Executive director lead:	Damien O'Brien (Executive Director of Finance)	**Level of assurance**	Limited
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. • Medium Term Capital Plan's reliance on material recurrent slippage, unconfirmed national funding and limited flexibility due to major programme commitments. • Challenges in maintaining aged infrastructure (both physical and digital) whilst delivering on strategic objectives and Major Programmes. • 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. ***There are no linked risks from the corporate risk register.***	• Increased the likelihood of estates-related incidents and digital-related incidents. • Risks planned to be mitigated through capital are not addressed leading to lack of CDEL 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 covering 5-year period to 2030/21 endorsed in March 2026. • 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. • Enhanced forecasting, tighter early-stage controls and closer scrutiny of delivery risk to identify and manage slippage early. • Active engagement with NHSE to secure timely approvals and identify any in-year funding opportunities early to support cash and CDEL compliance. • 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)*	• 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 2026/27 plan.	Alex Munn	November 2026		Cash application due to be submitted by August.
Capital cash support application required in order to finance existing capital plan.	Catherine Eyre	July 2025		CLOSED. £48m drawn down in December 2025.
Challenge of capital expenditure forecast delivery and CDEL mitigations.	Catherine Eyre	November 2025		CLOSED – covered in October's exceptional IPB. Due to deliver balanced capital position in 2025/26.
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		CLOSED. We attend monthly APC Capital Finance Group meetings to discuss medium term planning and other risks.
PDC drawdown.	Alex Munn	February 2026		CLOSED We received £43m of cash relating to PDC awards in March.
Refreshed 2025/26 mitigations list to support IPB decisions from Month 10.	Alex Munn	February 2026		CLOSED Updated mitigation schedule discussed with CFO and programme leads in February.

Principal Risk 10: Insufficient workforce enablement, development and transformation impairs the Trust's ability to achieve the right people capacity, capability and future-ready organisational culture needed 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)**	16 (likelihood 4 x impact 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.
- Necessary change and / or the delivery of it is resisted or disputed.
- 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, engagement, advocacy and delivery success.
- Poor colleague experience impacts 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.
- New PDR cycle embedding values, objectives (including dedicated Future Ready objectives), and career conversations (2024/2025 completion rate was 91.5%). We have refreshed the PDR this year based on feedback for an improved user experience.
- 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 maturing plans to embed.
- Line manager capacity and commitment to complete core training including PMP. Target for 26/27 is 90%, prioritising local areas of high impact.
- Consistent leadership advocacy for necessary change.

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

Tier 2 (oversight of controls)	• People & Capability Executive: Collective ownership and overall responsibility for the delivery of high-quality services provided across the people agenda.

Gaps in assurances (*further evidence required about effectiveness 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 priority 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 Monthly reporting: Workforce metrics (turnover, vacancy rate, stability index, PDR & Stat/Man Training compliance.	• Inclusive Recruitment – Regular analysis of the candidate experience and other success measures to 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 requires further maturation and oversight 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***
Inclusive Recruitment (improvement) Programme.	Andrea Williams-McKenzie	To revise		New Trust-wide oversight group established to oversee delivery of agreed high impact actions – target date May 2027.
Policy review through EDI Lens to improve the sense of belonging and retention.	Andrea Williams-McKenzie	Complete		Process established to ensure no policy is approved by the Pay & Policy Forum without an accompanying EQIA.
Finalise and launch EDI Delivery Plan 2026 – 2031.	Kate Tilley/ Savita Rana	Sept 2026		Pan-Trust engagement and input into the co-creation of this plan near complete, enabling a target date for launch aligned to national inclusion week 2026.
27% reduction in funding for the SWCAY grant review of impact currently underway.	Helen Kay	Ongoing		Ongoing review on track to manage grant reduction impact with further restructure/reduction within delivery team underway to increase efficiencies and contain spend within charity funding envelope.
Redesign/streamlining of staff wellbeing psychology service underway.	Helen Kay	Complete		New OH Psychology Service structure and operating model was implemented mid-March 2026. Candidate loss means recruitment to key leadership roles remains ongoing but is mitigated via direct line management from the OHSWB Director of Nursing.

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)**	9 (likelihood 3 x impact 3)
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 submitted to Board-in-Committee on 17 December.
- The Trust has responded 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.
- Green Plan has been launched with associated Delivery Board to ensure that our sustainability priorities are given the necessary resource and commitment to achieve desired outcomes.

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

- Agreement needed on oversight of improvement plans and where progress will be reported and how escalations can be made.
- Lack of an integrated document management system housing all corporate and clinical policies and guidance that is accessible to all staff.
- 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 draft quality statements have now been published and subject to a formal consultation. The post-consultation quality statements have not yet been published.
- Uptake of Board site visit programme remains variable and is being reported on routinely through TEC.

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- Increased Board visibility through a refreshed site visit programme, regular senior leader events (at corporate and clinical group level) and monthly all-staff briefings.
- Formal review of our governance and operating model has been undertaken at pace by Teneo, including our Scheme of Delegation and Accountability & Performance Framework. The findings of this review are being considered with updates to our internal governance arrangements pending.
- Weekly tactical meetings and monthly Oversight & Delivery meetings have been established to direct, track, and monitor our necessary readiness plans for the ongoing CQC inspection.
- Improving Together and Future Ready established as bespoke initiatives within the Trust to ensure that organisational excellence, quality improvement, and productivity are key focuses throughout the organisation.
- Formal application in September 2026 to become an Advanced Foundation Trust, with substantial evidence base developed to support this. While AFT status may offer the Trust additional freedoms, it would also reflect wider confidence in GSTT's leadership and performance; the evidence base and supporting statements also has significant overlap with Well-Led criteria so this exercise has also functioned as a self-assessment against much of this.

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<tr><th colspan="2">Key assurances (evidence that the controls are effective)</th><th>Gaps in assurances (further evidence required about effectiveness of controls)</th></tr>
<tr><td>Tier 2
(oversight of controls)</td><td>

- 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 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.

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- Dashboard providing key performance indicators against CQC domains is in development but has not yet been optimised.
- 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.
- Not all demographic data is available from Epic, restricting the ability of the Trust to fully understand its impact on health inequalities.

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<tr><td>Tier 3
(internal assurance)</td><td>

- 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.
- Throughout 2026, internal mock CQC inspections have been conducted throughout the organisation with feedback provided to Clinical Groups and the themes included in Trust-wide communications.

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<tr><td>Tier 4
(external assurance)</td><td>

- 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.

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	• External review of our governance and operating model conducted in 2026 with the recommendations submitted to the Board.	

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 finalise well-led improvement plans in a timely manner to address the identified gaps, and to iterate evidence bases and collation of documents to demonstrate Well-Led performance.	Simone Akuffo-Akoto	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, Ashley Parrott	4 months		Supplier has been on-boarded but project has been paused to review whether the proposed product is capable of meeting our needs. A detailed options appraisal is being conducted internally.
Development and deployment of an organisational excellence model within the Trust.	Simone Akuffo-Akoto, Ashley Parrott, Ronny Cheung, Laura Gudefin	2 months		Focus will be on the development of a quality management system pending the publication of NHS England's guidance on this, but wider conversations about the organisational excellence model are ongoing.
Ongoing mock inspections at both core service and Trust-wide Well-Led level to enhance readiness and preparedness as part of the ongoing CQC inspections.	Gemma Craig, Ashley Parrott, Cindy Sethi, Simone Akuffo-Akoto, Harry Richardson	3 months		Regular, ongoing reporting each TEC meeting; mock inspections have been completed across all sites and Clinical Groups and the findings shared with local areas. A self-assessment tool has been developed and shared with all clinical services for them to conduct their own reviews.
Trust-wide communication and engagement to clarify expectations and awareness of ongoing CQC inspections.	Anita Knowles, Michael Carden, Sarah Clark	3 months		Intranet landing page created, staff guide completed, 2x all-staff briefings undertaken with further work planned.

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:	Board-in-Committee	**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:	Ian Abbs (Interim CMO), Mark O'Neill (Medical Director)	**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 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).	• 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.

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 the 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.	Ian Abbs/Mark O'Neill	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.	Ian Abbs/Mark O'Neill	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.

Principal Risk 13: There is a risk that financial and delivery-capacity constraints and the need to maintain operational performance mean that the Trust is unable to meet the legally binding net zero targets for direct emissions by 2040 and indirect emissions by 2045, or to adapt sufficiently to the known impacts of climate change. This could disrupt services by overwhelming capacity, damaging infrastructure, breaking supply chains and adversely affecting staff wellbeing, directly impacting patient care.

Summary risk title:	**Climate change mitigation and adaptation**	**Date added to BAF**	September 2026
Board committee owner:	Board in 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:	Tendai Wileman (Chief of Staff)	**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*)**
The Trust faces significant challenges in achieving net zero targets (3% reduction in direct carbon emissions and 5% increase in indirect carbon emissions in 2024/25 compared to 2023/24) and in adapting its estate and services to the impacts of climate change to ensure operational resilience. • Climate change is not embedded into Board, executive or clinical/corporate group-level decision making to enable Green Plan and Climate Change Adaptation Plan delivery, and governance, strategy and risk management processes (and associated metrics/targets) have not been developed to a stage where prioritisation, resource and scrutiny of progress take place. • Ongoing focus on operational performance, workforce and capacity issues and financial challenges deprioritise sustainability and long-term planning. • Current and planned levels of resourcing (finance and people) are insufficient: there is a reliance on a few staff with sustainability in their job descriptions to implement change, and a reliance on external funding to deliver the sustainability programme. • Ageing building fabric and estate infrastructure that is prone to overheating and a lack of funding to decarbonise and adapt the estate. • Over 60% of the Trust carbon footprint is linked to its large and complex supply chain, which is difficult to understand and influence. • Culturally favourable decision-making instead of evidence-based decision-making hinders progress e.g. an over-reliance on disposable equipment and the reluctance to make change at pace, even where it has been successful in other Trusts. ***There are no linked risks from the corporate risk register yet.***	• Regulatory action against the Trust for failure to comply with Health and Care Act 2022 regulations with financial and reputational risks to the Trust including failure to secure or extend contractual agreements. Extreme weather events can lead to: (heatwaves, floods, storms and cold) • Compromised clinical productivity, patient and staff safety, and patient experience when key assets fail including heating, cooling and ventilation (HVAC), electrical distribution and water safety. E.g. power outages and failures of critical equipment including CT/MRI machines and HVAC systems in surgical theatres leading to delays in surgery/procedures, delayed blood tests and diagnostic imaging and a forced shift to paper-based operations (as happened in Jul 22). • Acute and emergency service disruption due to emergency department overload from spikes in patients suffering from heatstroke, cardiovascular issues and respiratory problems. • Temporary closure of facilities further impacts elective activity and operational productivity, and interrupts care for patients with chronic conditions. • Shortage of medical products because of disrupted supply chains. • Staff health and wellbeing impacted from physical heat exhaustion and mental health strains from increased operational pressures and infrastructure failures. • Organisational reputational risk should there be a major/catastrophic impact to staff/patients/visitors related to a failure to adapt to climate change.

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*)**
Appointment of Net Zero Board Lead: to drive forwards the sustainability agenda and promote environmental considerations. **Green Plan to 2028:** approved and launched in Jan 2026, following extensive staff consultation process and comprises 10 focus areas: Workforce and leadership, Net zero clinical transformation, Digital transformation, Medicines, Travel and transport, Estates and facilities, Supply chain and procurement, Food and nutrition, (Climate change) Adaptation and Air quality. Over 100 KPIs have been identified for the Green Plan. Completing all KPIs is predicted to significantly progress the Trust with meeting its net zero and climate change adaptation requirements. **External funding:** Over £1.5 M secured in 25/26 to deliver the sustainability programme from GSTT Foundation, Department for Energy Security and Net Zero, Department of Health and Social Care, Department for Transport, Centre for Sustainable Healthcare and NHSE.	To shape subsequent delivery windows, the Trust should commission a quantified gap analysis by 2028, which will compare progress to date to the system-wide net zero and climate change adaptation targets and identifying revised delivery milestones and timelines to 2040 and 2045. Further development of proposals to embed Green Plan KPIs into annual staff appraisals. Process for embedding sustainability requirements into governance and decision-making at board level and clinical/corporate group level are yet to be developed – reliance on goodwill and choice, and pockets of good practice.

Staff resource: Securing the funding above and implementing sustainability projects are the result of investing in staff with sustainability as part of their job descriptions. Project examples include: • Roll-out of reuse schemes including Walking aids reuse scheme, reusable sharps containers and Gloves-off campaign in 2025-26 Decommissioning of all remaining piped nitrous oxide systems in 2026 • Deployment of EV charging infrastructure across 7 sites in 2026 • Installation of solar photo-voltaic across 5 sites in 2026 • Implementation of Healthy by Nature programme to provide preventative care sessions for 3000 patients planned between 2026-28. **Carbon hotspots:** Energy consumption accounts for 93% of the Trust's direct carbon emissions. An Energy-as-a-Service model was developed in partnership with commercial, legal, specialist procurement and technical partners, with the main objective of decarbonising and futureproofing GSTT's building energy. A competitive dialogue procurement process took place throughout 2025 and a preferred bidder identified. The proposed solution will use a low temperature hot water system combined with air source heat pumps, and a future potential connection to a district energy network. Carbon reduction plans project over 50% operational CO_2 equivalent reduction by 2029, which, if achieved, would exceed NHS net zero targets.	Robust measurement and academic evaluation to help quantify the impact of the actions the Trust is taking Net Zero Leadership training to equip senior leaders and staff with the tools to lead, accelerate and measure progress towards the Green Plan

Key assurances (*evidence that the controls are effective*)		**Gaps in assurances (*further evidence required about effectiveness of controls*)**
Tier 2 *(oversight of controls)*	• Green Plan Delivery Board (GPDB) has senior representation from most clinical and corporate delivery groups. The GPDB meets every two months and reports biannually to TEC. The GPDB is chaired by the nominated Board-level Net Zero lead, whose role is to drive forwards the sustainability agenda and promote environmental considerations through the GPDB and its members.	• Formal reporting activity for Green Plan Delivery Board members not yet fully developed. • Formal reporting activity for Clinical group level networks / groups not yet developed. • Evidence based assurance not always available (e.g. through data/internal audit) • Lack of assurance on compliance with relevant environmental legislation. • No current method in place to monitor our resilience to climate change and extreme weather-related events. • No current method in place to integrate climate impacts into healthcare planning. • Resource and expertise very limited or not in place to assess sustainability data quality for data sources from other Trust departments or suppliers.
Tier 3 *(internal assurance)*	• Clinical group level: there are several sustainability networks/groups in across the clinical groups e.g. Green TAP and Green ED. • Trust-wide (facilitated by the Sustainability team) e.g. Travel & Transport working group and Climate Change Adaptation working group.	
Tier 4 *(external assurance)*	• CQC Well-led. • Task Force on Climate-related Financial Disclosures (TCFD). • Greener NHS Data collection. • Estates Return Information Collection (ERIC). • Premises Assurance Model (PAM).	

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***
Controls: Appropriate checks and balances developed for Green Plan Delivery Board (GPDB) including a Green Plan KPI tracker and TCFD assessment process, and for all working groups that report into the GPDB to provide assurance on progress.		Q3		Green Plan KPI tracker is under development with colleagues from Health Informatics and Planning & Performance. GPDB Strategic Leads are in the process of Green Plan KPI prioritisation for their own Focus area, as well as setting up working groups to lead on these priority KPIs.
Integration: integrate sustainability into all critical functions across corporate and clinical groups, to promote shared responsibility across the Trust through the development of a sustainability impact assessment process for new major		Q3-4		Links to Green Plan included in appraisal paperwork to inform staff objectives.

business plans and by embedding Green Plan KPIs into annual staff appraisals.				
Forecasting: Understand how far along the net zero journey and climate change adaptation journey delivering the Green Plan will take us, by commissioning a quantified gap analysis.		Q3		TBC.
Direct carbon footprint: Address the largest contributor to the Trust direct carbon footprint by implementing the Energy-as-a-service framework.		Next stage in progress		Contract signed with industry partner and detailed planning underway.
Training: Deliver Net Zero Leadership training to equip staff with the tools to lead, accelerate and measure progress towards our Green Plan to 2028.		Q3		Development session facilitated by the Centre for Sustainable Healthcare planned for 26 October for GPDB members. Will also be open to other staff.

Committee name	Academic Committee in Common
Date, time	Wednesday 8 July 2026 and Tuesday 6 October
Venue	King's College Hospital and Guy's Hospital
Chair	Graham Lord

Research funding and infrastructure: The partnership secured the National Institute for Health and Care Research (NIHR) London Applied Research Collaboration (ARC) award in 2026. The themes of the London ARC are Neighbourhood Health and Social Care; Prevention and Early Intervention; Productivity and Growth; and Data Science, AI and Predictive Analytics for Applied Health Research. Two complementary Biomedical Research Centre applications, led by Guy's and St Thomas' and South London and Maudsley NHS Foundation Trusts respectively, have also been submitted, with NIHR outline feedback is expected in December. The Committee continues to oversee the strategic alignment, governance and risks associated with these significant funding opportunities.

Clinical research delivery: Both the July and October meetings reviewed progress towards the national ambition of establishing clinical trials within 150 days, emphasising the need for sustained improvement while maintaining research quality and patient experience. An independent review of the Clinical Trials Office led by KPMG is nearing completion, and its findings are expected to be presented to the Committee in January.

Education and clinical academic workforce: The principal strategic discussion in October focused on capacity building and education, including financial pressures affecting educational provision and the need for stronger joint oversight. Implementation of the Clinical Academic Memorandum of Understanding between the organisations is continuing, with a focus on removing barriers to clinical academic careers across all professional groups. Further work is also under way in relation to honorary academic appointments.

Biobanking governance: The Committee identified the need to strengthen the governance, financial arrangements, access controls and management of potential conflicts of interest relating to the King's Health Partners Cancer Biobank. Partners are developing a joint approach to address these matters and establish arrangements that could be applied more widely.

Partnership governance: Revised ACiC Terms of Reference endorsed by the Committee are progressing through partner governance processes. The revisions reinforce the Committee's role in providing collective strategic oversight, identifying shared risks and escalating matters requiring action by partner organisations.

Overall position: The Committee provides an increasingly important forum for addressing matters that cannot be resolved effectively by individual organisations. The Trust's priorities remain to maintain research competitiveness, strengthen clinical academic capacity, support sustainable education and research infrastructure, and secure effective cross-partner governance.

Committee name	Quality and Performance Committee
Date, time	Wednesday 15 July 2026, 1.30pm – 4.30pm
Venue	Robens Suite, Guy's Hospital
Chair	Pauline Philip

Patient Story: A powerful patient story highlighted exceptional multidisciplinary care and family support provided following a child's emergency admission with severe sepsis, while also identifying the continued importance of vigilance in medication administration processes.

Board Assurance Framework (BAF): Consideration was given to the principal strategic risks within the Committee's remit, including operational performance, quality and safety, and estates infrastructure, which remained under ongoing oversight.

Feedback from Trust Site Visits: Positive feedback from recent site visits provided assurance regarding leadership visibility, staff engagement, service performance and patient experience during periods of operational change.

Clinical Group Assurance Reports: Detailed assurance was received from all Clinical Groups, highlighting learning from serious incidents and Never Events, progress in strengthening patient safety arrangements and ongoing management of key operational and quality risks, including chemotherapy capacity, maternity services, organisational learning and surgical safety.

Quality and Safety: Strong assurance was received regarding quality and safety performance, reflecting significant improvements in complaints management, duty of candour compliance, patient safety learning and regulatory performance, while acknowledging ongoing risks requiring active management.

Operational Performance and Activity: Performance updates demonstrated continued progress in cancer recovery, pathology services and oversight performance, although significant challenges remained in urgent care, diagnostics, referral-to-treatment waiting times and surgical capacity.

Maternity Quarterly Assurance Report: Assurance was provided on maternity and neonatal safety, governance and quality, alongside recognition of increasing national scrutiny and the continuing risks associated with obstetric theatre capacity and service demand.

Post-Death Care: Confirmation was provided that the Trust met NHS England post-death care assurance requirements, although ongoing operational risks relating to mortuary services, workforce capacity and sample traceability remained subject to close monitoring.

Patient Death Review Update: Progress in implementing recommendations arising from an external peer review demonstrated strengthened governance arrangements, improved incident oversight and a growing organisational culture focused on learning and continuous improvement.

Information Governance Update: Assurance was received that information governance risks with potential patient safety implications were being actively managed through strengthened controls, system improvements and a wider transformation programme.

Estates Update: Significant progress was reported across water safety improvements, cleaning services and environmental standards, providing assurance regarding the continued management of key estates-related risks.

Board Assurance Framework – Quality & Performance Risks: Review of the Board Assurance Framework confirmed that operational performance risks remained elevated, while quality and safety risks were stable and estates risks continued to be mitigated through ongoing improvement programmes.

Statutory and Regulatory Reports: The statutory and regulatory reports presented to the Committee were noted, with assurance taken from the detailed discussions held earlier in the meeting.

Chief Medical Officer Arrangements: Assurance was provided that interim Chief Medical Officer arrangements maintained appropriate statutory, legal and regulatory oversight pending the appointment of a substantive post-holder.

Guy's and St Thomas'
NHS Foundation Trust

Committee name	Finance, Commercial and Investment Committee
Date, time	Wednesday 29 July 2026, 2pm – 4pm
Venue	Virtual via Microsoft Teams
Chair	Simon Friend

Financial update: The Committee received an update on the financial position of the Trust at the end of the first quarter of the 2026/27 financial year, which was reported as broadly in line with the plan. However, a more ambitious approach to improving productivity and efficiency was needed to ensure recurrent savings were delivered through the Cost Improvement Programme (CIP) to improve the underlying financial run rate to achieve the planned breakeven position at year end.

A strengthened recovery programme was therefore being progressed, including targeted improvements to financial controls, specialist support to clinical groups, better use of patient-level costing data and the proposed appointment of a dedicated Recovery Director. The need for visible executive leadership, clear communication with staff and prompt sharing of successful approaches to service redesign and productivity improvement were emphasised.

Commercial income continued to grow, supported by private patient and estates-related activity, and education income remained stable. A report on international commercial opportunities and next steps would come to a later meeting.

Private Patient Strategy Development: An update was received on the development of the Trust's Private Patient Strategy, with work having moved from strategy development into implementation. The proposed approach brought together governance, organisational capability, investment decisions and corporate support within a single delivery programme to ensure a coordinated approach to implementation.

The emerging strategy focused on two key priorities: strengthening the Trust's internal operating model to maximise the existing private patient offer and developing external partnerships to support future growth where this could not be achieved by the Trust alone.

Alongside the development of the strategy, work continued to improve existing private patient services, including initiatives to harmonise billing and pricing arrangements and strengthen the overall patient offer.

Contract Approval: The Committee approved a three year contract for the delivery of Electrophysiology services

Committee name	People, Culture and Education Committee
Date, time	Wednesday 2 September 2026, 2pm – 5pm
Venue	Robens Suite, Guy's Hospital
Chair	Miranda Brawn

Review of Action Log and Matters Arising: The Committee closed actions relating to the Equality, Diversity and Inclusion (EDI) Plan, Board Assurance Framework (BAF) review and Brawn Review, noting that further consideration of the Brawn Review by the EDI Improvement Board was not required. An action relating to Non-Executive Director site visits remained open pending development of a consistent approach to reporting and escalation.

Chief People Officer's Update: An update was received on implementation of the NHS People Management Standards and Leadership Framework, noting the requirement for Board-level people and EDI objectives and further work on anti-racism and sexual safety. The Committee discussed the Clinical Administration transformation programme, industrial relations pressures and workforce implications arising from the national resident doctor settlement. Committee members also considered staff morale, workforce change fatigue and engagement with the Future Ready programme.

EDI Plan 2026-2030 and 2026/27 Delivery Priorities: The Committee reviewed the draft EDI Plan and supported the development of a single integrated delivery plan to strengthen accountability, local ownership and evaluation of impact. Discussion focused on accountability arrangements, delivery through clinical groups, and the need for measurable progress, particularly in relation to workforce inequalities, equitable reward and the consultant gender pay gap.

Workforce Race Equality Standard and Workforce Disability Equality Standard (WRES and WDES) Reports 2025/26: The Committee reviewed the annual workforce equality metrics and noted that more indicators had improved than deteriorated during the year. Committee members welcomed progress in reasonable adjustments for disabled staff and discussed the importance of moving beyond annual improvements towards closing experience gaps between minority and majority staff groups, supported by clear accountability and continued investment in staff networks.

General Medical Council (GMC) National Training Survey Results 2026: The 2026 GMC National Training Survey results were received and Committee members welcomed significant improvements across training quality measures, including the Trust's move from fourth to second within the Shelford Group. The Committee noted sustained improvements in educational governance, supervision and trainee experience, alongside one of the highest resident doctor response rates nationally, whilst recognising the need for continued focus on induction, supervision and clinical experience.

Care Quality Commission (CQC) Well led – Reflections from King's College Hospital: The Committee received reflections from King's College Hospital NHS Foundation Trust on its recent CQC Well-Led assessment. Discussion focused on staff voice, organisational culture, leadership visibility, inclusion, psychological safety and the importance of triangulating staff feedback with wider intelligence. Committee members considered how the learning could support the Trust's preparations for future regulatory inspections.

Workforce Metrics July 2026: The Committee noted stable workforce performance, strengthened workforce controls and implementation of a recruitment freeze. Sickness absence remained below 5% but continued to be a key area of focus, with emphasis placed on strengthening line manager capability and wellbeing support. The Committee also reviewed Performance Development Review performance and discussed opportunities to improve workforce reporting, including analysis of sickness absence and temporary staffing trends.

BAF Risk: Principal Risk 10 was reviewed and Committee members agreed that increasing industrial relations pressures, organisational change programmes and workforce fatigue had materially changed the risk environment. The Committee approved an increase in the risk score from 12 to 16 to reflect the current workforce risk profile.

Committee Terms of Reference Review: The Committee considered proposed changes to its Terms of Reference, including a reduction in meeting frequency from four meetings per year to two. Committee members raised concerns regarding the potential impact on oversight of people, culture and education matters and requested further time to consider the proposals before returning them for approval at the December meeting.

Committee name	Transformation and Major Programmes Board Committee
Date, time	Wednesday 9 September 2026, 2pm – 5pm
Venue	Governors Hall, St Thomas' Hospital
Chair	Ian Playford

Productivity Programme Update: The Committee noted strong organisational engagement and an 8% year-on-year improvement in productivity, placing the Trust first in London by the national measure. Delivery remained mixed, with progress across flow, ambulatory and clinical administration offset by shortfalls in bed reductions, financial benefits and surgical productivity. Autumn stocktakes would inform a refreshed position, while future reporting would show how productivity, transformation and other savings contributed to the five-year financial plan.

Children's Hospital Programme Update: The Committee welcomed the substantial progress following the national review of the Outline Business Case, including positive indications from the Joint Investment Committee, approval of the Charity grant agreement and constructive engagement with King's College London regarding relocation. Commercial negotiations, the Treasury review and fit-out dependencies remained live, alongside capital pressures arising from slippage in enabling works. Continued focus was required to conclude contractual arrangements and preserve value for money.

Children's Cancer Services: Principal Treatment Centre Programme Update: The Committee noted that Building Safety Act approval remained outstanding following further fire-safety requirements, creating continued uncertainty over whether the revised opening date would be achieved. Cost, workforce, pathology, radiotherapy and research implications were being actively managed with partners. The wider Committee discussion reinforced the need to capture lessons from major capital programmes and strengthen future approaches to programme set-up, cost, time and change control.

Guy's Surgical Centre Programme Update: The Committee noted that the forecasted cost had increased against the Outline Business Case. Additional inpatient theatres at Guy's remained a strategic requirement and no equivalent alternative had been identified, but affordability, value for money and the renewed national approval route would require further scrutiny. A detailed review of the cost plan and change orders would continue, with focus on completing RIBA Stage 4 and securing a fixed price.

Apollo Programme: Stabilisation and Benefits Realisation Update: The Committee welcomed progress in Epic adoption and confirmed that financial benefits remained on track. Achieving Honor Roll was supported as a means of embedding best practice rather than as an end in itself, with stronger expectations needed for personalisation, medication administration, business continuity and standardised ways of working. A three-year vision would return, setting out the priority measures, leadership expectations and opportunities from automation and artificial intelligence.

Central Portfolio Office Major Programme Report: The Committee noted increasing cost and affordability pressures across the portfolio, with programme slippage expected to move capital into 2027/28 and subsequently constrain funding for other priorities. An aggregate view of capital, milestones and dependencies would be brought back to the Committee for consideration, alongside the five-year capital plan refresh. Significant non-capital transformation would continue to be considered through the Committee's remit.

Board Assurance Framework: The Committee supported the proposed separation of transformation and organisational change from strategic capital and infrastructure delivery, with both risks remaining under its oversight. The detailed risk statements, scores and assurance ratings would be agreed by correspondence ahead of Board ratification.

Committee name	Audit and Risk Committee
Date, time	Wednesday 16 September 2026, 2pm – 5pm
Venue	Grand Committee Room, St Thomas' Hospital
Chair	Nilkunj Dodhia

Emergency Preparedness, Resilience and Response: The Committee noted partial compliance in four areas, including mandatory on-call training, business continuity planning and assurance over critical suppliers. It was agreed that stronger escalation, accountable improvement trajectories and further assurance on sustained clinical activity and record reconciliation during a prolonged Epic outage was required.

Assisted Conception Unit Audit: The Committee noted that the audit issues had been substantially addressed and appropriate controls were in place. Ongoing oversight would continue through the Quality and Performance Committee and the action was closed.

Site Security Audit: The Committee noted that most recommendations had been completed, with four partially implemented. A concluding report was requested on the effectiveness of the new management structure, remaining standardisation work and vulnerable legacy security systems at Royal Brompton and Harefield hospitals.

External Audit: Planning for the 2026/27 audit had recently commenced, with no formal matters to report. The Committee noted progress against the recommendations from the June 2026 external audit report.

Internal Audit Progress: Delivery of the annual plan was behind schedule due to delays in agreeing terms of reference and securing management engagement, although six reviews had been completed since the previous meeting. The Committee considered limited assurance findings relating to fire safety, medical equipment maintenance and the Children's Cancer Principal Treatment Centre (PTC) capital project, emphasising the need for stronger ownership, reliable data, robust financial and contractual controls, and clear delivery plans. The Committee requested a prioritised six-month fire safety update, the establishment of a single leadership structure for medical equipment management by the end of March 2027 and onward oversight of the Children's Cancer PTC actions by the Transformation and Major Programmes Committee. The Committee also noted that productivity improvements required more consistent implementation and measurement within a coherent operating model, requested clearer reporting of third-party cyber controls and reinforced the Committee's role in escalating overdue audit recommendations.

Counter Fraud: No material new issues were identified, although recurring themes included working during sickness absence, concurrent employment, contracted-hours concerns and weaknesses in season-ticket loan controls. Employment-related themes and the consistency of disciplinary outcomes would be raised with the People, Culture and Education Committee.

Waiver Report: The Committee noted a reduction in single tender waivers and agreed that future reports would be presented six-monthly. Reports would distinguish material cases caused by preventable planning or control failures from unavoidable urgent or specialist requirements.

Declarations of Interest Compliance: Compliance had improved to 71% as at 9 September 2026 but remained below the 90% compliance rate reported by peer organisations. The Trust aimed to reach 90% during 2026/27, with targeted follow-up and enhanced monitoring.

Data, Technology and Information Update: The Committee noted that the existing data-centre environment remained stable while an outline business case for sustainable hosting arrangements progressed through governance.

Board Assurance Framework (BAF) Risk 4: The BAF risk relating to the resilience of digital infrastructure and cyber security remained scored at 20 and the Committee requested that future reporting distinguish improvements in internal controls from the worsening external threat environment.

Any other business: The Committee identified to need to further strengthen integration following organisational changes, improve alignment across systems and teams and reinforce clear executive ownership and prioritisation. Sufficient senior executive representation was expected for items involving significant risk, cross-organisational action or direct executive accountability.

BOARD OF DIRECTORS

WEDNESDAY 21 OCTOBER 2026

Report title:	**Finance Report for the six months to 30th September 2026**
Executive sponsor:	Steven Davies, Chief Finance and Investment Officer
Report author:	Simon Hooton, Head of Financial Reporting – Financial Management
Purpose of report:	For awareness/noting only
	To provide the Board with an update on the Trust's financial performance, cash position, CIP delivery and capital expenditure for the six months to 30th September 2026.
Previously presented at:	N/a
Key points of report:	• The reported financial performance to 30th September is a deficit of £36.4M, which is £0.1M ahead of the planned deficit at month 06. • The Trusts financial plan is back-phased, deficits in the early part of the year, recovered through surpluses in the latter parts of the year. CIP achievement of £20.3M has been reported year to date. • The cash balance at 30th September 2026 stands at £102.7M, a reduction of £66.2M since the start of the year. • Capital spend stands at £35.6M against an equally phased YTD plan of £89.7M.
Primary BAF risk:	Risk 8: Financial sustainability
Supporting material:	• N/a
Recommendation(s):	The BOARD is asked to: 1. **Note** the content of this report.

1. Introduction

1.1. This paper updates the Board on the headline financial performance of the Trust for first six months of the financial year.

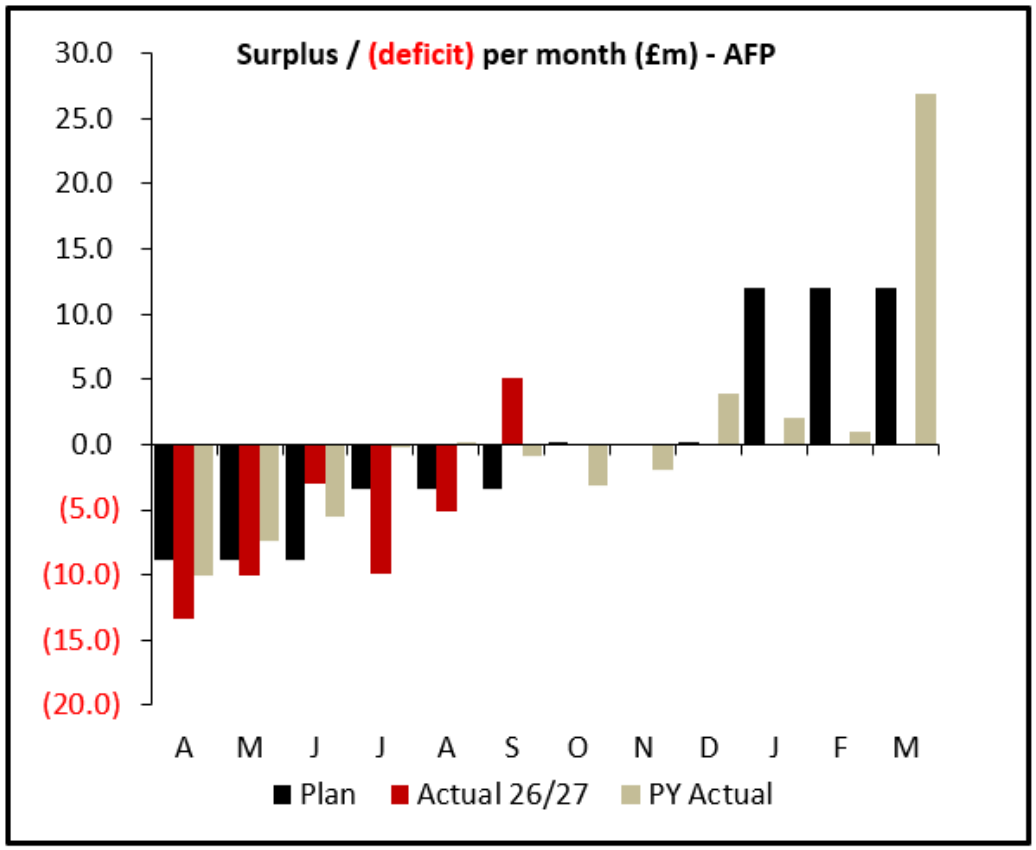
2. Background

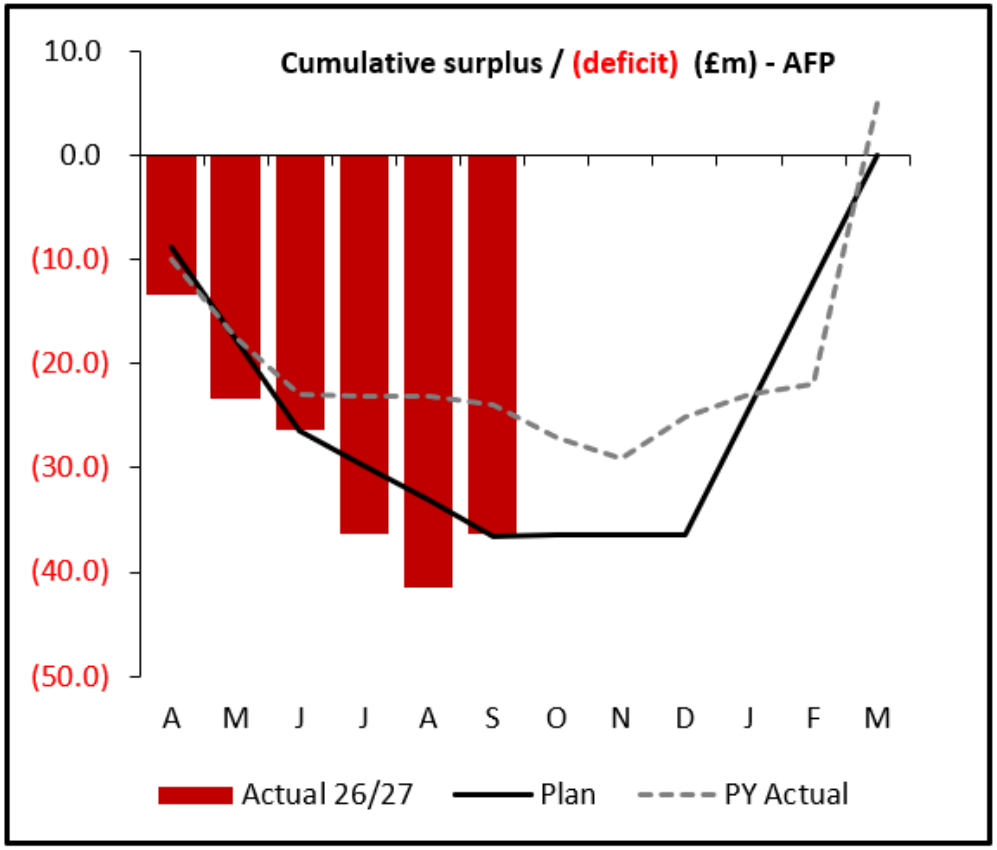
2.1. The Trust has reported a deficit for the first six months of the year of £36.4M which is £0.1M ahead of the phased plan.

Table 1: Trust I&E Summary at 30th September 2026.

Technical Adjustments	Budget Mth	Actual Mth	Variance Mth	Budget YTD	Actual YTD	Variance YTD
Income	263.2	269.2	6.1	1,558.7	1,554.9	(3.8)
Pay	(154.9)	(154.4)	0.4	(927.1)	(919.0)	8.1
Non Pay	(111.6)	(109.7)	1.9	(668.2)	(672.3)	(4.1)
Surplus / (Deficit) - Adjusted Financial Position (AFP)	**(3.3)**	**5.1**	**8.5**	**(36.5)**	**(36.4)**	**0.1**
DODA	(1.1)	(1.0)	0.0	(6.3)	(6.2)	0.1
Capital Donations	0.8	0.4	(0.5)	5.0	0.9	(4.1)
Technical Adjustments	0.0	0.0	0.0	0.0	0.0	0.0
Surplus / (Deficit) - Excl Fin Adj's	**(3.6)**	**4.5**	**8.1**	**(37.8)**	**(41.6)**	**(3.8)**

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





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

The in-month position includes

- NHS Contract Income (ICB/NHSE) – These now reflect variances based on performance against agreed contracts and using month 05 flexible income extrapolated to month 06, there is a favourable variance in month of £6.8M the key drivers are

- High Cost Device Income £2.2M Fav –this offsets expenditure recorded in month.
- High Cost Drugs Income £2.5M Fav – driven by one dose of Zolgensma in the month and increased drugs usage across groups (offset by expenditure).
- ICB / NHSE Ad Hoc Income offsetting expenditure £1.3M Fav.

- Private patient income is £1.3M ahead of plan. The run rate is slightly ahead of the trend noted in 2025/26.

- Pay Costs are £0.4M better than plan (£1.0M Adv when excluding Hosted Services). The favourable variance in Hosted Services is driven by vacant funded posts.

- Drugs are £4.3M overspent reflecting one dose of Zolgensma in the Evelina in month and increased usage across groups, this is offset by increased income as noted above.

- CIPs – There was an adverse variance in month on identified CIPs of £0.5M due to underperformance against identified schemes, planned and identified savings in month were £6.5M with actuals of £6.0M. Unidentified schemes equated to £4.8M adv in month.

3. CIPs

3.1. The reported CIP target for 2026/27 is £124.5M. This includes a 2% efficiency target on controllable costs, unbudgeted items offset by agreed funding, carry-forward of unmet 2025/26 CIP, and growth-related adjustments.

3.2. At the end of September identified CIPs stood at £66.7M, against the Trust target of £124.5M. This leaves £57.7M to be identified (*see Table 4).*

3.3. Year to date CIP delivery totalled £20.3M against the year to date identified plans of £24.1M *(see Table 5).*

3.4. This equates to a delivery rate of 84.1% against identified schemes. If including unidentified schemes, and measured against an evenly phased plan, the delivery falls to 32.5% underlining the need for both further identification of schemes and an increased pace of delivery as a priority *(see Table 5).*

4. Cash & Capital

4.1. **Cash** - The Trust closed the month with a cash balance of £102.7M; this is a £66.2M reduction from the opening balance on 1st April 2026.

4.2. **Capital** - The Trust was initially allocated a CDEL limit of £160.2M for 2026/27. Year-to-date the trust has spent £35.7M on capital schemes, which is £54.0M lower than the plan for the year including in year CDEL awards, additional PDC awards and donations.

5. Recommendations

5.1. The Board is asked to:

- Note the YTD deficit of £36.4M, which is £0.1M ahead of the planned deficit at month 06.
- Note the CIP delivery YTD of £20.3M, equating to 84.1% delivery against identified plans, with £57.7M of the total plan remaining unidentified.
- Note the current cash balance of £102.7M being a £66.2M reduction from the opening balance on 1st April 2026.
- Note the capital spend of £35.7M against a year-to-date plan of £89.7M.

Table 2: Trend in actual income

£M	2025/26 YTD Ave	2025/26 FY Ave	26/27 Ave	Last Six Months: Apr	May	Jun	JuL	Aug	Sep	YTD Total Plan	Actual	Variance
Income From Activities												
NHSE	18.04	18.48	14.29	14.11	13.01	13.19	14.44	14.44	17.86	86.23	85.72	(0.51)
SEL ICB	91.12	98.91	56.74	54.25	48.68	62.56	59.15	59.15	56.52	332.51	340.42	**7.91**
Other ICBs	71.37	72.10	42.25	39.45	37.84	50.35	40.28	40.28	41.49	254.95	253.52	(1.43)
High Cost Devices Income	5.85	6.47	7.00	5.29	7.13	7.10	8.85	8.85	5.98	36.02	41.98	**5.95**
High Cost Drugs Income	28.53	28.83	29.45	31.11	26.48	28.35	30.10	30.10	27.53	166.45	176.72	**10.27**
Private Patients	6.68	6.82	6.87	6.36	7.47	6.48	7.67	7.67	6.29	44.50	41.22	(3.28)
All Other Income from Activities	4.40	4.14	77.06	78.26	88.24	62.61	76.89	76.89	77.86	477.41	462.34	(15.07)
Total Income From Activities	**226.00**	**235.73**	**233.65**	**228.82**	**228.85**	**230.62**	**237.38**	**237.38**	**233.53**	**1,398.07**	**1,401.91**	**3.84**
Operating Income												
Research and Development	7.24	7.14	6.37	7.85	6.26	6.18	5.09	5.09	5.84	37.62	38.21	**0.59**
Education and Training	7.04	7.98	7.91	7.43	7.42	7.46	8.93	8.93	7.79	44.26	47.48	**3.22**
Non patient care services to other bodies	2.47	3.15	2.35	0.70	2.76	2.66	2.70	2.70	2.38	15.16	14.11	(1.05)
Income for Clinical Services	1.75	1.77	1.83	1.71	1.57	1.76	2.02	2.02	1.85	11.02	10.96	(0.07)
All Other Operating Income	8.27	8.28	7.04	0.00	5.92	9.77	4.69	4.69	6.76	52.61	42.25	(10.36)
Total Operating Income	**26.76**	**28.32**	**25.50**	**26.67**	**23.93**	**27.82**	**23.42**	**23.42**	**24.62**	**160.67**	**153.01**	(7.66)
Total Income	**252.76**	**264.05**	**259.15**	**255.49**	**252.78**	**258.45**	**260.80**	**260.80**	**258.15**	**1,558.74**	**1,554.92**	(3.82)

Table 3: Trend in actual spend

£M	2025/26 YTD Ave	2025/26 FY Ave	26/27 Ave	Last Six Months: Apr	May	Jun	JuL	Aug	Sep	YTD Total Plan	Actual	Variance
Pay												
Medical Staff	(40.75)	(41.16)	(42.33)	(41.65)	(41.18)	(45.23)	(41.74)	(41.65)	(42.54)	(251.99)	(253.99)	**(2.00)**
Nursing Staff	(48.80)	(48.95)	(50.23)	(50.11)	(50.30)	(51.13)	(50.32)	(49.45)	(50.06)	(302.87)	(301.36)	**1.51**
PAMs	(10.42)	(10.50)	(10.76)	(10.97)	(10.85)	(10.90)	(10.49)	(10.67)	(10.71)	(65.83)	(64.59)	**1.24**
Professional & Technical (PTB)	(5.98)	(6.04)	(6.38)	(6.25)	(6.28)	(6.27)	(6.54)	(6.33)	(6.60)	(38.33)	(38.27)	**0.06**
Admin & Clerical	(27.78)	(27.62)	(27.88)	(27.70)	(28.00)	(28.13)	(27.92)	(27.47)	(28.07)	(182.16)	(167.27)	**14.88**
Estate and Facilities Staff	(5.67)	(6.07)	(5.92)	(5.92)	(5.84)	(5.96)	(5.91)	(5.91)	(5.98)	(32.22)	(35.52)	**(3.30)**
All Other Staff	(8.94)	(9.10)	(9.66)	(9.47)	(9.58)	(9.44)	(9.49)	(9.53)	(10.47)	(53.67)	(57.98)	**(4.32)**
Total Pay	**(148.35)**	**(149.44)**	**(153.16)**	**(152.06)**	**(152.03)**	**(157.05)**	**(152.41)**	**(151.01)**	**(154.43)**	**(927.06)**	**(918.99)**	**8.07**
Non-Pay												
Drug Costs	(32.97)	(33.92)	(34.07)	(32.33)	(30.36)	(35.68)	(35.82)	(31.62)	(38.65)	(205.51)	(204.45)	**1.06**
Clinical Supplies	(35.27)	(37.28)	(36.22)	(33.57)	(37.26)	(41.16)	(38.69)	(36.49)	(30.14)	(205.64)	(217.32)	**(11.68)**
Premises Costs	(12.69)	(12.47)	(13.97)	(13.35)	(13.47)	(15.86)	(15.04)	(11.13)	(14.95)	(80.22)	(83.82)	**(3.60)**
Purchase of Healthcare (non-NHS)	(4.22)	(4.58)	(4.44)	(3.87)	(4.26)	(5.28)	(4.94)	(4.99)	(3.30)	(23.52)	(26.64)	**(3.12)**
Establishment Costs	(3.52)	(3.45)	(3.10)	(3.06)	(2.49)	(4.18)	(1.86)	(3.66)	(3.35)	(15.18)	(18.59)	**(3.41)**
Depreciation	(6.37)	(7.07)	(7.29)	(7.43)	(7.43)	(6.27)	(7.01)	(7.06)	(8.54)	(42.13)	(43.73)	**(1.60)**
Amortisation	(1.49)	(1.58)	(1.36)	(1.39)	(1.39)	(1.28)	(1.35)	(1.42)	(1.35)	(8.32)	(8.17)	**0.15**
Clinical Negligence	(3.21)	(3.31)	(3.42)	(3.43)	(3.43)	(3.43)	(3.43)	(3.43)	(3.41)	(20.56)	(20.54)	**0.02**
Movement in Bad Debt Provisions	0.68	0.11	1.82	(1.97)	2.07	9.91	0.72	(0.11)	0.31	(2.29)	10.93	**13.22**
Other Non-Pay Costs	(8.32)	(9.05)	(7.62)	(8.27)	(7.07)	(7.63)	(8.23)	(9.86)	(4.65)	(54.55)	(45.71)	**8.84**
Total Non-Pay	**(107.38)**	**(112.62)**	**(109.67)**	**(108.66)**	**(105.09)**	**(110.86)**	**(115.64)**	**(109.77)**	**(108.03)**	**(657.91)**	**(658.05)**	**(0.14)**
Other Adjustments												
Internal recharges inc Overheads	(0.12)	(0.00)	(0.00)	0.18	(0.21)	0.03	(0.09)	0.09	0.00	(0.06)	(0.00)	**0.06**
Finance costs	(0.69)	(1.58)	(3.36)	(3.01)	(3.41)	(3.51)	(3.53)	(3.56)	(3.13)	(19.49)	(20.15)	**(0.66)**
Budget Reserves	(0.22)	(0.00)	0.99	(5.31)	(2.09)	9.95	0.97	0.94	1.46	(28.85)	5.92	**34.77**
Further Improvement Target	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	38.14	0.00	**(38.14)**
AFP Surplus/Deficit	**(4.00)**	**0.42**	**(6.06)**	**(13.36)**	**(10.05)**	**(3.00)**	**(9.90)**	**(2.52)**	**(5.97)**	**(36.50)**	**(36.36)**	**0.14**

Table 4: 2026/27 CIP Plan Trust Summary

2026/27 CIP Plan Trust Summary 7th October 2026	Target	Planning Status £'000					(Unweighted) £'000		
		Unidentified	Opportunity	Plans in Progress	Fully Developed - delivery not yet started	Fully Developed - in delivery	Total Plan	Unidentif'd CIPs	Progress (%) RAG
		0%	25%	50%	75%	100%			
Clinical Groups / Delivery Group / Corporates									
C&S	***26,560***	0	3,255	1,590	26	6,768	**11,639**	-14,921	43.8%
Evelina	***9,458***	0	1,492	1,304	903	3,427	**7,127**	-2,331	75.4%
HLCC	***27,100***	0	683	2,644	1,573	10,529	**15,430**	-11,670	56.9%
ISM	***19,097***	0	1,270	375	876	7,516	**10,038**	-9,059	52.6%
Essentia	***6,186***	0	1,400	3,900	400	2,949	**8,649**	2,463	139.8%
Pathology	***10,608***	0	75	1,918	0	57	**2,049**	-8,559	19.3%
Corporate	***25,455***	0	3,897	274	0	7,614	**11,785**	-13,671	46.3%
Total Allocated CIP	**124,464**	**0**	**12,072**	**12,005**	**3,779**	**38,861**	**66,717**	**-57,747**	53.6%
Central	***0***	0	0	0	0	0	**0**	0	100.0%
Unallocated	***0***	0	0	0	0	0	**0**	0	100.0%
Total CIP	**124,464**	**0**	**12,072**	**12,005**	**3,779**	**38,861**	**66,717**	**-57,747**	53.6%

Table 5: Actual CIP Delivery against CIP plans and targets

2026/27 CIP Plan Trust Summary 7th October 2026	M6 YTD Performance £'000					M6 YTD Performance £'000			
	Plan £'000	Total Plan WTE (Opportunity and Developed)	Actual £'000	Variance to Plan £'000	Progress (%) RAG	Target*	Actual	Variance to Target	Progress (%) RAG
Clinical Groups / Delivery Group / Corporates									
C&S	**5,013**	**65.50**	**4,518**	**-495**	90.1%	**13,280**	**4,518**	**-8,762**	34.0%
Evelina	**2,493**	**76.99**	**2,172**	**-321**	87.1%	**4,729**	**2,172**	**-2,557**	45.9%
HLCC	**4,649**	**110.23**	**3,961**	**-687**	85.2%	**13,550**	**3,961**	**-9,589**	29.2%
ISM	**3,901**	**135.28**	**3,835**	**-67**	98.3%	**9,548**	**3,835**	**-5,714**	40.2%
Essentia	**1,239**	**36.68**	**1,239**	**0**	100.0%	**3,093**	**1,239**	**-1,854**	40.0%
Pathology	**1,017**	**0.00**	**215**	**-803**	21.1%	**5,304**	**215**	**-5,089**	4.0%
Corporate	**5,759**	**97.73**	**4,312**	**-1,447**	74.9%	**12,728**	**4,312**	**-8,416**	33.9%
Total CIP	**24,071**	**522.41**	**20,251**	**-3,820**	84.1%	**62,232**	**20,251**	**-41,981**	32.5%

** Target Budget equated to the CIP Plan shown in equal 12th*

Integrated Performance Report August 2026

Guy's and St Thomas' NHS Foundation Trust
Public Board
21 October 2026

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

NHS
Guy's and St Thomas'
NHS Foundation Trust

Highlight Report Contents

Guy's and St Thomas' NHS Foundation Trust

Domain	Theme	Indicator	Latest Actual	Month
Responsive	4.9 Recovery	Elective DC & IP vs 26/27 Operational Plan	98.0%	August 2026
Responsive	4.9 Recovery	Outpatient New & FU vs 26/27 Operational Plan	96.0%	August 2026
Responsive	4.3 Cancer access	Cancer - FDS	86.7%	August 2026
Responsive	4.1 A&E access	A&E stays less than 4 hours (type 1 2 3)	75.1%	August 2026
Responsive	4.3 Cancer access	Cancer - 62 day all referral types (total)	65.8%	August 2026
Responsive	4.4 Diagnostic access	Diagnostic waits - % over 6 weeks	26.3%	August 2026
Responsive	4.2 Elective treatment access - referral to tre...	RTT - Total incomplete pathways	109,320	August 2026
Responsive	4.9 Recovery	Number of 52 Week Waiters	916	August 2026
Responsive	4.9 Recovery	Number of 65 Week Waiters	163	August 2026
Responsive	4.1 A&E access	Number of patients spending >12 hours in A&E from decision to admit (DTA)	80	August 2026

Executive summary

Guy's and St Thomas' NHS Foundation Trust has continued to make good progress in delivering its strategic objectives despite significant financial and operational pressures during 2026/27. Under the National Oversight Framework (NOF) for Quarter 1, the Trust was ranked 25th out of 134 acute providers nationally. Whilst its overall oversight score increased to 2.12, resulting in a move to Segment 2 from Segment 1, the Trust remains within the top quartile of acute providers and continues to demonstrate strong performance and grip across a range of operational and quality indicators.

Accident and Emergency

- The percentage of emergency patients Admitted, Discharge or Transferred within 4 hours in August 2026 was 75.1%, demonstrating a steady performance position in quarter one and quarter two of 2026/27 despite the department and Trust facing significant operational pressures. The Trust ranked 45th out of 120 general acute Trusts nationally.

Diagnostics

- In August the Trust reported 26.3% of patients waiting longer than 6 weeks for their routine diagnostic procedure, an improvement of 9.9 percentage points since the end of April 2026.

Cancer

- The Faster Diagnosis Standard position reached 86.7% in August demonstrating continued improvement in-year with this strong performance expected to continue for the remainder of 2026/27.
- The percentage of patients treated for cancer within 62 days of referral has demonstrated year-on-year improvement and reached 65.8% in August 2026.

Activity

- The Trust delivered 96% of planned outpatient activity (new and follow-up appointments) and 98% of planned elective activity (day-case and overnight admissions) in August.

Referral to Treatment

- The total number of Referral to Treatment (RTT) patients waiting for treatment at the Trust in August was 109,320 and 67.7% of patients were waiting 18 weeks or less for their elective treatment.
- A total of 916 patients were waiting longer than 52 weeks for treatment in August, with 163 of these patients waiting longer than 65 weeks.
- The Trust remain committed to reducing the total waiting list number and to eliminating long waiting patients.

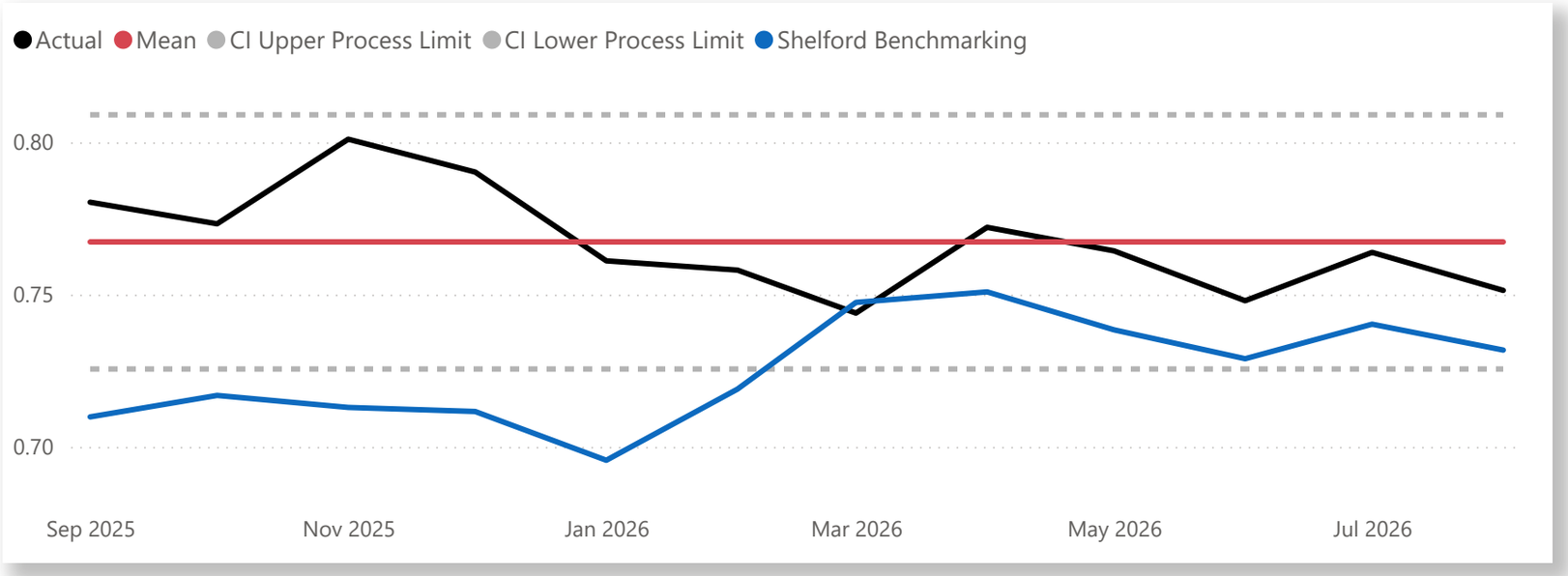
Responsive

Guy's and St Thomas'
NHS Foundation Trust

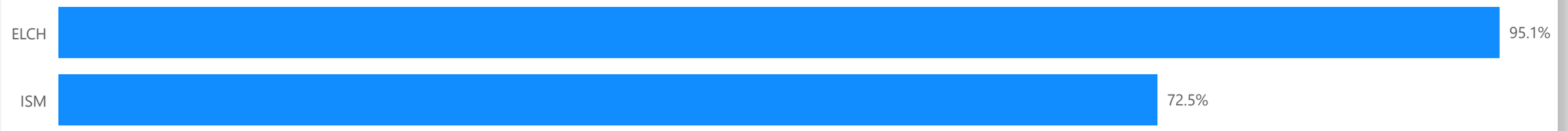
August 2026
75.1%

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

August 2026
80

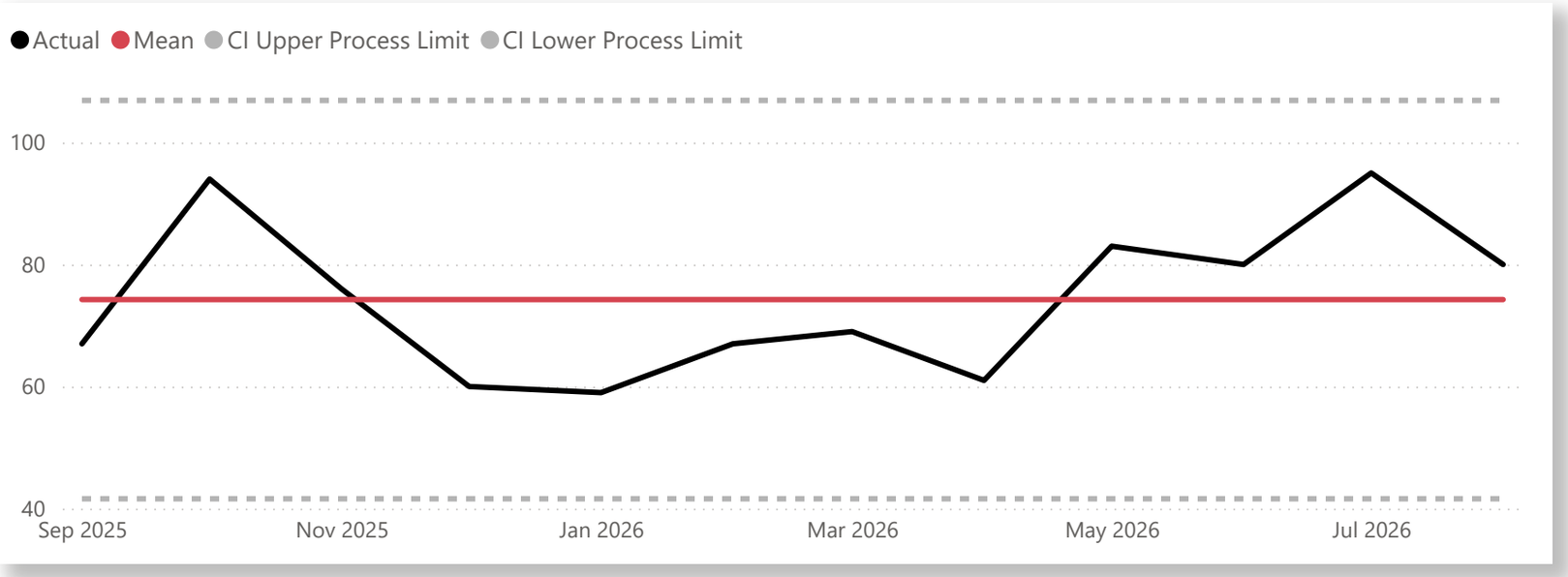
SPC

This indicator is showing common cause variation

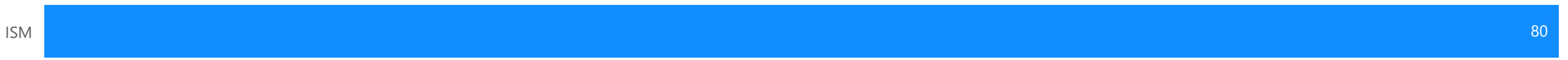
Caveat

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

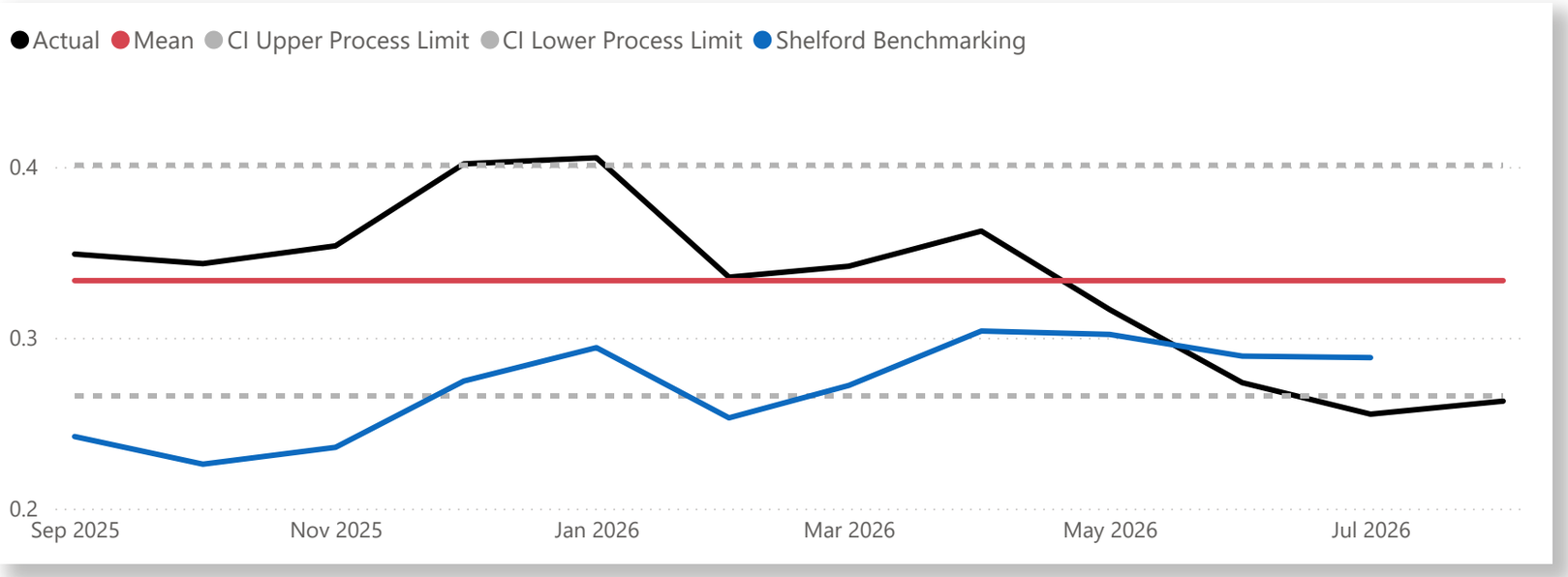
August 2026

26.3%

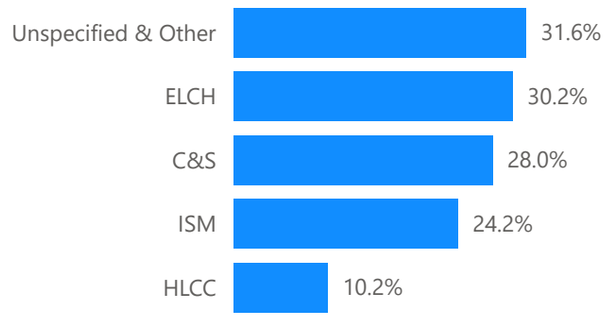
SPC

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

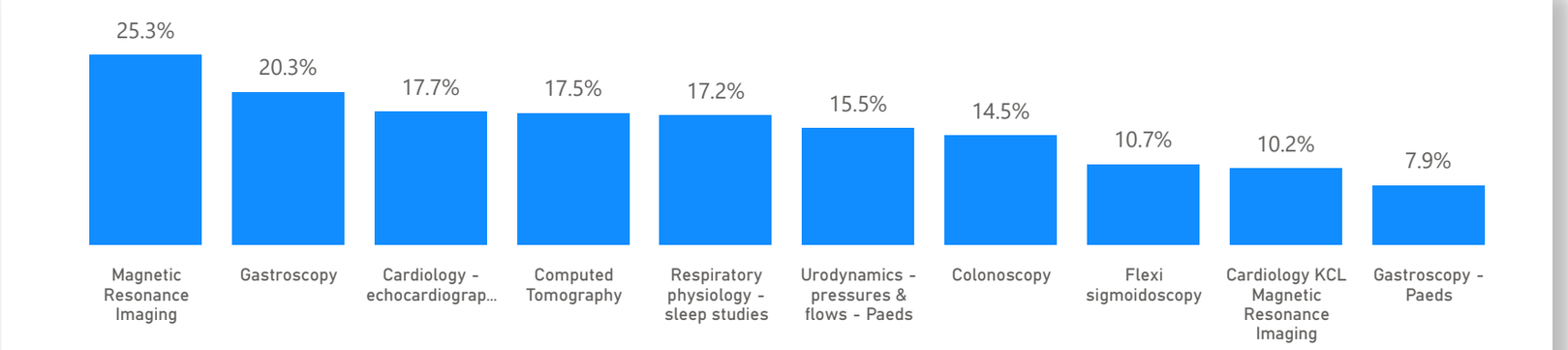
Diagnostic waits - % over 6 weeks



Clinical Group Overview



Bottom 10 Modalities



Responsive

Guy's and St Thomas'
NHS Foundation Trust

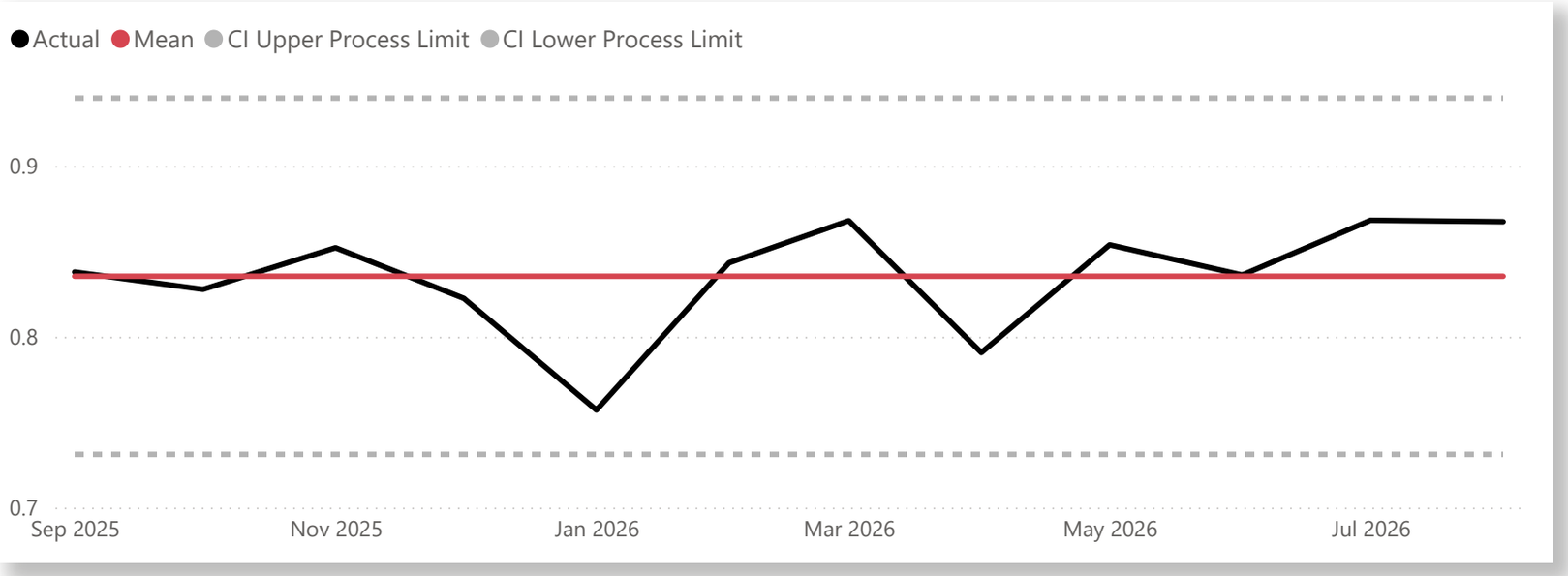
August 2026

86.7%

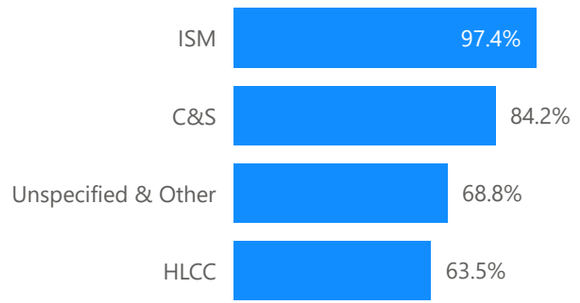
SPC

This indicator is showing common cause variation

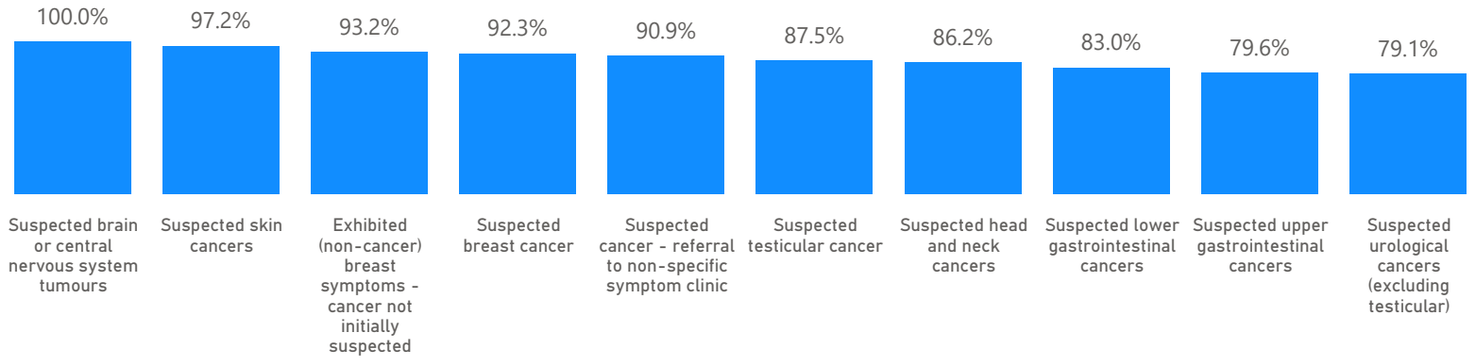
Cancer - FDS



Clinical Group Overview



Top 10 Tumour Groups



Responsive

Guy's and St Thomas'
NHS Foundation Trust

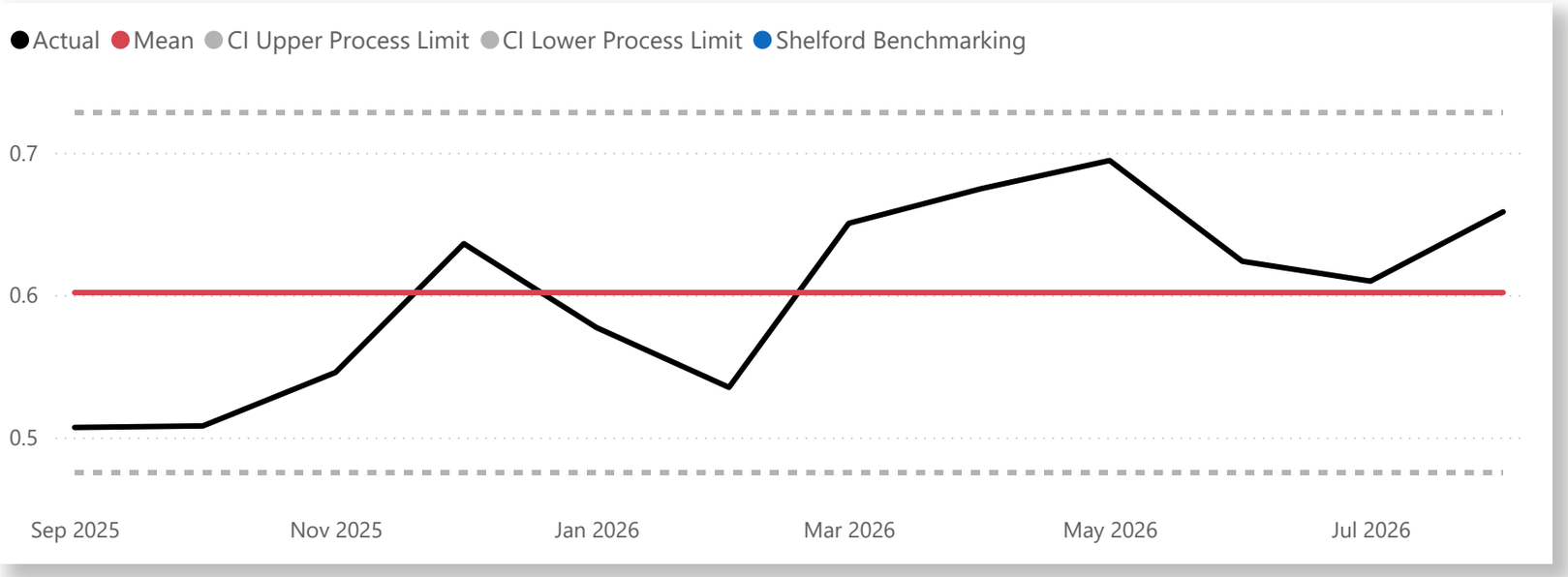
August 2026

65.8%

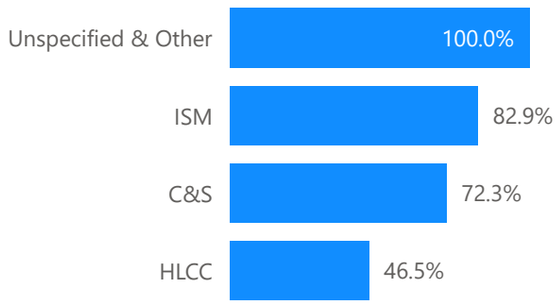
SPC

This indicator is showing common cause variation

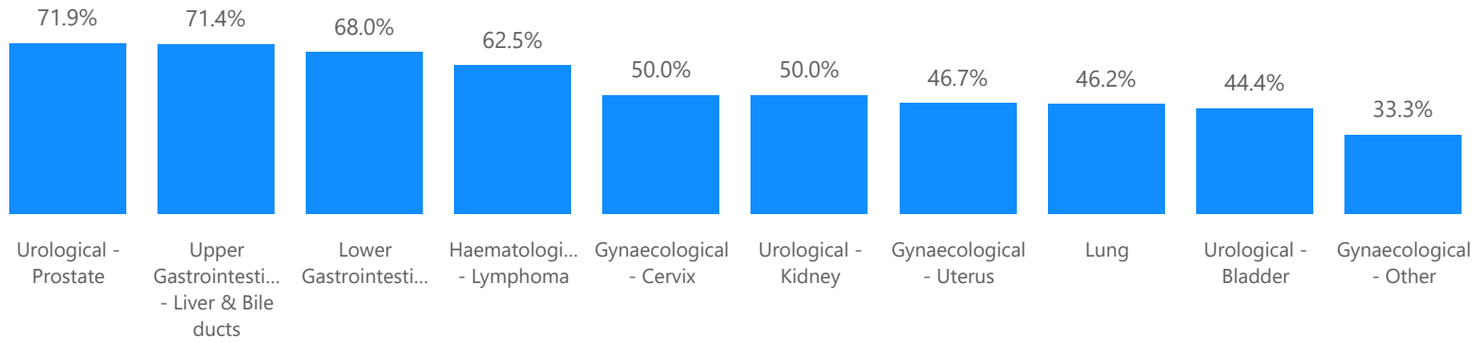
Cancer - 62 day all referral types (total)



Clinical Group Overview



Bottom 10 Tumour Groups



Responsive

Guy's and St Thomas'
NHS Foundation Trust

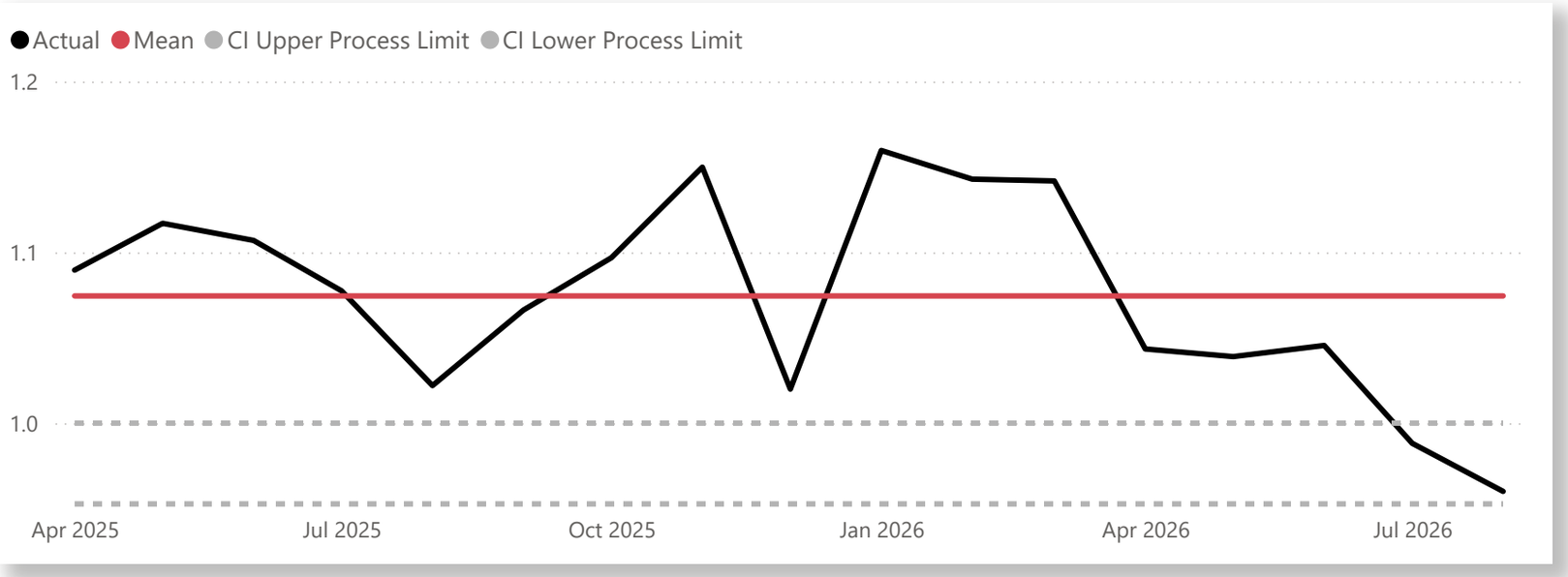
August 2026

96.0%

SPC

This indicator is showing special cause variation - 2 of 3 (Negative)

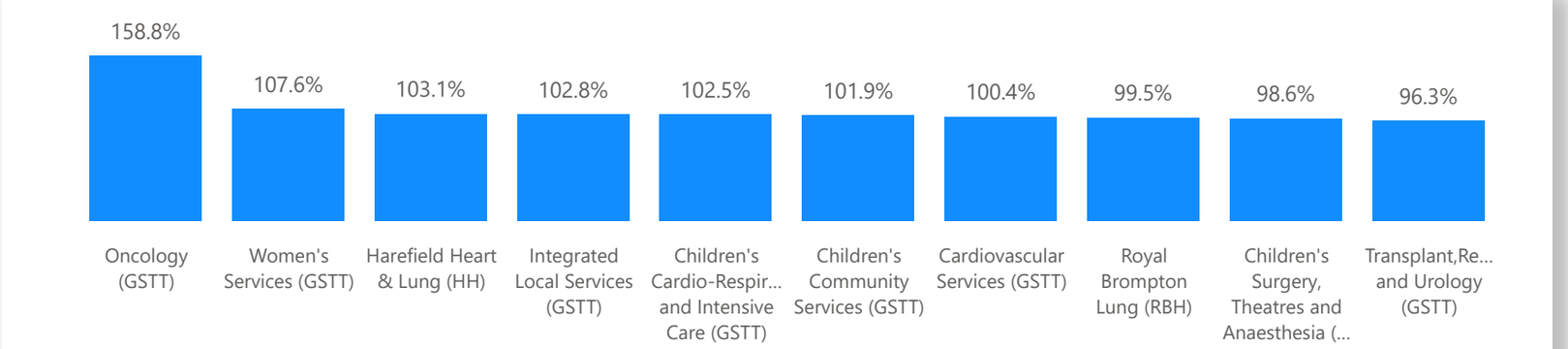
Outpatient New & FU vs 26/27 Operational Plan



Clinical Group Overview



Top 10 Directorates



Responsive

Guy's and St Thomas'
NHS Foundation Trust

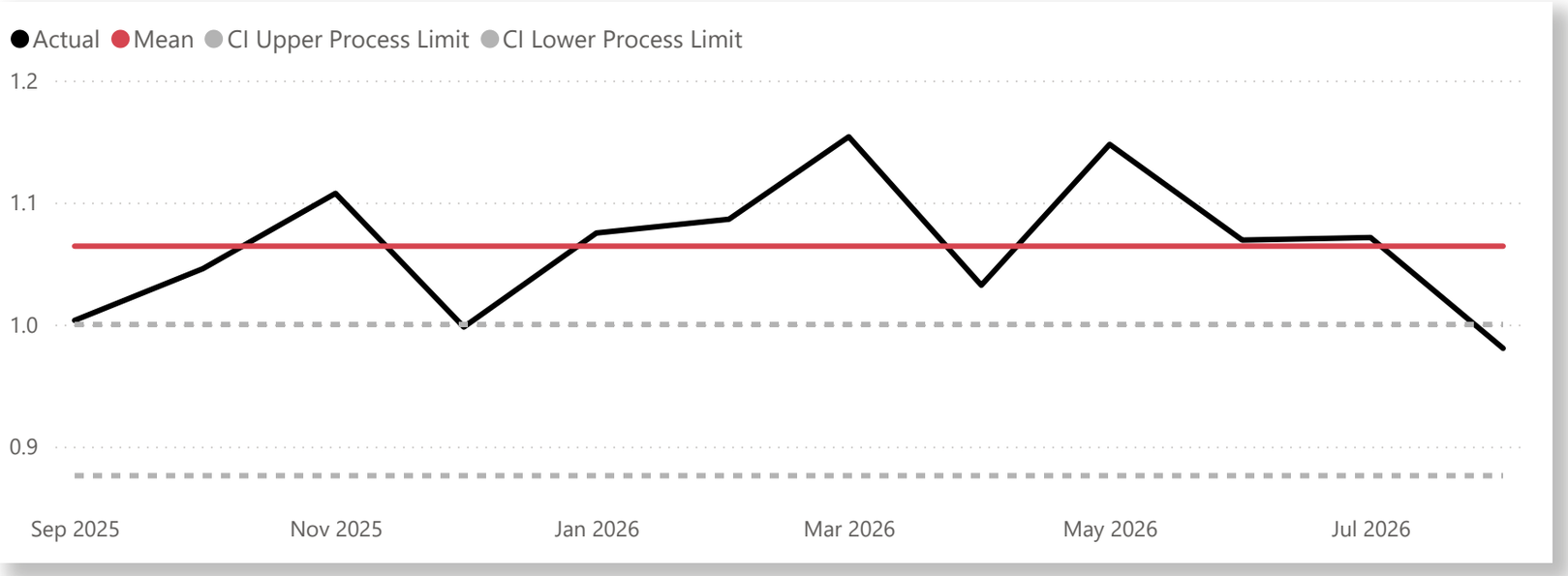
August 2026

98.0%

SPC

This indicator is showing common cause variation

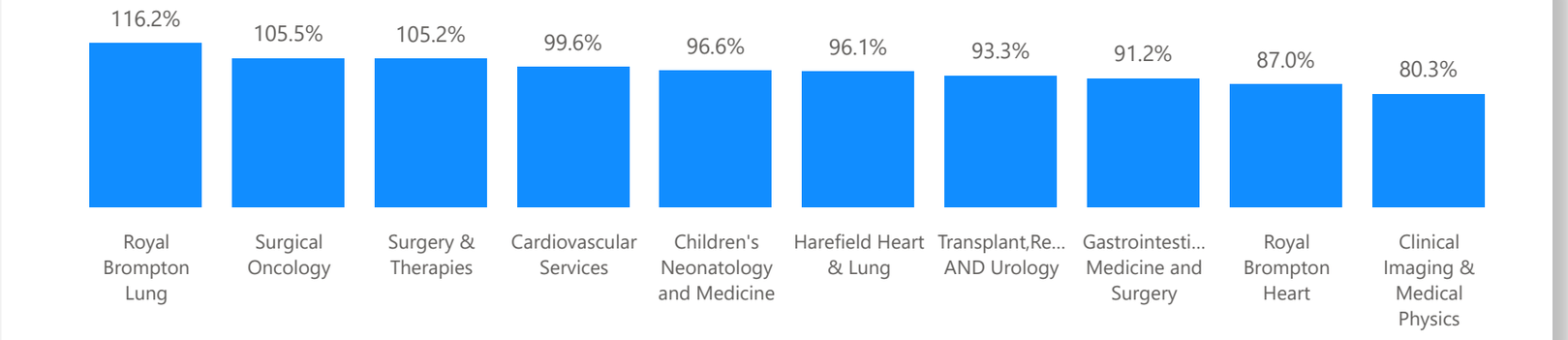
Elective DC & IP vs 26/27 Operational Plan



Clinical Group Overview



Top 10 Directorates



Responsive

Guy's and St Thomas'
NHS Foundation Trust

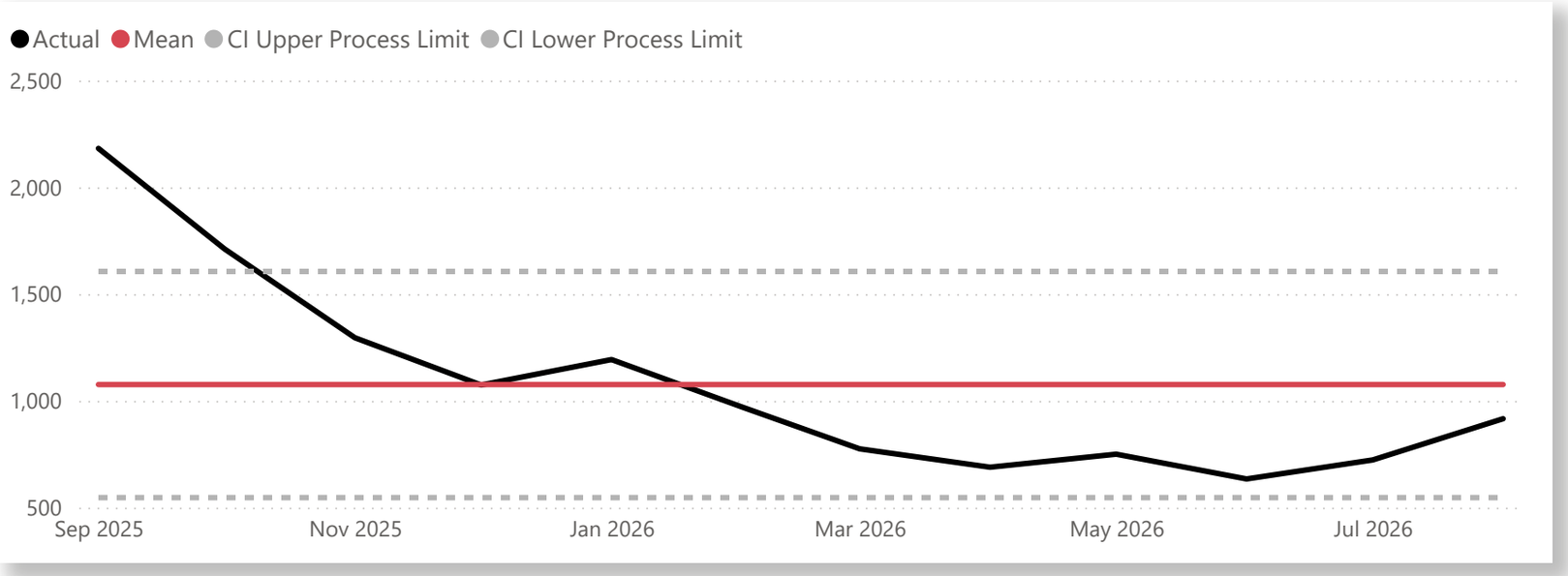
August 2026

916

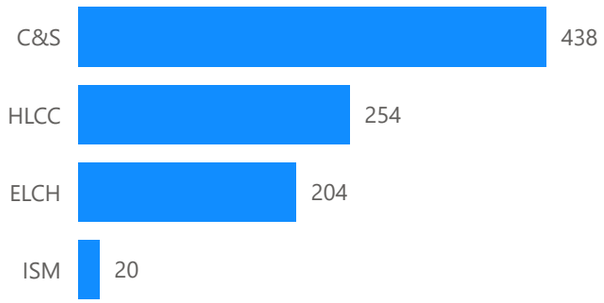
SPC

This indicator is showing special cause variation - Shift (Positive)

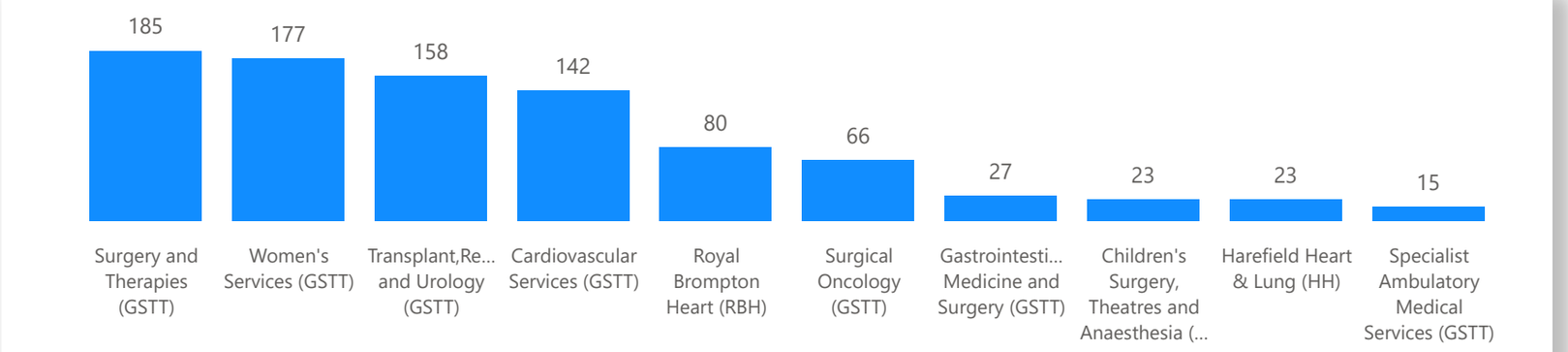
Number of 52 Week Waiters



Clinical Group Overview



Top 10 Directorates



Responsive

Guy's and St Thomas'
NHS Foundation Trust

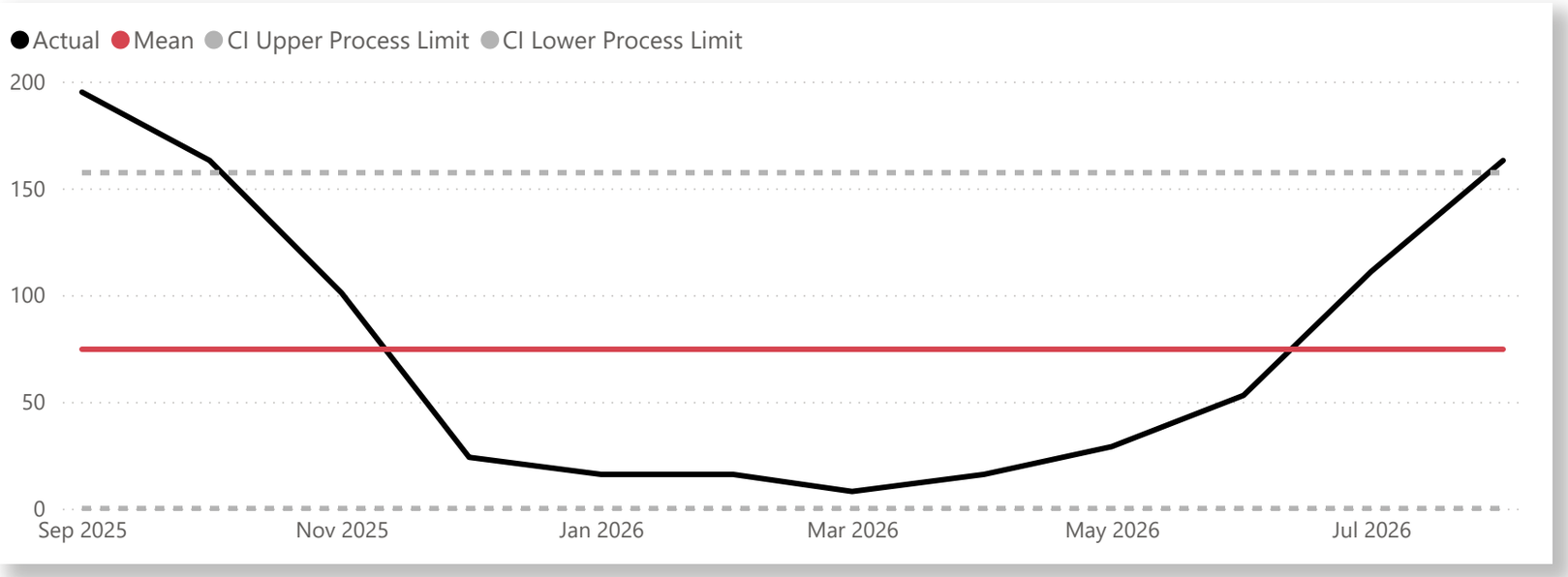
August 2026

163

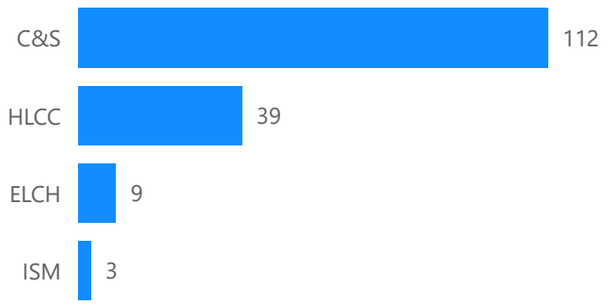
SPC

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

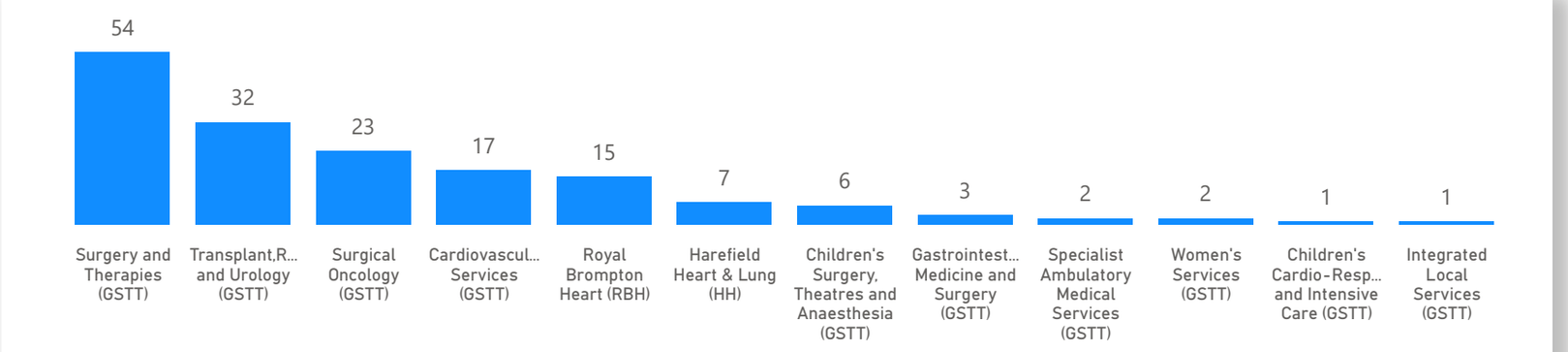
Number of 65 Week Waiters



Clinical Group Overview



Directorate Overview



Responsive

Guy's and St Thomas'
NHS Foundation Trust

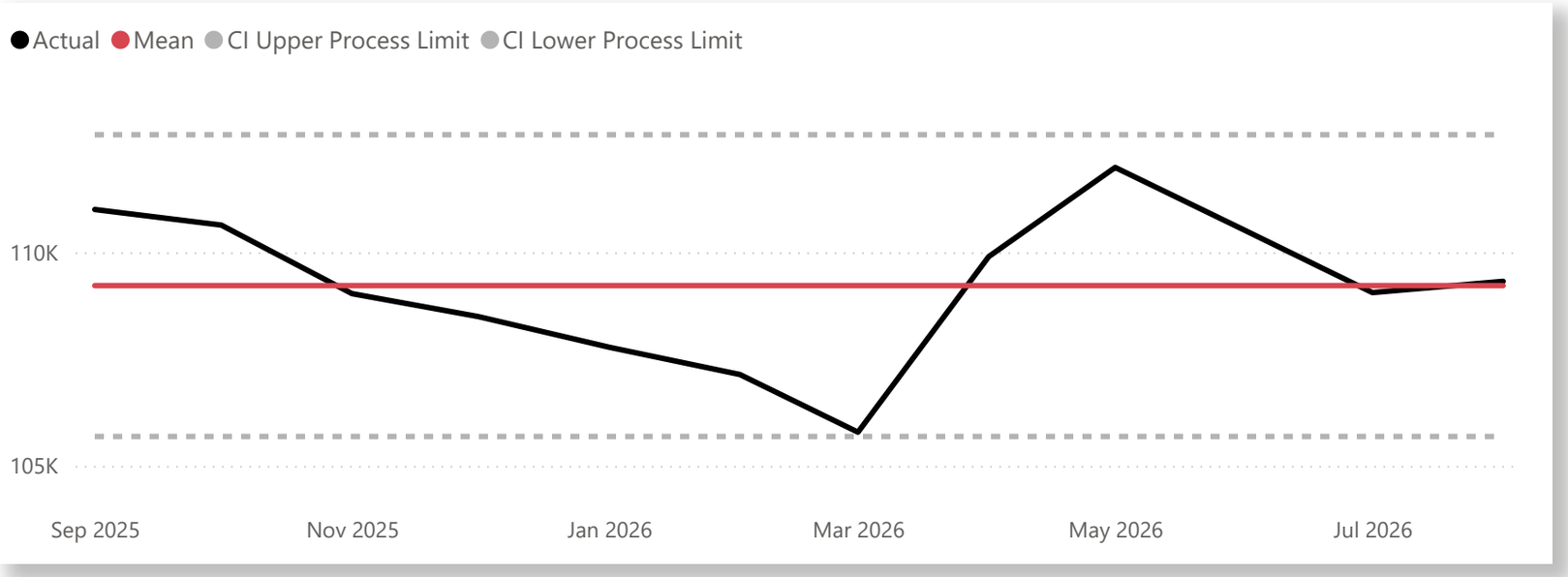
August 2026

109,320

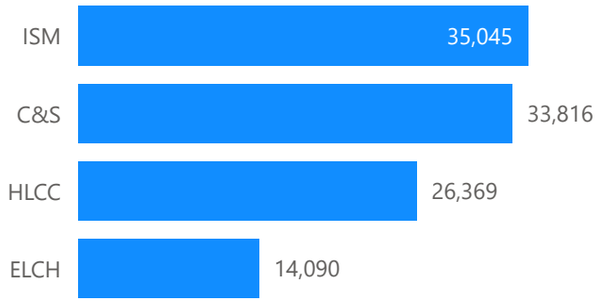
SPC

This indicator is showing common cause variation

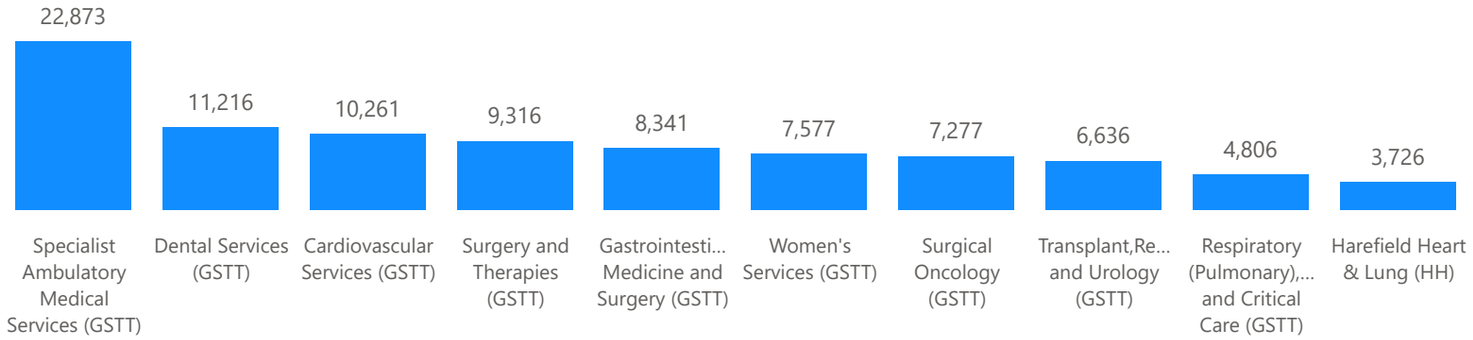
RTT - Total incomplete pathways



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

Guy's and St Thomas' NHS Foundation Trust

BOARD OF DIRECTORS

WEDNESDAY 21 OCTOBER 2026

Report title:	**Documents Signed under Trust Seal, 16 July 2026 to 14 October 2026**
Executive sponsor:	Charles Alexander, Chairman and Amanda Pritchard, Chief Executive
Report author:	Joshua Roles, Senior Business Manager
Purpose of report:	For awareness/noting only
	To provide the Board with assurance and a formal record of documents executed under the Foundation Trust Seal by the Chairman and Chief Executive in accordance with the Trust's Standing Financial Instructions.
Previously presented at:	N/a
Key points of report:	• 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.
Primary BAF risk:	Risk 11: Organisational excellence
Supporting material:	• N/a
Recommendation(s):	The BOARD is asked to: 1. **Note** the record of documents signed under Trust Seal

Our values: we are **Caring – we put patients first** | **Ambitious – we innovate and strive for excellence** | **Inclusive – we respect each other and work collaboratively**

1. Introduction

1.1. In line with the Trust's Standing Financial Instructions, Amanda Pritchard, Chief Executive and Charles Alexander, Chairman signed document numbers 1125 to 1128 under the Foundation Trust's Seal during 16 July 2026 to 14 October 2026.

2. Background

2.1. The Trust is required to maintain a record of documents executed under its Foundation Trust Seal. This report provides the Board with oversight and assurance by summarising documents signed and sealed on behalf of the Trust during the reporting period in accordance with the Standing Financial Instructions.

3. Proposals/ Recommendations

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

Number	Description	Date
1125	Signing and Sealing of the Lease between (1) Guy's and St Thomas' NHS Foundation Trust (GSTT) and (2) Creative Hair Studio pertaining to the unisex hair salon located on Part Ground Floor, North Wing, St Thomas' Hospital	12 August 2026
1126	Signing and Sealing of the Lease between (1) Guy's and St Thomas' NHS Foundation Trust (GSTT) and (2) Guy's and St Thomas' Foundation pertaining to the premises at 105 Borough High Street, London for storage purposes	12 August 2026
1127	Signing and Sealing of the Lease(s) between 1) Guy's and St Thomas' NHS Foundation Trust (GSTT) and (2) Elior UK PLC for the occupation and use of café and pantry space at Guy's Hospital Main Entrance.	12 August 2026
1128	Signing and Sealing of the standard building contract(s) between (1) Guy's and St Thomas' NHS Foundation Trust (GSTT) and (2) Storm Building Limited pertaining to the full redevelopment and refurbishment of the Maternity Assessment Unit (MAU), 7th Floor, North Wing of St Thomas' Hospital	15 September 2026