St George's University Hospitals NHS
NHS Foundation Trust

Quality Account 2024/25

Part 1 Statement on quality from the Chief Executive

I am pleased to introduce our Quality Report, which outlines our progress in advancing the quality of services for our patients. This document summarises the key milestones and challenges as we work continually to improve services and put patients at the forefront of everything we do. The Quality Report also highlights the collaborative work across GESH (St George's, Epsom and St Helier University Hospitals and Health Group; the Group).

February 2025 marked the third anniversary of working together as a Group. Over this time, we have consistently seen the benefits of working at scale. This year we have focused on the Group vision that fosters high-performing teams. This is crucial in driving our vision of improving the experience and health of our patients, a mission that lies at the heart of our organisation. We also continue to aim to be innovative while reducing costs and enhancing workplace experience for our workforce.

We have worked hard to get ready for the new and transformative electronic patient record system which will transition on 9 May 2025. iClipPro will bring all patient information together in one place across all our hospitals from medical history to results of investigations and prescribed medications. It will mean clinicians will have more information at their fingertips and represents a significant, innovative and exciting Group development, both for our patients and our staff.

This year, again, we have seen unprecedented demand for urgent and emergency care. In addition to higher attendance, we have seen a significant increase in the complexity of the needs of the patients we admit. This increased demand and severe operational and financial pressures have meant that for some of our patients, we were not able to ensure they were seen, treated, and either admitted or discharged within four hours. Presentations from people with mental health needs also remain significant, and we continue to work with local partners to ensure that people get the best care in the right place at the right time.

Further to the recent inspection of our services by the CQC we continue to work hard to ensure our services are safe. We have responded to the feedback received from the CQC and have a number of improvement initiatives underway whilst we await the publication of the inspection reports.

Having reviewed our Quality Priorities for last year, the St George’s Hospital leadership team and Board fully recognise the improvements made. Whilst we did not achieve everything we set out to do, we are proud of our successes and are clear about where we need to focus for the coming year.

I continue to be inspired by how much our teams at St George’s have achieved during periods of exceptionally high operational and financial pressure while supporting the safety of our patients. I want to extend my thanks to our staff for continuing to deliver compassionate and outstanding care for our patients during another challenging year.

To the best of my knowledge the information contained in this document is an accurate and true account of the quality of the health services we provide.

Jacqueline Totterdell

Group Chief Executive

27 June 2025

Part 2

2.0 Priorities for improvement and statements of assurance from the board

2.1 Our quality priorities for 2025/26

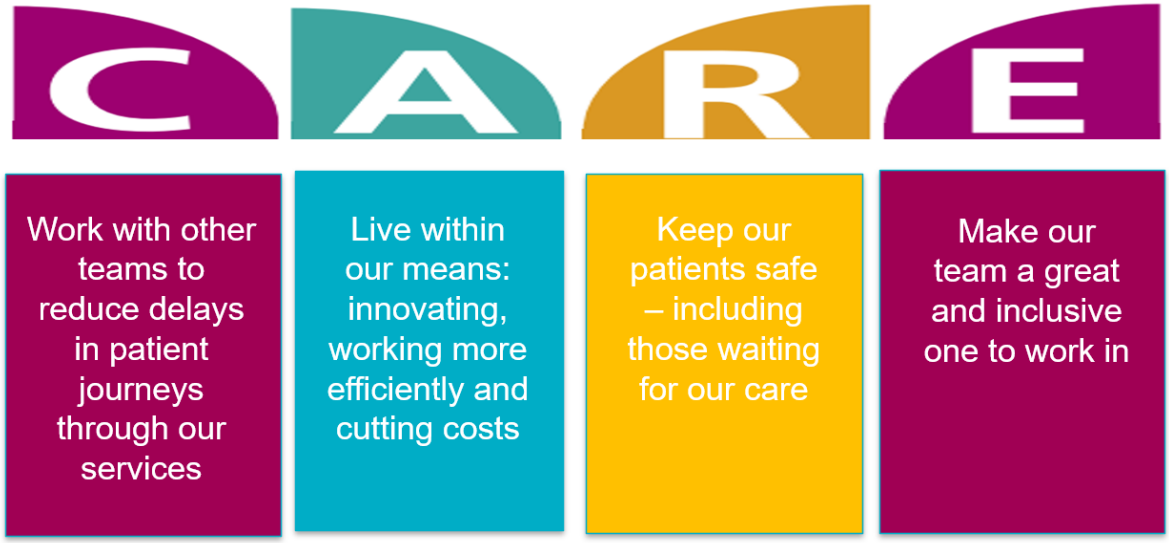
Our quality priorities flow from our five year strategy, published in May 2023.

Our vision is to deliver outstanding care, together:

A central part of our strategy is delivering 'the right care, in the right place, at the right time'. For us that means that by 2028, waiting times for our services will be among the best in the NHS, and we will have an outstanding safety culture, delivering lower than expected mortality rates and a reduction in avoidable harm. We will also be improving outcomes and patient experience and working with our partners to tackle health inequalities in our communities.

We will deliver our vision through:

1. Local improvement: Continuous improvement, pursued by teams of staff at every level in our organisations, from Board to ward, within a common framework of priorities. For 2025/26, those shared priorities are:



Our Approach to Quality Improvement

Building a Continuous Improvement Culture across and GESH group

The past year has seen us take further steps in our progress towards creating a CI culture across gesh group, building a clearer structure of our programme to deliver the strategic initiative of High Performing Teams (HPT) – our follow-on to NHS Impact and the thinking behind strategic quality management systems across organisations.

Our programme aligns strongly with the themes within NHS Impact, the table below outlines progress & work underway or completed in the last year.

Workstream Name	Purpose	Activities
Embedding Care (Shared Vision & Purpose)	To lead and support teams at all levels to identify and agree their improvement priorities, aligned to the Group's strategic priorities	• Supporting site teams to embed CARE priorities as part of business planning processes • Aims & objectives captured as a key workstream in our High performing teams programme • Locally supporting maternity at SGUH with aim of building their structured long term improvement plan

Building Capability	To train, coach and support a growing community of improvement leaders across the group	• Delivered specialist (6 month) Leading & Improvement practitioner programmes to over 90 staff across both organisations. • Delivered dedicated improvement training to over 150 staff including clinical teams, foundation doctors and operational staff across our organisations • Delivered improvement modules as part of wider leadership development programmes for over 160 staff. We have held celebration and network 'CI converge' events building the improvement community & sharing the improvement work and projects staff lead during and after the development programmes continually embedding learning.
Building Leadership Behaviours for Improvement	Equipping our leaders with the skills to create an environment where continuous improvement is embedded into day-to-day life.	• Group leadership training & programmes co-designed in Continuous Improvement and Organisation Development (OD) teams • A dedicated & defined 'developing our leaders' workstream within our HPT programme • Designed & delivered refreshed improvement modules in our senior leader development programmes • Further developing leadership through delivering wider bespoke workshops including the Neonatal, Children & Young people's senior nursing team at ESTH. • Designed and delivered the leading improvement module on the Kings Fund Programme for our care group leads and clinical directors across the group.
Daily Improvement & Quality management system (Embedding Improvements)	To develop and embed continuous improvement ways of working into management systems & processes	• Aligned to NHS IMPACT we completed a group-wide assessment to identify current strengths and areas for improvement with the High performing teams programme focusing on taking forward more detailed assessment and planning • At a local level we have defined a 'Daily improvement system' workstream within the HPT programme building upon successful staff engagement and

		improvement huddle support in Mary Seacole unit at ESTH
Invest in People & Culture	Ensure strong alignment and collaboration across the High Performing Teams and site / group culture development programmes	• Group leadership training & programmes co-designed in Continuous Improvement and Organisation Development (OD) teams • OD, patient experience & Group Strategy teams embedded in improvement training workshops • Supporting team building workshops for senior nurses in the ESTH Critical care team and community therapies (Falls & Bone health) teams at SGUH with a focus on supporting ongoing improvement activity

In addition, members of the Continuous Improvement team are embedded within some of our group's largest programmes including theatres improvements at Epsom and St Helier and maternity services at St George's.

They have also continued to provide specialist coaching support to a variety of improvement projects, particularly to those staff participating in the many improvement training programmes & workshops, with the community of practice group and CI converge events now including staff across the organisation from both ESTH and SGUH.

It has been a busy year building upon existing activities, embarking on closer collaboration with our OD team on leadership development and enhancing our intranet information and further resources.

Our quality priorities for 2025/26

We identified our quality priorities under three quality themes:

- **Priority 1 – Improve patient safety:** having the right systems and staff in place to minimise the risk of harm to our patients and, if things do go wrong, to be open and learn from our mistakes
- **Priority 2 – Improve patient experience:** meeting our patients' emotional as well as physical needs
- **Priority 3 – Improve effectiveness and outcomes:** providing the highest quality care, with world class outcomes whilst also being efficient and cost effective

Our Quality Priorities for 2025/26 were informed by:

- Progress against the Quality Priorities for 2024/25
- Themes highlighted from our ward and departmental accreditation programme
- The findings of the 2019 CQC inspection and the resulting improvement action plan which we implemented during 2020-21
- The feedback from the following CQC inspections (reports awaited)
  - October 2024, Maternity Services
  - December 2024, Emergency and Urgent Care
  - January 2025, Surgery
  - February 2025, Well Led
- Analysis of our complaints and PALs enquiries
- Analysis of our serious incidents and moderate and low harm incidents
- Local and national audit
- National priorities for sepsis, safe staffing, falls, pressure ulcer prevention, and infection prevention and control

As with previous years we have linked our Quality Priorities for 2025/26 to our 5-year strategy for St George's, Epsom and St Helier Hospitals Healthcare Group (2023-2028) which has the following domains:

- Collaboration and Partnership
- Affordable healthcare, fit for the future
- Right care, right place, right time
- Empowered, engaged staff

Our Quality Priorities for 2025/26 will help us to deliver our strategy for Right care, Right place, Right time.

Also, as with previous years, we have linked our Quality Priorities to the Quality and Safety Strategy 2023-28 to help us deliver against our strategic priorities for **Stronger Governance, Shorter Waits** and being **A Learning Organisation.**

Priority 1 – Improve Patient Safety

Patients are safer when there is a safety culture that is fully embedded in everyday business. We believe that all our staff have responsibility to take all necessary steps to avoid harm to our patients, to learn from best practice, deliver the best possible outcomes and reduce unwarranted variation

Priority 1 – Improve Patient Safety 2025-26		
Domain from 5-year Clinical Strategy: Right care, right place, right time		
Improve patient safety		Improve patients' outcome and experience with us
Quality and Safety Strategy		
Strong Governance		A learning Organisation
What	**How**	**What will success look like**
We will focus on improving the delivery of fundamentals of care for: • Pressure ulcer prevention • Venous Thromboembolism (VTE) risk assessment • Falls prevention • Delirium assessment	We will get the basics right every time and consistently complete risk assessments in line with expected standards of performance	**Pressure ulcer prevention:** We will have no category 4 pressure ulcers and see a 10% reduction in category 3 when compared with previous year. **VTE risk assessment:** We will achieve the 95% target for VTE assessment within 14 hours of admission by the end of Q4 2025/26. **Falls prevention:** We will standardise reporting across gesh. We will see a reduction in the number of falls per bed day resulting in moderate and above harm when compared with previous year. **Delirium assessment:** We will achieve the 95% target for Delirium assessment by the end of Q4 2025/26.

Priority 2 - Improve patient experience

We want to listen to our patients and their carers and use patient feedback to focus on continuous improvement.

Priority 2 - Improve patient experience 2025-26		
Domain from 5-year Clinical strategy: Right care, right place, right time		
Reduce waiting times		
Quality and Safety Strategy		
Shorter Waits		A learning Organisation
What	**How**	**What will success look like**
We will improve flow in the Emergency Department to reduce overcrowding and long waits for treatment	We will deliver our flow programme	We will reduce the proportion of patients (total number of patients attending ED) who wait for more than 12 hours in the Emergency Department compared with 2024-25. (Current national average is 8%. Long term national ambition is to achieve less than 2%). We will deliver the 4-hour performance target of 78% of patient attendances being seen and discharged or admitted within 4 hours.

Priority 3 - Improve effectiveness and outcomes

We want to support continuous learning and improvement. We want to demonstrate measurable improvement in patient outcomes and reduce unwarranted variation as evidenced in the results of national audits and quality standards reviews.

<table>
<tr><th colspan="4">Priority 3 - Improve effectiveness and outcomes 2025-26</th></tr>
<tr><td colspan="4">Domain from 5-year Clinical Strategy: Right care, right place, right time</td></tr>
<tr><td>Reduce waiting times</td><td>Improve patient safety</td><td>Improve patients' outcome and experience with us</td><td>Tackle health inequalities</td></tr>
<tr><td colspan="4">Quality and Safety Strategy</td></tr>
<tr><td colspan="2">Shorter Waits</td><td colspan="2">A learning Organisation</td></tr>
<tr><td>What</td><td>How</td><td colspan="2">What will success look like</td></tr>
<tr><td>We will ensure our Maternity Services are safe.</td><td>We will strengthen the governance and quality of our Maternity Services</td><td colspan="2">We will deliver the integrated improvement plan for maternity services within agreed timeframes.</td></tr>
</table>

2.1.4 How progress to achieve these priorities will be reported

The progress against 'what will success look like' will be reported and monitored by progress reports to site leadership meetings, the gesh Quality Group and the Quality Committee in Common, a sub-committee of the Trust Board.

2.1.5 Progress against priorities for 2024/25

[See part 3]

2.2 Statements of assurance from the Board of Directors

This section contains the statutory statements concerning the quality of services provided by St George's University Hospitals NHS Foundation Trust. These are common to all quality reports and can be used to compare our Trust with other organisations.

St George's is the largest healthcare provider in South West London, and one of the largest healthcare providers in the country. The Trust serves a population of 1.3 million people across South West London. A number of services, such as cardiothoracic medicine and surgery, neurosciences and renal transplantation, also cover significant populations from Surrey and Sussex, providing care for about 3.5 million people in total.

Most of our services are provided at our main site, St George's Hospital in Tooting, but we also provide services from Queen Mary's Hospital in Roehampton and from health centres in Wandsworth.

We also provide care for patients from a larger catchment area in South East England for specialist services such as complex pelvic trauma. We also provide specialist services for patients across England for family human immunodeficiency virus (HIV) and bone marrow transplantation for non-cancer diseases.

A number of our services are members of established clinical networks which bring together doctors, nurses and other clinicians from a range of healthcare providers working to improve clinical outcomes and patient experience. These networks include the South London Cardiac and Stroke Network and the South West London and Surrey Trauma Network, for which St George's Hospital is the designated heart attack centre, hyper-acute stroke unit and major trauma centre.

As outlined in the Chief Executive's introduction, the NHS has remained pressured - with St George's being no exception. Our urgent and emergency care pathway has been very busy and flow is increasingly difficult through the hospital, to the wards and home.

St George's, Epsom and St Helier University Hospitals and Health Group - After many years of collaboration and creating closer working ties, Epsom and St Helier University Hospitals NHS Trust and St George's University Hospitals NHS Foundation Trust formed a hospital group and appointed a Group Chief Executive in August 2021 (following the appointment of a Chairman in Common in 2019) and a single executive team in February 2022.

The Group was formed to provide further opportunities for collaboration and allows for more joined up decision making for local people, a larger and more resilient clinical workforce, reduced variation in care and access to a wider range of services for our patients.

This year we have seen a number of exciting developments across the Group.

- Driving forward organisational culture remains a key priority for the Group. Three leadership events, the "gesh 100", have been held to bring together leaders across the Group to develop a leadership community and discuss strategic priorities including quality.

- Together with Epsom and St Heliers University Hospital Trust we previously signed complimentary contracts with Cerner to provide a shared electronic patient records system to deliver streamlined patient care. Due to transition on 9 May 2025, the shared system means that our clinical teams will be able to access patient hospital information and records, irrespective of where care is provided across the Group. It also enables

more effective working with health and care partners including neighbouring hospitals, with the potential for benefits to be scaled across the South West London Integrated Care System (ICS).

- We continue to make strides towards collaboration with Epsom and St Helier for the benefit of staff and patients. We look at where we have variations in care, where we can learn from each other, integrate services across the group, and are asking our staff to talk to their partners at St George's.

- Our programme of integrating our corporate services has continued, with the completion of consultations on the restructure of our corporate nursing teams and the first phase of restructuring of our corporate medical teams. This comes on top of the restructures already completed in Corporate Affairs, Communications and the Deputy CEO's office. We have also agreed timescales for the remaining corporate services to come together on a Group-wide basis.

- In May 2024 the London Cyber Attack disrupted blood tests and transfusions at several hospitals in South East London (King's College Hospital, Guy's and St Thomas' and some primary care services). St George's and Epsom and St Helier were not directly affected by the cyber attack, but have been active in supporting our colleagues in South East London while they respond to the incident. The Group has worked closely with system partners to make sure we continue to provide services to our patients while supporting others. We have, for example, taken on some specialist patient where care was impacted at other hospitals.

- In June 2024 we completed the phased implementation of the new national Patient Safety Incident Response Framework (PSIRF) across the Group. PSIRF will have significant implications for the way in which we treat and investigate incidents, but this new approach will help identify and embed learning from incidents and help promote a culture of patient safety.

- We have continued our plans to improve kidney care in South West London, Surrey and beyond, which will be transformed into a specialist renal unit designed to treat the most seriously ill patients. The proposed facility, which will be based at St George's, will be used by patients who currently receive care at St George's and St Helier hospitals and will be one of the largest and most modern renal services in the UK. Our plans will help transform the quality of kidney care in the region by having specialist inpatient care in one place. The local delivery of most outpatient care and dialysis will still occur close to people's homes, with 95% of patients continuing to receive care and treatment in local hospitals, clinics and at home.

- The Care Quality Commission (CQC) inspected maternity and midwifery services at St George's in March 2023 and at Epsom and St Helier in August 2023. During and after its inspections, the CQC identified areas where significant improvements needed to be made to maintain safe services to patients. Following this, the Group commissioned a review of quality governance arrangements across GESH, with the objective of identifying improvements that can be made to strengthen the governance of maternity services. The first phase of this work which focused on quality governance in maternity services was completed in May 2024. Throughout this year we focussed on implementing the recommendations and actions arising from Phase 1. A second phase of work has been commissioned to assess the maturity of quality governance arrangements at the divisional level. For this pilot phase, three divisions - Integrated Care and Renal at Epsom and St Helier and Surgery, Cancer, Neurosciences and Theatres at St George's were selected to test the approach. The findings of the second phase will be implemented in 2025-26 in a way that enables

the Group to adopt a model of reviewing quality governance maturity in a robust and ongoing basis.

- Our maternity services were rated the best in London by our patients, with over 6,000 babies delivered across the Group.

- We launched a new Cancer Hub, creating a dedicated space for our exceptional Cancer Clinical Nurse Specialists to collaborate effectively.

- We have continued to see increased joint working in Infection Prevention and Control (IPC) with the infection prevention and control teams from both sites working together on a weekly basis led by the Group Chief Nurse and Director of infection Prevention and Control to discuss any IPC issues and agree required actions.

- In December 2024, we hosted our first-ever gesh CARE Awards. This event is linked to our CARE strategy, which aims to sustain an organisation of 'Engaged and Empowered' staff. Nearly 400 guests attended the event to celebrate the dedication and achievements of our teams, while nearly 300 people watched online. We heard firsthand from patients about the impact our staff at gesh have had on their lives. Sky News presenter Jacquie Beltrao spoke movingly about her care and cancer treatment, while our celebrity host, Myleene Klass, shared stories about her mother, an NHS nurse, highlighting the compassion, empathy, and commitment required to care for others.

St George's

Despite the ongoing demand for our services and capacity issues this year we have seen a number of exciting developments at St George's.

- For the past 25 years, St George's University Hospitals (SGUH), in partnership with the Royal Marsden, has been the primary provider of children's cancer services for South London and large parts of the South East of England. In September 2023, NHSE launched a public consultation on the proposed future location of the Principal Treatment Centre (PTC) for Paediatric Cancer in South London. Two options were considered: SGUH in concert with the Royal Marsden and the Evelina London Children's Hospital. Following a public consultation and options-appraisal process and despite public, MP and local councillor opposition the decision was made to transfer the service to the Evelina. This move will take effect in October 2026 at the earliest. We continue to work alongside the Royal Marsden to provide outstanding care to children and young people with cancer.

- St. George's was one of 143 hospital sites that tested and rolled out Martha's Rule in its first year, with the aim of ensuring that patients and families have a clear and consistent way to seek urgent review if they or their loved one's condition deteriorates and are concerned it is not being responded to. The scheme is named after Martha Mills, who died from sepsis in 2021 at age 13 due to the failure to escalate her intensive care despite concerns raised by her family of her worsening condition. Martha's Rule is made up of three components to ensure concerns about deterioration are responded to swiftly. First, an escalation process will be available 24/7 through various publicly displayed advertisements, enabling patients and families to contact a critical care outreach team to assess and escalate care if necessary. Second, NHS staff will also have access to this same process if they have concerns about a patient's condition. Third, clinicians at participating hospitals will also formally record daily insights and information about a patient's health directly from their families, which will help to identify

and address any concerning changes in behaviour or condition noticed by the people who know the patient best. We believe that as this policy expands in future years, these principles will greatly improve patient partnership and positively impact patient outcomes and experiences.

- We pioneered a technique for sickle cell patients that uses ultrasound to detect veins in children with sickle cell disease who are having blood transfusions. It means they do not need to have a permanent port, and it halves the time they spend in hospital

- St George's Anaesthetics Department secured Anaesthesia Clinical Services Accreditation (ACSA) re-accreditation for the third time in a row, placing St George's among an exclusive group of hospitals to earn such a recognition. ACSA, a programme run by the Royal College of Anaesthetists (RCoA), allows departments to showcase excellence in crucial areas such as patient experience and safety. St George's was the fourth hospital in the country to receive ACSA accreditation when it was first launched in 2015, highlighting the department's long-standing commitment to delivering the best care to our patients.

For our commissioned services

2.2.1 During 2024/25 the Trust provided and/or subcontracted 64 relevant health services. A detailed list is available in the Statement of Purpose on our website www.stgeorges.nhs.uk/about

2.2.1.1 The Trust has reviewed all the data available to us on the quality of care in 64 of these relevant health services through our performance management framework and our assurance processes.

2.2.1.2 The income generated by the relevant health services reviewed in 2024/25 represents 100% of the total income generated from the provision of relevant health services by St George's University Hospitals NHS Foundation Trust for 2024/25.

Participation in clinical audit and National Confidential Enquiries

During 2024/25, 79 national clinical audits and 5 national confidential enquiries covered NHS services that St George's University Hospitals NHS Foundation Trust provides.

During that period St George's University Hospitals NHS Foundation Trust participated in 91% of national clinical audits and 100% of national confidential enquiries of the national clinical audits and national confidential enquiries which it was eligible to participate in.

The national clinical audits and national confidential enquiries that St George's University Hospitals NHS Foundation Trust was eligible to participate in during 2024/25 are listed below in Table 1.

Table 1

Project Title	Workstream Title	Relevant	Participating
BAUS Data & Audit Programme	a) BAUS Penile Fracture Audit	Y	Y
	b) BAUS I-DUNC (Impact of Diagnostic Ureteroscopy on Radical Nephroureterectomy and Compliance with Standard of Care Practices)	Y	Y
	c) Environmental Lessons Learned and Applied to the bladder cancer care pathway audit (ELLA)	Y	Y
Breast and Cosmetic Implant Registry	Breast and Cosmetic Implant Registry	Y	Y
British Hernia Society Registry	British Hernia Society Registry	Y	N
Case Mix Programme (CMP)	Case Mix Programme (CMP)	Y	Y
Child Health Clinical Outcome Review Programme	Paediatric Surgery (Emergency - Non Elective)	Y	Y
Cleft Registry and Audit NEtwork (CRANE) Database	Cleft Registry and Audit NEtwork (CRANE) Database	N	N/A
Emergency Medicine QIPs:	a) Care of Older People	Y	Y
	b) Time Critical Medications	Y	Y
	c) Mental Health Self-Harm	Y	Y
Epilepsy12: National Clinical Audit of Seizures and Epilepsies for Children and Young People	Epilepsy12: National Clinical Audit of Seizures and Epilepsies for Children and Young People	Y	Y
Falls and Fragility Fracture Audit Programme (FFFAP):	a) Fracture Liaison Service Database (FLS-DB)	Y	Y
	b) National Audit of Inpatient Falls (NAIF)	Y	Y
	c) National Hip Fracture Database (NHFD)	Y	Y
Learning from lives and deaths – People with a learning disability and autistic people (LeDeR)	Learning from lives and deaths – People with a learning disability and autistic people (LeDeR)	Y	Y
Maternal, Newborn and Infant Clinical Outcome Review Programme	Maternal, Newborn and Infant Clinical Outcome Review Programme	Y	Y
Medical and Surgical Clinical Outcome Review Programme	Acute Limb Ischaemia	Y	Y
	Blood Sodium	Y	Y
	Rehabilitation following Critical Illness	Y	Y
	Acute Illness in people with a Learning Disability	Y	Y
Mental Health Clinical Outcome Review Programme	Mental Health Clinical Outcome Review Programme	N	N/A
National Adult Diabetes Audit (NDA):	a) National Diabetes Core Audit	Y	Y
	b) Diabetes Prevention Programme (DPP) Audit	N	N/A
	c) National Diabetes Footcare Audit (NDFA)	Y	Y
	d) National Diabetes Inpatient Safety Audit (NDISA)	Y	Y
	e) National Pregnancy in Diabetes Audit (NPID)	Y	Y
	f) Transition (Adolescents and Young Adults) and Young Type 2 Audit	Y	Y
	g) Gestational Diabetes Audit	Y	Y
National Audit of Cardiac Rehabilitation	National Audit of Cardiac Rehabilitation	Y	Y
National Audit of Cardiovascular Disease Prevention in Primary Care (CVDPrevent)	National Audit of Cardiovascular Disease Prevention in Primary Care (CVDPrevent)	N	N/A
National Audit of Care at the End of Life (NACEL)	National Audit of Care at the End of Life (NACEL)	Y	Y
National Audit of Dementia (NAD)	National Audit of Dementia (NAD)	Y	Y
National Bariatric Surgery Registry	National Bariatric Surgery Registry	Y	Y
National Cancer Audit Collaborating Centre (NATCAN):	National Audit of Metastatic Breast Cancer (NAoMe)	Y	Y
	National Audit of Primary Breast Cancer (NAoPri)	Y	Y
	National Bowel Cancer Audit (NBOCA)	Y	Y
	National Kidney Cancer Audit (NKCA)	Y	Y
	National Lung Cancer Audit (NLCA)	Y	Y
	National Non-Hodgkin Lymphoma Audit (NNHLA)	Y	Y
	National Oesophago-Gastric Cancer Audit (NOGCA)	Y	Y
	National Ovarian Cancer Audit (NOCA)	Y	Y
	National Pancreatic Cancer Audit (NPaCA)	Y	Y
	National Prostate Cancer Audit (NPCA)	Y	Y

National Cardiac Arrest Audit (NCAA)	National Cardiac Arrest Audit (NCAA)	Y	Y
National Cardiac Audit Programme (NCAP):	a) National Adult Cardiac Surgery Audit (NACSA)	Y	Y
	b) National Congenital Heart Disease Audit (NCHDA)	N	N/A
	c) National Heart Failure Audit (NHFA)	Y	Y
	d) National Audit of Cardiac Rhythm Management (CRM)	Y	Y
	e) Myocardial Ischaemia National Audit Project (MINAP)	Y	Y
	f) National Audit of Percutaneous Coronary Intervention (NAPCI)	Y	Y
	g) National Audit of Mitral Valve Leaflet Repairs (MVLR)	N	N/A
	h) UK Transcatheter Aortic Valve Implantation (TAVI) Registry	Y	Y
	i) Left Atrial Appendage Occlusion (LAAO) Registry	N	N/A
	j) Patent Foramen Ovale Closure (PFOC) Registry	Y	Y
	k) Transcatheter Mitral and Tricuspid Valve (TMTV) Registry	Y	Y
National Child Mortality Database (NCMD)	National Child Mortality Database (NCMD)	Y	Y
National Clinical Audit of Psychosis (NCAP)	National Clinical Audit of Psychosis (NCAP)	N	N/A
National Comparative Audit of Blood Transfusion	a) National Comparative Audit of NICE Quality Standard QS138	Y	Y
	b) National Comparative Audit of Bedside Transfusion Practice	Y	Y
National Early Inflammatory Arthritis Audit (NEIAA)	National Early Inflammatory Arthritis Audit (NEIAA)	Y	Y
National Emergency Laparotomy Audit (NELA)	National Emergency Laparotomy Audit (NELA)	Y	Y
	National Emergency Laparotomy Audit (NoLap)	Y	Y
National Joint Registry	National Joint Registry	Y	Y
National Major Trauma Registry (NMTR)	National Major Trauma Registry (NMTR)	Y	Y
National Maternity and Perinatal Audit (NMPA)	National Maternity and Perinatal Audit (NMPA)	Y	Y
National Neonatal Audit Programme (NNAP)	National Neonatal Audit Programme (NNAP)	Y	Y
National Obesity Audit (NOA)	National Obesity Audit (NOA)	Y	Y
National Ophthalmology Database (NOD)	a) Age-related Macular Degeneration Audit	N	N/A
	b) Cataract Audit	N	N/A
National Paediatric Diabetes Audit (NPDA)	National Paediatric Diabetes Audit (NPDA)	Y	Y
National Perinatal Mortality Review Tool	National Perinatal Mortality Review Tool	Y	Y
National Pulmonary Hypertension Audit	National Pulmonary Hypertension Audit	N	N/A
National Respiratory Audit Programme (NRAP)	a) COPD Secondary Care	Y	Y
	b) Pulmonary Rehabilitation	Y	Y
	c) Adult Asthma Secondary Care	Y	N
	d) Children and Young People's Asthma Secondary Care	Y	Y
National Vascular Registry (NVR)	National Vascular Registry (NVR)	Y	Y
Out-of-Hospital Cardiac Arrest Outcomes (OHCAO)	Out-of-Hospital Cardiac Arrest Outcomes (OHCAO)	N	N/A
Paediatric Intensive Care Audit Network (PICANet)	Paediatric Intensive Care Audit Network (PICANet)	Y	Y
Perioperative Quality Improvement Programme	Perioperative Quality Improvement Programme	Y	Y
Prescribing Observatory for Mental Health (POMH)	a) Rapid tranquillisation in the context of the pharmacological management of acutely disturbed behaviour	N	N/A
	b) The use of melatonin	N	N/A
	c) The use of opioids in mental health services	N	N/A
Quality and Outcomes in Oral and Maxillofacial Surgery (QOMS):	a) Oncology & Reconstruction	Y	N
	b) Trauma	Y	N
	c) Orthognathic Surgery	Y	N
	d) Non-melanoma skin cancers	Y	N
	e) Oral and Dentoalveolar Surgery	Y	N
Sentinel Stroke National Audit Programme (SSNAP)	Sentinel Stroke National Audit Programme (SSNAP)	Y	Y
Serious Hazards of Transfusion (SHOT): UK National Haemovigilance Scheme	Serious Hazards of Transfusion (SHOT): UK National Haemovigilance Scheme	Y	Y

Society for Acute Medicine Benchmarking Audit (SAMBA)	Society for Acute Medicine Benchmarking Audit (SAMBA)	Y	Y
UK Cystic Fibrosis Registry	UK Cystic Fibrosis Registry	N	N/A
UK Renal Registry Chronic Kidney Disease Audit	UK Renal Registry Chronic Kidney Disease Audit	Y	Y
UK Renal Registry National Acute Kidney Injury Audit	UK Renal Registry National Acute Kidney Injury Audit	Y	Y

The national clinical audits and national confidential enquiries for which data collection was completed during 2024/25 are listed in Table 2 alongside the number of cases submitted to each audit or enquiry as a percentage of the number of registered cases required by the terms of that audit or enquiry. For the remaining projects that the Trust participated in (Table 1) the 2024/25 data collection completes during 2025/26 and therefore submission rates are not available at the time of this report.

Table 2

Project Title	Workstream Title	Submission Rate (%)
BAUS Data & Audit Programme	a) BAUS Penile Fracture Audit	100%
	b) BAUS I-DUNC (Impact of Diagnostic Ureteroscopy on Radical Nephroureterectomy and Compliance with Standard of Care Practices)	100%
	c) Environmental Lessons Learned and Applied to the bladder cancer care pathway audit (ELLA)	Ongoing
Breast and Cosmetic Implant Registry	Breast and Cosmetic Implant Registry	100%
British Hernia Society Registry	British Hernia Society Registry	0%
Case Mix Programme (CMP)	Cardiothoracic ICU	Ongoing
	General ICU	Ongoing
	Neuro ICU	Ongoing
Child Health Clinical Outcome Review Programme	Paediatric Surgery (Emergency - Non Elective)	100%
Cleft Registry and Audit NEtwork (CRANE) Database	Cleft Registry and Audit NEtwork (CRANE) Database	N/A
Emergency Medicine QIPs:	a) Care of Older People	6%
	b) Time Critical Medications	0%
	c) Mental Health Self-Harm	13%
Epilepsy12: National Clinical Audit of Seizures and Epilepsies for Children and Young People	Epilepsy12: National Clinical Audit of Seizures and Epilepsies for Children and Young People[1]	100%
Falls and Fragility Fracture Audit Programme (FFFAP):	a) Fracture Liaison Service Database (FLS-DB)	100%
	b) National Audit of Inpatient Falls (NAIF)	100%
	c) National Hip Fracture Database (NHFD)	100%
Learning from lives and deaths – People with a learning disability and autistic people (LeDeR)	Learning from lives and deaths – People with a learning disability and autistic people (LeDeR)	Ongoing
Maternal, Newborn and Infant Clinical Outcome Review Programme	Maternal morbidity confidential enquiry - annual topic based serious maternal morbidity	Ongoing
	Maternal mortality confidential enquiries	Ongoing
	Maternal mortality surveillance	Ongoing
	Perinatal mortality and serious morbidity confidential enquiry	Ongoing
	Perinatal Mortality Surveillance	Ongoing
Medical and Surgical Clinical Outcome Review Programme	Acute Limb Ischaemia	100%
	Blood Sodium	100%
	Rehabilitation following Critical Illness	100%
	Acute Illness in people with a Learning Disability	Ongoing
Mental Health Clinical Outcome Review Programme	Mental Health Clinical Outcome Review Programme	N/A
National Adult Diabetes Audit (NDA)	a) National Diabetes Core Audit. Includes:	100%
	b) Diabetes Prevention Programme (DPP) Audit	N/A
	c) National Diabetes Footcare Audit (NDFA)	100%
	d) National Diabetes Inpatient Safety Audit (NDISA)	100%
	e) National Pregnancy in Diabetes Audit (NPID)	100%
	f) Transition (Adolescents and Young Adults) and Young Type 2 Audit	100%
	g) Gestational Diabetes Audit	100%
National Audit of Cardiac Rehabilitation	National Audit of Cardiac Rehabilitation	100%
National Audit of Cardiovascular Disease Prevention in Primary Care (CVDPrevent)	National Audit of Cardiovascular Disease Prevention in Primary Care (CVDPrevent)	N/A

National Audit of Care at the End of Life (NACEL)	National Audit of Care at the End of Life (NACEL)	100%
National Audit of Dementia (NAD)	National Audit of Dementia (NAD)	Ongoing
National Bariatric Surgery Registry	National Bariatric Surgery Registry	Ongoing
National Cancer Audit Collaborating Centre (NATCAN):	National Audit of Metastatic Breast Cancer (NAoMe)	100%
	National Audit of Primary Breast Cancer (NAoPri)	100%
	National Bowel Cancer Audit (NBOCA)	100%
	National Kidney Cancer Audit (NKCA)	100%
	National Lung Cancer Audit (NLCA)	100%
	National Non-Hodgkin Lymphoma Audit (NNHLA)	100%
	National Oesophago-Gastric Cancer Audit (NOGCA)	100%
	National Ovarian Cancer Audit (NOCA)	100%
	National Pancreatic Cancer Audit (NPaCA)	100%
	National Prostate Cancer Audit (NPCA)	100%
National Cardiac Arrest Audit (NCAA)	National Cardiac Arrest Audit (NCAA)	Ongoing
National Cardiac Audit Programme (NCAP):	a) National Adult Cardiac Surgery Audit (NACSA)	Ongoing
	b) National Congenital Heart Disease Audit (NCHDA)	N/A
	c) National Heart Failure Audit (NHFA)	Ongoing
	d) National Audit of Cardiac Rhythm Management (CRM)	Ongoing
	e) Myocardial Ischaemia National Audit Project (MINAP)	Ongoing
	f) National Audit of Percutaneous Coronary Intervention (NAPCI)	Ongoing
	g) National Audit of Mitral Valve Leaflet Repairs (MVLR)	N/A
	h) UK Transcatheter Aortic Valve Implantation (TAVI) Registry	Ongoing
	i) Left Atrial Appendage Occlusion (LAAO) Registry	N/A
	j) Patent Foramen Ovale Closure (PFOC) Registry	Ongoing
	k) Transcatheter Mitral and Tricuspid Valve (TMTV) Registry	Ongoing
National Child Mortality Database (NCMD)	National Child Mortality Database (NCMD)	100%
National Clinical Audit of Psychosis (NCAP)	National Clinical Audit of Psychosis (NCAP)	N/A
National Comparative Audit of Blood Transfusion:	a) National Comparative Audit of NICE Quality Standard QS138	100%
	b) National Comparative Audit of Bedside Transfusion Practice	100%
National Early Inflammatory Arthritis Audit (NEIAA)	National Early Inflammatory Arthritis Audit (NEIAA)	100%
National Emergency Laparotomy Audit (NELA)	National Emergency Laparotomy Audit (NELA)	95%
	National Emergency Laparotomy Audit (NoLap)	Ongoing
National Joint Registry	National Joint Registry	95%
National Major Trauma Registry (NMTR)	National Major Trauma Registry (NMTR)	Ongoing
National Maternity and Perinatal Audit (NMPA)	National Maternity and Perinatal Audit (NMPA)	100%
National Neonatal Audit Programme (NNAP)	National Neonatal Audit Programme (NNAP)	100%
National Obesity Audit (NOA)	National Obesity Audit (NOA)	Ongoing
National Ophthalmology Database (NOD)	a) Age-related Macular Degeneration Audit	N/A
	b) Cataract Audit	N/A
National Paediatric Diabetes Audit (NPDA)	National Paediatric Diabetes Audit (NPDA)	Ongoing
National Perinatal Mortality Review Tool	National Perinatal Mortality Review Tool	Ongoing
National Respiratory Audit Programme (NRAP)	a) COPD Secondary Care	Ongoing
	b) Pulmonary Rehabilitation	Ongoing
	c) Adult Asthma Secondary Care	Ongoing
	d) Children and Young People's Asthma Secondary Care	Ongoing
National Vascular Registry (NVR)	National Vascular Registry (NVR)	Ongoing
Out-of-Hospital Cardiac Arrest Outcomes (OHCAO)	Out-of-Hospital Cardiac Arrest Outcomes (OHCAO)	N/A
Paediatric Intensive Care Audit Network (PICANet)	Paediatric Intensive Care Audit Network (PICANet)	Ongoing
Perioperative Quality Improvement Programme	Perioperative Quality Improvement Programme	Ongoing
Prescribing Observatory for Mental Health (POMH)	a) Rapid tranquillisation in the context of the pharmacological management of acutely disturbed behaviour	N/A

	b) The use of melatonin	N/A
	c) The use of opioids in mental health services	N/A
Quality and Outcomes in Oral and Maxillofacial Surgery (QOMS)	a) Oncology & Reconstruction	0%
	b) Trauma	0%
	c) Orthognathic Surgery	0%
	d) Non-melanoma skin cancers	0%
	e) Oral and Dentoalveolar Surgery	0%
Sentinel Stroke National Audit Programme (SSNAP)	Sentinel Stroke National Audit Programme (SSNAP)	90%
Serious Hazards of Transfusion (SHOT): UK National Haemovigilance Scheme	Serious Hazards of Transfusion (SHOT): UK National Haemovigilance Scheme	100%
Society for Acute Medicine Benchmarking Audit (SAMBA)	Society for Acute Medicine Benchmarking Audit (SAMBA)	100%
UK Cystic Fibrosis Registry	UK Cystic Fibrosis Registry	N/A
UK Renal Registry Chronic Kidney Disease Audit	UK Renal Registry Chronic Kidney Disease Audit	100%
UK Renal Registry National Acute Kidney Injury Audit	UK Renal Registry National Acute Kidney Injury Audit	100%

National clinical audits - action taken

The reports of 40 national clinical audits were reviewed by St George's University Hospitals NHS Foundation Trust in 2024/25 and we are taking the following actions to improve the quality of healthcare provided.

Project Title	Action Plan
Intensive Care National Audit & Research Centre (ICNARC): Case Mix Programme (CMP)	The Case Mix Programme (CMP) is a national clinical audit of patient outcomes from adult critical care. The audit has three streams and SGH participate well in all three. The data period runs from April to March each year, with data submission closing six weeks after the end of March. Focus of actions for the year ahead will look at quality improvement related to delayed admissions and work is being done to liaise with the Critical Care Outreach Team to improve documentation, as well ensuring that date/time of decisions made to admit patients to ICU are recorded for more than 80% of eligible patients.
National Confidential Enquiry into Patient Outcome and Death: Child Health Clinical Outcome Review Programme - Juvenile Idiopathic Arthritis	This study looked at the quality of care provided to children and young adults aged 0-24 years, coded before their 16th birthday for a diagnosis of juvenile idiopathic arthritis between April 2019 and March 2023. The Trust participated fully in all elements required. The report was published in February 2025 and Lead Paediatric Rheumatologist at the Trust commented on the findings: the Trust Paediatric service is small and that care and treatment after diagnosis is mostly managed by Great Ormond Street Hospital or Evelina Children's Hospital however action is still needed to ensure patients are referred to the correct team to prevent delays in treatment and diagnosis; multidisciplinary working between paediatric and adult Rheumatology services at the Trust; further applications for funding to bring in dedicated allied health professionals for the patients within the paediatric service. The Lead hopes that this report will serve as a catalyst for change in the coming years.
Emergency Medicine QIPs:	The Royal College of Emergency Medicine Quality Improvement Projects (RCEM QIPs) aim to improve quality of care for patients who attend the Emergency Department and cover different topics, running from January to December each year. The Clinical Lead identified low submission rates in Year 2 for the three streams and has developed an action plan to improve rates in the coming year which includes: • Establishing a dedicated team for each RCEM Quality Improvement Project stream. • Ensure that five patients are audited each week to make submission targets easier to meet. • Follow RCEM guidance and collaborate with the assembled teams to achieve the targeted rates. • Provide regular updates on progress, findings, and proposed interventions at the bi-monthly departmental audit/QIP meetings.
Epilepsy12: National Clinical Audit of Seizures and Epilepsies for Children and Young People	In April 2024 the Trust received a positive outlier notification from the Audit Provider related to *specialist epilepsy nurse's input by first year of care* in the data analysis Cohort 5. The latest report was published in July 2024 on Cohort 5 (December 2021 and November 2022) and the Clinical Lead reports that the Trust continues to meet Best Practice Tariff for Epilepsy for clinic configuration, also that data entry remains at 100%. The audit measures 10 KPIs and the Trust has done well. Areas for improvement have been identified around: • Children diagnosed with epilepsy being seen within 2 weeks of first referral by a paediatrician with expertise in epilepsy. The Trust does not meet this standard, with higher than national average numbers waiting 16 weeks after referral. This has been raised a risk and will be addressed in the year ahead. • A local audit to understand the high prescription of rescue medication at the Trust in comparison with national average.

	• Improving the number of children with epilepsy aged 5 and above who have a school individual healthcare plan by the first year in comparison with national average.
Falls and Fragility Fracture Audit Programme (FFFAP): Fracture Liaison Service Database (FLS-DB)	The latest audit report, released in January 2025, reviewed performance from 2023 and shows the Trust achieved above national average for 5 of the 10 Key findings and below average for the remainder. In response to the report outcomes, the clinical lead developed an action plan with the following key actions: • Non-Spine Case Identification and Assessment Within 90 Days: A business case has been developed for the osteoporosis service to include an additional Fracture Liaison Service (FLS) nurse and additional consultant time. This is to ensure the safe management of the osteoporosis/fracture prevention workload, in line with recommendations from the Royal Osteoporosis Society. • Falls Risk Assessment: All patients attending the FLS clinic will undergo a falls risk assessment to improve early identification and intervention. • Strength & Balance Programme Within 16 Weeks: Patients will be referred to strength and balance classes as soon as they are identified, rather than waiting for an FLS clinic appointment. This change is necessary due to FLS clinic waiting times exceeding eight months. • 16-Week Follow-Up and Treatment at First Follow-Up: Follow-up dates will be recorded immediately after telephone consultations to ensure timely monitoring and treatment. • 1-Year Drug Adherence Monitoring: Due to staffing shortages, one-year follow-ups for drug adherence will not be conducted at this time.
Falls and Fragility Fracture Audit Programme (FFFAP): National Audit of Inpatient Falls (NAIF)	The latest audit report, released in October 2024, reviewed performance over 2023 and showed that the Trusts outcomes are in line with national averages for most metrics. The clinical lead submitted an action plan for the upcoming year: • Promote Safe Activity: Revise policies to support older inpatients in staying active, integrating safe activity into care plans and staff training. • Screen for Delirium: Use the 4AT tool to screen for and monitor delirium in older patients during hospital stays. • Improve Post-Fall Checks: Strengthen governance to ensure fall-related injuries are correctly identified during post-fall assessments. • Timely Analgesia: Ensure patients with femoral fractures receive pain relief within 30 minutes of injury. • Prepare for Audit Expansion: Plan for the 2025 expansion to include head injuries, spinal injuries, and all fracture types from inpatient falls.
Falls and Fragility Fracture Audit Programme (FFFAP): National Hip Fracture Database (NHFD)	The Trust performed within expected limits for five out of six performance metrics in the latest report published in September 2024. To address areas for improvement, the Clinical Lead developed the following action plan: • Ensure the Site management team prioritises hip fracture patients for transfer to orthopaedic wards. • Assess the need for clinical coverage on public holidays. • Utilise quarterly governance meetings as opportunities for assurance and improvement. • Consider involving an Ortho-geriatrician in morning Trauma & Orthopaedics handover meetings to support decision-making. • Hold regular meetings with Physical Therapy/Occupational Therapy teams to review performance and implement action plans. • Maintain a strong focus on completing pre- and post-operative delirium assessments. • Work closely with nursing colleagues to identify delirium early and mitigate risk factors. • The Trust-wide Delirium and Dementia team will continue reviewing patients diagnosed with delirium through screening. • Investigate issues around how the bone plan metric is calculated for formal follow-ups. • Monitor progress and collaborate with nursing colleagues to ensure optimal patient outcomes.
Maternal, Newborn and Infant Clinical Outcome Review Programme: Maternal morbidity confidential enquiry - annual topic based serious maternal morbidity	The latest Maternity morbidity confidential enquiry was completed in conjunction with the Perinatal mortality and morbidity confidential enquiry. The report was published in December 2024. The topic focused on care of recent migrant women with languages barriers who have experienced a stillbirth or neonatal death. All MBRRACE reports are discussed at quarterly Maternity Governance Meetings to identify key themes, and many aspects of MBRRACE reports are embedded in ongoing compliance work such as the Clinical Negligence Scheme for Trusts, Saving Babies Lives Care Bundle and quarterly Perinatal Mortality Review.
Maternal, Newborn and Infant Clinical Outcome Review Programme: Perinatal Mortality Surveillance	The latest report for this MBRRACE stream was published in July 2024 on 2022 data. MBRRACE reports often make recommendations which are often targeted at Maternity services – these are reviewed and discussed at quarterly Maternity Governance Meetings. This report made a recommendation which the Quality Improvement and Governance Midwife indicated was relevant for the Neonatal team. Consultant for Neonatal confirmed that all processes mentioned by the report are covered by ongoing work submitted for the Clinical Negligence Scheme for Trusts Maternity Incentive Scheme and Saving Babies Lives Care Bundle.

Medical and Surgical Clinical Outcome Review Programme: End of Life Care	This study report made seven recommendations in areas including ensuring patients with advanced chronic diseases have access to palliative care and disease modifying treatment; to normalise conversations about palliative/end of life care, advance care plans, death and dying; to ensure all patients with advanced chronic diseases are allocated a named care co-ordinator; train patient-facing healthcare staff in palliative and end of life care; ensuring that existing advance care plans are shared between all providers involved in a patient's care. The Clinical Lead has conducted a gap analysis and is working with the Trust senior leadership, the Clinical Audit Team and the NCEPOD ambassador to develop improvement goals.
Medical and Surgical Clinical Outcome Review Programme: Endometriosis	This study examined the pathway and quality of care provided to patients aged 18 years and over with a diagnosis of endometriosis over the period February 2018 to July 2020. The Trust participated fully in all elements required. The report was published in July 2024 and the Trusts Lead Gynaecologist for the Endometriosis service reports that the service is well regarded by service users. The Trust was one of the first centres in South-West London to provide robotic excision for patients with severe endometriosis. The Lead further commented that efforts to develop into an Endometriosis Centre are restricted as a dedicated Clinical Nurse Specialist to reduce current waiting times is limited by resource constraints. The Lead plans to develop a business case as becoming a centre will increase remuneration and further support patients with endometriosis who use our current service.
National Adult Diabetes Audit (NDA): National Diabetes Core Audit	The clinical lead confirmed that data collection is progressing well. The latest dashboard with outcomes from 2023 to 2024 shows that the Trust is performing in line with national averages for Type 1 diabetes, however below national average for Type 2. The following action plan has been developed by the Clinical Lead: • Define the Trust Type 1 Diabetes Population: Data has been collated through an information request. The pre-clinic NDA form will be updated to include additional questions for gathering relevant patient information. • Improve the Type 1 Diabetes Clinic and Referral Pathway: Review the current patient pathway, including the number of patients seen over the past year and the clinics they attended. A revised pathway model will be proposed and discussed with the Care Group. • Identify Patients on HCL Insulin Pump Therapy: Analyse data from the information request to determine the number of patients who have used HCL insulin pump therapy in the last year. • Enhance Education and Training for Healthcare Professionals in Pump Therapy: Secure funding, identify appropriate training courses, and facilitate attendance for healthcare professionals to improve their knowledge of insulin pump therapy. • Secure Additional Administrative Support: Develop a business case to obtain additional administrative resources.
National Adult Diabetes Audit (NDA): National Diabetes Footcare Audit (NDFA)	The Clinical Lead reports that data collection is progressing well. The latest report was published 2024 and reviewed data from 2018 to 2023. The Trust have been performing above or in line with national averages for the four key metrics. The Clinical Lead shared following action plan: • Insulin Safety Training for New and Internationally Trained Nurses: Ensure adequate staffing is available to deliver insulin safety training for new and internationally trained nurses. • Training for Non-Specialist Doctors: Develop a training course for non-specialist doctors. This course will be written, reviewed, and approved by the Medicine and training teams before final approval by the Care Group. • Update Diabetes Management Guidelines for Inpatients: Review and update current inpatient diabetes management guidelines, including the hypoglycaemia pathway, to ensure they remain accurate and up to date.
National Adult Diabetes Audit (NDA): National Diabetes Inpatient Safety Audit (NDISA)	Data collection for this audit is ongoing. The latest report was published in 2024 and reviews data from 2018 to 2023. The following has been planned for implementation in the coming year, confirmed by the Clinical Lead: • Insulin Safety Training for New and Internationally Trained Nurses: Ensure adequate staffing is available to deliver insulin safety training for new and internationally trained nurses. • Training for Non-Specialist Doctors: Develop a training course for non-specialist doctors. This course will be written, reviewed, and approved by the Medicine and training teams before final approval by the Care Group. • Update Diabetes Management Guidelines for Inpatients: Review and update current inpatient diabetes management guidelines, including the hypoglycaemia pathway, to ensure they remain accurate and up to date.
National Adult Diabetes Audit (NDA): Transition (Adolescents and Young Adults) and Young Type 2 Audit	The Clinical lead reports that data collection is progressing well. No report was published in 2024/25 however the service is working on the following improvement goals: • Diabetes Psychologist for Young Patients: Develop a business case with operational and senior leadership for expanding and establishing a dedicated psychologist role. • Administrator Support: Explore the need for an administrator to assist with audit and clinical administrative tasks, with discussions to be held with the Care Group Lead. • Audit on Diabetes Control and Clinic Attendance: Conduct an audit to assess diabetes management and patient attendance at clinics.

National Audit of Care at the End of Life (NACEL)	No report was published for this audit in 2024/2025 however the Clinical Lead shared the following ongoing work: • Treatment Escalation Plans (TEP): Increase completion from 45% to 100%, TEP & DNACPR embedded in discharge summaries, UCP fully integrated with on Trust electronic patient record system for updates. • Palliative Care Improvements: Holistic assessments for all palliative patients, Fast Track CHC funding applications as needed, Specialist Palliative Care Team: 7-day service + 24-hour advice line. • Training & Education: Mandatory EOLC training for all staff, Induction for nurses, healthcare support workers, and junior doctors, specialty-specific & simulation training. • Care for the Dying: Updated care plan (2023) aligned with NICE standards, covers symptom control, nutrition, hydration & family support. • Support for Families: Psychological & bereavement support, EOLC Companions pilot for patient & family care, annual memorial service & Macmillan financial advice.
National Audit of Dementia (NAD)	The latest report was published in December 2024. The Trust performed lower than expected in areas around delirium screening, pain assessment, a lack of a robust system to identify patients with dementia upon admission, and monitoring the harm caused by adverse events during a patient's hospital stay. In response to these findings the Clinical Lead has outlined the following actions for improvement over the coming year: • Enhance Dementia Identification ▪ Improve Trust systems for the timely identification of patients with dementia or suspected dementia upon hospital admission. • Standardise Dementia Training ▪ Address inconsistencies in Tier 2 dementia training requirements. ▪ Conduct a Dementia Training Needs Analysis and develop an education plan with an options appraisal for executive decision-making. • Strengthen Information Systems ▪ Implement a robust system to track inpatient falls, pressure ulcers, delayed discharges, readmissions within 30 days, and violent incidents. ▪ Add questions to the Datix incident reporting system to flag incidents (falls, violence, pressure sores) involving patients with dementia or delirium. • Improve Person-Centred Care ▪ Increase completion and use of hospital passports. ▪ Launch the "Forget Me Not" scheme across inpatient wards at the acute site and QMH. ▪ Review ward accreditation criteria related to person-centred care. • Enhance Delirium Screening ▪ Develop a Group Dementia and Delirium Dashboard for wards, areas, and divisions to monitor performance. ▪ Track compliance monthly via site heatmaps and identify necessary improvements. • Improve Carer Experience ▪ Relaunch John's Campaign to promote carer involvement. ▪ Relaunch Carer Passports to facilitate support for carers. ▪ Update the carer feedback survey with input from Wandsworth Carers.
National Cancer Audit Collaborating Centre (NATCAN): National Audit of Metastatic Breast Cancer (NAoMe)	The latest audit report on Metastatic Breast Cancer (MBC) was released in September 2024, and reviewed data from 2021. The Clinical Lead developed an action plan in response to the findings: • Enhance MDT Discussions for Newly Diagnosed MBC Patients: Ensure the care for people newly diagnosed with MBC (either de-novo or recurrent) is discussed within a breast multidisciplinary team (MDT) meeting. • Ensure the updated M1 TNM staging is entered or updated appropriately. • Increase Biopsy Rates for MBC Where Feasible: ▪ Assess the last two years of patients with new metastatic breast cancer and review biopsy rates. ▪ Advocate for biopsy when feasible and when results may have therapeutic implications. • Strengthen Data Quality in Breast MDTs: Confirm that breast multidisciplinary teams (MDTs) have a data lead responsible for ensuring the quality of national data submissions. • Improve Fitness Assessments for Older Patients: ▪ Record fitness assessment data items for people aged 70+ years. ▪ Review the process of capturing these data within a breast MDT. ▪ Ensure data are uploaded to cancer datasets.
National Cancer Audit Collaborating Centre (NATCAN): National Bowel Cancer Audit (NBOCA)	The 2025 clinical audit report reviewed performance from 2023. The Clinical Lead developed an action plan for the upcoming year: • Review Performance Against NBOCA KPIs for 2024: Assess progress and identify areas for improvement based on key performance indicators. • Collect Data from Major Resections - Ensure comprehensive data collection for all major resections to support accurate reporting. • Improve Data Accuracy in NBOCA Databases

	▪ Verify that all relevant data is correctly captured in the databases used by NBOCA. ▪ Collaborate with the Data Team - Work closely with the data team to review and optimise database accuracy and functionality.
National Cancer Audit Collaborating Centre (NATCAN): National Kidney Cancer Audit (NKCA)	The 2024 clinical audit report reviewed performance from 2021. The Clinical Lead submitted an action plan for the upcoming year: • Reduce System-Level Delays for High-Risk Renal Cell Carcinoma (RCC) Patients ▪ Review pathways to ensure patients receive treatment within 31 days from the decision to treat. ▪ Work with administration to ring-fence 1–2 urgent slots per week. ▪ Expand the renal consultant workforce to increase clinic capacity. • Enhance Multidisciplinary Team (MDT) Discussions and Nephron-Sparing Treatment ▪ Ensure stage T1aN0M0 RCC patients are discussed in specialist MDT meetings. ▪ Offer nephron-sparing treatment where appropriate. ▪ Expand the surgical team's skill - set three surgeons can now perform nephron-sparing surgery, increasing treatment capacity.
National Cancer Audit Collaborating Centre (NATCAN): National Lung Cancer Audit (NLCA)	The Clinical Lead developed an action plan in response to the April 2024 clinical audit report: • Improve Data Completeness: Work with Cancer Data Manager to enhance data collection processes to ensure comprehensive and accurate reporting. • Address non-compliance with National Clinical Nurse Specialist-to-Patient Ratio: Develop a business case to convert a fixed-term Band 7 role into a substantive position. • Review Pathology Turnaround Times: Conduct a local audit to assess the time from biopsy to final molecular results, evaluating any delays in treatment and their impact on 62-day breach targets.
National Cancer Audit Collaborating Centre (NATCAN): National Non-Hodgkin Lymphoma Audit (NNHLA)	The latest report reviewing performance from 2021 was released in September 2024. The Clinical Lead worked with the Clinical Audit Team to develop the following action plan: • Work with the Trust Information Team to ensure the accuracy and completeness of submitted data. • Ensure that all lymphoma cases are discussed in the MDT within four weeks of diagnosis. This will involve working with the Haematology/Oncology MDT coordinator to compile a list of all new diagnoses for review.
National Cancer Audit Collaborating Centre (NATCAN): National Oesophago-Gastric Cancer Audit (NOGCA)	The clinical audit report of January 2025 found that the Trust had fallen short in metrics around patients diagnosed with stage 4 disease who died within 30 days of starting systemic anti-cancer treatment (SACT), patient diagnosis after an emergency admission, and patient diagnosis within 28 days of an urgent GP referral. The Clinical Director has responded to the findings with following actions: • Conducting audits on approaches to treatment by clinicians, clinicians then to reflect on best practice guidance and other cancer centre performance to improve performance. • Work with the Endoscopy department around diagnostics and patient pathways.
National Cancer Audit Collaborating Centre (NATCAN): National Ovarian Cancer Audit (NOCA)	The latest audit report released in September 2024 reviewed performance from 2022. The Clinical Lead developed an action plan in response to the findings: • Reduce the Rate of Ovarian Cancers Diagnosed via Emergency Admissions: Work with the GP Liaison Team to increase symptom awareness among GPs and women. Review diagnostic pathways to ensure earlier and more timely testing. • Analyse Treatment Disparities in Advanced Ovarian Cancer (AOC): Assess the proportion of patients with AOC who receive or do not receive treatment and explore the reasons for variation. Increase the proportion of eligible patients receiving surgery and chemotherapy. • Evaluate the Use of Platinum-Based Chemotherapy in Advanced Epithelial Ovarian Cancer (AEOC): Investigate variations in the use of platinum-based chemotherapy across Integrated Gynaecological Cancer Systems (IGCS). Increase the proportion of AEOC patients receiving platinum-based chemotherapy. • Review One-Year Survival Rates for Ovarian Cancer (OC): Conduct a retrospective study on one-year survival outcomes for OC patients within the Trust. • Enhance Data Completeness and Quality in National Cancer Datasets: Audit the completeness of recorded data for newly diagnosed OC patients, with a focus on the five key data items in the NOCA dataset.
National Cardiac Audit Programme (NCAP): National Audit of Cardiac Rhythm Management (CRM)	The latest report was published in 2025, and the Clinical Lead developed an action plan to address areas for improvement in the upcoming year: • Achieve >90% compliance with NICE Guidelines for Dual Pacing in Atrioventricular Block: Lead physiologists will work with device physiologists to ensure accurate details for implantation are inputted into Pacenet. • Achieve >80% compliance with NICE Guidelines on Implantable Cardioverter Defibrillator (ICD) Use for Primary Prevention: Lead physiologists will amend Pacenet to ensure accurate data boxes reflect the implanting indications for ICDs.
National Comparative Audit of Blood Transfusion: National Comparative Audit of Bedside Transfusion Practice	The 2024 report reviewed performance from 2023. The Clinical Lead noted that the introduction of a new electronic registration system across the Trust has improved outcomes. Work for the year ahead will be to conduct an internal audit to assess if staff are using devices in line with Trust policy, to maximise improvements to patient safety.

National Early Inflammatory Arthritis Audit (NEIAA)	The latest audit report, released in October 2024, reviewed performance from 2023. In response an action plan was developed by the Clinical Lead: • Establish an Early Inflammatory Arthritis (EIA) Pathway: Develop a referral form and publish it on e-referrals to make it more easily accessible to GPs. • Implement dedicated EIA Clinic Slots: Ensure patients are seen within three weeks, with appropriate triage into EIA slots. Work with GP colleagues to use the referral form for consistency. • Ensure treatment within six Weeks: Control entry to the EIA pathway to ensure timely appointments. Require GPs to conduct pre-assessment blood tests. • Increase Recruitment for Rare Diseases: Engage other consultants to contribute their patients to the National Early Inflammatory Arthritis Audit (NEIAA).
National Emergency Laparotomy Audit (NELA)	The latest audit report was released in November 2024 and reviewed performance from 2023. The Trust performed extremely well with respect to lower-than-average mortality scores. The Clinical Lead confirmed work for the year ahead includes Enhancing Pre-Operative Risk Assessment & Documentation, Improving Geriatric Medicine Input, ICU Involvement Documentation and Standardising Risk Scoring Documentation.
National Major Trauma Registry (NMTR)	The National Registry for Major Trauma (NMTR) went live in April 2024 with all Trusts asked to submit data from January 2024 onwards. The local team have been working hard to establish a sustainable system for date entry. The Clinical Lead reported that the service is expanding work to look at Length of Stay (LOS) for major trauma patients not admitted to the major trauma ward for improved data completeness. The team have also developed a major trauma dashboard to support the Trusts review of rib fractures and LOS.
National Maternity and Perinatal Audit (NMPA)	A separate topic-specific report was published by the NMPA in July 2024 which examined Perinatal Mental Health in NHS Secondary Care. One of the recommendations of this report was aimed at Maternity Service Providers and the Trust Named Midwife for Safeguarding commented that, local clinical guidelines recommends staff offer women/birthing people with a significant history of mental illness (perinatal or otherwise) a referral to the specialist perinatal mental health midwife, who, after review of the woman's/birthing person's mental health history, will offer referral to specialist perinatal psychiatry services in their local area. The Clinical Lead is working with system partners to establish an effective pathway where women and birthing people with a significant mental health diagnosis and/or history of serious perinatal mental health illness can access their GP for pre-conception advice, and where indicated offer the patient referral to secondary perinatal mental health services for individualised pre-conception advice.
National Neonatal Audit Programme (NNAP)	The latest National Neonatal Audit Programme (NNAP) report published in October 2024 indicates that the Trust is performing well or in line with the national average for all 20 key metrics of the project. The Clinical Lead reports that work for the year ahead includes using the restricted dashboard data to feed into local quality improvement activities, continuous review of adverse outcomes and ensuring subsequent action plans for improvement and results are shared with the wider Neonatal Network and Local Maternity and Neonatal System.
National Paediatric Diabetes Audit (NPDA)	The latest National Paediatric Diabetes Audit (NPDA) report was published in April 2024 and showed that the Trust is performing in line or above national average for most outcomes. There is a shortfall in performance related to eye screening, the Clinical Lead indicated that eye appointments are part of national screening invitations and are not managed locally - patients are routinely asked within the service if they have received their eye screening and if not, rebooking is facilitated. Ongoing work includes to continue to ensure data is submitted quarterly (previously once annually) and the team now have administrative support which has reduced the data entry burden.
National Perinatal Mortality Review Tool	The latest Perinatal Mortality Review Tool (PMRT) report was published in December 2024. Quarterly reports are shared within the Maternity service and at Trust Board. The Lead Midwife for Governance reported that local PMRT reports, and national reports are used to support prioritising resources for quality improvement work and to develop strong system level actions and changes to improve service quality.
National Respiratory Audit Programme (NRAP): COPD Secondary Care	The latest report was published in August 2024, and examined data collected in 2022-23. The Trust performed well in 3 out of 6 key metrics. The focus of actions this year is to improve data quality from the Trust to the audit provider, this has involved developing an electronic report with the Trust Informatics team, which will assist in data collection moving forward.
National Respiratory Audit Programme (NRAP): Pulmonary Rehabilitation	The latest report was published in August 2024, and examined data collected in 2022-23. The service fell below expected standards on 5 out of 6 key metrics. The clinical lead shared an action plan for the coming year: • Exploring Alternative Models of Pulmonary Rehabilitation: Trialling direct access to digital platforms as an alternative to the current six-week, centre-based pulmonary rehabilitation (PR) programme (12 sessions in total). • Reviewing Staffing Levels: Assess the proportion of the service with administrative and clerical support. Therapy admin staff handle appointment bookings, but smaller admin tasks are distributed among clinical team. • Ensuring dedicated time for service development: The Clinical Lead currently has a 0.4 WTE post within PR but no allocated time for service development, as they are required to run classes. Resource constraints are impacting service delivery.

National Respiratory Audit Programme (NRAP): Adult Asthma Secondary Care	The latest report was published in August 2024, and examined data collected in 2022-23. The Trust performed well in 3 out of 6 key metrics. The focus of actions this year is to improve data quality from the Trust to the audit provider. This has involved developing an electronic report with the Trust Informatics team, which will assist in data collection moving forward.
Paediatric Intensive Care Audit Network (PICANet)	The latest report was published in December 2024 with the Clinical Lead commenting that the Trust is doing well and highlighted that our Trust risk adjusted in-PICU mortality rate is within the lower control limit. Work for the year ahead will be to maintain the positive results achieved and continue to ensure that patients are well cared for.
Perioperative Quality Improvement Programme	The latest report was released in September 2024 which reviewed performance from 2023. The Trust performed well for most metrics in the audit. The Clinical Audit Lead has acknowledged the report, is working towards delivering the same standard of care going forwards. Actions for this year include strengthening links with surgical and anaesthetic colleagues for better oversight of the patient pathway and improvement opportunities.
UK Renal Registry: Chronic Kidney Disease Audit	The latest report was released in July 2024 and reviewed performance from 2022. The Clinical Lead reports that work for the coming year includes enhancing Integrated Care Board collaboration to provide a more tangible approach to care and working with the renal community to optimise data returns to optimise data returns.
UK Renal Registry: National Acute Kidney Injury Audit	The Clinical Audit Lead reports that data collection is ongoing. The service is focussed on enhancing Integrated Care Board collaboration and working with the renal community to optimise data returns to provide more meaningful data.

*Based on information available at the time of publication

Local clinical audits

The reports of 16 local clinical audits were reviewed by St George's University Hospitals NHS Foundation Trust in 2024/25 and we intend to take the following actions to improve the quality of healthcare provided.

Local Clinical Audit	**Action***
Controlled Drugs Check & Stock Audit	This audit is carried out quarterly and ensures that controlled drugs are correctly stored and secured and that an adequate record is kept which complies with controlled drug guidance. The Project Lead confirmed that performance in this quarterly audit has been largely positive. A new focus for the 2024-2025 audit year was to introduce a standardised approach to the audit across the Group and this resulted in a new GESH tool which added 14 new standards for compliance. The focus of actions for the coming year will be to continue work to finalise the Group approach to the quarterly programme of audit alongside further IT improvements; Ensure any issues highlighted and action plans put in place because of the checks are followed up and resolved locally. Particular attention needs to be paid to those areas where non-compliance has been observed for several quarters.
Audit of Local Safety Standards for Invasive Procedures (LocSSIPs) - Theatre areas	This audit takes place quarterly and examines theatre procedures for adherence to the Local Safety Standards for Invasive Procedures. Data entry and improvement rounds have continued each quarter throughout the year. The methodology has been modified this year to reflect the publication of the new National Safety Standards for Invasive Procedures (NatSSIPs 2) in January 2023. The data collection tool has been revised to include the sequential standards ('the NatSSIPs 8'). This revised data collection tool is currently being piloted with support from the Group Quality Data Analyst.
Audit of Patient Group Directions (PGD)	This audit examines the Trust adherence to Patient Group Directions (PGDs) compliance. These allow some registered health professionals to supply and/or administer specified medicines to a pre-defined group of patients. The 2024 annual audit took place in July 2024 and 100% compliance with audit standards is the target for areas using PGDs in practice. The Project Lead shared that the latest results show compliance was notably lower compared with previous years. Mandatory local level clinical audits indicated an improvement in this performance. Work being done in the year ahead includes: The PGD Advisory Group (PAG) will continue to meet monthly to ensure ongoing review and maintenance and appropriate implementation of PGDs in the Trust. PAG will ensure all areas with PGDs are audited on an annual basis; consideration of an unannounced PGD audit and divisional teaching sessions with healthcare professions.
Bereavement Survey - End of Life Care	This audit project gathers information on bereaved people's views on the quality of end-of-life care provided to their friend or relative.

	The first cycle of this survey has been completed and the Project Lead confirmed that the team has developed a new proforma which will be reviewed with their senior management prior to piloting and re-audit.
Consent Audit	This corporate audit assesses the quality of consent by different health professionals in the Trust and identifies areas for potential improvement. Findings from the latest round were largely positive with all consent forms available to review on the electronic patient record system. All consent forms were signed by a clinician and by either the patient or the parent of the patient when the patient was a child. Most fields had over 80% completion and this included key fields such as the patient details, nature of the procedure, the potential risks of the procedure and patient / parent and clinician signatures. Areas of improvement laid out by the clinical lead: • Working with trainers to improve completeness of the form. • Devolving responsibility of data collection to individual clinical specialities to promote greater engagement, and individual action planning. • Expanding the central data collection to include a qualitative element to examine the wider patient pathway.
Clinical Negligence Scheme for Trusts (CNST)- Safety Action related audits	The CNST Maternity Incentive Scheme (MIS) is a financial incentive program designed to enhance maternity safety within NHS Trusts. It rewards Trusts that can demonstrate they have implemented a set of core safety actions and comprises of 10 Safety Actions. For Year 5, the Trust were compliant with all 10 Safety Actions. The Clinical Lead reports that the service is aiming to keep up these standards in the year ahead.
Early Warning Score Audit	This audit measures the graded response strategy used by the Trust for patients identified as being at risk of clinical deterioration as per NICE guidelines, the project is carried out bi-annually. The 4 key measures for the audit are: frequency of observations consistent with triggers; complete set of observations recorded; NEWS scored correctly; and where NEWS has triggered a score, an appropriate response has been documented. The compliance target is 100% for each of these. The Project Lead provided an action plan with the following ongoing priorities: Ongoing NEWS2 teaching sessions supported by Practice Educators and Critical Care Outreach (CCOT) team; improving complete observations; better linkage to the medical physics department when failures in equipment are reported physics, and logging these failures as a clinical risk; reintroducing NEWS2 champions on the wards due to success on CCOT.
Falls Prevention Audit	This biannual clinical audit aims to provide granular detail across the organisation to improve inpatient falls prevention and post-fall care through data collection and analysis. The Project Lead confirmed that work for the year ahead includes implementing a new Trust wide falls plan; ensuring teaching standards related to falls, which is now mandatory and is included at induction for Nurses and HCAs; developing a group wide approach to Falls Awareness Week.
IV to oral switch compliance audit	The Antimicrobial Stewardship report is presented to the Infection Control Committee six-monthly. The Antimicrobial resistance CQUIN for 2023/2024 focused on IV to oral switch with a target of 40% non-compliance to the set standard of patients being inappropriately on IV antibiotics. SGH rate of non-compliance was between 11% to 18%, well within the threshold. The Clinical Lead reported that ongoing work includes maintaining low levels of non-compliance for the year ahead with continued six-monthly review.
Nasogastric (NG) Tube Audit	This audit takes place annually and examines insertion and correct placement of nasogastric tubes (NGT) to avoid serious incidents and never events related to misplaced tubes. The most recent results show that amongst adult wards, documentation on NG insertions remains poor. For critical care areas, improvement is needed to ensure that two clinicians must check initial placement as per policy. Actions from the Clinical Lead indicate that: Further training is needed to ensure adherence to NGT Policy and this will be completed across the Trust and locally in ward areas; ensuring NG audit results are disseminated and discussed among staff for training purposes to improve practice and based on current risks associated with NGT; forming a Trust wide working group to support medics and nurses to improve care driven by senior leaders (nursing, medical, dietetics, radiology, radiography).
Nutritional Screening Audit	This audit forms part of a wider Fundamentals of Nursing Care workstream. Results from the last round show the main issue reducing accuracy of nutritional screening tools on the wards is incomplete data entry, however great outcomes were noted for a patient's weight being recorded within 24 hours of admission to the ward and height documented. Further improvement is needed for full screening completed within 24

	hours of admission. Actions for the year ahead, confirmed by the Project Lead, include: • iClip update with guidance for Acute Disease effect and automatic referrals. • Care Plans are currently in development. • Continuation of the Bi-annual audit programme for Nutritional Screening. • Continue to support robust training at nurse induction, link nurse study day and ad hoc onwards. • Report results at the Nutrition and Hydration steering committee and PSQG Bi-annually.
Pressure Ulcer Audit	Hospital Acquired pressure ulcers are reviewed monthly as a patient safety priority. Category 3 and 4 pressure ulcers are logged each month and ward specific actions reviewed and tracked. Ongoing work includes continuing with mandatory and induction training sessions; poster for categories of pressure ulcers in dark skin tones currently being developed; trialling After Actions Reviews (AAR) in line with new Patient Safety Incident Response Framework (PSIRF) guidance, and development of a working group set up by the Fundamentals of Care Leads to review continence products at the Trust.
Protected Mealtimes Audit	This audit forms part of a wider Fundamentals of Nursing Care workstream. The latest audit results show positive results for information on nutrition boards being correct and identifying patients who require a modified diet. Areas identified for improvement included visibility of Nutrition and Hydration posters, and visibility of mealtime champions. In line with these areas for improvement the clinical lead reports: Ward managers to ensure the mealtime co-ordinator role is undertaken as stipulated. This will also be audited by facilities and include clearing bedtables, ensuring the patient is positioned and handwashing prior to meal service, add key Nutrition and Hydration prompts to nursing handover checklist/admission checklist, Protected mealtimes and red trays improvements – ward managers to focus on this along with ensuring mealtime champion responsibilities are followed.
Saving Lives Audits	The Saving Lives workstream consists of multiple clinical audit projects that are completed monthly and overseen by the Infection Control Committee, mostly through the Quality Observatory. The committee monitor compliance with these projects and discuss and chase action plans. Recent discussions have involved directorates and care groups working towards improving MAST compliance and this is monitored through divisional Performance review meetings and Focus topics.
Treatment Escalation Plan Audit	Completion of Treatment Escalation Plans (TEPs) is monitored monthly electronic reporting and discussed at the Deteriorating Patient Group. The Lead shared that since 2022, there has been continuous work to understand why TEPs were not being completed. Pop-up reminders have been introduced and emails sent to consultants to reiterate the importance of completing TEPs for patients. Work for 2025 includes revising the TEP form, subject to GESH approval. The form will be easier to complete as this was a difficulty found. Once the new form is approved and implemented, further work will begin to improve compliance and ensure regular communications to support this.
VTE - Risk assessment compliance	This audit is conducted quarterly with results and actions monitored by the Hospital Thrombosis Group (HTG). From April 2024 there have been changes in the criteria for VTE risk assessment data submission to NHS England. The latest report shows that the overall VTE risk assessment completion rates across the Trust falls significantly short of the 95% national target. The Clinical Lead has developed the following actions as agreed by HTG: • Target 10% improvement in risk assessment compliance within 14 hours of admission by Q1 2025/26. • Use the VTE prevention power plan to ensure appropriate prescribing of pharmacological prophylaxis. • Surgery and Neuroscience Directorate & Corporate Team to improve compliance with the VTE prevention. • Develop a new eLearning module.

*Based on information available at the time of publication

2.2.3 Our participation in clinical research

Research is core to the purpose of St George's. Through research, we play our part in developing the treatments for tomorrow, give our patients access to new treatments and improve our clinical care. We lead and undertake research across our clinical specialities, supported by our diverse research nursing teams and Clinical Research Facility.

St George's 2019-2024 Research Strategy set out plans to build on our strong research base, including investing more in our staff to support their research ambitions and developing our IT research infrastructure. Another key part of our research strategy was to gain core National Institute for Health Research (NIHR) funding, which we have achieved through a successful application for NIHR Clinical Research Facility designation which commenced in September 2022. In 2023, we bid for and were awarded £440K NIHR capital funding for the Clinical Research Facility, with a further £522K NIHR capital funding awarded in 2024.

A key way to develop and offer new treatments is through participation in clinical research studies that are approved by the NIHR, which supports NHS and academic institutions to deliver quality research that is patient-focused and relevant to the NHS. The number of patients receiving relevant health services provided or subcontracted by St George's University Hospitals NHS Foundation Trust in 2024/25 that were recruited during that reporting period to participate in research approved by a research ethics committee was 6,970 compared with 8,532 in the previous year.

Crucial to our research is our partnership with St George's, University of London. We have set up four Clinical Academic Groups in specific areas where both institutions have expertise and critical mass, in which clinicians, clinical academics and scientists can collaborate to improve research activity. In 2020, we established the St George's Translational and Clinical Research Institute (TACRI), a joint NHS-University structure to increase collaboration and further our research. TACRI funds fellowships for St George's clinical staff to give them the opportunity to formulate research proposals, which are available through an internal competitive process. This year, TACRI awarded two Junior Research Fellowships and seven Senior Research Fellowships.

Increasing research activity from nursing, midwifery and allied health professions (NMAHPs) is a key objective and we support the UK ambition for 1% of our NMAHPs to be clinical academics in posts that combine research with clinical practice. Under the leadership of the Research Director for NMAHPs, development programmes and mentorship for aspiring NMAHP academics have led to 6 successful applications for prestigious national research fellowship programmes. Research is now a feature on Trust nurse induction and is included as part of the Matrons' quality observatory report.

2.2.4 Our Commissioning for Quality and Innovation (CQUIN) performance

There were no CQUIN schemes in 2024/25.

2.2.5 Our registration with the Care Quality Commission (CQC)

The Care Quality Commission (CQC) is the regulator for all health and social care services in England and is the organisation that checks that our services meet the appropriate standards for care.

St George's University Hospitals NHS Foundation Trust is required to register with the Care Quality Commission and its current registration status is "registered without conditions or restrictions".

Ratings for St George's Hospital

	Safe	Effective	Caring	Responsive	Well-led	Overall
Urgent and emergency services	Requires improvement Dec 2019	Good ↑ Dec 2019	Good Dec 2019	Requires improvement Dec 2019	Good ↑ Dec 2019	Requires improvement Dec 2019
Medical care (including older people's care)	Requires improvement Dec 2019	Requires improvement Dec 2019	Good Dec 2019	Requires improvement ↓ Dec 2019	Requires improvement ↓ Dec 2019	Requires improvement Dec 2019
Surgery	Good ↑ Dec 2019	Good ↑ Dec 2019	Good Dec 2019	Requires improvement Dec 2019	Good Dec 2019	Good ↑ Dec 2019
Critical care	Requires improvement Nov 2016	Good Nov 2016	Good Nov 2016	Good Nov 2016	Good Nov 2016	Good Nov 2016
Maternity	Inadequate ↓ Mar 2023	Outstanding Nov 2016	Good Nov 2016	Good Nov 2016	Inadequate ↓ Mar 2023	Inadequate ↓ Mar 2023
Services for children and young people	Good ↑ Dec 2019	Good Dec 2019	Outstanding ↑ Dec 2019	Outstanding ↑ Dec 2019	Good ↑ Dec 2019	Outstanding Dec 2019
End of life care	Requires improvement Nov 2016	Requires improvement Nov 2016	Good Nov 2016	Good Nov 2016	Requires improvement Nov 2016	Requires improvement Nov 2016
Outpatients	Good ↑ Dec 2019	Not rated	Good Dec 2019	Requires improvement Dec 2019	Requires improvement ↑ Dec 2019	Requires improvement Dec 2019
Overall*	Requires improvement Dec 2019	Requires improvement Dec 2019	Good Dec 2019	Requires improvement Dec 2019	Requires improvement Dec 2019	Requires improvement Dec 2019

*Overall ratings for the Trust are identified by the CQC by combining the ratings for the services. The CQC decisions on overall ratings take into account the relative size of services. The CQC uses their professional judgement to reach fair and balanced ratings.

On 28 March 2023 following the inspection of Maternity and Midwifery Services as part of the national inspection programme focusing on the key lines of enquiry Safe and Well-led, the CQC issued the Trust with a section 29A Warning Notice. The Trust immediately commenced a targeted improvement plan to address the issues highlighted by the CQC which included:

- Effective and timely triage services
- Environment and equipment maintenance
- Staffing levels
- Oversight and governance

Maternity Services were rated Inadequate in the Safe and Well led domains overall. An overarching improvement action plan was also developed to address the MUST and SHOULD Dos in the full inspection report, published in August 2023. The Trust has formally responded to the CQC and provided assurance on the completion of the improvement actions taken together with the provision of supporting evidence.

In February 2024 the Trust informed the CQC of two incidents where patients fell in the Emergency Department and sadly died from the injuries they sustained. The Trust identified and immediately commenced improvement actions to be undertaken with reference to the maintenance of staff records for the provision of falls prevention training and consistent audit of falls risk assessment. On 6 March and 9 March 2024 the CQC conducted an unannounced inspection of the Emergency Department focussing on the Safe key line of enquiry. The Trust has formally responded to the CQC and provided assurance on the completion of the improvement actions taken together with the provision of supporting evidence.

The CQC conducted the following unannounced inspections within this reporting period:

- October 2024, Maternity Services
- December 2024, Emergency and Urgent Care
- January 2025, Surgery at St George's and Queen Mary's Hospitals

In addition, in February 2025 the CQC conducted a planned inspection of Well Led.

The Trust has responded to the feedback provided and has initiated improvement actions whilst awaiting the publication of the inspection reports. When available these can be viewed on the CQC website at www.cqc.org.uk

2.2.6 Participation in special reviews or investigation by the CQC

St George's University Hospitals NHS Foundation Trust has not participated in any special reviews or investigations by the CQC during the reporting period apart from the maternity services inspection as stated above (as part of the national inspection programme) and the unannounced inspection of the Emergency Department.

Reports on inspections carried out by the CQC on services provided by St George's University Hospitals NHS Foundation Trust are available on the CQC website at www.cqc.org.uk

From 1 April 2024 the Care Quality Commission (CQC) has introduced a new single assessment framework that applies to providers, local authorities and integrated care systems. It is expected to provide national insights on the progress and challenges of care quality, as well as share information that supports improvement and learning across the health and care system. There will be no large-scale site inspections and the new assessment process will involve continuous assessment of information from various off-site sources, e.g. concerns raised directly with the CQC, national audits, NHS key performance indicators.

Six evidence categories will be used to collect and analyse information for each quality statement; people's experiences, feedback from staff and leaders, observations of care, feedback from partners, processes and outcomes of care. Quality statements have been introduced which link to the relevant regulations.

Inspection reports will include a sliding-scale score within the rating which will identify how close a provider is to being rated higher or lower.

2.2.7 Our data quality

SGUH

The percentage of records in the published data which included the patient's valid NHS Number was:

- 99.6% for admitted patient care (against 99.7% national average).
- 99.5% for outpatient care (against 99.7% national average).
- 98.7% for accident and emergency care (against a 98.2% national average)

The percentage of records in the published data which included the patient's valid General Medical Practice code was:

- 99.8% for admitted patient care (against 99.4% national average)
- 99.6% for outpatient care (against 99.3% national average)
- 99.8% for accident and emergency care (against a 99.2% national average)

2.2.8 Our Information Governance Assessment Report

All organisations that have access to NHS patient information must provide assurances that they are practising good information governance and use the Data Security and Protection Toolkit to evidence this by the publication of annual assessments.

The Data Security and Protection (DSP) Toolkit, which reflects legal rules and Department of Health policy, enables organisations to measure their performance against data security and information governance requirements.

The Toolkit has been developed in response to The National Data Guardian Review (Review of Data Security, Consent and Opt-Outs) published in July 2016 and the government response published in July 2017.

In September 2024 the DSPT changed to adopt the National Cyber Security Centre's Cyber Assessment Framework (CAF) as its basis for cyber security and IG assurance.

The submission date for the year 2024/25 is 30 June 2025.

St George's University Hospitals NHS Foundation Trust Data Security and Protection Toolkit (DSPT) for 2023/24 was submitted as 'Standards Met'. The Trust aims to at least maintain "Standards Met" for the 2024-25 submission for reporting in June 2025.

The Data Security and Protection Toolkit managed by NHS Digital submission history is available at https://www.dsptoolkit.nhs.uk/ together with facilities to view organisation compliance status.

2.2.9 Payment by results

St George's University Hospitals NHS Foundation Trust was not subject to the Payment by Results clinical coding audit during 2024/25.

2.2.10 Learning from deaths

During 2024/25 1369 of St George's University Hospitals NHS Foundation Trust's patients died. This comprised of the following number of deaths which occurred in each quarter of this reporting period:

- 333 in the first quarter
- 285 in the second quarter
- 381 in the third quarter
- 370 in the fourth quarter

By 31 March 2025, 177 case record reviews have been carried out in relation to 12.9% of the deaths included.

The number of deaths in each quarter for which a case record or an investigation was carried out was:

- 52 in the first quarter
- 43 in the second quarter
- 43 in the third quarter
- 39 in the fourth quarter

4 (representing 0.29%) of the patient deaths during the reporting period are judged to be more likely than not to have been due to problems in the care provided to the patient.

In relation to each quarter this consisted of:

- 1 representing 0.30% of the number of deaths which occurred in the first quarter
- 0 representing 0% of the number of deaths which occurred in the second quarter
- 1 representing 0.26% of the number of deaths which occurred in the third quarter
- 2 representing 0.54% of the number of deaths which occurred in the fourth quarter

These numbers have been estimated using the structured judgement review, which was based on the Royal College of Physicians (RCP) tool. Any death that was judged to be more than likely avoidable (more than 50:50) is included in this figure.

This figure does not include deaths reviewed through other patient safety and governance processes.

What we have learnt and action taken

We have conducted several investigations during the year and have continued to review a proportion of deaths, as described by our Learning from Deaths policy. In the course of these investigations and reviews, issues were highlighted for local reflection and learning, including instances where excellent practice was observed. Examples of this work are summarised below.

Over the course of the year, we have investigated mortality within cardiology, specifically related to acute myocardial infarction (AMI) and patients that have undergone a procedure. This work was triggered by data suggesting higher than expected mortality both through SHMI (summary hospital level mortality indicator) data published by NHS Digital and HSMR (hospital standardised mortality ratio) data provided by commercial benchmarking platforms. The

investigation involved the clinical team and the central learning from deaths team and considered both the quality of data and the clinical pathway, specifically:

- Audit of the accuracy of AMI coding
- A detailed audit of the timeliness to catheter lab access
- A detailed review of procedure related mortality
- Prospective review of cardiology deaths over a nine-month period by the learning from deaths team

A detailed review of patients who were being coded as non-ST elevation myocardial infarction (NSTEMI) showed a large number of patients with other diagnoses had been miscoded. This made up approximately 15% of cases. A clinical validation process has been introduced to support improved accuracy of coding, and in-turn, benchmarked data. Analysis of the data suggests this action is having a positive impact and we expect to see a reduction in miscoded deaths going forward.

The second theme concerned timely access to the catheter labs for non-ST elevation MI (NSTEMI) patients. The British Cardiovascular Intervention Society (BCIS) suggest that 60% of patients who have had a NSTEMI should go to the catheter lab within 72 hours of presentation. At St George's over the period examined, this target was achieved in only 50 per cent. Work has been undertaken with Acute Medicine and the Emergency Department (ED) to reorganise the schedule, prioritising these non-elective patients at the start of the morning list. Cohorting patients and considering discharging low risk cases to be treated as early outpatients has also been introduced. The latest assessment suggests we are now achieving the required standard for 70% of NSTEMI patients.

A detailed analysis of percutaneous coronary intervention (PCI) related deaths was carried out by a consultant specialising in high risk interventions who had not been directly involved in any of the cases. The reviewer concluded that none of the deaths were directly related to the procedure. The reviewer found that the mortality was related to the volume of high risk cases.

This work was overseen by the Mortality Monitoring Group (MMG) and the group felt assured that the mortality data was understood and was not caused by poor care or treatment. A number of monitoring actions have been agreed with the service to ensure the outcome of improvement actions is tracked and mortality oversight maintained.

In addition, independent review of all deaths following a cardiology procedure was conducted by the Learning from Deaths team. Over the 9 month audit period 53 deaths were reviewed using the SJR methodology. Overall care was deemed as good or excellent in 50 cases, with the remaining 3 being identified as adequate. Problems in care were noted for 19 patients. These problems were not felt to have led to definite harm, but where there were questions or potential concerns these were raised with the clinical team to inform Mortality & Morbidity (M&M) discussion. The problems observed ranged from missed blood tests to device problems during procedures. The most common problem was delayed procedures which was found in three of the 19 cases. The improvement actions implemented by the clinical team are expected to reduce this problem. Overall, the learning from deaths team did not identify any concerning trends in the cohort examined.

Well established mortality review using structured judgement reviews has continued and we have sought to increase the value of this work for learning across the Trust. Any patient who is deemed by a single reviewer to have suffered poor care, or where there is an indication that death may have been avoidable, is discussed in a monthly mortality review meeting. The

details of each case are presented for discussion between all reviewers. The group take a decision regarding the need for notification to the Patient Safety Team, if that has not already been done, and/or referral to the clinical team to discuss in their M&M. This process helps to triangulate medical examiner scrutiny, the M&M process, structured judgement reviews and patient safety processes within the trust to achieve learning from deaths.

Over the year there have been a number of reviews completed that have contributed to positive change, a selection of which are outlined.

- Contributed to policy development for the role of Physician Associate.
- Informed a new standard operating procedure for patients brought directly to the catheter lab who are not suitable for a procedure.
- Review of diabetes training and education for nurses.

Individual SJRs are shared with clinical teams regardless of outcome so good practice can also be shared with the specialty group. The SJR reviewers will often ask questions about care delivery that will help the specialty and divisional governance teams to focus their internal reviews. SJRs also provide a degree of external oversight to the governance process within the care group and division. A quarterly summary report is provided for each division promoting transparency and facilitating triangulation.

Summary of action taken in 2024/25 and plans for 2025/26

Over the year we have continued to strengthen mortality governance through support of M&M meetings. This progress is regularly reviewed and monitored through the trust level MMG.

In 2024/25 461 M&M meetings took place at SGH, supported by the central team. This was an increase from 427 the previous year (2023/2024). This increase is due to several new speciality groups being supported by the M&M team and less meetings being cancelled, demonstrating the increased priority given to M&M activity and the impact of providing expert administrative support.

Within these 461 meetings, 1062 mortalities were discussed across 46 specialty groups. This number includes 231 cases that have been discussed more than once across different specialty groups. During the same period 802 morbidities were discussed, with 124 cases were discussed more than once.

Where there are specialities which would benefit from additional support this is identified and provided, with the Group Senior Manager for Learning from Mortality and the Clinical Lead for Learning from Deaths attending meetings and agreeing improvement actions with the M&M lead. In our Emergency Department (ED) meeting it was identified that adherence to several key M&M standards could be improved. The main issue highlighted was the lack of clear selection criteria for cases to be discussed. Attendance was variable and discussion did not take place in a dedicated forum. Subsequent meetings have demonstrated that improvement has been made. Clear patient selection criteria have been implemented, attendance has improved, and the meeting is now focused solely on M&M. Monitoring of this improvement is incorporated in a broader ED governance improvement plan and will also be monitored by the Group Senior Manager for Learning from Mortality.

This year we have improved the sharing and triangulation of learning from deaths data. Quarterly divisional level reporting is now established, which summarises benchmarking data and alerts, learning from SJRs and M&M activity. This forms part of divisional quality and safety reports, linking mortality governance to other key indicators. Members of the Learning from Mortality team are also members of the Central Incident Review Group, which considers

patient safety incidents at divisional and trust level, facilitating the use of mortality review in the evaluation of care and contributing to the identification of learning.

Throughout the year the Medical Examiner (ME) service continued to scrutinise all deaths where St George's clinicians have issued a medical certificate of cause of death. In operation since 2020, the service is well embedded and supports accurate and consistent certification and support for the bereaved. The ME has continued to perform an important role in the identification of potential governance issues that need to be further explored, referring deaths to the Lead for Learning from Deaths, the Patient Safety Team, or the relevant clinical team.

The ME system moved to a statutory footing on 9th September 2024. The ME service hosted by St George's is responsible for scrutinising all deaths in Merton and Wandsworth, both in-hospital and in the community, that are not investigated by a coroner. The service had been preparing for the statutory system for a number of years and was already working with the majority of community providers. In preparation for the final change the service devised a risk-assessed implementation plan, overseen by the Mortality Monitoring Group. All actions were successfully completed, and the ME service now scrutinises every death that occurs in Merton and Wandsworth that is not investigated by a coroner.

Since the introduction of the statutory system the ME service has provided an out of hours provision on every weekend and mandated bank holiday. Extending the service has facilitated the rapid release of deceased patients, particularly where there is a specific religious requirement.

Over the coming year we will use learning from deaths to support the Quality and Safety Strategy. We will strengthen learning from mistakes and from others, supporting the strategic aim of being a learning organisation.

In 2024/25 we have continued to collaborate with our colleagues at Epsom & St Helier to share ideas and learn from each other. This working relationship has been strengthened through the integration of corporate services at both trusts and since October 2024 mortality services have been managed at group level. In the next year we will look at how we can maximise on the opportunity this presents to learn from what works well in each trust and implement best practice across the group.

Next year we will extend our triangulation of data to reinforce our understanding of quality and safety. A key element of this will be increasing divisional and service level engagement in the work of MMG. We aim to achieve this by expanding our membership and by enhancing the use of service level data, both from M&Ms and relevant national clinical audits.

We will continue to utilise the SJR methodology to support focused review in areas where benchmarking data, or other sources, suggest additional scrutiny may be of value. Our immediate priority is to develop a methodology which allows us to identify deaths outside of hospital, within 30 days of discharge and to complete reviews for these cases. We will refine our approach so that these reviews form a routine element of our mortality governance. Alongside implementing this at a trust-wide level, we will support relevant specialities to develop this approach, beginning with Acute Medicine. We will also review our SJR methodology and potentially move towards a more aligned approach at group. Closer working across the two trusts will enable us to continue strengthening our shared learning.

We will continue to further develop the M&M service at SGH, by working on wider shared learning across Divisions and the trust. This will be achieved by strengthening relationships with the divisions and building on how triangulation of data and sharing of best practice can be achieved. We plan to introduce joint meetings within specialty groups who discuss the same patient cohort.

Where specialty groups require support with the fundamentals we will continue to deliver this and will monitor and respond to the support needed across the year. As we move towards group working, improvements in procedure can be shared across all three acute sites to help strengthen M&M structure and productivity.

There were no (0) case record reviews and no (0) investigations completed after 30 April 2023 which related to deaths which took place before the start of the reporting period.

0 representing 0% of the patient deaths before the reporting period, are judged to be more likely than not to have been due to problems in the care provided to the patient. This number has been estimated using the structured judgement review, which is based on the Royal College of Physicians (RCP) tool.

2.2.11 Standards for Seven Day Services

NHS England has issued four priority clinical standards in relation to seven day services:

- Standard 2 – Time to first consultant review
- Standard 5 – Inpatient access to diagnostics
- Standard 6 – Inpatient access to consultant led interventions
- Standard 8 – Ongoing review

With reference to performance against standards 2 and 5 in the last year the Trust has maintained increased weekend consultant presence across medical and surgical specialties. The review process undertaken at divisional level has confirmed that adequate mitigations for safety and hospital flow are in place.

We are compliant with reference to standard 6.

With reference to standard 8 and 7-day equitable access to MRI scanning, the service not yet resourced to fully provide this, and priority is given to the most urgent conditions and clinical presentations. A multi-disciplinary group has now been convened to identify key improvement priorities that can be delivered in 2025/6 to move us closer to compliance with these standards in respect of MRI provision.

Hospital SITREP data continues to show a similar length of stay for non-elective admissions over 7 days, with no significant weekend disparity. The average length of stay is 7.6 days – ranging from 7.1 days for Monday admissions to 8.1 days for Saturday admissions. Elective admissions on a Sunday seem to have a longer length of stay but activity numbers are comparatively small. The percentage of discharges occurring at the weekend continues to be lower than weekday activity, and this pattern for discharge activity is similar to regional and national benchmark data. Specialities identified for deep dives due to variance with benchmark data are general & colorectal surgery, vascular surgery, maxillo-facial surgery and respiratory medicine.

2.2.12 How our staff can speak up

Staff are encouraged and supported to speak up about any concerns or suggestions they have about any aspect of their work and have various ways of doing so. The Trust has in place a clear policy that sets out how staff can raise concerns which reflects relevant national guidance from NHS England and the National Guardian's Office for Freedom to Speak Up.

Staff are encouraged in the first instance to raise issues with their line manager, often concerns can be resolved at this level. However, it is recognised that some staff may not feel

comfortable in taking this route, especially if the concern being raised pertains to their line manager.

Staff can raise concerns with:

- Any manager/ leader within their department
- Group Freedom to Speak up Guardian/ Champion
- Their Human Resource Adviser/ Manager
- Executive and Non-Executive leads for Freedom to Speak Up
- Any other Executive and non- executive
- Group Chair

Staff can raise concerns in different ways such as:

- Face to Face (verbally)
- In writing (letter/ email)
- Telephone contact.

Staff are also advised how they can raise concerns externally if they are unhappy with using any of the internal routes for raising concerns or if they indicate that after raising a concern they do not feel the concern was investigated in line with the Trust policy. These external routes include the Care Quality Commission and recognised professional or union body. Staff with concerns about potential fraud are encouraged to raise concerns with our Local Counter Fraud Specialist or with NHS Counter Fraud.

Staff who speak up are advised to report incidents where they feel due to speaking up they have come to a detriment from speaking up. If it is found that this is the case, the Trust will take appropriate action to mitigate the risk to the staff member concerned and, if necessary, appropriate action taken under the Trusts disciplinary procedure and in line with national guidance. Staff are also regularly referred for additional support after raising concerns to our staff support team and or Occupational Health by agreement with the staff member.

Once an outcome is received the feedback is given to the person raising the concern either in writing or verbally dependent upon the issue raised, how it was resolved i.e. formally or informally and the preference of the person raising the concern. Anonymous concerns cannot be fed back however the outcome is logged by the Trust.

Themes and trends in the concerns raised by staff that come to the FTSU Service are reported to the Trust Board and to the Board's People Committee.

A Group-wide FTSU team is now well established and actively supports staff across the St George's, Epsom and St Helier University Hospitals and Health Group, and as such will have a wider reach and more flexibility when supporting teams and groups of staff members. The team currently comprises of 1 Group FTSU Guardian and 4 Group Deputy FTSU Guardians covering all of the sites and services across the hospital Group.

2.2.13 Guardian of safe working (GoSW)

2024-25 has seen a changes for Guardian of Safe Working Hours with a change in leadership. The Wellbeing fellow has continued in post and has undertaken several events to understand issues with resident doctor wellbeing in the Acute Medical Unit.

For the year 1 January to 31 December 2024, there were a total of 582 exception reports (compared to 432 reports for the previous year). As previously, a higher number of reports

were seen over the winter period, likely due to increased pressures, patient numbers and patient flow over this period. More than half of reports were received from Acute/General Medicine, as has been the pattern for many years. This reflects both the high workload for resident doctors in this area, as well good engagement from resident doctors and consultants in the department with the process of exception reporting. Resident doctors in the department are encouraged to report and reports are signed off promptly.
Issues with anaesthetic rota gaps have improved with a marked decline in exception reports and feedback from the specialty representatives has included that the hard work of the consultant team has led to improved working conditions and rota.

During 2024-25 general surgery has seen a rise in exception reporting, coinciding with rota gaps and missed training opportunities due to service pressures. The concerns were raised by the specialty representatives to the Resident Doctor's Forum and resident doctors have been encouraged to exception report. The division is building on the SW London clinical workforce efficiency review to explore optimal recruitment models for surgical rotas, with a programme of work led by the Site Chief Medical Officer.

Locally Employed Doctors (LEDs) have continued to exception report throughout the year, following the first reports in January 2023. Approximately 25% of reports now come from LEDs and we continue to encourage this group and improve engagement with exception reporting by working with the Lead for LEDs and attending the Trust bespoke induction for International Medical Graduates.

The Resident Doctor's Forum has been very active throughout the year, with new co-chairs who started in October 2024. Meeting attendance continues to be low but the new chairs are actively engaging with specialty representatives to improve both attendance and reporting of issues. A poster with a QRL code directly linking to the exception reporting system has been widely circulated and assisted greatly in solving issues with low levels of exception reporting.

The GoSWH has provided quarterly reports to the Trust Board, including data on rota gaps. Accurate data has been challenging, due to the complexity of different rotas across departments, the frequent rotations, increased less than full time working and employment of LEDs to fill gaps. This is further compounded by the lack of universal electronic, real time rotas. A medical e-rostering programme is being overseen by the Site Chief Medical Officer to improve this. Most recent data shows 40% of rotas have at least one gap.

The rota gaps by Division for 2023-24 are summarised below.

Division	Number of rotas	Q1	Q2	Q3	Q4	Average
Medicine	**20**	**6**	**11**	**17**	**7**	**10.25**
Surgery	**22**	**11**	**10**	**10**	**6**	**9.25**
Children and women	**20**	**7**	**2**	**6**	**2**	**4.25**
Total	**62**	**24**	**23**	**33**	**15**	**23.75**

2.3 Reporting against Core Indicators

National Core Set of Quality Indicators

In 2012 a statutory core set of quality indicators came into effect. Eight indicators apply to acute hospital Trusts. All Trusts are required to report their performance against these indicators in the same format with the aim of making it possible for the reader to compare performance across similar organisations.

For each indicator our performance is reported together with the national average and the performance of the best and worst performing Trusts (where available).

2.3.1 Mortality

The Summary Hospital Level Mortality Indicator (SHMI) is a measure of mortality that considers various factors, including a patient's condition. It encompasses patients who have passed away during treatment in hospital or within 30 days after discharge. The SHMI score is benchmarked against the NHS average, which is set at 1. A score below 1 indicates a mortality rate lower than the average. It is important to note that the SHMI is not suitable for directly comparing mortality outcomes between different Trusts. Therefore, rankings of 'best' and 'worst' Trusts are not provided for this indicator.

The SHMI for the last reporting period is as expected, which is consistent with previous reporting periods between December 2020 and including up to October 2024.

Summary hospital level mortality indicator (SHMI)	Nov 18 – Oct 19	Dec 18 – Nov 19	Jan 19 – Dec 19	Jan 20- Dec 20	Dec 20-Nov 21	Jan 21- Dec 21	Jan22-Dec 22	Nov22-Oct 23	Nov23-Oct 24
SHMI	0.85	0.85	0.86	0.84	0.9	0.91	0.94	0.96	0.87
Banding	Lower than expected	Lower than expected	Lower than expected	Lower than expected	As expected	As expected	As expected	As expected	Lower than expected
%Deaths with pa	49	48	47	49	54	54	58	56	55

Source Summary Hospital-level Mortality Indicator (SHMI) - Deaths associated with hospitalisation, England, November 2023 - October 2024 - NHS England Digital
Percentage_of_deaths_with_palliative_care_coding_Dec23-Nov24_xlsx.xlsx

2.3.1.1 The Trust considers that this data is as described for the following reasons:

- Our data is scrutinised by the Mortality Monitoring Group and validated through the examination of additional data including daily mortality monitoring drawn directly from our own systems. When validated internally we submit data on a monthly basis to NHS Digital. The SHMI is then calculated by NHS Digital with results reported quarterly for a rolling year. Our coding team work closely with our palliative care team to continually improve the accuracy of coding to fully capture the involvement of palliative care services.

2.3.1.2 The Trust has taken and plans to take the following actions to improve this indicator and so the quality of our services:

- We have fully implemented the Learning from Deaths Framework and embedded the implementation of the Medical Examiner System. We review all deaths to ensure we identify and share every opportunity to learn and improve the care our patients receive.

2.3.2 Patient reported outcome measures (no data submitted for St George's)

For Trusts providing relevant acute services patient reported outcome measures (PROMs) quality is measured from the patient perspective. Trusts seek to calculate the health gain experienced by patients following one of two clinical procedures, which are hip replacement or knee replacement.

St George's has not participated in the PROMs audit in recent years due to the low number of procedures undertaken. The Trust's rate of participation will remain low as most elective procedures are carried out at SWLEOC.

2.3.3 Readmission within 30 days of discharge

Emergency readmission occurs when a patient has an unplanned re-admission to hospital within 30 days of previous discharge.

30 Day Readmissions	2019-20		2020-21		2021-22		2022-23		2023-24		2024/25	
	0-15	16+	0-15	16+	0-15	16+	0-15	16+	0-15	16+	0-15	16+
Number of provider spells	20498	132936	13703	97043	16152	112266	16390	111037	13660	97,050	4615	37050
30 day readmissions	1558	11659	900	8421	1064	8187	1008	7356	740	6513	360	5575
30 day readmissions rate	7.60%	8.77%	6.57%	8.68%	6.69%	7.29%	6.15%	6.62%	5.42%	6.71%	8.40%	15.10%

Source: I02040 Compendium Readmissions Dataset (Main) 2024 v2.xlsx

2.3.3.1 The Trust considers that this data is as described for the following reasons:

- This data is validated through the Trust's informatics and reporting processes

2.3.3.2 The Trust has taken and plans to take the following actions to improve this indicator and so the quality of our services:

- By committing to reducing re-admission for all patients irrespective of whether that care is planned or unplanned, by ensuring that all patients are discharged when it is safe to do so and that there is a coordinated approach with our partners and local authorities to ensure that the right support is in place for them.

2.3.4 Patient experience

The national inpatient survey asked five questions focussing on the responsiveness and personal care of patients. Further to the merger of NHS Digital and NHS England the data in this format set out in the following table is no longer available via the https link below.

Patient Experience	*2017-18*	*2018-19*	*2019-20*	*2020-21*	*2021-22 and ongoing*
St George's University Hospitals	**65**	**67.2**	**67.1**	65	Not available
National average	68.6	67.2	64.2	67.1	
Highest (best)	85	85	84.2	84.4	
Lowest	60.5	58.9	59.5	54.4	

Source: https://digital.nhs.uk/data-and-information/publications/clinical-indicators/nhs-outcomes-framework/current/domain-4-ensuring-that-people-have-a-positive-experience-of-care-nof/4-2-responsiveness-to-inpatients-personal-needs
https://nhssurveys.org/all-files/02-adults-inpatients/05-benchmarks-reports/2021/
Question 49 – Overall Experience

We have reviewed a related section in the national CQC inpatient survey (2022/23). This section is made up of several questions relating to personal care, food, and assistance with eating.

Patient Experience	*2021-22*	*2022-23*	*2023-24*	*2024-25**
St George's University Hospitals	**7.3**	**8.1**	8.1	

Source: St George's University Hospitals NHS Foundation Trust - Care Quality Commission (cqc.org.uk) St George's University Hospitals NHS Foundation Trust.pptx (live.com)
_RJ7_St George's University Hospitals NHS Foundation Trust.pptx The above score is pulled from the CQC report looking at "Overall Experience" * The 2024/25 data has not been published at the time of submitting this report. This data will be included in the Quality Report 2025/26

2.3.4.1 The Trust considers that this data is as described for the following reasons:

- This data is validated through the external CQC national inpatient survey methodology

2.3.4.2 The Trust has taken and plans to take the following actions to improve this indicator and so the quality of our services:

- Continue to maintain and improve performance, by continually engaging with patients, family, friends and carers
- Respond to the findings of our ward and department accreditation programme

2.3.5 Staff recommendation to friends and family

We consider that this data is as described for the following reasons:

- We outsource the collection of data for the NHS National Staff Survey; it is collected and submitted annually to the Staff Survey Co-ordination Centre.

The data for 2024/25 shows a 0.73% improvement in staff who would recommend St George's to their friends and families when compared with the previous year.

Staff recommendation	2020/21	2021/22	2022/23	2023/24	2024/25
St George's University Hospitals	67.19%	58.47%	58.56%	59.54%	63.12%
Average for Acute	66.98%	58.40%	56.46%	60.53%	60.90%
Highest Acute Trust	84.01%	77.87%	75.29%	77.14%	79.38%
Lowest Acute Trust	46.35%	38.38%	40.89%	44.05%	35.43%

NHS Staff Survey 2024 Benchmark Report Question 25c
NHS Staff Survey dashboard (nhssurveys.co.uk)Local results for every organisation | NHS Staff Survey (nhsstaffsurveys.com)
NHS Staff Survey dashboard Local results for every organisation | NHS Staff Survey

2.3.5.1 The Trust considers that this data is as described for the following reasons:

- This data is validated through the Trust's informatics and reporting processes

2.3.5.2 The Trust has taken and plans to take the following actions to improve this indicator and so the quality of our services:

- Focus on staff engagement and quality improvement, listening to staff and addressing their concerns.

2.3.6 Patient recommendations to friends and family

Our patients are very positive about our inpatient services in 2024/25 with 95% of our Inpatients saying they would recommend our services to their friends and family.

Due to the significant demand for Emergency Department (ED) services and the associated waiting times 77.7% of those visiting our ED said they would recommend our services to their friends and family, which was an improvement of 3.5% when compared with the previous year.

Friends and Family Test	2021-22		2022-23		2023-24		2024-25	
St George's University Hospitals	A&E	Inpatient	A&E	Inpatient	A&E	Inpatient	A&E	Inpatients
Response rate	12.82%	32.71%	12.43%	29.17%	11%	29%	13.8%	31%
% would recommend	77.86%	97.70%	74.42%	98.42%	80%	98%	77.7%	98.6%
% would not recommend	12.82%	0.60%	17.24%	0.41%	13%	0.49%	14.8%	0.52%
National comparison positive response rate								
National comparison as at March 2020 % would recommend								
National comparison as at March 2020 % would not recommend								

NHS England » Friends and Family Test data – December 2024

* FFT data collection was suspended in March 2020 and was re-started in December 2020 due to Covid-19. No national data has been published since national collection restarted.

2.3.6.1 The Trust considers that this data is as described for the following reasons:

- This data is validated through the Trust‘s informatics and reporting processes

2.3.6.2 The Trust has taken and plans to take the following actions to improve this indicator and so the quality of our services:

- Continue to improve the quality of its services, by listening to patients and addressing their concerns

2.3.7 Venous thromboembolism

Venous thromboembolism (VTE) occurs when a deep vein thrombosis (blood clot in a deep vein, most commonly in the legs) and pulmonary embolism (where such a clot travels in the blood and lodges in the lungs) causes substantial long term health problems or death. Risk assessments for VTE ensures that we intervene with preventative measures at the earliest possible time.

Data was collected by the Trust, but submission was deferred during the pandemic which resumed in April 2024 in line with the NHSE plan. As data was not submitted the data has not been benchmarked at a national level and therefore data for the average, highest and lowest performers is not available.

2.3.7.1 The Trust considers that this data is as described for the following reasons:

- This data is validated through the Trust's informatics and reporting processes. It should be noted that the VTE risk assessment data submission to NHS England Digital now requires assessments to be completed within 14 hours, in line with NICE standards. As a result, performance in 2024-25 has been impacted.

VTE Assessments	2017-18	2018-19	2019-20	2020-21	2021-22	2022-23	2023-24	2024-25
St George's University Hospitals	95.90%	96.00%	93.90%	96.18%	96.80%	97%	96.1%*	58.80%
National Average	95.80%	95.60%	95.50%	95.33%	N/A	N/A	N/A	90.40%
Best performing Trust*	100%	100%	100%	100%	N/A	N/A	N/A	100%
Worst performing Trust*	72%	74.40%	71.70%	77.16%	N/A	N/A	N/A	13.70%

Venous Thromboembolism (VTE) Risk Assessment Data Provision Notice - NHS England Digital
Quality & Performance Report for Trust Board: Patient Safety - Tableau Server

2.3.7.2 The Trust plans to take the following actions to improve this indicator further and so the quality of our services:

- Continue working to achieve higher VTE risk assessment rates as a site priority in our annual Patient safety incident response plan and all Divisions have been asked to develop their local plans for improvement. The initial focus will be on ED and acute medicine, with VTE champions helping to drive change in these areas.

- Optimisation of iClip and anticoagulation prescribing.

2.3.8 Infection control

We are committed to improving safety by avoiding or reducing Clostridium Difficile which results in shorter length of stay and improved patient experience.

Clostridium Difficile	2020-21	2021-22	2022-23	2023-24	2024-25
Trust apportioned cases due to lapses in care	41	43	60	41	60
Trust bed-days	225,244	278,832	290,474	267,252	291471
Rate per 100,000 bed days	16.03	13.74	20.3	15.34	20.6
National average	53	63	27.51	73	84
Worst performing trust	211	245	98.8	275	288
Best performing trust	0	0	0	0	0

NOTE: In 2020-21 Hospital capacity was organised in new ways as a result of the pandemic to treat Covid-19 and non-Covid-19 patients separately and safely in meeting the enhanced Infection Prevention Control measures. This results in beds and staff being deployed differently from in previous years in both emergency and elective settings within the hospital. As a result, caution should be exercised in comparing overall occupancy rates between this year and previous years. In general, hospitals will experience capacity pressures at lower overall occupancy rates than would previously have been the case.

2.3.8.1 The Trust considers that this data is as described for the following reasons:

- We have a process in place for collating data on Clostridium Difficile cases. The data is collated internally and submitted to Public Health England. The Integrated Care Board reviews the root cause analysis undertaken and provides validation as to whether Clostridium Difficile acquisition was due to a lapse in our care.

2.3.8.2 The Trust plans to take the following actions to improve this indicator and so the quality of our services:

- Continue to implement a range of measures to tackle infection and improve the safety and quality of our services. These include a strong focus on improved environmental hygiene and antibiotic stewardship supported by continuous staff engagement and education.

2.3.9 Patient safety incidents

Patient Safety Incidents	Apr 17-Sep 18	Oct 18-Mar 19	Apr 19-Sep 19	Oct 19 – Mar 20	Apr 20-Mar 21	Apr 21-Mar 22	Apr 22-Mar 23	April 23-Mar 24	April 24-Mar 25
St George's University Hospitals									
Total reported incidents	5548	5934	6268	6697	12352	13092	13880	14741	13622
Rate per 1000 bed days	34.2	39.5	45.3	45.4	51.2	51.7	55.0	55.16	63.44
***National average (acute non-specialist)**	42.8	46.1							
***Highest reporting rate**	111.7	95.9							
***Lowest reporting rate**	23.5	16.9							

Patient Safety Incidents	Apr 20- Mar 21	Apr 21-Mar 22	Apr 22-Mar 23	Apr 23- Mar 24	Apr 24- Mar 25
Incidents causing severe harm or death	21	46	28	25	Not available at time of writing
Rate per 1000 bed days	0.17%	0.35%	0.10%	0.08%	

Source: Datix

The data submitted to the National Reporting and Learning System (NRLS) was previously published every six months. This has now changed to use annual timeframes, rather than six-monthly, and from 2020/21 the data is published on an annual basis.

2.3.9.1 The Trust considers that this data is as described for the following reasons:

- This data is validated through the Trust's informatics and reporting processes

2.3.9.2 It should be noted that in 2024/25 there were 12 never events. Serious incident investigations or patient safety incident investigations were completed and the learning was identified. Improvement action plans were developed and implemented.

2.3.9.3 The Trust has taken the following actions to improve this indicator and so the quality of our services:

- Continue to work towards enhancing existing mechanisms throughout 2024/25. These include: risk management input into training programmes, increased frequency of

Patient Safety Incident Investigation training, increased involvement from all staff in following up incidents, a bi-monthly patient safety newsletter and a quarterly analysis report and thematic learning

- Implemented of the new Patient safety Incident reporting Framework (PSIRF) in line with the new National Patient Safety Strategy.

Part 3

3.1 Our performance against the Single Oversight Framework

A number of national measures to assess access to services and outcomes, and to make and assessment of governance at NHS foundation Trusts.

In October 2024 two new targets were introduced:

- 62-day treatment standard: commence treatment within 62 days of being referred or consultant upgrade (target >=85%)
- Faster diagnosis standard: a diagnosis or ruling out of cancer within 28 days of referral (target >=75%).

Performance against all these indicators can be seen in the table below and acts as a trigger to detect potential governance issues.

Key performance indicators

SGUH	SGUH Metric	Target	Annual Performance					
			2019-20	2020-21	2021-22	2022-23	2023-24	2024-25
Referral to treatment times	Maximum time of 18 weeks from point of referral to treatment (RTT) in aggregate – patients on an incomplete pathway	>=92%	78.79%	71.80%	75.97%	67.14%	65.91%	61.30%
	Number of 52-week breaches	0	3	829	193	517	853	1,162
ED access	78% of patient wait less than 4 hours	>=78%	85.60%	90.05%	83.51%	74.22%	75.90%	79.60%
Cancer access	62-day treatment standard: commence treatment within 62 days of being referred or consultant upgrade	>=70%			85.32%	85.78%	90.18%	81.40%
	Faster Diagnosis Standard: a diagnosis or ruling out of cancer within 28 days of referral	77%			78.20%	79.80%	83.70%	84.80%
Diagnostic waits	Maximum 6 week wait for diagnostic procedures	95%	83.50%	93.20%	93.40%	90.00%	96.22%	94.80%

Source:
https://www.england.nhs.uk/statistics/statistical-work-areas/rtt-waiting-times/
https://www.england.nhs.uk/statistics/statistical-work-areas/ae-waiting-times-and-activity/
https://www.england.nhs.uk/statistics/statistical-work-areas/cancer-waiting-times/
https://www.england.nhs.uk/statistics/statistical-work-areas/diagnostics-waiting-times-and-activity/monthly-diagnostics-waiting-times-and-activity/

3.2 Our performance against our Quality priorities in 2024-25

The progress we have made in delivering our quality priorities for last year is set out in the table below and where able, compared with performance for the previous year.

All the data used to assess our success in achieving our objectives has been derived from the Trust performance management systems and, where applicable, the indicators are consistent with national definitions.

In addition, all qualitative measures of success have been assured through the relevant Trust governance frameworks.

1.0 Patient Safety			
Our quality priorities	**What will success look like?**	**How did we do in 2024/25?**	**How our performance compared with 2023/24**
1.1 Delivering Fundamentals of Care We will get the basics right every time and consistently complete risk assessments in line with expected standards of performance.	With reference to pressure ulcer prevention there will be: • no category 4 pressure ulcers • a 10% reduction in category 3 pressure ulcers when compared with the previous year (approximately 8 cases)	**We did not achieve this.** There were 8 category 4 pressure ulcers. There were 95 category 3 pressure ulcers against the annual threshold of 89. The review of pressure ulcer cases highlighted inconsistent application of pressure ulcer prevention tools.	There were 12 category 4 pressure ulcers. There were 98 category 3 pressure ulcers.
	With reference to VTE there will be: • a consistent approach to data capture across the Group will be established	**We did not achieve this.**	N/A

	before the end of Q2 • We will see 95% of VTE assessment within 14 hours of admission (in line with Nice Guidance) in Q3 and Q4	We achieved 65.9% of VTE assessment within 14 hours of admission against the 95% performance target. We developed a consistent approach to data capture. The agreed reporting standards commenced from April 2025.	
	With reference to falls we will see: • a 50% reduction in the number of falls with harm per 1000 bed days when compared with the previous year (approximately 11 cases)	**We did not achieve this.** There were 34 falls with moderate and above harm against the threshold of 17. The total number of falls by 1000 bed days was 0.11 compared with the previous year of 0.12. Case reviews have highlighted inconsistent application of falls prevention risk assessments and required actions.	The total number of falls with moderate and severe harm (3) by 1000 bed days was 0.10.
	With reference to Delirium, we will see: • A consistent approach to Delirium assessment data capture across the Group will be established before the end of Q2 including the screening question for delirium • In Q3 and Q4 we will see 45% and 50% of patients with a completed Delirium assessment within 72 hours of admission (in line with Nice	**We partially achieved this.** We have agreed the consistent approach to data collection, which is a standardised assessment for Delirium (4AT) To date we have not captured meaningful data on a quarterly basis due to inconsistent completion of the assessment across staff groups. The October 2025 National Audit of Delirium (NAD) results will be available in Autumn 2025.	The National Audit of Delirium (NAD) undertaken in October 2024 showed the following compliance for completion of delirium assessment within 24 hours of admission (national average 91%): • 86.3%

	Guidance) against the national target of 95% of patients.		
1.2 Learning from Patient safety Incidents	In line with the national patient safety strategy, we will implement the new patient safety incident response framework.	**We did achieve this.** We have a divisional incident review group (DIRG) in place that reports on a weekly basis to the central incident review group (CIRG). This enables a rapid response to patient safety incidents identifying related themes and immediate safety actions. We monitored the number of incidents reported in the new LFPSE (Learning from Patient Safety Events) which highlighted that there was no reduction in incident reporting activity. We held 2 learning events across the Group to improve patient safety in Theatres and Maternity Services.	One clinical division and Maternity Services were using the new framework by end of March 2024. We completed implementation across all services by end June 2024. The Governance Structure, Patient Incident Response Plan and Group Policy for Patient safety Incident reporting are in place.
1.3 Ensure our Maternity Services are safe	We will strengthen the governance and quality of our Maternity Services	**We did not achieve this.** Unannounced inspections undertaken by the Care Quality Commission (CQC) identified further improvement work was required to strengthen quality and safety governance: • SGUH March & October 2024 (issued a section 29a Warning Notice after both inspections) SGUH provided a comprehensive response to each Warning Notice including confirmation of the immediate improvement actions undertaken. Each Site Maternity Service has an improvement action plan in place with a governance and monitoring process overseen by an Executive member of the Board.	N/A

		The five key safety metrics for maternity services have been monitored on a monthly basis via the Integrated Quality and Performance Report at Quality Committee in Common and bi-monthly at Group Board. SGUH has been identified as a potential alarm-level outlier for postpartum haemorrhage (PPH) in the 2023 National Maternity and Perinatal Audit (NMPA). A review has been undertaken and improvement actions put in place, including training for staff.	
2.0 Patient experience			
Our quality priorities	**What will success look like?**	**How did we do in 2024/25?**	**How our performance compared with 2023/24**
2.1 Mobilising our Health Inequalities Programme	We will use data to understand our population and know where health inequalities exist	**We partially achieved this** There is an established gesh Community of Practice for staff working with Health Inequalities – a forum to showcase successes, share best practice, and identify common issues and solutions. There is a charity-funded Equity Lead in place for a period of three years who will lead the Community of Practice and other initiatives and workstreams across the Healthcare Group. **RE the data quality priority:** *Data quality will be significantly improved, particularly regarding Ethnicity, in which the use of uninformative codes ("not known" and "any other") will be minimised or stopped as evidenced by data quality reports.* We did not achieve this, but we did identify those key areas on which improvement work is now being focused. **RE the high intensity service user priority:** *High intensity service users will receive proactive outreach with initiatives to improve their experience and reduce their use of unplanned care. We will develop*	N/A

		an effective data capture mechanism to evidence this. We partially achieved this, in part through ongoing work by the SGUH Homelessness Inclusion Team, but improvement work is ongoing **RE the introduction of Artificial Intelligence tools:** *Evolving software AI tools will be used to make reasonable adjustments to outpatient waiting lists, so that appointment cancellations, changes, and DNAs in those most affected by health inequalities are minimised, and waiting times are shortened for those whose health inequalities put them at most risk.* We partially achieved this. Ambient Voice recognition AI has been piloted in the ED, and lessons from that pilot are informing an Executive-led Group-wide approach to the acquisition and Group-wide roll out of AI tools for both planned and unplanned care. This work is being done in close collaboration with SW London ICB, and is also designed to free up clinical time and contribute to financial recovery. Robotic Process Automation is also being piloted to improve outpatient productivity and waiting times.	
3.0 Effectiveness and Outcomes			
Our quality priorities	**What will success look like?**	**How did we do in 2024/25?**	**How our performance compared with 2023/24**
3.1 Improve flow in the Emergency department to reduce overcrowding and long waits for treatment	We will deliver our flow programme	**We did achieve this.**	

		79.64% of patient attendances were seen and discharged or admitted within 4 hours (against the target of 78%) We reduced the proportion of patients (total number of patients attending ED) who waited for more than 12 hours in the Emergency Department from 8.8% to 8.5% when compared with 2023-24 (Current national average is 8%. Long term national ambition is to achieve less than 2%)	
3.2 Ensuring a quality, safety and learning culture that promotes psychological safety for our staff	We will integrate our Quality Improvement resources across the Group to maximise service improvement activity and actively encourage psychological safety in all improvement activity	**We did achieve this.** We have taken further steps in our progress towards creating a Continuous Improvement culture across gesh group. We have built a clearer structure of our programme to deliver the strategic initiative of High Performing Teams (HPT) – our follow-on to NHS Impact and the thinking behind strategic quality management systems across organisations. Our programme aligns strongly with the themes within NHS Impact (see Quality Account page 5 for further detail).	N/A

Annex 1: Statements from commissioners, local Healthwatch organisations and overview and Scrutiny Committees

A1.1 Statement from South West London Integrated Care Board

Thank you for sharing the Trust 2025/2026 Quality Account with South West London Integrated Care Board (SWL ICB). We recognise the dedication to improving care standards, patient outcomes, and staff experience. A strong commitment to quality is the foundation of excellent patient care, and it's encouraging to see such dedication reflected in the Quality Account.

The ICB recognises the progress made for the priorities set out in 2024/2025 Quality Account. In particular:

- Patient safety - Learning from Patient safety Incidents; the ICB is pleased to see the full implementation of the new Patient Safety Incident Response Framework (PSIRF) We recognise that this is a significant transformation in patient safety management, and it's great to hear that the changes have been successfully embedded with a positive impact.
- Effectiveness and Outcomes – Improving patient flow in the emergency department to reduce overcrowding and long waits. The ICB congratulates the Trust on achieving 79.64% of patient attendances being seen and discharged or admitted within 4 hours and reducing the number of people with 12 hour waiting times. This clearly has a positive impact on patient flow across departments, this is testament to the dedication and collaboration of your teams striving for better outcomes. This kind of progress not only benefits patients but also enhances staff morale and operational effectiveness.
- Ensuring a quality, safety and learning culture that promotes psychological safety for staff. It's great to see the commitment to fostering a culture of continuous improvement across the group. The creation of a structured programme to support high-performing teams is a strong step forward, and aligning this initiative with NHS Impact actions demonstrates a clear focus on sustainability and excellence. Investing in staff and teams' development not only strengthens operational efficiency but also empowers staff, which ultimately enhances patient care and outcomes.

  In addition to the above, we recognise the significant positive impact the Trust had in supporting other Hospital Trusts when the cyber attack in May 2024 disrupted blood tests and transfusions at several hospitals in South East London, the dedication and support of staff at St Georges was exemplary.

In terms of future programmes of work, we welcome the Trust initiatives to improve patient safety, with a focus on: Fundamentals of Care: continued focus on improving pressure ulcer care, falls prevention, and VTE risk assessment; Maternity services - progress in response to the Care Quality Commission (CQC) inspections in March and October 2024; Emergency Department (ED) - patient flow and a focus on actions following the CQC inspection in December 2024; and Reducing Never Events - the ongoing efforts and learning from the Trust to minimise the number of Never events.

We welcome the identified quality priorities for 2025/26:

- Priority 1 – Improve patient safety: having the right systems and staff in place to minimise the risk of harm to our patients and, if things do go wrong, to be open and learn from our mistakes
- Priority 2 – Improve patient experience: meeting our patients' emotional as well as physical needs
- Priority 3 – Improve effectiveness and outcomes: providing the highest quality care, with world class outcomes whilst also being efficient and cost effective

We will be interested to see the details underpinning these key priorities and look forward to seeing how these initiatives unfold and the tangible benefits they bring across the Trust and wider integrated care system. We appreciate the open and transparent approach the Trust has in working with us and look forward to continuing work with the Trust in 2025/26.

Elaine Clancy
Chief Nursing Officer

A1.2 Statement from Healthwatch Wandsworth

Healthwatch Wandsworth once again welcomes the opportunity to comment on this annual Quality Account. After another very challenging years for all staff with operational pressures and increasing complexity of patients, we want to offer thanks to those making continued efforts to manage quality and improve patient experience for our residents.

The following are our comments on the information available in the draft circulated, in which a number of sections were still awaiting content (including the performance against NHS Improvement Single Oversight Framework, which seem to be some of the key indicators). Therefore, our comments on the achievement of quality outcomes for 2024-5 has been limited by the information available in the report. For example, there is a great deal of information about national clinical audits, but this is difficult to digest because of the variety of different reports mentioned, many with limited information about the specifics of the quality findings and much of it relates to actions to be taken.

St George's Hospital was one of the test sites for Martha's Rule aiming to give patients and families routes for review if they are concerned. We understand that this has been rolled out across the hospital. We look forward to hearing about what impact this has had on patient outcomes and experience. It would be good to ensure that information about this is available in accessible formats and to patients and carers who may not have a good understanding of written English.

After our report on perinatal mental health at the end of 2023, we had understood that there were links between maternity teams and the specialist perinatal mental health service at SWLSTG. We were interested to read in the report of the National Maternity and Perinatal Audit (NMPA) that work is ongoing to establish an effective pathway for referring women and birthing people with a significant mental health diagnosis and/or history of serious perinatal mental health illness to secondary perinatal mental health services. We would encourage this as a priority and we continue to take an interest in improvements that are planned to support people for whom English is not a first language, given the additional barriers this creates when discussing mental health (it is possible that this may be in linked with the MBRACE reports referenced, but a specific mention of work in this area is not clear). Indeed, one of the next years' priorities is to improve safety in maternity services, it would be useful to know more about the integrated improvement plan.

It was a shame to see that the CQC had picked up a number of issues in their inspection this year, even though patients had rated the services highly. Although we understand that patient feedback doesn't always represent the wide range of demographic groups who use St George's Hospital. The Trust's focus on immediate improvement plans are welcomed, but it is important that there is rapid delivery on improvements. By publication, it would be useful if the coloured chart about CQC inspections could be up-to-date if and when latest reports are available.

Patient experience information in 2.3.4 did not show data for last year in the draft we received, nor did it give any information about experiences that related to quality or safety of services. With our interest in patient experience we would like to see more relevant information here, although limitations may be due to the national reporting template.

The Patient Safety Incident Response Framework has been implemented and it would be useful to hear more about the data and improvements this brings in next years' report. For this report it is important to demonstrate the active involvement of Patient Safety Partners, which we understand are not yet an integral part of the process.

Progress against Quality Priorities for 2024/5 It is positive to see some successes this year on areas that are not ones that can be easily resolved by quick fixes. There are some clear pieces of information indicating difficulties in achieving success in the areas that were identified as priorities throughout the report. As some of these priorities have been a focus over time, it might be useful to see or plan to see change over a longer period.

Quality Priorities for 2025/6

Priority 2 is described as ‘Improve patient experience: meeting our patients’ emotional as well as physical needs’, however the detail of the plans mainly focuses on reducing waiting times in ED and doesn’t refer to mental health. The ‘How’ columns could provide more information about the specific actions that could help us understand more about how outcomes will be achieved and how these relate to the priorities.

It is worth noting here that we did see positive outcomes around mental and emotional health when we visited Thomas Young stroke ward in September 2024. A psychologist offered 1-1 support and group sessions which were both highly valued by patients. We have heard that these types of measures are also in place in other specialties and it would be really useful to see the impact this support is having on outcomes and patient experience across the hospital if the priority has a focus on emotional needs.

As we have read the report at a formative stage, we hope our comments are useful to support reporting progress on quality improvement and quality measures. In such a challenging context there is much to be done. A lot of work has been done to improve IT systems which will hopefully also support reporting. A more general theme we hope will become more imbedded in future reports will be health inequalities and how some of the issues affect some patient groups more than others. There was a priority on this topic last year, which was partially achieved, and we hope to see this emphasis carry forward in future accounts.

Deputy Director (Research, Engagement and Consultancy) and Healthwatch Wandsworth Lead Officer

A1.3 Statement from Wandsworth Adult Care and Health Overview Scrutiny Committee

- Provision of comments is voluntary – not requested

A1.4 Our response to our stakeholders

The Trust is grateful for the considered responses from all our stakeholders and their input in developing our Quality Account. These responses have been helpful and will be considered with the relevant stakeholders in developing the Quality Account for 2025-26.

A1.5 Limited assurance report on the content of the Quality Reports and mandated performance indicators

[Not required and limited to a read through against the Annual Report and Accounts]

A1.6 Independent auditor's report to the Council of Governors of St George's University Hospitals NHS Foundation Trust on the Quality Report

[Not required]

Annex 2:

A2.1 Statement of Directors' responsibilities for the Quality Report

The directors are required under the Health Act 2009 and the National Health Service (Quality Accounts) Regulations to prepare Quality Accounts for each financial year.

NHS Improvement has issued guidance to NHS foundation Trust boards on the form and content of annual quality reports (which incorporate the above legal requirements) and on the arrangements that NHS foundation Trust boards should put in place to support the data quality for the preparation of the quality report. In preparing the Quality Report, directors are required to take steps to satisfy themselves that:

- the content of the quality report meets the requirements set out in the *NHS Foundation Trust Annual Reporting Manual 2021/22* and supporting guidance *Detailed requirements for quality reports 2021/22*
- the content of the quality report is not inconsistent with internal and external sources of information including:
  - board minutes and papers for the period April 2024 to June 2025
  - papers relating to quality reported to the board over the period April 2024 to June 20255
  - feedback from the Integrated Care Board
  - feedback from Governors
  - feedback from local Healthwatch organisations (voluntary)
  - feedback from overview and scrutiny committee (voluntary)
  - the Trust's complaints report 2023-24 published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009
  - the latest national patient survey for Adult Inpatients; Urgent and Emergency Care; Children and Young People; and Maternity Services
  - the latest national staff survey
  - the Head of Internal Audit's annual opinion of the Trust's control environment dated [Not required]
  - the CQC inspection reports dated 18 December 2019
  - the CQC inspection reports received in August 2024 for Maternity Services Safe and Well led

- the quality report presents a balanced picture of the Trust's performance over the period covered
- the performance information reported in the quality report is reliable and accurate
- there are proper internal controls over the collection and reporting of the measures of performance included in the quality report, and these controls are subject to review to confirm that they are working effectively in practice
- the data underpinning the measures of performance reported in the quality report is robust and reliable, conforms to specified data quality standards and prescribed definitions, is subject to appropriate scrutiny and review
- the Quality Report has been prepared in accordance with NHS Improvement's annual reporting manual and supporting guidance (which incorporate the quality accounts regulations) as well as the standards to support data quality for the preparation of the quality report.

The directors confirm to the best of their knowledge and belief they have complied with the above requirements in preparing the quality report.

By order of the board.

Sir Mark Lowcock

Chair

27 June 2025

Jacqueline Totterdell

Chief Executive

27 June 2025