Group Board

Agenda

Meeting in Public on Friday, 05 September 2025, 12:45 – 15:55

Wandsworth Professional Development Centre, Building 1, Burntwood School, Burntwood Lane, SW17 0AQ

Introductory items					
Time	**Item**	**Title**	**Presenter**	**Purpose**	**Format**
12:45	1.1	Welcome and Apologies	Chair	Note	Verbal
	1.2	Declarations of Interest	All	Note	Verbal
	1.3	Chair's Update	Chair	Note	Verbal
	1.4	Minutes of previous meeting	Chair	Approve	Report
	1.5	Action Log and Matters Arising	Chair	Review	Report
13:00	1.6	Group Chief Executive Officer's Report	GCEO	Review	Report

Quality – Items for Review and Assurance					
Time	**Item**	**Title**	**Presenter**	**Purpose**	**Format**
13:15	2.1	Quality Committees Report	Committee Chair	Assure	Report
13:25	2.2	Care Quality Commission Inspection Reports	Site CNO's	Review	Report
13:35	2.3	Group Maternity Services Report	Site CNO's / GCMO	Assure	Report
13:45	2.4	Responsible Officer Report on Medical Appraisal and Revalidation	GCMO	Approve	Report

Finance, Performance, Audit and Risk – Items for Review and Assurance					
Time	**Item**	**Title**	**Presenter**	**Purpose**	**Format**
13:50	3.1	Finance and Performance Committees Report	Committee Chair	Assure	Report
14:00	3.2	Finance Report – Month 4	Committee Chair	Review	Report
14:10	3.3	Integrated Quality and Performance Report	GDCEO	Review	Report

People – Items for Review and Assurance					
Time	**Item**	**Title**	**Presenter**	**Purpose**	**Format**
14:40	4.1	People Committees Report	Committee Chair	Assure	Report
14:50	4.2	Workforce Race and Disability Equality Standard Reports	GCPO	Approve	Report

Infrastructure – Items for Review and Assurance					
Time	**Item**	**Title**	**Presenter**	**Purpose**	**Format**
15:05	5.1	Infrastructure Committees Report	Committee Chair	Assure	Report

Items for noting					
Time	**Item**	**Title**	**Presenter**	**Purpose**	**Format**
15:15	6.1	Complaints and PALS Annual Report	Site CNO's	Note	Report
	6.2	Patient Experience Annual Report	Site CNO's	Note	Report
	6.3	Safeguarding Annual Report	Site CNO's	Note	Report

Closing items					
Time	**Item**	**Title**	**Presenter**	**Purpose**	**Format**
15:20	7.1	New Risks and Issues Identified	Chair	Note	Verbal
	7.2	Questions from members of the public and Governors of St George's*	Chair		Verbal
	7.3	Any Other Business	All	Note	Verbal
15:30	7.4	Patient / Staff Story	GCNO	Review	Verbal
15:50	7.5	Reflections on the Meeting	Chair	Note	Verbal
15:55	-	CLOSE	-	-	-

***Questions from Members of the Public and Governors**

The Board will respond to written questions submitted in advance by members of the Public and from Governors of St George's University Hospitals NHS Foundation Trust.

Membership and Attendees		
Members	**Designation**	**Abbreviation**
Mark Lowcock	Chair	Chair
Jacqueline Totterdell	Group Chief Executive Officer	GCEO
Natalie Armstrong	Non-Executive Director – ESTH/SGUH	NA
Mark Bagnall*^	Group Chief Officer – Facilities, Infrastructure and Estates	GCOFIE
Ann Beasley	Non-Executive Director and Vice Chair ESTH / SGUH	AB
James Blythe*	Managing Director – ESTH	JB
Pankaj Davé	Non-Executive Director – SGUH	PD
Richard Jennings	Group Chief Medical Officer	GCMO
Stephen Jones*^	Group Chief Corporate Affairs Officer	GCCAO
Yin Jones	Non-Executive Director – ESTH/SGUH	YJ
Peter Kane	Non-Executive Director – ESTH/SGUH	PK
Khadir Meer^	Non-Executive Director – SGUH	KM
Michael Pantlin*^	Interim Group Deputy Chief Executive Officer	IGDCEO
Thirza Sawtell*	Managing Director – Integrated Care	MD-IC
Kate Slemeck^	Managing Director – SGUH	MD-SGUH
Victoria Smith*^	Group Chief People Officer	GCPO
Claire Sunderland Hay^	Associate Non-Executive Director - SGUH	CSH
In Attendance		
Lizzie Alabaster	Site CFO- ESTH	CFO-ESTH
Liz Dawson	Group Deputy Director Corporate Affairs	GDDCA
Anna Macarthur	Group Chief Communications Officer	GCCO
Theresa Matthews	Site Chief Nursing Officer - ESTH	CNO-ESTH
Ralph Michell	Group Chief Transformation Officer	CGTO
Nicola Shopland	Site Chief Nursing Officer - SGUH	CNO-SGUH
Apologies		
Andrew Grimshaw	Group Chief Finance Officer	GCFO
Andrew Murray	Non-Executive Director – ESTH / SGUH	AM
Phil Wilbraham*	Associate Non-Executive Director – ESTH	PW
Observers		
Leonie Penna	Non-Executive Director Designate (SGUH)	
Bidesh Sarkar	Non-Executive Director Designate (ESTH / SGUH)	

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

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

Minutes of Group Board Meeting

Meeting in Public on Thursday, 03 July 2025, 12:30-15:30

Conference Room 1, Wells Wing, Epsom Hospital, Dorking Road, Epsom KT18 7EG

PRESENT		
Mark Lowcock	Group Chair	Chair
Jacqueline Totterdell	Group Chief Executive Officer	GCEO
Mark Bagnall*^	Group Chief Facilities, Infrastructure and Environment Officer	GCFIEO
Ann Beasley	Non-Executive Director, Vice Chair – ESTH / SGUH	AB
James Blythe*	Managing Director – ESTH	MD-ESTH
Pankaj Davé	Non-Executive Director – SGUH	PD
Andrew Grimshaw	Group Chief Financial Officer	GCFO
Richard Jennings	Group Chief Medical Officer	GCMO
Stephen Jones*^	Group Chief Corporate Affairs Officer	GCCAO
Peter Kane	Non-Executive Director – ESTH / SGUH	PK
Khadir Meer^	Associate Non-Executive Director – SGUH	KM
Ralph Michell	Group Chief Transformation Officer	RM
Andrew Murray	Non-Executive Director – ESTH / SGUH	AM
Michael Pantlin*^	Interim Deputy Group Chief Executive Officer	IGDCEO
Victoria Smith*^	Group Chief People Officer	CPO
Arlene Wellman	Group Chief Nursing Officer	GCNO
Phil Wilbraham*	Associate Non-Executive Director – ESTH	PW
IN ATTENDANCE		
Elizabeth Dawson	Group Deputy Director of Corporate Affairs	GDCCA
Anna Macarthur	Group Chief Communications Officer	GCCO
Karyn Richards-Wright	Group Freedom to Speak Up Guardian	FTSUG
APOLOGIES		
Natalie Armstrong	Non-Executive Director	NA
Yin Jones	Non-Executive Director – ESTH / SGUH	YJ
Thirza Sawtell*	Managing Director – Integrated Care	MD-IC
Kate Slemeck^	Managing Director – SGUH	MD-SGUH
Claire Sunderland-Hay^	Associate Non-Executive Director – SGUH	CSH
OBSERVERS		

Chair Approved

** Denotes non-voting member of the Group Board (Epsom and St Helier)*
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		Action
	FEEDBACK FROM WARD VISITS	
	SWLEOC: AM, GCPO: This was the first time that AM had visited SWLEOC. He had been impressed with it being clean and well set up with the high level of morale amongst staff palpable. Since this was a specialist centre, the focus on getting the process right to ensure patients received quality treatment and home quickly was clear, and everything was well thought through. It was an impressive and encouraging visit. **Endoscopy: GCEO, GCNO, KM, PW:** KM said that it was a pleasure to visit Endoscopy. It was clean, clear and well organised with basics such as bare below the elbow being followed and equipment in good order. Staff had been welcoming and had explained how patients moved through and the volume of people they saw. Staff survey results had been positive. PW added that they saw about 28 patients a day, mostly on day case, and it seemed a very efficient unit. GCEO said they were embracing that new EPR with some challenges that she would feed back to the team. **Outpatients: PD, GDCEO, GCNO:** PD reported that the outpatient area they had visited had been clean and well organised and the staff had been welcoming. The financial constraints and need to make savings had been raised as a concern. Staff had also raised that the lack of computers made it difficult to complete online training, and also suggested that mandatory training could be more role specific. A member of the public (MoP) asked whether the Board thought about who kept the wards clean as they were amongst the cleaners, caterers and porters who did not have access to IT and for whom sick pay was denied for the first 3 days of absence. MoP asked whether the Board felt it was acceptable to balance the books on the backs of BAME and the lowest paid staff who were denied basic employment rights and benefits. The Chair explained that this was a meeting of the Board in public and not a public meeting and the questions that they had submitted in advance would, as set out in the agenda and explained before the meeting, be taken at the end. MoP stated those staff observing the meeting would not be paid if they stayed, and asked whether permission would be granted for them to remain in the meeting on full pay and without fear of disciplinary action. The Chair stated that all were welcome to stay until the end of the meeting if they wished. However, on this occasion the questions from this MoP would be taken now to allow those observers who did not wish to stay for the whole meeting to leave. The Chair invited the GDCEO to respond to the questions that had been submitted in advance. GCDEO said that all felt uncomfortable about the differences in terms and conditions and the Trust wanted to work through these. All who worked in the Trust were a team and were interdependent. There had been changes in terms and conditions over time and there had been a group working on the implications of this. A thorough review was underway, and he would publish the terms of reference and keep the MoP and staff informed on progress. Staff would be consulted on any proposed changes to terms and conditions, although changes could be difficult in the current financial climate. GCDEO added that there was lot of detail to work through. MoP responded that he was glad to hear that there was discomfort, but there was real discrimination and institutional racism – a legal claim was being prepared. It	

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could also cost the Trust huge sums of money and that a strike by 300 staff was imminent, which was an incredibly difficult decision for staff to make, they were not willing to wait any longer. Staff had been given promises 4 years ago and they had been duped and deceived over their terms and conditions which had cost them tens of thousands of pounds. They had less annual leave and did not have the same pension benefits. A review would not solve the issues, and he wanted to know when they would be treated lawfully, with clarity and fairly. A date for resolving through negotiation must be set. MoP asked that GDCEO agree to start negotiations within a month. There could be indeterminate industrial action and he called on the Trust to be a good employer.

GDCEO said that he would be able to discuss the issues further but he would not use the term negotiate. The Trust was doing its homework and there was a sequence of events to be worked through.

The Chair said that having permitted the questions to be raised, the discussion now needed to close.

AMU – GCTO, GCFIEO: GCFIE fed back that they had met with the ward manager of AMU which had 34 beds. The unit was calm and under control and staff were busy. A Multi Disciplinary Team meeting was held at the start of the day and staff said they felt well supported by site leadership and that they were included in Cost Improvement Plan (CIP) discussions. There were some pressures, but these were not impacting on patient care. Staff had had different experiences of the roll out of the EPR.

MoP intervened and asked for a response to his question about a meeting. The Chair reminded that this was a meeting of the Board in public and not a public meeting. A full response to the 14 questions that had been submitted would be sent as soon as possible, and would be appended to the Minutes, but the meeting would need to be suspended if there were further interruptions.

MoP continued to request a meeting to negotiate on the issues. The Chair stated that having been given the opportunity to raise his questions and been given an answer, the Board meeting would be suspended if there were continued interruptions to the business of the Board. The GCEO confirmed that there would be a meeting, but this would not be a negotiation. GDCEO added that he would like to say that a meeting would take place before the end of July and he would be able to provide more information soon. He noted that this issue affected lots of staff and the Trust would be talking to the recognised unions.

After it being confirmed that there was a commitment to a meeting with the UVW before the end of July, MoP and staff observers left the meeting.

SCBU – Chair, AB, GCCO, GCMO: GCCO said that the group had visited SCBU and Casey Ward, where SCBU was temporarily located. The ward had 12 beds and was a modern and beautiful space with staff having fundraised for a sensory area. Due to the heat, SCBU was currently co-located with Casey. Staff had been quite positive about the EPR roll out. GCMO added that there were no patient safety concerns with the EPR system.

Alexandra Ward (Care of the Elderly) – CFO, MD-ESTH, PK: PK reported that the ward had been recently refurbished. Staff had said that the key area of challenge was moving patients on once they no longer needed hospital care – this reconfirmed the patient flow issues that had been raised on other occasions. Changes within local authorities were having an impact and a better system was needed.

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1.0	**INTRODUCTORY ITEMS**	
1.1	**Welcome, introductions and apologies**	
	The Chair welcomed everyone to the meeting, Apologies were received from Natalie Armstrong, Yin Jones, Thirza Sawtell, Kate Slemeck and Claire Sunderland Hay.	
1.2	**Declarations of Interests**	
	The standing interests in relation to shared roles across the St George's, Epsom and St Helier University Hospitals and Health Group of the following directors was noted, which have previously been notified to the Board: • Mark Lowcock as Group Chair. • Ann Beasley, Peter Kane and Andrew Murray as non-executive Directors; • Jacqueline Totterdell, Mark Bagnall, Andrew Grimshaw, Richard Jennings, Stephen Jones, Ralph Michell, Michael Pantlin, Victoria Smith and Arlene Wellman as Executive Directors. AM declared a new interest from 1 July 2025 having been appointed to the role of Chief Clinical Transformation Officer at the SWL ICB on a 6-month contract for 2 days per week. There were no other declarations other than those previously reported.	
1.3	**Minutes of the Previous Meeting**	
	The minutes of the Group Board meeting on 1 May 2025 were approved as a true and accurate record.	
1.4	**Action Log and Matters Arising**	
	PUBLIC20241107.2 The GCCAO recommended that the action relating to a revised Freedom to Speak Up (FTSU) strategy be postponed until October to allow any relevant feedback from the CQC Well Led inspection to be incorporated – the report was expected in late July. The Board agreed with this proposal. PUBLIC20250901.1 The action to report on a review of mandatory training was not yet due.	
1.5	**Group Chief Executive's Officer (GCEO) Report**	
	The GCEO took the report as read and invited questions. The following issues were raised and noted in discussion: The 10 Year Plan had been published that day. Although there had not been an opportunity to review in detail, it was agreed that gesh endorsed and supported the plan. The move from hospital to community was noted as one of the three key strands with the GCEO adding that the gesh was well placed to move forward with this. Detailed discussions with all partners on how 'hospitals at home' could be set up and services moved into the community would be needed as it would not be viable	

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	to double run both in-hospital and in-community at the same time. How the money would move was a key aspect as was ensuring the availability of reliable data. Responding to a question on staff reactions to the information that had already been released about the content of the 10 Year Plan, the GCEO said that a series of roadshows were taking place with the executive sharing information about the cost improvements that were needed. Staff were up for the challenge and she wanted to empower and excite staff, using the high performing teams programme, about the opportunities within the 10 Year Plan as it contained the right things for patients. MD-ESTH said that to make the Plan a success the number of outpatient appointments needed to reduce. To do this better, support was needed from primary cared to reduce unnecessary referrals, this could be achieved if there was more access for them to specialist advice but time could only be released to provide this advice if the number of outpatient appointments were reduced. Time would be needed to work through issues such as this. **The Group Board noted the Group Chief Executive's Report.**
2.0	**STRATEGY, RISK AND GOVERNANCE**
2.1	**Strategy Stocktake including Group Operational Plan**
	GCTO reminded the Board that the Group Strategic Plan had been reviewed in light of the changing situation that the sector and gesh were in. As had been discussed at the Development Session in June 2025/26 should be a year of transition working on the board to ward priorities. The publication of the NHS 10 Year Plan earlier that day showed, on an initial read, the high-level portfolio of activity that had been constructed was consistent with its content. In discussion the Board agreed that the priorities identified were pragmatic and sensible, with the proposal to work alongside the review currently underway by SWL a good one. It was noted that the focus on Place, and the co-dependency on partnerships with the local authority were key and that additional challenges could be presented if the new funding formula disadvantaged London. GCEO added that the priority had to be patients who were often stuck in the middle when well enough to go home but support from local authorities did not move quickly enough. The impact this had needed to be understood by local authorities. It was noted that the CEO of Merton Council was visiting in the next few weeks and the issue would be raised with them. After discussion the Board noted the report and agreed, as set out in the report: • That 2025/26 should be seen as a year of transition, working with partners to develop the strategy for South West London ahead of any gesh-specific revised strategy • The performance indicators for our board to ward priorities • The high-level shape of our transformation portfolio

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2.2	**Group Board Assurance Framework: Q1 2025/26 Review**

The GCCAO introduced the review of the Board Assurance Framework, explaining that 11 of the 14 risks were overseen by committees and had been considered at their June meetings. The remaining 3 risks, relating to collaboration and partnership, were reserved for the decision of the Board. It was not proposed that there were any changes to the risk scores at this time. With the group operating in a fundamentally higher risk environment, even in some cases where progress has been made on implementing some of the mitigating actions the risk rating has not changed.

In relation to the assurance ratings, there was one proposed change – increasing the assurance rating for SR11 (tackling health inequalities) from "limited" to "reasonable".

In relation to target risk scores and target assurance ratings for year-end 2025/26, the proposal was to roll forward those targets from 2024/25, which were not achieved, as the targets for the current year. The exceptions to this are SR5 (estates), SR6 (digital), SR9 (improving patient safety) where the relevant Committees of the Board did not feel that it was realistic to propose a reduction in the risk score by the end of the year. The Committees did, however, propose stretching targets for all assurance ratings by year end.

AB thanked the GCCAO for the very helpful paper and asked AM for further information on SR11 (health inequalities) and the change from limited to reasonable assurance as this seemed like a fairly balanced decision. AM responded that there had been a good discussion at the Quality Committees on this, taking into account recent appointments to key roles and a working group now established. This gave the Committee greater assurance that activity and an action plan was in place but the impact of this needed to be seen before the risk score could be reduced.

PD asked how the group assessed the cumulative risk of these individual areas. GCCAO said that this was not straightforward - the totality of the risk was not considered specifically but the BAF was meant to be a way of triangulating the information. The role of the Audit and Risk Committee had also been strengthened through the new risk framework that had been agreed and he believed that this would help in this area.

After discussion, and as set out in the report, the Board:

a) Noted the recommendations relating to the risk scores and assurance ratings from the Committees of the Board for Strategic Risks 4-14
b) Agreed the risk scores and assurance ratings for Strategic Risks 1-3 which are reserved to the Group Board
c) Agreed the risk scores and assurance ratings for the Group BAF as a whole as at Q1 2025/26
d) Agreed the proposed target risk scores and target assurance ratings for year-end 2025/26.

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3.0	**Items for Review and Assurance – Quality**
3.1	**Quality Committees Report**
	AM took the report as read but drew to the Board's attention 2 incidents of equipment failure in the Vascular Surgery Hybrid Theatres. These were known risks and mitigations were in place but it was important that the Board were aware of the issue. The Committee had taken a deep dive into Pressure Ulcers – one of the Fundamentals of Care, with different levels of assurance for each trust. ESTH had done well over the past three years on reducing grade 4 pressure ulcers but at SGUH, although the data was not too bad, it was below target giving limited assurance. The Executive had been encouraged to consider what lessons could be learnt from ESTH. AB raised a Never Event where a patient had fallen when the right number of staff had not been present, and sadly died. This had happened in 2024 but only now reported. AM responded that there had not been a meeting of the Committee since the Board had been informed but it would be discussed at the next meeting. Information flow relating to Learning From Deaths was a theme that needed exploring and he would report back to the Board on the discussions. The Chair asked whether the Committee felt that they had enough sight of CIPs and the associated Quality Impact Assessments. AM said that the Committee had reasonable assurance that the right process was in place and the right people were involved. It was not the Committees place to review individual decisions but they had asked for examples and had been encouraged by seeing how proposals had been modified by the group which showed this was not a tick box exercise. GCMO added that it was relatively unusual for the group to reject a proposal but this was because it would have gone through several stages of review at site level. The group did however ask for modifications and for metrics to be reported back so that the success of the plan and any unexpected consequences could be monitored. The Board noted the report from the Quality Committees.
3.2	**Group Maternity Services Quality Report**
	The Chair reminded the Board that they had requested that a paper be brought to the July meeting bringing together the key elements of the integrated maternity improvement plan for SGUH and the actions being taken in relation to leadership of the service. AM introduced the paper that had been discussed in detail by the Quality Committees. The integrated plan, which had started to group actions by themes, meant that the totality of progress and the ability to track actions would be easier to do. GCNO added that the plan as presented was focused on SGUH, with work underway on ESTH. The Committee had been unable to give an assurance rating on the proposed leadership arrangements for maternity across the group as it was still felt that there

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	was a lack of clarity on the role of the Group Chief Midwifery Officer. It was noted that it was not just about the structure but getting the right people into those roles. It had been agreed that a meeting would be arranged with AM, GCEO, GCNO, GCMO and the site MDs to discuss the leadership arrangements in more detail. An update would come to the September meeting. It was noted that MD-ESTH would continue with the recruitment of a Head of Midwifery for the Trust. GCNO reminded the Board that the needs of both trusts were different and that there was not a single maternity service across the group. **The Board noted the report and the actions being taken.**	
5.0	**Items for Review and Assurance – People (this item was taken out of order)**	
5.1	**People Committees Report**	
	In the absence of YJ, PW informed the Board that the Committee had received a series of good reports from the GCPO at their last meeting. The Committee had noted that progress was being made on reducing the use of agency, and to a lesser extent, bank staff but more work was needed on the WTE. The GCPOs team had been commended for the new dashboards that aided the Committee in their discussions. **The Group Board noted the report.**	
5.2	**Freedom to Speak Up Annual Report**	
	GCCAO introduced Karyn Richards-Wright (FTSUG) to the meeting. The annual FTSU report highlighted that the key themes being raised where Trust practices around recruitment, bullying and harassment and the timeliness of the resolution of concerns. There was a target of 30 days to resolve non complex issues but this was impacted if an investigator needed to be appointed. To address this, HR were running additional training to increase the number of investigators available. Moving forward, the FTSUG was looking at the structure of the service and how to address the increasing number of requests from managers for 1:1 support. It was also highlighted that 50% of concerns raised with FTSU had already been raised with a manager but not resolved – giving managers the tools to be able to respond to concerns with confidence was key. It was noted that at SGUH all staff completed mandatory FTSU but only 60 staff at ESTH, where it was not mandatory had completed it. A new group FTSU policy had been launched. GCCAO endorsed the comments from FTSUG and said that the new Raising Concerns Group was helping to triangulate information so that there could be more timely responses to issues, it would also help to move longstanding concerns forward to resolution. He noted that the National Guardian's Office was to be disbanded with its work transferred into NHS England and then DHSC – he did not believe this would impact on the trust level service.	

	MD-ESTH said that he massively welcomed the improvements to the service under the leadership of FTSUG, and there as an improved culture of speaking up at ESTH. For clarity, there was no resistance at the trust to undertaking FTSU training but it was not mandatory at present and there would be cost pressures and an impact on staff time if this was introduced, so the implications would need to considered if this were to change. GCPO noted that NHSE were carrying out a piece of work to review the efficacy of mandatory training. FTSU was a key lever in helping staff to raise concerns but the group would need to be cognisant of the outcome of this review when considering any changes. AB said that she was struck by the data that said 50% of concerns had already been raised with managers. GCEO responded that how we train managers to have difficult conversations was key to addressing this. GCMO felt that it should be celebrated that the most frequent issues raised were linked to patient safety, which was the original aim of the FTSU model, and showed the work done to promote the service. FTSUG said that in the past, more concerns had been raised about behaviours not safety and she felt that the visibility of the FTSU service helped staff to come forward. The next step for her was to do more triangulation to look at hot spots and areas of learning that could be shared with site teams. T**he Board:** **a. Noted the number of concerns reported to the FTSU Guardians in 2024/25 for both SGUH and ESTH and the staff groups reporting.** **b. Noted the themes emerging from FTSU cases in this period.** **c. Noted the recommendations of the Group FTSU Guardian as set out in section 7 of the report.** **d. Noted the priorities of the new Group FTSU service in the coming months which includes developing a new gesh FTSU vision and strategy.**	
4.0	**Items for Review and Assurance – Finance and Performance**	
4.1	**Finance and Performance Committees Report**	
	AB took the report as read, highlighting that both trusts were on plan for M2 but this would get harder to maintain and the BAF score for finance was 25. The risk score may reduce during the year as CIP were fully developed. The QIA report which AM had referred to in relation to the Quality Committees, had also been discussed by the Finance and Performance Committees as these decisions would, as already been noted by the Board, impact on performance so it was important to understand the areas concerned. The Committees had noted some strong performance data and commended the staff for their efforts. AB said that the 2025/26 financial situation was more severe than previous years, with the implications of not being on plan also more severe. PK remarked that communication with stakeholders about the difficulties, and recognition that some areas were already highly efficient was important. He queried whether there would	

	be penalties if the trusts did not meet the target they had been given by NHSE to improve 18 week waits by 5%. GCEO responded that the national finance director recognised that some services were quite efficient, with ESTH being one of the top 6 for elective care. **The Board noted the report and approved the revised terms of reference for the Committee.**	
4.2	**Finance Report – Month 2**	
	GCFO informed that both trusts were on plan in M2 but delivery of the CIP remained a key risk. Progress on identification of CIPs was making good progress but the ask was much higher than in previous years. He highlighted that more detailed cash forecasting was underway as there was a net outflow of cash and there was no easy mechanism for cash relief and so we need to deliver the plan. The financial plan would be refreshed over the next 3 months and then this would be built on as part of the NHS 10 Year Plan work. PD asked whether there was recognition for teams that delivered their CIP. MD-ESTH said that the finance roadshows started by thanking people. Engagement with the sessions had been superb and some incredibly robust plans have come through. The message being given was to thank staff for their efforts but that more was needed. It was agreed that a balance needed to be found in the messaging. **The Board noted the report, the scale of the task and the limited assurance on delivery of the plan.**	
4.3	**Integrated Quality and Performance Report**	
	GDCEO informed the Board that the IQPR had been reviewed by both the Quality and Finance and Performance Committees, noting that the pressure to provide timely access to quality good and balance the finances would augment over the coming months. It was also noted that the updated NHS Oversight Framework would require changes to the IQPR with some additional KPIs added. **The Board noted the report.**	
4.4	**Audit and Risk Committees Report**	
	The Chair opened the item by thanking the Committees for their work on the annual report and accounts in an unusually complex year end. PK, as Chair of the Audit and Risk Committees, echoed the thanks to the GCFO and his team for their work. The annual report and accounts had now been submitted and would be shared at the ESTH Annual Public Meeting and SGUH Annual Members Meeting in September. PK informed the Board that the Head of Internal Audit had highlighted the number of areas where there was only partial assurance. In most cases, policies were in place but there was a compliance issue, which related to culture. This was an area that would be monitored closely by the Committee.	

	PW referred to the internal audit report on violence and aggression at ESTH and asked whether there was any follow up to the informal task force. GCEO responded that a huge amount of work had been done on violence and aggression but unfortunately the two driving forces behind it had left and progress had stalled. A new Head of Health and Safety had just joined and would be taking this forward as a priority. PD asked about the impact of increasing numbers of mental health patients being seen in the EDs. GCEO said the at the ED staff were very good at speaking up and, at SGUH, there was a very good relationship with South West London, St George's. However, ESTH did not have similar links in their area and as a small ED it did not take much for the area to become full. GCCEO, MD-ESTH and the London Regional office were using their best efforts to address the issue. The Chair asked in relation to cyber security whether any testing was done to see if staff would respond to a phishing email – this was a helpful way of highlighting an area that was a source of weakness for many organisations. GCTO said that staff would not be forewarned if testing was to be carried out. More information on cyber security would be form part of the digital strategy which would be presented to the Board later in the year. **The Board noted the report.**	
5.0	**Items for Review and Assurance – Infrastructure**	
5.1	**Infrastructure Committees Report**	
	AB, as Committee Chair, took the report as read and reminded the Board that the Committee alternated the focus of its meetings between digital and estates. The Committees had congratulated the team for the tremendous implementation of the EPR at ESTH and thanks were due to MD-ESTH and COO-ESTH for their leadership of the project. As with all projects of this scale, there had been some issues but to date the feedback had been mostly positive. The Committees had also reviewed the refreshed Green Plan which was recommended for approval later on the agenda. The lack of progress on the digital strategy was disappointing, with the NHS 10 Year Plan making this even more important. The appointment of an Interim Chief Digital Officer was encouraging. The Committees had also reviewed the relevant risks in the BAF, with the risks around IT and estates high due to the lack of capital. The lack of certainty over the timing of new building regulations and how this would link with action required by external regulators was also noted. **The Group Board noted the report.**	
5.2	**Group Green Plan**	

	GCFIE reminded the Board that the Group Green Plan had first been approved in 2022 and in line with NHSE requirements had now been refreshed. It had been reviewed in detail by the Infrastructure Committees. PK said that it was great to see the enthusiasm of the team for sustainability but noted that this was an uncosted plan with some big ticket items to be delivered if net zero was to be achieved on time. He noted that if the SECH had been allowed to proceed it would have helped with the delivery. **The Board approved the Group Green Plan.**	
7.0	**CLOSING ITEMS**	
7.1	**New Risks and Issues Identified**	
	No new risks or issues had been raised.	
7.2	**Questions from members of the public and Governors of St George's**	
	In addition to the questions responded to earlier in the meeting the following questions were raised by members of the public: Ms M Parkes had raised questions regarding PACS and requested a written response. The written response provided but the GCFO is set out below. 1. Has the contract for this system been terminated by the SWL team of which the STG DoF is a member? No, it has not been terminated. 2. Is it the intention of the SWL team to continue with this system even though £4m has been spent on it and in addition, further £m's spend with incumbent the supplier to maintain the Radiology Service? All four Trusts within SWL continue to work together with Optum to address the issues raised to date. Positive progress has been made to-date and work is ongoing with Optum on the remaining aspects that need to be implemented. Clearly there are aspects of this work that are subject to legal and contractual process and associated legal privilege and therefore we are unable to share details at this time but we have strong clinical engagement in this and we are keeping the Boards updated. When completed the appropriate elements of the outcome will be reported in public. 3. If so, where is this new funding coming from? Please refer to the above response. 4. Is re-negotiating the contract and including functionality not invented at the time of contract signature (Nov 2021) within the Public Sector procurement rules? The Public Contracts Regulations (2015) which apply to this contract permit changes to contracts without the need to retender. The Trust is satisfied that	

Chair Approved

any changes are within the boundaries of the appropriate clause of the Regulations.

5. Who does the STG DoF hold responsible for this debacle?
   All parties recognise that implementing such a complex programme is challenging. When the work is finished there will be a review of the project to ensure lessons are learned.

MD-ETSH responded to questions submitted by Councillor McCabe:

Does the Board have plans to cut bed numbers in any of its hospitals?
Both Trusts are planning to make efficiencies resulting from lower lengths of stay which could reduce the number of beds required. The focus had to be on admitting the right people and providing quality and efficient care. Returning home quickly, once well enough to do so, was better for patients. This would also reduce corridor care.

How much money had been budgeted in 2025/6 to tackle the maintenance backlog for Epsom & St Helier hospitals before the Government provided the additional £12 million?

£9m had been budgeted prior to the release of Estates Sustainability Fund. The GCFO would provide more detail on this to Councillor McCabe when available.

Why is Merton the only Borough in South West London without a breast screening centre and how will the Board rectify this issue of health inequality?

GESH is not commissioned to provide this service in this location. This would be a question for the ICB.

Will student nurses graduating this year from St Helier hospital be offered a job at St Helier hospital?
We are confident that we will find jobs for all our student nurses. The majority should be at our Trust. Where this is not possible we will work with partners across the sector to find other opportunities

Will the Board ensure that cleaners, porters and catering staff at St Helier hospital enjoy the same terms and conditions as other staff at the hospital? Councillor McCabe was referred to the answers given earlier in the meeting.

7.3 Reflections on meeting

The Chair asked GCMO to lead the Board in reflecting on the meeting.
GCMO noted the articulate way in which MoP spoke and how he had been listened to with respect, he (GCMO) reflected that additional thought could be given to how issues were resolved and how it could be ensured that people were heard.

He felt that the papers presented were well written and clear and that quality and safety came through well – the papers had allowed for better challenge across the board members. It had also been good to hear from the FTSUG and that he had liked the question from PD on how staff were acknowledged for their CIP efforts.

Chair Approved

5.4	**Patient Story**	
	Simon Littleford was welcomed to the meeting and invited to present the patient story. SL noted that it had not been possible to engage with patient AB to join the meeting. In late 2022, community nurses were providing diabetic care to a gentleman with a learning difficulty. There were several service delivery issues, around insulin delivery, monitoring of health and well-being, behavioural concerns and a lack of coordination between partners. Sadly, this gentleman died whilst in our care, and we are awaiting coroners court to review the multi-agency involvements. During this period we have delivered several system learning events and introduced changes to practice to prevent future deaths This patient story is presented to assure the Board that we have implemented learning and embedded changes into practice. AB is a 49yr old man, referred to the community nursing team for diabetic care (insulin administration). He has presented to A&E on multiple occasions with ketoacidosis due to poorly controlled and has a complex social history, including alcohol and drug dependence. AB had been diagnosed with Schizophrenia and adjustment disorder and lives alone, with parents supporting as much as they can, KM spends more time with his dad, he takes KM for a coffee/ breakfast, hospital appointments. In April 2024 his parents went away on holiday – resulting in complications and access issues with his insulin regime. Complex patients require multi-agency intervention to coordinate and guide through periods of difficulty and the risk needs to be share, with GP and specialists central to decision making. Clear escalation plans for staff are vital to minimise variation of response. Learning lessons from the 2022 case, community staff quickly escalated their concerns – via patient of concern meeting and co-ordinated a local MDT with the GP – for medical advice and guidance. Social care, mental health team and diabetes specialist were also included and a 'one page' multi-agency agreed action plan for monitoring and escalation. SL noted that other actions were still in development or presented challenges. • Access to proactive mental health services is challenging • Access in an 'urgent situation' is attendance to A&E • Caseload management is key – complex patients need consistent oversight and coordination, challenge to identify who this could be when multi agencies involved. • Lifelong medication, where a direct healthcare intervention is required, in those with the potential to deteriorate and reach crisis, should have MDT decision maker at the point of prescribing.	

Chair Approved

	SL was thanked for his presentation. During discussion the importance of ill health, both physical and mental, prevention and partnership working to support patients in the community was raised. It was confirmed that the safeguarding team were part of the MDT. The potential impact of the 10 Year Plan on community services was also noted.	

CLOSE
The meeting closed at 4.10pm.

Chair Approved

Group Board (Public) - Updated September 2025

Action Log

ACTION REFERENCE	MEETING DATE	ITEM NO.	ITEM	ACTION	WHEN	WHO	UPDATE	STATUS
PUBLIC20250901.1	09-Jan-25	3.6	Group Freedom to Speak Up Report	The Mandatory Training Group to review the current mandatory training requirements package to ensure there is a consistent approach to MAST across the group, particularly in key areas such as Freedom to Speak Up training. (GCPO)	04-Sep-25	GCPO	**Update 05/09/2025** We are currently reviewing all of our mandatory learning in line with guidance from NHS England (available in the Reading Room). This review needs a clear process to ensure the decisions we make are robust and justifiable. That process has been designed and is being tested with stakeholders. FTSU will be one of the subject topics we'll be using as an example. We may get a clear decision in conjunction with testing the decision-making tool. Otherwise, we'll take FTSU as one of the first topics to be officially applied to the new process and approved by the wider Mandatory Learning Oversight Group membership which needs to sign this off. Revised date of 6 November proposed.	**REVISED DATE PROPOSED**
PUBLIC20241107.2	07-Nov-24	3.1.5	Interstitial Lung Disease at ESTH	The Board requested that a report detailing the timescales of when systems and functions to support whistleblowing and FTSU are to be embedded into the organisation, be presented at a future meeting to allow the Board to track the progress of this.	04/07/2025 Revised date of October 2025 proposed	GCCAO	This was orginally proposed as an action for the March meeting but is to be brought to the Group Board for review alongside the draft FTSU strategy for the Group, this would be the July meeting. July update: Given that it would be beneficial to have sight of the CQC Well Led Inspection Report so that any feeedback can be incorporated, it is proposed that this now come to the Board in the autumn.	**NOT YET DUE**

Group Board

Meeting in Public on Friday, 05 September 2025

Agenda Item	1.5	
Report Title	**Group Chief Executive Officer's Report**	
Non-Executive Lead	Jacqueline Totterdell, Group Chief Executive Officer	
Report Author(s)	Jacqueline Totterdell, Group Chief Executive Officer	
Previously considered by	n/a	-
Purpose	**For Review**	

Executive Summary

This report summarises key events over the past three months to update the Group Board on strategic and operational activity across the St George's, Epsom and St Helier University Hospitals and Health Group. Specifically, this includes updates on:

- The national context and impact at Group and Trust level
- Our work as a Group
- Staff news and engagement
- Next steps

Action required by Group Board

The Group Board is asked to note the report.

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

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

Group Chief Executive Officer's Report

Group Board, 05 September 2025

1.0 Purpose of paper

1.1 This report provides the Group Board with an update from the Group Chief Executive Officer on strategic and operational activity across St George's, Epsom and St Helier University Hospitals and Health Group and the wider NHS landscape.

2.0 National Context and Updates

NHS 10 Year Plan

2.1 The Government published its much anticipated NHS 10 Year Plan, *Fit for the Future,* on 3 July 2025. As anticipated, the Plan sets out the 'three shifts' that will shape the NHS over the coming decade:

- Moving more care from hospitals to communities, by providing more tests, scans, treatments and therapies nearer where people live and providing more health services at places such as GP clinics, pharmacies, local health centres and in people's homes.
- Making better use of technology in health and care, by moving from analogue to digital and utilising artificial intelligence and advanced robotics.
- Focusing on preventing sickness not just treating it, but spotting illness earlier and tackling the causes of ill health to help people stay healthy and independent for longer and take pressure off health and care services.

2.2 Within these three shifts, the Plan contains a number of detailed commitments including:

- The move to create new neighbourhood health services to bring together care locally through patient-centred teams located in community settings, operating six days a week, 12 hours a day, with single neighbourhood providers delivering care for neighbourhoods of 50,000 people and multi-neighbourhood providers providing services to 250,000 people across several neighbourhoods.
- Improvements in access to General Practitioners (GPs) by increasing capacity in primary care, reducing burdens on GPs, and using artificial intelligence (AI).
- A refocusing on patients beginning elective treatment within 18 weeks of referral by unlocking hospital capacity through more care being delivered locally and in people's homes, and with a greater focus on patient-initiated follow-up and AI tools to enable triage without hospital visits, and reducing pressures on urgent and emergency care by expending urgent care in the community, including greater use of virtual wards.
- Mental health services being transformed into 24/7 neighbourhood care models, with assertive outreach care and treatment.
- Greater focus on patient choice, with a new patient charter, more focus on patient experience, and an expansion of personal health budgets.

- A greater focus on quality and on listening to patients and staff, including the rejuvenation of the National Quality Board, the publication of a new national quality strategy in the autumn, and greater transparency in the quality of care provided.

- A focus on restoring rigorous financial discipline, with the phasing out of deficit support by 2026/27, the introduction of a more transparent financial regime, longer-term financial and operational planning, and an expectation that most providers will generate a surplus by 2029/30.

- The NHS App becoming the 'front door' to the NHS by 2028, a new single patient record operating as a 'patient passport', a single sign on for all NHS software, and greater use of digital and AI across the system.

- The intention by the Government to publish a new 10 Year Workforce Plan by the end of this year.

- Confirmation of the simplification of the responsibilities and accountabilities across the NHS architecture, with the abolition of NHS England, the refocusing of Integrated Care Boards (ICBs) as strategic commissioners, the removal of NHS trusts from the boards of ICB, and the abolition of Integrated Care Partnerships (IPCs).

- There is to be a focus on reinvigorating the NHS Foundation Trust (FT) model, with a focus on earned autonomy, a restoration of existing FT flexibilities, a requirement for all remaining NHS Trusts to become FTs by 2035, and the potential for the highest performing FTs to apply to become Integrated Health Organisations, holding the whole health budget for local populations.

2.3 The Plan will have significant implications for how we organise and deliver health services across our local system, involve a greater focus on neighbourhood health, and will involve close working with our partners in the NHS, local government and across our communities to help realise the three shifts. We have already spent time as an Executive team and as a Board in considering the potential implications of these changes and we will need to continue this over the coming months.

Review of patient safety across the health and care landscape

2.4 On 7 July 2025, the DHSC published the Review of Patient Safety across the health and care landscape, which was commissioned by the Secretary of State for Health and Social Care last year and undertaken by the new NHS England Chair, Dr Penny Dash. The report provides an overview of patient safety and recommendations for improvement. The review concluded that while there had been a shift towards safety over the past 5-10 years, relatively small improvements had been seen and that there had been limited strategic thinking and planning on improving quality of care. The report noted the proliferation in and lack of coordination between organisations undertaking reviews of care. It found that the current complaints system is confusing and lacks responsiveness and that insufficient use is made of NHS data to generate insights and support improvement.

2.5 The report set out nine recommendations, including: (i) revamping and revitalising the role of the National Quality Board; (ii) Continue to rebuild the CQC with a clear remit and responsibility; (iii) Continue the Health Services Safety Investigation Body's role and clarify the remit of future investigations; (iv) transfer the hosting arrangements for the Patient Safety Commissioner to NHS England and, ultimately, to DHSC; (v) bring together the work of Local Healthwatch and

the patient engagement functions of ICBs and providers, to ensure patient and community input into planning and design of services; (vi) streamline functions in relation to staff voice; (vii) reinforce the responsibility and accountability of commissioners and providers in delivery and assurance of high quality care; (viii) technology, data and analytics should be playing a far more significant role in supporting the quality of health and social care; and (ix) there should be a national strategy for quality in adult social care, underpinned by clear evidence.

2.6 The review aligns closely with the priorities of the NHS 10 Year Plan. We anticipate that a new national quality strategy will be published in the coming months. Together, the changes will have significant implications for how we lead, manage and assure ourselves on the quality of our services internally, as well as how the quality of services are overseen by external bodies.

Planning Framework for the NHS in England

2.7 In support of the delivery of the NHS 10 Year plan, NHS England has developed a draft model of planning to meet the challenges and changing needs of the population and to help build the foundation for the transformation of services. The new Framework is expected to move away from annual funding settlements and planning cycles to focus on long-term strategic planning. We expect that, under the Framework, all trusts will be asked to prepare credible, integrated five-year plans an demonstrate how financial sustainability will be secured over the medium-term and which will likely need to demonstrate robust triangulation between finance, quality, activity and workforce. We anticipate that these plans will cover the period 2026/27 to 2030/31.

2.8 The Framework is expected to set out a key role for NHS trust boards in developing these medium-term plans – in setting direction, reviewing drafts, and constructively challenging assumptions – rather than simply endorsing the final version of the plan. Boards are also expected to need to ensure that the plans are evidence-based and realistic in scope, align with the organisation's purpose and the wider system strategy, and support the delivery of national ambitions. Our Group Board has, of course, already held a session considering the implications of the NHS 10 Year Plan and, as part of this, has discussed plans and potential timescales for the development of our medium-term plans. The Board forward plan for the remainder of the year has been adjusted to ensure that the Board can actively shape and inform the development of these plans. We anticipate that plans will need to be developed during the autumn and potentially be submitted in December, with review by NHS England taking place in January and February.

Provider Capability Assessment

2.9 In August 2025, NHS England announced the launch of a new Provider Capability Assessment, as part of the NHS Oversight Framework. Under these arrangements, NHS England will assess trusts' capability and will use this alongside each trust's segment position on the NHS Oversight Framework (NOF) to judge what actions or support are appropriate at each trust. As a key element of this, NHS boards have been asked to assess their organisation's capability against a range of expectations across six areas derived from NHS England's 2024 Insightful Provider Boards guidance:

- Strategy, leadership and planning
- Quality of care
- People and culture
- Access and delivery of services
- Productivity and value for money
- Financial performance and oversight

2.10 NHS England has stated that these Board self-assessments are intended to strengthen board assurance and help NHS England's oversight teams to take a view of NHS trust capability based on boards' awareness of the challenges their organisations face and subsequent action to address them. NHS England has said that the purpose of the assessment is "to focus trust boards' attention on a set of key expectations related to their core functions as well as encourage an open culture of 'no surprises' between trusts and oversight teams". The new Provider Capability Assessments will also help to inform each trust's annual governance statement.

2.11 Trusts have eight weeks from the date on which they receive the documentation from NHS England to carry out the self-assessment, meaning that we will need to submit these by 26 October. Our submissions will need to highlight any areas where we feel we do not meet the criteria, the reasons why, and the actions being taken or planned to address these. Trusts are then required to submit the self assessments for regional oversight, with supporting evidence. Oversight teams at regional level will then review the self-assessment and triangulate this with other information sources to develop a holistic view of capability, and will use this to derive a capability rating:

- Green – indicating high confidence in management and in the trust's ability to deliver on its priorities based on its track record over the past 12-24 months.
- Amber-Green – indicating there are some concerns or areas they need addressing, including where trusts have plans in place plans to address these areas, and where the trust's historical performance or track record means that NHS England does not (yet) have full confidence in the board.
- Amber-Red – indicating that there are material issues they need addressing or that there has been a failure to address major issues over time, including failure to deliver on agreed plans or potential breaches of the trust's provider licence.
- Red – indicating significant concerns arising from poor delivery, governance and other issues, including material or long-running concerns at the organisation that management has been unable to grip or where the trust is likely to be in breach of its licence.

2.12 Oversight teams will then monitor in-year trust performance considering whether the self-assessments still hold, and whether subsequent performance, events or third party information presents any cause for concern.

National maternity investigation

2.13 As mentioned in my update to the Board in July, the Department of Health and Social Care (DHSC) has announced a new 'rapid national investigation' into NHS maternity and neonatal services. The investigation, announced on 23 June 2025, will examine the worst-performing maternity services across England and also review the whole of the maternity system. The stated intention is to bring together the findings of past reviews into maternity into a single set of actions to ensure that every woman and baby received, safe, high quality and compassionate maternity care. In August, the DHSC announced that Baroness Amos has been appointed to lead the investigation, following feedback from bereaved families who expressed a preference for someone with distance from the NHS who is able to bring a fresh pair of eyes to the role. Bereaved and harmed families are expected to be central to the investigation, including working with the Chair to shape her team of expert advisers and the terms of reference. Although there has been some reporting as to which maternity units will be reviewed, the list of the 10 worst performing has not been published at this stage and will be decided by Baroness Amos. The review is expected to produce an initial set of national recommendations by December 2025.

3.0 Our Group

CQC report for services at St George's

3.1 The Care Quality Commission (CQC) published its reports on services at St George's on 28 August 2025. The reports followed inspections of maternity services, urgent and emergency care, and surgery at St George's Hospital and Queen Mary's Hospital in late 2024. Maternity services has improved from a rating of "inadequate" following the previous inspection in 2023 to "Requires Improvement", but the CQC also highlighted concerns that further improvements were needed and issued a warning notice earlier this year. In the 11 months since the inspection, we have made a number of improvements, including strengthening our triage system so that complications can be dealt with more quickly, and introducing a new governance lead to strengthen local leadership. In relation to urgent and emergency care, the service was rated as "Requires Improvement", but the CQC highlighted concerns with overcrowding. In response, our Same Day Emergency Care service has been doubled in size, meaning we can treat more people without an overnight stay and bypassing the emergency department, freeing up beds for those who need admission which helps shorten waits. The rating for surgery at St George's Hospital was "Requires Improvement" and "Good" at Queen Marys Hospital.

3.2 As the Board is aware, the CQC also undertook a planned "well led" inspection at St George's between 25 and 27 February 2025. We understand the final report is in preparation. A date for its publication is not yet confirmed.

Group Quality and Safety Governance Improvement Plan

3.3 In response to the CQC's inspection of maternity services at St George's in March 2023, the Group Board commissioned a two-part review looking first at maternity services and, second, at quality governance across the gesh Group. The outcomes of these have previously been reported to the Group Board. Building on this, we have developed a new Quality Governance Improvement Plan, which has been reviewed by the Quality Committee, and which sets out the improvements we plan to make to strengthen quality governance across the Group, in line with our Group Quality and Safety Strategy. The Plan involves: setting standards, undertaking a gap analysis of current practices against these standards, identifying training needs, coordinating activities effectively across the Group, implementing improvement work to deliver the agreed standards; and putting in place regular reviews and reporting to improve oversight and assurance on the improvements we are making. The Plan has an ambitious timescale, with focused improvement work commencing this month, and its implementation will be overseen at Executive level by the Group Executive Committee and at Board level by the Quality Committee.

Equality, Diversity and Inclusion

3.4 The Group Board will be considering the latest Workforce Race Equality Standard (WRES) and Workforce Disability Equality Standard (WDES) reports for the two Trusts as a separate item on the agenda. However, given the importance of developing an inclusive culture to our Group Strategy, I wanted to highlight some of the positives as well as underscore the areas where we need to make progress. In relation to the WRES, I am pleased that Epsom & St Helier (ESTH) has seen improvement in three of the 10 WRES indicators in 2024 and that St George's (SGUH) has seen an improvement in 4 of 10 indicators. These improvements include fairness recruitment, greater equality in staff from a global majority background entering disciplinary processes, and reductions in reported experiences of harassment, bullying and abuse directed at global majority staff. In both organisations, however, we continue to see under representation

of global majority staff at more senior levels of the organisations. In relation to the WRES, the picture is mixed with improvements in some areas and deterioration in others. On a positive note, we have seen increases in the number of staff declaring disabilities across both Trusts and improvements in the relatively likelihood of disabled candidates being appointed in recruitment processes. However, there have been reductions in the number of disabled staff reporting satisfaction with reasonable adjustments, and satisfaction with how their work is valued, as well as experiencing levels of harassment, bullying or abuse that are higher than abled bodied colleagues.

3.5 The latest WRES and WDES results demonstrate that we are making progress in a number of areas, but that we also have much we still need to do. The action plans we have developed in response to the WRES and WDES, which align with the Group Board's Equality, Diversity and Inclusion Plan agreed earlier this year, will help us make progress, and this is an area I know the whole Board is focused on and committed to improving.

4.0 Events, Appointments and Our Staff

Celebrating South Asian Heritage Month

4.1 Between 18 July and 17 August, we have been celebrating South Asian Heritage Month, to celebrate the history and vibrant cultures, traditions and contributions of the South Asian diaspora across our gesh Group. Members of the South Asian community play a huge role across our services and I have been delighted to celebrate their contribution to the care we provide to our patients, staff and the communities we serve.

Annual public meetings across gesh

4.2 Later this month, we will host our annual public meetings across the gesh Group. On Wednesday 17 September, the Epsom and St Helier Annual Public Meeting will take place at Epsom Playhouse, and a week later, on Wednesday 24 September, the St George's Annual Members' Meeting will take place at St George's Hospital. These meetings provide an opportunity for the public from across our local communities to hear about our achievements over the past year and our plans for the future, learn about how our teams are improving care, and to ask questions to our Board.

Gesh CARE Awards 2025

4.3 Following their huge success last year, I am delighted that we will be holding our second gesh CARE awards in December. Our gesh CARE Awards celebrate our people and show how thankful we are for the care and support all of our staff give to our patients, local communities and each other as colleagues. Last year, we received almost 500 nominations for awards, and we are hoping to double the number of nominations this year. Listening to what you said in the last NHS Staff Survey, we want to make sure all of our staff feel valued for what they do, and we want the gesh CARE awards to be an annual event we can all enjoy. I would like to thank, in particular, our hospital charities – the St George's Hospital Charity and the Epsom and St Helier Hospital Charity – for their support, without which the awards would not be possible.

24 Hours in A&E

4.4 The popular TV series, 24 Hours in A&E, is coming home to St George's, with preparations already underway ahead of filming starting later this month. The award-winning Channel 4 show provides a fly-on-the-wall look at the patients who come through the emergency department, as well as the dedicated and talented teams who treat them. After hosting the series for seven

years between 2014 and 2021, we are looking forward to the homecoming as the countdown to filming begins. While a broadcast date has yet to be confirmed, 24 Hours in A&E is expected to return to TV screens next year.

Appointment of Michael Pantlin as permanent Group Deputy Chief Executive Officer

4.5 Michael Pantlin has been appointed as the permanent Group Deputy Chief Executive Officer, following a competitive recruitment process. Michael joined us earlier this year on secondment from Surrey Heartlands Integrated Care Board and has quickly become a valued member of the leadership team. During his time with us, he has been leading the Financial Recovery Board and overseeing programmes to increase efficiency and resource use, ensuring we continue to deliver safe and high quality care across the Group. Michael brings a wealth of experience, having previously worked in both the private sector and the NHS. His leadership, expertise and collaborative approach have already made a positive impact across gesh. Michael took up his permanent appointment on 1 September. He will focus on strengthening how our hospitals work together as one Group, while also leading on our long-term vision in line with the NHS 10 Year Plan.

Thank you to Arlene Wellman

4.6 Arlene Wellman, Group Chief Nursing Officer, left the organisation at the beginning of this month to take on a new role with the Florence Nightingale Foundation. Arlene has been our most senior nursing leader since 2018 – first as Chief Nurse at Epsom and St Helier and later as our Group Chief Nurse. She has kept our patients and staff safe as Director of Infection Prevention and Control and has led our midwifery and Allied Health Professional workforce. Her leadership and commitment, especially vital during the Covid-19 pandemic, has guided us through immense challenges, and she was awarded an MBE in recognition of her contribution to nursing in 2021. Arlene has been a driving force for innovation and inclusion – most notably through the creation of the award-winning Ask Aunty App which aims to ensure international nurses receive a warm welcome to the country when they arrive from overseas. Arlene has made a remarkable contribution to our Group and we wish her all the very best in her new role.

4.7 An open, competitive process to recruit a new permanent Group Chief Nursing Officer will commence shortly. As it is likely to be some months before Arlene's permanent successor is in post, we are finalising arrangements for the role to be covered on an interim basis and, until then, Theresa Matthews, Site Chief Nursing Officer at Epsom and St Helier, and Nicola Shopland, Site Chief Nursing Officer at St George's, will together act-up to cover the role over the coming weeks.

And finally…Thank you to you all

4.8 After eight wonderful years at St George's and four at Epsom and St Helier, I will be stepping down later this month to take up a new position as Chief Executive of NHS Wales and Director General for Health, Social Care and Early Years in the Welsh Government. While this is a wonderful opportunity, leaving gesh has not been an easy decision to make and I would like to take this opportunity to thank the Board, our wonderful staff, and local communities for your support. Working with and alongside you all has been one of the greatest privileges of my professional life. The commitment, resilience, compassion and drive to improve care demonstrated by our staff, often in the most challenging of circumstances, has inspired me every day.

5.0 Recommendations

5.1 The Group Board is asked to note the report.

Group Board Meeting (Public)

Meeting on Friday, 05 September 2025

Agenda Item	2.1	
Report Title	**Quality Committees Report**	
Executive Lead(s)	Richard Jennings, Group Chief Medical Officer	
Report Author(s)	Andrew Murray	
Previously considered by	n/a	05 August 2025
Purpose	**For Assurance**	

Executive Summary

This report sets out the key issues considered by the Quality Committees at their meetings in July and August 2025 and the matters the Committees wish to bring to the attention of the Group Board. These include:

1. Quarterly Maternity Services Report: It was agreed that, whilst awaiting the newly appointed Director of Midwifery to begin at gesh, a Quality Committees sub-group is to be established. The group will review maternity reports prior to submission to the Quality Committees and determine an effective way to structure the information being presented, to therefore allow a more meaningful discussion at the Committees meeting.
2. Group Patient Safety Incident Report: A discussion was held on never events, in which it was emphasised that although there are explanations for the reported never events, this cannot become something which is tolerated, but instead proactive work should be undertaken to reduce the frequency of these events occurring.
3. CQC inspection Update: The Committees discussed the draft CQC inspection ratings for the 3 core services (maternity, emergency care and surgery). In response to the ratings, the Committees agreed that a deep dive into safety of care in all group Emergency Departments will take place in September, along with an in-depth review of both Trusts' Maternity Improvement Action Plans in October.
4. Annual Reports: The Committees reviewed and approved both the PALs and Complaints Annual Report and the Patient Experience Annual Report, noting their onward submission to the Group Board for final approval.

Action required by Group Board

The Group Board is asked to note and discuss the issues escalated by the Quality Committees and the wider issues on which the Committees received assurance in July and August 2025.

Committee Assurance	
Committee	Quality Committees
Level of Assurance	Not Applicable – Assurance Varies depending on the area

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

Implications

Group Strategic Objectives

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

Risks

As set out in the paper

CQC Theme

☐ Safe	☐ Effective	☐ Caring	☐ Responsive	☒ Well Led

NHS system oversight framework

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

Financial implications

N/A

Legal and / or Regulatory implications

N/A

Equality, diversity and inclusion implications

As set out in the paper

Environmental sustainability implications

N/A

Quality Committees Report
Group Board, 05 September 2025

1.0 Purpose of paper

1.1 This report sets out the key issues considered by the Quality Committees at its meetings in July and August 2025 and includes the matters the Committees specifically wish to bring to the attention of the Group Board.

2.0 Background

2.1 At its meetings on 31 July 2025 and the 28 August 2025 the Committees considered the following items of business:

31 July 2025	28 August 2025
• Group Quality & Safety Governance Improvement Plan • Update on Oversight and Monitoring Process for gesh Quality Priorities • Group Key Issues Report • Quarterly Maternity Services Report • Group Patient Safety Incident Report • Nursing Establishment Review • Group – Integrated Quality and Performance Report • Infection Prevention and Control Report • Medicines Optimisation – St George's CQC Section 29a Warning Notice Response and Actions • Controlled Drugs Annual Report • Annual Safeguarding Report	• Quality Priorities Q1 Update • Group Key Issues Report • CQC Inspection Update • Group – Integrated Quality and Performance Report • Complaints and PALs Annual Report • Patient Experience and Engagement Annual Report

2.2 The Committees was quorate at the meetings in July and August 2025.

3.0 31 July – Key Issues for Escalation to Group Board

3.1 Quarterly Maternity Services Report

3.1.1 The Committees noted that there is a high volume of data to review with regards to maternity, which can make it difficult to digest and understand the information. It was agreed that, whilst awaiting the newly appointed Director of Midwifery to begin at gesh, a Quality Committees

sub-group is to be established. The membership of the sub-group will consist of the Committees Chair, the Group Chief Medical Officer, the Group Chief Nursing Officer and one additional Non-Executive Director. The group will review the data prior to its submission to the Quality Committees and determine an effective way to structure the information being presented, to therefore allow a more meaningful discussion at the Committees meeting.

3.1.2 The Committees noted that a Maternity Improvement Plan for SGUH had been previously discussed, agreeing that it was important to see the equivalent plan for ESTH. It was agreed that this plan be presented to the Committees in October 2025. This would also be an opportunity to review progress against the SGUH improvement plan.

3.1.3 Assurance Rating: The Committees concluded that with regards to taking assurance that the risks and mitigations in place effectively manage the maternity division, limited can be taken for SGUH and reasonable assurance can be taken for ESTH.

3.2 Group Patient Safety Incident Report

3.2.1 The Committee welcomed the report, noting that across SGUH and ESTH, a number of patient safety incidents and safety concerns have been identified and addressed, including how concerns relating to renal patients' medical fitness to be sent to ESTH on a 'treat and return' basis from neighbouring hospitals has resulted in initial discussions with other hospitals to determine a pre-treatment protocol.

3.2.2 Whilst discussing never-events as part of this report, the Committees noted that there are comparative trusts which either have zero never events, or have them occur less frequently than is occurring at gesh. It was emphasised that although there are explanations for the reported never events, this cannot become something which is tolerated, but instead proactive work should be undertaken to reduce the frequency of these events occurring.

3.2.3 A representative from the ICB SWL advised that the ICB recently visited all the acute trusts in SWL, undertaking learning reviews at each site. As part of the review at gesh, the ICB reviewed 19 never events which had taken place between January 2023 and May 2025. 8 never events were randomly selected, with 44 actions being identified. The finalised report on this will be presented to the Committees in October 2025.

3.2.4 Assurance rating: The Committees agreed that **reasonable** assurance can be taken that the broader approach to patient safety is managed effectively, however, **limited** assurance can be taken with regards to the risks and mitigations in place to manage the occurrence of never events.

3.3 Key Issues Report

3.3.1 The Committees discussed the current anxiety around the future of the birthing centre at SGUH, with the Committees Chair noting that this was raised at the Maternity and Neonatal Voices Partnership Meeting which he attends. It was emphasised that currently the Trust is solely at an initial options appraisal stage, and no definitive decision has been made. It is important that the group Board is aware that these discussions are taking place and needs to be kept appraised of any developments.

3.3.2 Committees members discussed the potential quality concerns as a result of the recent industrial action. It was confirmed that although the strike uptake was significant, in-patient areas were able to be covered safely. Given the extent of the industrial action, some cancer work was required to be rescheduled, all of which was done so within one week.

3.3.3 Assurance rating: The Committees agreed they could take **reasonable** assurance that appropriate actions and mitigations are in place to manage the key issues detailed in the report.

4.0 31 July 2025 – Key issues to which the Committees received assurance

4.1 Nursing Establishment Review

4.1.1 The Committees welcomed the report and endorsed the proposal to develop and implement a Group-wide Establishment Review Framework for 2025/26, incorporating standardised triangulation methods and benchmarking data

4.2 Infection Prevention and Control Report

4.2.1 The Committees reviewed the report, which detailed that both Trusts recorded one case of MRSA bacteraemia against a national objective of zero avoidable cases. Following full investigation, both were deemed clinically unavoidable. The priorities for 2025/26 were also approved.

4.2.2 Assurance rating: The Committees felt that **reasonable** assurance could be taken that the risks and mitigations around infection prevention and control are being managed appropriately.

4.3 Medicines Optimisation – St George's CQC Section 29a Warning Notice Response and Actions

4.3.1 The Committees welcomed the report, which advised that the section 29a warning notice which the Trust had received includes medicines optimisation as one of the areas where we must deliver significant improvements. The report provided an update on the progress of embedding the actions and improvements in each identified area.

4.3.2 The Committees took **reasonable** assurance that the St George's CQC Section 29a Response & Actions were effective and appropriate.

4.4 Controlled Drugs Annual Report

4.4.1 The Committees reviewed the report, and felt it demonstrated continued progress in embedding a unified approach to Controlled Drugs governance across the Group and provides assurance to the Committee that proactive measures are in place to support safety, compliance, and continuous improvement

4.4.2 The Committees **approved** the Controlled Drugs Annual Report.

4.5 Annual Safeguarding Report

4.5.1 The Committees felt the report demonstrated that the Trust is meeting its responsibilities under statutory Section 11 duties of the Children's Act, and under the Care Act, and details how the Trust is assessed on its performance both internally and externally regarding safeguarding adults, children and young people.

4.5.2 Committees members agreed that the amount of time staff are required to spend on mandatory training is quite substantial, noting the importance of ensuring that mandatory training is delivered in the most efficient way. It was confirmed that the team are constantly reviewing the training packages to determine the most effective way to deliver this.

4.5.3 The Committees **approved** the Annual Safeguarding Report.

5.0 28 August 2025 – Key Issues for Escalation to the Group Board

5.1 CQC Inspection Update

5.1.1 The Committees discussed the update which stated that the draft CQC inspection reports for the 3 core services (maternity, emergency care and surgery) were received for factual accuracy checking on Friday 18 July 2025. The factual accuracy response and supporting evidence were returned to the CQC within the required 10 working days on Friday 1 August 2025.

5.1.2 The Committees noted that the overall ratings in the draft CQC report for each service were as follows:

Maternity – Requires improvement

Urgent and Emergency Care – Requires improvement

Surgery (SGUH) – Requires improvement

Surgery (Queen Mary's Hospital) – Good

5.1.3 Committees members expressed concern that, with regards to the safe domain, both maternity and urgent and emergency care were rated as inadequate. It was agreed that in response to this, there must be continued scrutiny and oversight of the two services at the Committees.

5.1.4 The Committees noted that there was a deep dive into the Emergency Department already scheduled for the September meeting, agreeing that the progress against the CQC actions which relate to this service will be discussed in detail at that meeting.

5.1.5 Committees members noted that the Maternity Improvement Plan is scheduled to be presented in October 2025, noting that the plan has multiple actions already in place to address the issue of safety in the maternity department. The Committees Chair requested that these specific actions be the focus of the discussion at the October meeting.

5.2 Quality Priorities

5.2.1 The Committees welcomed the report, which detailed progress in quarter 1 against the quality priorities for 2025/26. These priorities are:

- Pressure ulcer prevention
- Venous Thromboembolism (VTE) risk assessment
- Falls prevention
- Delirium assessment
- Improve flow in the Emergency Department to reduce overcrowding and long waits for treatment
- Ensuring safe maternity services

5.2.2 Committees members had a robust discussion on each individual priority, and agreed that in the next update, it would be helpful to have sight of the entire action plans for each of these priorities, as this would provide more insight into the progress against the mitigations in place to achieve the priority target.

5.3 Complaints and PALs Annual Report

5.3.1 The Committees reviewed the report, which detailed how the 2024-25 reporting year reflects both strong progress in complaint and PALS handling performance and persistent challenges in response timeliness and service consistency across both sites.

5.3.2 Committees members welcomed the report, requesting that, before its submission to the Group Board, the complaint performance is shown as a % of the patients seen, and also includes national benchmarking for comparison.

5.3.3 The Committees members agreed that it would be beneficial to reduce the list of priorities for the next year, as having a smaller number of priorities to focus on will allow ample time to be given to each one and therefore help ensure they are achieved.

5.3.4 With the caveat of the changes listed in 5.3.2 and 5.3.3 being made, the Committees **approved** the report, noting its onward submission to the Group Board for final approval on 5th September 2025.

5.4 Patient Experience and Engagement Annual Report

5.4.1 The Committees noted the key achievements listed in the report, which included strategic alignment post-integration, strengthened patient/carer engagement, national recognition for Armed Forces support, expanded Friends and Family Test (FFT) participation, and improved inclusive communication practices.

5.4.2 Committees members requested that the report should list the priorities be delivered over the next two years rather than just one year. It was agreed that before its submission to the Group Board, the report would be updated to show the priorities being delivered between 2025-2027.

5.4.3 With the caveat of the change listed in 5.4.2 being made, the Committees **approved** the report, noting its onward submission to the Group Board for final approval on 5th September 2025.

6.0 28 August 2025 – Key issues to which the Committees received assurance

6.1 Group Key Issues Report

6.1.1 The Committees welcomed the report, which summarised significant quality, safety, and compliance risks discussed at the gesh Group Quality Group meeting on 14 August 2025. They key themes included:

- C. Diff and MRSA: Increasing cases both nationally and locally. Enhanced measures in place by decanting/deep cleaning of wards; enhanced cleaning and bay closures; IPC boarding guidance to be implemented across all sites.
- Legionella (Neonatal Unit, St Helier): Ongoing estates review, external reviews (nursing & medical), interim safety measures in place until final report from external reviewers (due September 2025).
- Medicines Management at ESTH: Ongoing issues identified in internal CQC mock inspections. Continued monitoring via PSQG; further governance and assurance processes under review

6.1.2 The Committees reviewed the risks detailed in the report and **noted** that there are mitigations in place to manage the risks. It was agreed that more detail on these actions would enable the Committees to take assurance that the plans were effective in mitigating the risks. It was subsequently agreed that future reports would include detail on the mitigations in place.

6.2 Group Integrated Quality & Performance Report (IQPR)

6.2.1 The Committees reviewed the report, which provided an overview of the key operational and quality performance information, and improvement actions across St George's Hospitals (SGUH), Epsom and St Helier Hospitals (ESTH), and Integrated Care (IC) sites.

6.2.2 The overall picture provided illustrates the challenge to improve access to safe care for patients while achieving substantial cost reductions. Whilst emergency department attendance trends have remained broadly stable, the key challenge lies in directing patients to appropriate care settings and managing capacity effectively.

6.2.3 The Committees **noted** the report.

7.0 Recommendations

7.1 The Group Board is asked to note the issues escalated by the Quality Committees to the Group Board, and note the update on wider issues discussed at the Committees meetings in July and August 2025.

Group Board (public)

Meeting on Friday, 05 September 2025

Agenda Item	**2.2**	
Report Title	**St George's Hospital CQC Inspection Update**	
Executive Lead(s)	Arlene Wellman, Group Chief Nursing Officer	
Report Author(s)	Alison Benincasa, Group Director of Compliance	
Previously considered by	n/a	Click or tap to enter a date.
Purpose	**For Noting**	

Executive Summary

1. Unannounced inspection of Core Services
The CQC has undertaken the following unannounced inspections at St George's and Queen Mary's Hospitals

- Maternity Services, 16 and 17 October 2024
- Urgent and Emergency Care, 4 and 5 November 2024
- Surgery at St George's, 28 and 29 January 2025
- Surgery at Queen Mary's, 11 February 2025

The Trust received a section 29a Warning Notice on 23 December 2025 with reference to Maternity Services and Urgent and Emergency Care. The Trust responded to the warning notice on 16 January 2025 providing an improvement plan and supporting evidence for assurance where required. The Quality Committees and discussed the identified concerns and the Trust improvement plan at its meeting on 30 January 2025.

The draft CQC inspection reports for the 3 core services were received for factual accuracy checking on Friday 18 July 2025. The factual accuracy response and supporting evidence were returned to the CQC within the required 10 working days on Friday 1 August 2025. The final reports were issued on 27 August 2025.

The table below shows the ratings in the inspection report for each core service across the key lines of enquiry.

Core Service	Overall	Safe	Effective	Caring	Responsive
Maternity	RI	Inadequate	RI	RI	Good
Urgent and Emergency Care	RI	Inadequate	Good	RI	RI
Surgery (SGUH)	RI	RI	Good	Good	RI
Surgery (QMH)	Good	Good	Good	Good	Good

*RI = Requires Improvement

Whilst there has been progress on our improvement plans since the time of the inspections, it is acknowledged that there is still more to be done. Now that we have the final core service inspection reports an updated, and co-ordinated, action plan will be prepared and presented to the Board in November. This will also take into account the outcome from the Well Led inspection which is expected shortly.

Action required by Group Board

The Board is asked:

- Note the report.

Committee Assurance

Committee	
Level of Assurance	Choose an item.

Appendices

Appendix No.	Appendix Name
Appendix 1	**CQC Inspection Report – St SGUH**
Appendix 2	**CQC Inspection Report - QMH**

Implications

Group Strategic Objectives

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

Risks

Failure to apply due diligence to the draft inspection reports and successfully challenge factual inaccuracies could lead to reputational damage.

Failure to acknowledge the key issues identified in the draft inspection reports could lead to missed opportunities for improvement.

CQC Theme

☒ Safe	☒ Effective	☒ Caring	☒ Responsive	☒ Well Led

NHS system oversight framework

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

Financial implications

No issues to consider at this stage.

Legal and / or Regulatory implications

The Section 29a notice was received in December 2024.
Equality, diversity and inclusion implications
The CQC inspection reports identify bullying and harassment and lack of opportunities for BAME staff.
Environmental sustainability implications
No issues to consider at this stage.

LAP assessment report

St George's Hospital (Tooting)

LAP Assessment Report ID : LAP-01239

Inspection visit date(s): 16 and 17 October 2024

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Responsive 128
Well-led 136

St George's Hospital (Tooting)
Location findings

Ratings for this location

Overall	Requires improvement
Safe	Inadequate
Effective	Requires improvement
Caring	Requires improvement
Responsive	Requires improvement
Well-led	Requires improvement

Overall location summary

Date of assessment:

- 28 and 29 January 2025 surgery.
- 16 and 17 October 2024 maternity.
- 4 November 2024 to 5 November 2024 urgent and emergency services (ED)

St Georges University Hospital provides urgent and emergency services, medical care, critical care, end of life care, maternity, outpatient, surgery and medical care services. This assessment looked at maternity services due to a previous inadequate rating. Surgery due to aged ratings and concerns regarding Never Events and at urgent and emergency services due to aged ratings and information of concern. We inspected all quality statements across the five key questions: all services looked was rated as requires improvement. The rating from maternity, surgery and urgent and emergency services were combined with ratings of medical care, services for children and young people, critical care, end

St George's Hospital (Tooting)
Location findings

of life care and outpatient from the last inspection. See our previous reports to get a full picture of all other services at St Georges University Hospital. The rating of St Georges University Hospital remains requires improvement.

In our assessment of maternity we found some improvements had been made in specific areas. There was an improvement in the categorisation of incidents and in the provision and facilities for families who experienced bereavement. Staff said the culture and the way multidisciplinary teams reviewed incidents had also improved. However, despite these improvements, there were still some areas of concern that had not been resolved from the previous inspection. Staff did not always complete risk assessment documentation appropriately for each woman or birthing person. Medicines were not always managed safely. The design, maintenance and use of facilities, premises, and equipment did not always follow safety standards. Some equipment safety checks were out of date and daily checks had not always been completed. The service provided mandatory training and appraisals in key skills to all staff but did not always ensure everyone had completed it. The service did not have enough maternity staff with the right qualifications, skills, training and experience to keep women safe from avoidable harm and to provide the right care and treatment. Staff monitored the effectiveness of care and treatment via audits however, appropriate action was not always taken in response to this. There was no stable leadership team within the service. Following the inspection, under Section 29A of the Health and Social Care Act 2008, we issued a warning notice to the provider. We took this action as we believed women, birthing people or babies would or may be exposed to the risk of harm if we had not done so.

In our assessment of surgery services we found the risks to people had not been consistently assessed and mitigated and we were not assured that learning from previous incidents had been embedded fully. Care was not always delivered in line with national clinical guidance, and evidence-based best practice. The service was not always easy to access and patient at times experienced long waits in the hospital for their surgery. The governance systems in place had failed to identify and rectify some of the concerns found at this assessment. However, staff were kind, caring and compassionate. Staff and teams worked together well to deliver good person-centred care. The service was in breach of the legal regulation relating to safe care and treatment. We were not assured that the service appropriately assessed risks to the health and safety of patients receiving care or treatment and did all that was reasonably practicable to mitigate any such risks

In our assessment of urgent and emergency services we found there were a few improvements. However, there were still concerns that had not been resolved from the previous assessment as well as new concerns. Medicines were not always managed safely. Staff did not always complete risk

St George's Hospital (Tooting)
Location findings

assessments and update them swiftly. Staff did not keep detailed records of patients' care and treatment and records were not always clear and up to date. The environment did not consistently support safe care. Some equipment was out of date and premises were not secure. Patients at risk of deterioration were not always promptly assessed and documentation was inconsistent. Overcrowding was an ongoing issue where privacy and dignity was not always maintained in corridors and triage areas. Following the inspection, under Section 29A of the Health and Social Care Act 2008, we issued a warning notice to the provider. We took this action as we believed the service had not managed patient acuity appropriately during streaming and triage processes and medicine management, including delayed administration of time critical medicines. Breaches were also found around poor standards of documentation and information security.

Safe

Rating Inadequate

Our overall rating of safe at St George's Hospital (Tooting) is now inadequate. We looked at urgent and emergency care, maternity and surgery services only and rated safe as inadequate in urgent and emergency services and maternity and requires improvement in surgery.

Effective

Rating Requires improvement

Our overall rating of effective at St George's Hospital (Tooting) remains requires improvement.

Caring

Rating Requires improvement

Our overall rating of safe at St George's Hospital (Tooting) is now requires improvement. We looked at urgent and emergency services, maternity and surgery services only and rated caring as requires improvement in urgent and emergency care and maternity and good in surgery.

Responsive

Rating Requires improvement

Our overall rating of responsive at St George's Hospital (Tooting) remains requires improvement.

St George's Hospital (Tooting)
Location findings

Well-led

Rating Requires improvement

Our overall rating of well-led at St George's Hospital (Tooting) remains requires improvement.

Acute services
Maternity

Maternity

Overall	Requires improvement
Safe	Inadequate
Effective	Requires improvement
Caring	Requires improvement
Responsive	Good
Well-led	Requires improvement

Our view of the service

St George’s Hospital is a large teaching hospital in Tooting with 1,300 beds and employs approximately 3,500 staff; serving a population of 1.3 million across Southwest London and surrounding areas. The maternity service provides consultant-led and midwife-led care for both high and low risk women. The hospital's maternity services offer a wide range of specialised care, including a consultant-led labour ward, a birth centre, an outpatient antenatal clinic, a fetal medicine unit (FMU), a maternity day assessment unit, a triage unit, antenatal and postnatal inpatient wards (including transitional care), and bereavement services. From October 2023 to October 2024, there were 4,301 babies born at this hospital.

We inspected the maternity service at St George's Hospital. We last carried out a focused inspection of the maternity service in 2023 as part of our national maternity inspection programme and it was rated inadequate. We carried out an unannounced, comprehensive inspection of the maternity service, looking at all key questions (safe, caring, effective, responsive and well-led). We rated maternity services overall as requires improvement.

Acute services
Maternity

Since the last inspection in March 2023, some improvements had been made in specific areas. There was an improvement in the categorisation of incidents and in the provision and facilities for families who experienced bereavement. Staff said the culture and the way multidisciplinary teams reviewed incidents had also improved.

However, despite these improvements, there were still some areas of concern that had not been resolved from the previous inspection:

- Staff did not always complete risk assessment documentation appropriately for each woman or birthing person.
- Medicines were not always managed safely.
- The design, maintenance and use of facilities, premises, and equipment did not always follow safety standards. Some equipment safety checks were out of date and daily checks had not always been completed.
- The service provided mandatory training and appraisals in key skills to all staff but did not always ensure everyone had completed it.
- The service did not have enough maternity staff with the right qualifications, skills, training and experience to keep women safe from avoidable harm and to provide the right care and treatment.
- Staff monitored the effectiveness of care and treatment via audits however, appropriate action was not always taken in response to this.
- There was no stable leadership team within the service.

The service was previously in breach of Regulation 12 (safe care and treatment) of the Health and Social Care Act 2008. Although some improvements had been made, they were insufficient, and the service remained in breach of this regulation. Following the inspection, under Section 29A of the Health and Social Care Act 2008, we issued a warning notice to the provider. We took this action as we believed women, birthing people, or babies would or may be exposed to the risk of harm if we had not done so. In response to the warning notice, the trust made a number of changes to ensure women, birthing people, and babies were safe.

Acute services
Maternity

People's experience of the service

Women and birthing people we spoke with as part of the inspection were generally positive about the service and reported they received effective monitoring, and appropriate processes were in place. Staff were described as “very professional and kind”, and “lovely”. The 2024 Care Quality Commission maternity survey scored St George’s Hospital (Tooting) as about the same as other trusts on all 24 questions. Therefore, the responses of people who used this service are comparable to those who have used other services.

Women, birthing people, and their relatives knew how to complain and felt that their complaint would be acted on. Women and birthing people felt involved in planning and making decisions about their care, including when plans had to change. The service had a dedicated and well-equipped bereavement suite to meet the needs of women, birthing people, and their families. Women and birthing people could access care and support when needed. Women and birthing people could access maternity services through their GP, community midwives, self-referral by phone, or an online booking form.

However, the 2023 Wandsworth Health Watch report, which included feedback from women and birthing people who had accessed maternity services in the region including St George’s Hospital, found a significant number of people felt that their ethnicity had negatively influenced the maternity care they received. Experiences documented in the report included feeling like they weren’t being listened to. This meant that not everyone experienced the same level of care and treatment. The service had developed a maternity strategy and vision which focused on addressing health inequalities within the local population.

Safe

Rating Inadequate

At our last inspection we rated this key question as inadequate. At this inspection the rating has remained inadequate. This meant that people were not safe and were at risk of avoidable harm.

We looked for evidence that safety was a priority for everyone, and leaders embedded a culture of openness and collaboration. We checked that people were safe and protected from bullying, harassment, avoidable harm, neglect, abuse, and discrimination. We also checked people’s liberty was protected where this was in their best interests and in line with legislation.

Acute services
Maternity

The service was in breach of the legal regulations relating to safe care and treatment. We saw high levels of staff shortages and lack of oversight in maternity triage. We also raised concerns regarding the storage of medicines and found out of date medicines on the wards. Following our inspection, we issued a warning notice to the trust asking for significant improvements to be made. The trust then made some improvements to the service to help keep women, birthing people, and babies safe.

Learning culture

Score

2. Evidence shows some shortfalls in the standard of care

Managers did not always investigate and manage complaints and safety incidents well. The service did not always ensure that actions and learning from safety incidents were implemented in a timely manner and monitored to drive improvement. However, staff recognised and reported incidents and near misses.

The service had systems and processes in place for the reporting and investigation of incidents and complaints. However, investigations were not always completed in a timely way impacting the services ability to learn from incidents and make required changes to keep women, birthing people, and babies safe. We reviewed minutes from an internal meeting in September 2024 and found 144 incidents were overdue. In addition, the trusts complaints policy mandated a 25-day and 40-day turnover. However, in July and August 2024 only 50% of complaints were responded to within 35 days, which was below the target of 85%. Whilst they met a 55-day response time for complaints, this was not in line with the stated timeframes in the complaints policy. This could put women, birthing people, and babies at risk. This concern was also raised at the last inspection.

We reviewed the November 2023 Maternity Improvement Advisor report which highlighted that staff have reported not feeling supported or valued. The report also highlighted a ‘blame culture’ where incidents were not seen as an opportunity for learning but to find blame. However, the multidisciplinary staff we spoke with during inspection reported they were encouraged and supported to raise concerns and reported an improved culture around

reporting incidents.

Staff recognised and reported incidents appropriately and knew how to raise concerns using the hospital's electronic incident reporting system in line with the hospital's incident reporting policy. Managers were responsible for investigating incidents and sharing the learning. Learning from incidents was shared through various means, for example handovers, 5 facts shared learning emails, staff meetings, and posters. There was evidence that changes had been made and embedded because of learning identified from previous incidents and was widely disseminated. Staff we spoke to were able to give examples of how the service had improved following incidents. This was an improvement from the last inspection.

Most staff we spoke with were able to explain the duty of candour. They were open and transparent and gave women, birthing people and their families a full explanation if and when things went wrong. In all 3 incident investigations reviewed, managers shared duty of candour and draft reports with the families for comment. An audit completed in August 2024 which assessed service user engagement in the perinatal mortality review process, found that 76% of women, birthing people and their families were sent a duty of candour letter. Further improvements could be made to ensure all staff understand the importance of duty of candour and are able to act appropriately.

Staff and leaders we spoke with told us that there had been an improvement in the categorisation of incidents since our last inspection. However, during the inspection, we identified issues with the categorisation of post-partum haemorrhage (PPH) and third-degree tear incidents. Following the inspection, the trust evidenced that managers and governance teams corrected all PPH and tear incident grading errors to ensure all incidents were graded appropriately. All cases of PPH over 1.5 litres and third- and fourth-degree tears were discussed at daily incident review meetings led by the divisional governance team and escalated directly to the obstetric risk lead.

In November 2023, the Maternity Improvement Advisor Group's diagnostic report revealed a relatively low number of reported moderate harm incidents. This raised concerns about potential incorrect incident grading. Subsequently, in January 2024, an external team of midwives and doctors conducted a perinatal mortality report based on deaths within the service in 2020. Their review found that 23.6% of cases, initially graded "A" (meaning "would not have had an impact on the outcome"), were incorrectly categorised. The external team

Acute services
Maternity

subsequently changed these gradings to "B". This demonstrated the need for further improvements in incident categorisation and grading to ensure all learning opportunities are fully explored.

By October 2024, midwives had achieved 85% mandatory training completion, while doctors had reached 78%, falling below the 85% trust target. PREVENT Level 2 training completion was 80% for midwives and 62% for doctors, also below target. This raised concerns about staff knowledge and service user safety. In August 2024, 86% of midwives completed cardiotocography (CTG) training, and a plan was put in place to reach the 90% target by November 2024. Post-inspection, the trust reported improved mandatory training compliance. Data showed doctors achieved 78.1% PREVENT Level 2 and 92.1% PREVENT Level 3 training completion. Since the inspection, the trust had reviewed and updated its governance framework for the oversight of mandatory training compliance and an action plan had been put in place for staff to achieve 90% compliance by the end of March 2025.

Incidents were appropriately referred to the Maternity and Newborn Safety Investigations (MNSI) team and findings were discussed by the senior leadership team.

Women and birthing people we spoke with felt safe, reported risks were not ignored and knew how to raise a complaint.

Safe systems, pathways and transitions

Score

1. Evidence shows significant shortfalls in the standard of care

Staff did not assess, manage, or monitor risks to the safety of women, birthing people, and babies. Documentation was not completed fully.

Staff told us they were trained to respond to risk and were able to identify and act when women and birthing people were at risk of deterioration. However, staff did not always complete risk assessments or take action to remove or minimise risks, and documentation was not always completed appropriately.

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The Maternity Early Obstetric Warning Score (MEOWS) audit, completed in October 2024, identified significant gaps in patient records as “additional concerns” were correctly documented in 55% of women and birthing people notes. This was significantly below the trust target of 80%. This meant a full risk assessment was missing in a high proportion of notes and could mean that there were delays identifying deteriorating women or birthing people. Similar results had been identified in previous audits and appropriate action had not been taken and there had been incidents which have been associated with poor documentation and risk assessment. Following our inspection, the trust provided us with the results from an audit completed in February 2025 examining the use of MEOWS on the maternity wards. This audit showed increased compliance, with “additional concerns” being documented in 85% of notes examined. This was an improvement and met the trust target of 80%. However, the MEOWS was still not fully completed as postnatal pulse rate was recorded in 74% of the notes examined. This highlighted that further work was needed to ensure risk assessments are fully completed to ensure women and birthing people are safe. The trust had reported that a revised governance framework for monitoring of audits and areas of poor performance had been put in place.

Although there had been improvements in triage since our last inspection, systems and processes were not fully embedded to ensure women and birthing people were safe. A trust audit completed in September 2024 found that the time doctor consultations took place were recorded in 49.8% of patient notes. There were also gaps in the daily checks of triage results completed by staff. This meant that women and birthing people were put at risk of harm as results of investigations were not being followed up appropriately in line with trust policy. In response to the warning notice, the trust added an electronic whiteboard to track medical reviews and changed triage procedures to ensure all test results were acted upon. A new operating procedure had been implemented outlining roles and responsibilities to ensure the daily checks were completed and all investigation results were acted upon. A follow-up audit in December 2024 and January 2025 showed that compliance was below the trust target of 80% (70% and 74% respectively). Therefore, further work was needed to ensure daily checks are completed so that women and birthing people are safe.

Staff did not effectively assess, document, or respond to ongoing risks to the safety of women, birthing people, and babies at all stages of pregnancy in line with national guidance. Staff did not always use a triage system to prioritise women and birthing people when they arrived in

triage, and we observed gaps in the documentation of the “red, amber, green” (RAG) rating in the patient records. This was an on-going concern which was raised at the previous inspection. There were gaps in the completion of the risks assessments in patient records, for example during telephone triage conversations, and there were also gaps in the documentation within triage. We found inconsistency in the telephone triage assessment and documentation used during working hours and out of hours. The telephone triage line did not have dedicated cover 24 hours per day, 7 days a week. The triage telephone line was diverted to the labour ward and manned by the labour ward coordinator during staff breaks during the day and out of hours from 8pm to 8am. This was not in line with guidance from the Royal College of Obstetricians and Gynaecologists (RCOG). Following the inspection, the trust was issued a warning notice and asked to make significant improvements to the maternity service, including the triage service. The trust changed its practice, and a 24-hour maternity triage telephone line was put in place to ensure women and birthing people can get help and advice when they need it, and calls are no longer diverted. A new electronic notes system was also introduced after the inspection with mandatory fields to ensure full assessments are completed during working hours and out of hours.

Staff told us there was only one resident doctor who covered all the maternity units, gynaecology and emergency gynaecology cases in the emergency department at night. The hospital did not have a dedicated gynaecology ward, and the emergency department was not located within close proximity of the maternity units, which contributed to the delay in care by medical staff at night and out of hours. Therefore, the service was unable to provide assurance that women and birthing people received a timely medical review at night.

Despite staff receiving training in CTG interpretation, we found there was inconsistency in the categorisation of CTG and staff used different terminology in documentation when classifying and interpreting CTG traces which was not in line with their policy. Variation in terminology could lead to confusion when CTGs were discussed or when concerns were escalated. As part of the warning notice, we asked the trust to make improvements in this area. Since the inspection, the trust introduced a new electronic documentation system which mandated set terminology from drop down boxes to ensure consistent terminology in line with policy.

NHS Resolutions conducted a thematic review of all cases referred to MNSI by the service between April and May 2024 and the findings were reported in the January 2025 board papers. The review identified that there should be greater assurance around the documentation of CTG

traces to ensure that women, birthing people, and babies were kept safe.

The trust's policy mandated hourly CTG review and two hourly "fresh eyes", deviating from the 2022 National Institute for Health and Care Excellence (NICE) guideline of hourly "fresh eyes". This deviation had been risk assessed by the trust. However, an MNSI report from November 2024 found that staff were over reliant on the electronic CTG central monitoring system rather than completing regular "fresh eyes" reviews and escalating concerns. This was consistent with what we observed whilst onsite. Post-inspection, the trust aligned its CTG monitoring with the NICE hourly "fresh eyes" recommendation.

The service had specialist midwives to support vulnerable women and consultant obstetricians were present for difficult births. Staff reported it was easy to escalate concerns. Staff were confident to escalate concerns, and reported it was easy to do so, and staff felt they were adequately trained to respond to risk.

Staff and senior leaders collaborated with external teams appropriately for example the Maternity and Neonatal Voices Partnership (MNVP) and the Maternity Safety Support Programme. Staff and senior leaders engaged with these external agencies around their systems and pathways and took their views into account. Following the inspection, we reviewed the MNVP action plan for 2024 – 2025. Several projects were included through collaboration between the trust and MNVP and a lead for the trust and the MNVP was included for each project area.

The service had improved their documentation around bereavement since the last inspection.

Staff followed up-to-date policies and processes that align with other key partners involved in patient care. The service had systems, processes, and policies in place to assess and respond to deteriorating patients, sepsis, and PPH. Staff had received appropriate training on sepsis and perinatal mental health.

Acute services
Maternity

Safeguarding

Score

1. Evidence shows significant shortfalls in the standard of care

The service did not have effective systems in place to ensure staff received adequate safeguarding training to carry out their roles and responsibilities safely. There were ineffective systems in place to reduce the risk of baby abduction.

Relevant safeguarding training was available; however not all staff had completed this. In October 2024, 69% of midwives had completed Level 2 safeguarding children training, below the trust's 85% target. Medical staff compliance was also below target: 73% for Level 2 safeguarding children and 82% for Level 2 safeguarding adults. We escalated this to senior leadership and following the inspection, the trust provided data to show that mandatory training compliance rates had improved. As of January 2025, 85.8% of midwives and 78.7% of doctors had completed the Level 2 safeguarding children training and there was an action plan in place to achieve 90% compliance by the end of March 2025.

Senior staff told us the baby abduction policy was embedded in the maternity safeguarding policy. However, staff we spoke with were either not aware of this or had difficulty locating the policy on the trust intranet. Therefore, we were not assured staff had a good understanding of the protocols in place to prevent baby abduction. The maternity wards had some security controls such as CCTV, swipe card, and buzzer access. However, on the postnatal ward there was a fire exit opposite the staff desk which could be easily accessed to exit the ward without staff oversight. This increased the risk of baby abduction. This was raised with the trust at the time of the inspection, and we were told that an alarm would sound if the exit was used which would alert staff to the situation. However, during the inspection we found the fire exit door open on 2 occasions, and we escalated this to senior staff. At this time, no alarm was heard, and staff were unaware the door was not securely closed. The risk of baby abduction was further increased as there was no baby tagging system in place on the postnatal ward. Inspectors also received concerns from staff regarding the lack of swipe card controlled access between the delivery suite and maternity theatres which meant that surgical staff could access maternity areas, contradicting Health Building Note 09-02 guidelines. These guidelines mandate

restricted access to maternity areas because less restricted access increases the risk of baby abduction.

The service had implemented a maternity safeguarding policy since the last inspection. Staff were able to explain how they identified adults and children at risk of, or suffering from, significant harm and how to report safeguarding concerns. There was a safeguarding lead midwife within maternity who provided additional support and guidance as required. There were systems in place to investigate, discuss, and share learning from any safeguarding incidents, as well as a system to flag any safeguarding concerns on the electronic patient records. We observed safeguarding concerns being appropriately discussed during handovers and documented within electronic patient records.

Women and birthing people we spoke with felt safe and well supported by staff.

Involving people to manage risks

Score

2. Evidence shows some shortfalls in the standard of care

The service did not always work well with women and birthing people to understand and manage risks. Staff did not always provide care to meet people's needs that was safe, supportive, and enabled people to do the things that mattered to them. Significant issues persisted with risk assessments, particularly for women and birthing people attending triage.

Local Safety Standards for Invasive Procedures (LocSSIPs) were developed in line with NHS England and World Health Organisation (WHO) Safer Surgery Checklist. Trust data from May and October 2024, showed non-compliance with LocSSIPs putting women, birthing people, and babies at risk of harm. There was a large amount of incomplete data and one of the action points identified by the service was to liaise with team leaders regarding the lack of audits completed.

During our inspection, we found that staff did not follow the telephone triage line processes to

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ensure thorough assessments were completed. There was no standardised assessment or documentation during and outside working hours. Inconsistent assessment and documentation meant delayed care escalation, risking harm to women, birthing people, and babies. Post-inspection, the trust implemented a standardised electronic notes system for maternity triage assessments and introduced electronic audit reporting for compliance monitoring.

Staff told us that midwifery staff working in areas other than triage were expected to answer triage calls, especially during lunch and out of hours, without specific training or completion of required competencies. This raised concerns about their ability to manage triage calls, conduct risk assessments, and maintain records. This was particularly concerning during high-acuity periods on the delivery suite which could put women, birthing people, and babies at risk. Following the inspection, the trust reviewed the cover in maternity triage to ensure that there was dedicated midwifery cover within the telephone triage service 24 hours a day.

RCOG recommends that women and birthing people are triaged within 15 minutes of attending maternity triage. Data from the September 2024 triage audit showed that 95% of women presenting were seen within the trust 30 minute target and 79% of women were seen within 15 minutes. There were significant gaps in staff documentation which impacted in the accuracy of the waiting time data. The audit identified that 60.5% of women and birthing people had a medical review in line with targets. Medical review times were not always documented in records, and it was therefore unclear how long women and birthing people were waiting for a review by a doctor. Due to problems with the paper documentation used, the RAG rating assessments included in this audit were calculated retrospectively. Following the inspection, a new electronic notes system was introduced by the trust to support better record keeping.

The Newborn Early Warning Trigger and Track risk assessment tool was used by the service to highlight babies at risk of deterioration. An audit completed in July 2024 found that the total score was documented in 85.3% of cases and with “additional concerns” documented in 92% of cases against the trust target of 80%.

Staff felt they were adequately trained to respond to risk and had completed relevant training including Practical Obstetric Multi-Professional Training (PROMPT). Staff told us they knew how to assess, identify, and manage patient risks.

Acute services
Maternity

Safe environments

Score

1. Evidence shows significant shortfalls in the standard of care

The service did not always detect and control potential risks in the care environment. Staff did not make sure equipment, and facilities supported the delivery of safe care. Facilities were not always well-maintained, and some areas presented risks that could impact patient safety.

The maternity unit layout breached Health Building Note (HBN) 09-02 guidelines due to its multi-floor design. There was a risk assessment for transferring women and birthing people in labour from the birth centre to the delivery suite. Staff had priority passes for lifts to ensure transfers were managed in a time-appropriate way. However, lifts were situated in public corridors which did not maintain the privacy and dignity of women and birthing people being transferred. During our inspection we also observed that one lift was out of order which delayed the transfer and movement of women within the maternity units. This could also impact on availability of lifts and transfer of women during an emergency transfers. Staff told us the trust had completed some repairs and responded to feedback, but further improvements were needed. The maternity unit maintained a dedicated second operating theatre, ensuring immediate availability for emergency procedures.

The maternity service breached HBN 09-02 guidelines; birthing rooms lacked ensuite facilities, and postnatal women and birthing people had to walk some distance to access bathrooms. There were issues around flooding and sewage that mostly impacted the birth centre and antenatal ward areas. Leaders were aware of these issues, and it was recorded on their risk register. We observed the bathrooms on the postnatal ward were not always kept to a good standard and general wear and tear and mould was observed. This was escalated to senior leaders. A toilet on the postnatal ward was out of order at the time of our inspection. Staff told us that maintenance and repairs were not completed in a timely way. The trust told us improvements had been made, following the inspection, to treat the mould and strengthen the cleaning audit process. There was a plan in place to refurbish toilet and shower facilities on the postnatal ward by the end of March 2025.

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During our inspection, we observed three beds being stored in the postnatal ward corridor which posed a safety risk. It is important that corridors are kept clear to ensure easy access and space to move women, birthing people, and babies in an emergency.

The service did not always have suitable facilities to meet the needs of women and birthing people. The service had birthing pool facilities in the birth centre and the labour ward, however, two of these were out of order. There were appropriate legionella water checks in place and staff said that pool evacuation drills had taken place. Data regarding pool evacuation drills was requested however this information was not received from the trust. In November 2024, an audit was completed looking at the documentation of birthing pool temperatures. There was an 83% compliance on hourly water temperature checks, but hourly maternal temperature checks were documented 72% of the time which was below the trust target of 80%. This showed that there were improvements to be made in the assessments completed during labour to ensure women, birthing people, and babies were safe.

We found out of date emergency medicines on the adult emergency trolley in the delivery suite. Daily checks were not always completed for equipment, including emergency equipment, in the birth centre and triage. For example, we reviewed the records from May to October 2024 and found 5 omissions in the daily checks of the PPH trolley, 12 omissions on the emergency neonatal trolley and 34 omissions in the daily checks of 2 resuscitaires in the Birth Centre.

We also found out of date medical consumable items in the clinical trolleys in triage and out of date medicines on the resuscitation trolley in the delivery suite. This could put women, birthing people, and babies at risk as emergency equipment may not be safe or ready to use during an emergency. Following the inspection, a warning notice was issued to the trust which asked them to make significant improvements. Post inspection, the trust told us they have reviewed the standard operating procedures and processes have been clarified and confirmed with staff and managers.

We observed 6 gaps in the daily check of equipment in triage from 5 to 10 October 2024 along with 5 gaps in the daily checks of the emergency PPH trolley in the delivery suite. We reviewed the resuscitation equipment audits for September 2024 which showed 69% compliance. This was not in line with the trust's policy and could expose women, birthing people, and their babies to harm.

Acute services
Maternity

Staff were proud of the new bereavement suite which was designed in line with guidelines from the Stillbirth and Neonatal Death Society (SANDS) which is a charity that supports anyone affected by pregnancy loss or the death of a baby. This was an improvement since the last inspection.

There were policies and processes in place for deep cleaning and decontamination of equipment after use. Staff disposed of clinical waste safely; we observed sharps bins being filled within a safe limit and clinical waste and domestic waste being segregated and labelled correctly.

Women and birthing people we spoke with reported they were cared for in safe environments that met their needs. Staff reported there was enough suitable equipment to meet the needs of their patients and their families, for example CTG machines, resuscitation equipment, and fetal blood analyser, however they pointed out that equipment was sometimes faulty.

Women could reach call bells, and we observed staff responding quickly when called on the maternity wards.

Safe and effective staffing

Score

1. Evidence shows significant shortfalls in the standard of care

The service did not make sure there were enough qualified, skilled, and experienced staff. While efforts were made to maintain safe staffing levels, such as redeploying staff and using bank and agency staff, this approach often resulted in gaps in coverage across some areas. Managers did not always make sure staff received effective support, supervision, and development. This was an ongoing concern from the previous inspection.

Staffing levels did not always match the planned numbers putting the safety of woman, birthing people, and babies at risk. There were a high number of unfilled shifts in the midwifery rota. The unfilled shift rates for registered nurses and midwives from June to August 2024 was 19.5% on the wards. This meant there was insufficient staffing cover which could impact on the

ability of the ward to offer safe care and treatment to women, birthing people, and babies. Furthermore, an audit into the maternity high dependency unit (HDU) found that, during July to September 2024, 13% of night shifts did not meet local guidance of 1 HDU trained midwife and 1 HDU trained nurse.

Shortage of midwifery staff had been rated as an “extreme risk” on the trust’s risk register. Safe staffing was impacted by a number of factors including the high level of sickness across the service. Sickness rates of 4.04% and 5.05% were reported in May and June 2024 respectively. This was consistently higher than the trust target (3.2%) and had been included on the trust’s risk register. Data showed low staffing numbers had been raised as a concern by staff during the weekend of 24 and 25 August 2024, when annual leave and high sickness rates impacted on patient care. As a result, there were 10 delays in the induction of labour (IOL), no home birth team on Saturday 24 August 2024 and there was no midwifery manager on call. Appropriate mitigations and escalations were not always put in place which put women, birthing people, and babies at risk of harm.

There was an escalation policy and processes in place to attempt to mitigate staffing levels and the birth rate plus acuity tool was embedded into the service. Staffing levels were discussed at regular meetings to help senior leaders adjust staffing levels. However, the ward manager did not always have the resources to adjust staffing levels daily according to the needs of woman and birthing people. Managers moved staff according to the number of woman and birthing people in clinical areas but staff told us this was at short notice and sometimes meant they were expected to work in areas unfamiliar to them.

The service reported maternity ‘red flag’ staffing incidents in line with NICE guideline 4 - ‘Safe midwifery staffing for maternity settings’. A midwifery ‘red flag’ event is a warning sign that something may be wrong with midwifery staffing. Between January and September 2024 there were 62 red flag incidents reported. The most common incidents were delays of 2 hours or more between admission for an IOL and the start of the process (23) and delays or cancelled time-critical activity (16).

Following the inspection, staff raised concerns with us around the low staffing levels on the transitional care service. Staff identified occasions where unqualified support staff were expected to care for a high number of babies on their own during night shifts putting babies at risk. After the inspection, the service informed us that the transitional care service was a new

service being set up. Staff recruitment was ongoing, aiming for operation 24 hours per day, 7 days a week by January 2025.

Staff reported that the maternity triage telephone line occasionally had to close due to sickness and records showed the telephone line was closed six times from August to October 2024. Women, pregnant people, and babies were at risk of delays in accessing advice and support due to the closure of this service which may have put them at risk of harm.

The RCOG maternity triage paper published in 2023 recommend at least two midwives to cover maternity triage services. This enables one midwife to be responsible for the initial assessment and the other midwife to carry out the subsequent care and investigations. The trust guidelines recommended 2 midwives on shift to cover triage during the day. Data supplied by the trust showed that staffing in triage did not consistently meet local guidelines with 2 midwives allocated to the day shift in triage 18.4% of the time between May to July 2024. Between May and July 2024, 100% of night shifts had one midwife working in triage. This is in line with trust recommendations but does not meet RCOG guidance.

Staff reported managers were having to work longer than permitted in the working time regulations (1998) due to the way the on-call pattern was arranged. The trust did not have an on-call policy which led to inconsistencies in payments and advice on compensatory rest required after working an on-call shift. This issue had been escalated and was included on the trust's risk register.

Midwives told us that they needed additional resident doctor cover at night. The medical out of hours team covered both maternity and gynaecology services. This high workload may impact on their ability to respond to emergencies in a timely manner and we raised these concerns to the trust following the inspection.

Staff did not always have regular appraisals. Data provided by the trust showed that 66.4% of non-medical staff (e.g. midwives) and 72.3% of medical staff had completed their appraisal. This was below the trust's target of 90% and was not included on their risk register. This was an on-going concern from the last inspection. Following the warning notice issued to the trust, an improvement plan for appraisal compliance was developed with a target of 90% compliance by the end of March 2025.

Acute services
Maternity

Women and birthing people we spoke with felt they were supported by competent staff, involved in decision making, and kept informed about their care. We found evidence that consent forms were being completed appropriately. Audits, submitted by the trust following the inspection, showed that gaining consent was taken seriously by staff. An audit looking at whether consent was gained prior to using instruments to assist with delivery found that it was documented 100% of the time.

Staff, including agency staff, bank staff, and volunteers were appropriately experienced and competent, and the skill mix of senior and more junior midwifery staff was appropriate. Managers requested bank staff familiar with the service and made sure all bank and agency staff had a full induction and understood the service.

The service had an induction process in place for staff. Staff reported they had access to additional training opportunities and support to help them, and said they were adequately trained for their role. The service had appropriate recruitment systems in place, for example disclosure and barring service (DBS) checks, to ensure the safety of women, birthing people, and babies.

Infection prevention and control

Score

1. Evidence shows significant shortfalls in the standard of care

The service did not assess or manage the risk of infection. Appropriate measures to manage risks to infection prevention and control were not carried out.

The maternity services were not always clean or well maintained. During the inspection we observed “I am clean” stickers in use in the maternity areas however, some stickers were out of date. We found stickers on 4 pieces of equipment in the birth centre which were dated 11 October 2024 which meant we could not be assured that all equipment was being cleaned after contact. There was a cleaning schedule in place and cleaners were observed regularly cleaning maternity areas, however mould was observed in the bathrooms on the postnatal ward, which was escalated to leaders. Following the inspection, improvements were made by the trust to

treat the mould.

We identified other potential risks to infection prevention and control, for example torn and old mattresses in use on the postnatal ward. We also observed the roof leaking in the birth centre during inspection.

Staff were observed washing hands and adhering to “bare below the elbow” recommendations and dress code policy. Staff were aware of policies for infection prevention and control and were aware of the importance of hand hygiene. Similarly to the last inspection we found completion rates for the infection prevention and control mandatory training was below the trust target of 85%. Data from October 2024 showed compliance was 71.6% for doctors and 82.6% for midwives. We issued the trust with a warning notice to address this, and they aimed to achieve 90% compliance by March 2025.

Various infection control and prevention audits had been completed by the trust and the results were shared with us following the inspection. The saving lives hand hygiene audit tool was completed regularly in all in-patient maternity areas and showed high compliance with hand hygiene principles. In October 2024, staff on the postnatal ward achieved 98% compliance on the correct hand hygiene technique which was below the expected target of 100%. Staff achieved 100% compliance on the other three standards audited. Cleaning and decontamination audits were completed, however not consistently. For example, from August to October 2024 there are no recorded cleaning and decontamination audits for the birth centre. The perinatal quality surveillance model data presented to the quality committee in October 2024, highlighted the July and August 2024 cleaning audits did not reach the required level and an action plan was put in place including weekly meetings and biweekly spot checks.

Medicines optimisation

Score

1. Evidence shows significant shortfalls in the standard of care

The service did not always make sure that medicines and treatments were safe and met people’s needs, capacities, and preferences.

Acute services
Maternity

Concerns around medicine storage and management were raised with the trust following the previous inspection and they were asked to make significant improvements. However, we found similar concerns during this inspection which meant the trust had not put sufficient improvements in place.

Staff did not always follow systems and processes to prescribe and administer medicines safely. The trust had an electronic prescribing and medicines administration system (EPMA) which had improved prescribing of medicines. However, during the inspection we found that the prescribing system was not always kept up to date. The system was not always updated when women and birthing people moved wards. There were examples of medication being left on the system when it was no longer required which placed women and birthing people at risk. Following the inspection and the warning notice, the trust reinforced the practice of deprescribing, and a plan was put in place to audit this process to monitor compliance.

On occasions we noted that women and birthing people missed doses of medications. This was escalated and staff reported this was often because medicines were unavailable. However, the reasons why medicines were not given was not always recorded. Missed doses of medications, particularly antibiotics and pain killers, can impact on the safe care and treatment of women and birthing people. We raised our concerns with senior leaders. Following this inspection, the trust told us they had introduced a new electronic patient record which allowed staff to order medications for individual patients that were not in stock on the maternity ward. They had also updated evidence collected as part of their accreditation process to audit this area.

Staff did not always store and manage medicines safely. Medicines including controlled drugs (CD), were stored securely, however water for injection and saline were not stored securely. We noted that CD management did not always meet the recommended standard and record keeping in CD books did not follow the trust policy. Following the inspection, the trust was asked to make a number of improvements in the storage of medications. As part of this, the service completed risk assessments and storage locations were reviewed.

We also found that the storage of some medicines required in an emergency was not in line with local or national guidance. For example, staff did not maintain a log of pre-prepared emergency medicine syringes raising concerns about their timely use within 24 hours. Following the inspection, the service changed their practice and emergency medicines were no longer pre-prepared. We also found some out of date medicines, as well as gaps in the daily

checks of medicine fridge temperatures. Out of date medications or medications stored at incorrect temperatures may not be effective and therefore may put women, birthing people, and babies at risk of harm. Following the inspection, the service introduced a daily review of the maternity triage drug cupboard as part of the matron daily checklist.

The maternity Care Quality Commission (CQC) action plan which was updated in July 2024 stated that audits demonstrated improvements in medicines management and audits result was consistently above the 80% trust target however, copies of these audits were not included with the data supplied to CQC by the trust.

Findings from the CQC maternity survey published in 2024, showed that service users gave an average of 6.7 out of 10 (10 being the highest) when asked about whether staff did everything they could to manage their pain after the birth of their baby. This was about the same when compared to other trusts.

Effective

Rating Requires improvement

We looked for evidence that people and communities had the best possible outcomes because their needs were assessed. We checked that people's care, support, and treatment reflected these needs and any protected equality characteristics, ensuring people were at the centre of their care. We also looked for evidence that leaders instilled a culture of improvement, where understanding current outcomes and exploring best practice was part of their everyday work.

We did not rate this key question at our last inspection. This key question has been rated requires improvement. This meant some aspects of the service were not always safe and there was limited assurance about safety. There was an increased risk that people could be harmed.

Assessing needs

Score

2. Evidence shows some shortfalls in the standard of care

Acute services
Maternity

The service did not always make sure women and birthing people's care and treatment were effective because they did not always check and discuss people's health, care, wellbeing, and communication needs with them.

Staff were able to describe how they assessed and reviewed patient needs from the antenatal and postnatal period to provide holistic support. However, there were some gaps in the completion of risk assessments, particularly in triage. In July 2024, there was a 6.6% abandoned call rate in the maternity telephone triage. This meant that there were delays in assessing the needs of women and birthing people. There were also delays in women and birthing people accessing appropriate support from suitably qualified staff. Following the inspection, the trust informed us that abandoned calls made to maternity telephone triage during working hours were monitored and the individual was called back by a midwife. However, out of hours when the line was on divert, the caller information was not available and therefore a return call could not be made. The trust was in the process of developing practices to allow them to collect more information regarding abandoned call rates and to audit their processes to gain further information.

Where there were cases of baby loss, the service completed the perinatal mortality review tool (PMRT). An audit of this data looked at whether staff were documenting the language spoken by the woman or birthing person and whether interpreting services were required. From January to June 2024, the audit found that 95% of the cases included had the spoken language documented correctly and 19% required an interpreter. Half of the cases where an interpreter was required had no documentation if there was an attempt to book an interpreter for every contact. An external report into perinatal mortality commissioned by the trust in 2023 found there was limited evidence of interpreter services being made available. This demonstrated that further work was required to ensure the service can assess the needs of all those who use it and ensure an equitable standard of care.

Audits and incident investigations completed by the trust did highlight issues with documentation and risk assessments not being fully completed however insufficient action was taken to address the issues. A trust audit looking at the use of the Maternity Early Obstetric Warning Score (MEOWS) found that "additional concerns" were correctly documented in 55% of notes looked at as part of the audit. This was below the trust target of 80%. Similar results had been identified in previous audits and appropriate action had not been taken. This could put women and birthing people at risk of harm.

Acute services
Maternity

Local guidance deviated from national guidelines in several areas. For example, trust policy required hourly CTG review and two hourly “fresh eyes”, deviating from the 2022 National Institute for Health and Care Excellence (NICE) guideline of hourly “fresh eyes”. This deviation was risk assessed and agreed by the trust board, however, appropriate measures were not put in place to ensure that women, birthing people, and babies were kept safe.

Women and birthing people were given information and advice about their health, prenatal and postnatal care. They told us during the inspection that they felt well supported by the multi-disciplinary team and felt they were involved in the assessment of their needs.

Delivering evidence-based care and treatment

Score

2. Evidence shows some shortfalls in the standard of care

The service did not always plan and deliver women and birthing people’s care and treatment with them, including what was important and mattered to them.

Staff followed trust policies to plan care for women, birthing people, and babies however this was not always in line with evidence-based practice and national guidance. Staff did not always follow national guidance or best practice around triage provision, management of cardiotocography (CTG) traces, and GAP/GROWTH Assessment Protocol (GAP) to monitor fetal growth. The trust had completed risk assessments to detail why they were not following national guidance, and these decisions had been agreed by the trust board. Post inspection, the trust updated its local guidance on the management of CTG traces to align with national recommendations. The trust stated that the 36-week ultrasound offered to pregnant women and birthing people detects more cases of small for gestational age (SGA) and growth-restriction compared to following GAP. A Maternity and Newborn Safety Investigations (MNSI) team investigation in November 2024 stated that the trust’s SGA detection rate for babies born at 37 weeks and above who weighed on or below the 10th centile at birth was 64%, compared to the national average of around 54%.

Local policies, protocols, and guidelines were reviewed regularly and available for staff to

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access on the intranet and some hard copies were available. The service completed regular audits to ensure the service was effective and check improvement over time. The venous thromboembolism (VTE) October 2024 audit result showed that 90% of the cases examined had the correct assessment completed which was above the trust target of 80% and ensured that women and birthing people were receiving the correct venous thromboembolism management.

In the “Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries” (MBRRACE) perinatal mortality surveillance report based on births in 2022, the stabilised and adjusted perinatal mortality rate at the trust was around average when compared to similar trusts and health boards. Trust data supplied following the inspection, showed that there were 6 still births between August and October 2024 and the number of still births which occurred before 37 weeks was above the trust target in September and October 2024. Data on outcomes, such as still births, was regularly discussed at clinical governance meetings with staff.

Staff used a nationally recognised screening tool to monitor women and birthing people at risk of malnutrition and referred women to the dietitians when needed.

How staff, teams and services work together

Score

2. Evidence shows some shortfalls in the standard of care

The service did not always work well across teams and services to support women and birthing people.

Communication within the service was unstructured. Staff held regular and effective multidisciplinary meetings to discuss patients and improve their care; however, they were not always structured. We observed that staff did not introduce themselves or use the Situation, Background, Assessment, Recommendation (SBAR) format during the handover meetings observed. We observed multiple interruptions during the labour ward handover and the co-ordinator had to leave before the end. This disrupted the flow of information, could potentially lead to key information being missed and could prevent the team from working together to

achieve the best care and treatment for people using the service. However, multidisciplinary staff considered patients' individual needs, circumstances, ongoing care arrangements, and expected outcomes during the handovers and ward round meetings observed.

Staff reported that they had access to the information they needed to appropriately assess, plan, and deliver care and treatment, however we found evidence that prescriptions were not always updated when women and birthing people were moved between different areas.

Staff we spoke with reported that there was good, collaborative working between all members of staff within the multidisciplinary team, particularly in the maternal medicines team. Information was shared between teams and services effectively to ensure continuity of care of women, birthing people, and babies. There was a multidisciplinary team for all people who used the service where there were safeguarding concerns, long term conditions, mental health needs or other additional needs. Staff gave several examples of how they had worked with other professionals such as GPs, education teams, the justice system and social services to support vulnerable women and birthing people (such as teenage mothers) and those in prison to ensure good levels of care.

Staff reported a number of initiatives run by the multidisciplinary team to support women and birthing people. For example, the smoking cessation project was run by a multidisciplinary team to reduce the risks of smoking in pregnant people and mothers. The service also had a comprehensive birth reflection service which was run by midwives, with obstetric support, to ensure parents received appropriate support following difficult births. We observed staff, including doctors and midwives, working together as a team to benefit women, birthing people, babies, and their families.

The service worked collaboratively with system partners, such as the Integrated Care Board (ICB), other maternity services within their Local Maternity and Neonatal System (LMNS) and maternity improvement advisors. We saw evidence of regular meetings with the maternity improvement advisors for the trust and agreed actions to improve services.

Women and birthing people could access information and advice about their health, care and support from the hospital maternity pages on the internet, printed leaflets as well as from staff during their appointments.

In the 2024 Care Quality Commission (CQC) maternity survey, service users scored "Staff

Working Together" at an average of 8.7 out of 10 (with 10 being the highest). This was about the same when compared with other trusts.

Supporting people to live healthier lives

Score

3. Evidence shows a good standard of care

The service supported people to manage their health and wellbeing to maximise their independence, choice, and control. The service supported people to live healthier lives and, where possible, reduce their future needs for care and support.

The service had relevant information promoting healthy lifestyles and support on the wards, website, and internet. Staff assessed each woman's and birthing person's health when admitted and provided support for any individual needs to live a healthier lifestyle.

The service also promoted women, birthing people, and their families to maintain a healthy lifestyle by providing information and antenatal classes on various topics. This included healthy eating, physical activity, maternal mental health, paternal mental health, smoking cessation, substance misuse, sexual health and pelvic floor exercises. Staff described the multidisciplinary smoking cessation project which had been set up to support women and birthing people.

During inspection we found a range of initiatives designed to help support people to live healthier lives. Staff told us the service had good infant feeding support on the ward and a good breastfeeding initiation rate, as both midwives and band 3 midwifery support workers were trained as lactation consultants, and there was good initiation rates of breastfeeding in women and birthing people who have used the service.

From our observation and the records reviewed, we noted that staff explored women and birthing people's emotional wellbeing and mental health and referred them to the perinatal mental health services when needed. The 2024 CQC maternity survey found that, on average, people using the service scored the service 6.8 out of 10 (10 being the highest) when asked about whether they received information and explanations they needed following the birth of

their baby. This score was similar to other trusts.

A Health Watch Wandsworth report, published in 2023, reported that 38.4% of the people they spoke with said they did not have an opportunity to talk about their emotional or mental health at maternity appointments. This report included conversations with a small number of people from black and ethnic minority backgrounds. Promoting mental health is an important part of supporting people to live healthier lives particularly during the antenatal period when women and birthing people are at risk of poor mental health. However, during our inspection, people using the service told us they felt supported to manage their health and wellbeing in a way that made sense to them, and they felt like they were supported by staff to live a healthy lifestyle.

Monitoring and improving outcomes

Score

2. Evidence shows some shortfalls in the standard of care

The service did not always routinely monitor people's care and treatment to continuously improve it. Staff did not always ensure that outcomes were positive and consistent, or that they met clinical expectations.

The service did not follow national guidance on the interpretation of CTG traces or the frequency of "fresh eyes" assessments of CTG traces as detailed in the NICE guidelines for fetal monitoring in labour (2022). This had been risk assessed by the trust and the decision had been agreed by the board, however not following national guidance could put women, birthing people, and babies at risk of harm. We found that there were insufficient monitoring systems in place to ensure that standards of care were being maintained despite these deviations from national guidance. Following the inspection, the trust put several improvements in place to ensure the safety of people who used the service. The new electronic notes system used drop down boxes to ensure that standard terminology was used when describing CTG traces and the frequency of "fresh eyes" had been changed to align with NICE recommendations.

Local guidance for monitoring fetal growth did not meet national recommendations as the service did not use individualised growth charts or complete symphysis fundal height

measurements to monitor fetal growth during pregnancy. However, the service offered women and birthing people an ultrasound scan at 36 weeks. NICE guidelines on antenatal care published in 2021 stated that women and birthing people should be offered symphysis fundal height measurement at each antenatal appointment after 24 weeks unless they were having regular growth scans. This deviation in NICE guideline was risk assessed and agreed by the trust board. An MNSI team investigation from November 2024 stated that the trust's growth restriction detection rate for babies born at 37 weeks and above who weighed on or below the 10th centile at birth was 64%, compared to the national average of around 54%.

The previous inspection carried out in 2023 found that compliance rate for carbon monoxide monitoring was below national recommended guidance. Evidence submitted by the service showed that this was still an area for improvement. In the maternity services quality report presented to the trust board in September 2024 stated that there was an ongoing drive to ensure that carbon monoxide monitoring was recorded at 36 weeks.

The service was working towards achieving the Saving Babies Lives Care Bundle Version 3.

Processes were in place to drive improvement and to ensure good clinical practice was embedded. Managers and staff carried out a comprehensive programme of repeated audits to check improvement over time. Managers shared audit results via emails and during team meetings and made sure staff understood information from audits through the 5 facts shared learning emails that were circulated. There was an audit plan in place with multiple trust guideline audits being completed which covered the whole of the maternity pathway. Several audits were completed regularly, and an action plan was put in place if the results was lower than the trust target. However, we identified some audits where poor performance was identified and there was no evidence actions were taken to drive forward improvements. For example, the triage audits completed between January to September 2024 identified poor record keeping. This was also raised as a concern following our previous inspection in 2023. The missing data made it difficult to make firm conclusions and meant that potential areas for improvement were missed.

The trust monitored outcomes through data collected through the maternity dashboard. Data supplied by the trust from their maternity dashboard showed that, the service achieved their target of less than 5% of births resulting in third- or fourth-degree tear every month in the period of October 2023 to October 2024.

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The service completed a high percentage of caesarean sections. Data supplied by the trust from their maternity dashboard for the period October 2023 to October 2024 showed that they were consistently above their target of 28%. This meant that more women had caesarean sections and 49.5% of these were non-elective.

Data supplied by the trust showed that, an average of 4.5 women and birthing people were readmitted to the service per month with an average length of stay of 7.4 days between May and October 2024. The biggest reason for readmission was infection (6). An average of 13.3 babies (up to 28 days of age) were readmitted each month between May and October 2024. This means that an average of 13.3 babies needed to return to hospital each month after they had been discharged because they were unwell.

Leaders tracked the effectiveness of care and treatment provided by monitoring staff and patient surveys, looking at patient outcome results, monitoring and benchmarking maternity information dashboards and looking for themes and trends in care responses and complaints. Staff told us about the high dependency unit (HDU) provision on the ward and there were HDU trained nurses and midwives who covered the service. The service had portable monitors which allowed staff to offer HDU care anywhere in the maternity unit. Staff described good multidisciplinary team working between staff in the HDU, anaesthetics, and obstetrics teams to improve outcomes.

The service had completed several quality improvement projects to improve the standards of care. Midwives completed a thematic review of “baby falls” which occurred on the post-natal ward. As a result, action was taken to improve safety by introducing “safe sleeping rounds” ensuring safe sleeping advice was followed and in turn reduced the risk of falls. A poster around baby falls was created to improve awareness for staff, women, birthing people, and their partners or relatives.

Following some serious incidents, a quality improvement project took place focusing on sending appropriate placentas to histopathology. The project involved education for staff and audits which resulted in increased in compliance in the number of appropriate placentas sent to histopathology by staff.

The service had introduced a maternal vaccine clinic resulting in 60% higher vaccination rate compared to 2 years ago. This meant that more women and birthing people were being

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protected from illnesses which could harm them or their baby. The service was a centre of national and international excellence for fetal medicine.

Patients and their families we spoke with as part of the inspection spoke positively about their experiences and the care they received.

Consent to care and treatment

Score

3. Evidence shows a good standard of care

Staff understood how and when to assess whether a woman or birthing person had the capacity to make decisions about their care and made sure women and birthing people consented to treatment based on all the information available. Staff gained consent from women and birthing people for their care and treatment in line with legislation and guidance and clearly recorded consent in the woman's and birthing person's records.

The service told people about their rights around consent and respected these when delivering person-centred care and treatment. People we spoke with during the inspection were aware of the importance of consent. During our inspection, we observed a consent form being completed appropriately and we observed staff explaining risks appropriately to the individual before completing a procedure.

Several audits had been completed by the service looking at consent and whether this was appropriately documented by staff. One audit, completed in November 2024, looked at whether consent was documented prior to an elective caesarean section date and whether the consent form was signed by the relevant clinician and patient. The results showed that 100% of the notes included were signed by both the clinician and the women and birthing people and 90% were signed prior to the caesarean date. Both results were above the trust's target of 80%.

Caring

Rating Requires improvement

We looked for evidence that people were always treated with kindness, empathy, and compassion. We

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checked that people's privacy and dignity was respected, that they understood that their experience of how they were treated and supported mattered. We also looked for evidence that every effort was made to take people's wishes into account and respect their choices, to achieve the best possible outcomes for them.

This key question has been rated requires improvement. This meant some aspects of the service were not always safe and there was limited assurance about safety. There was an increased risk that people could be harmed.

Kindness, compassion and dignity

Score

2. Evidence shows some shortfalls in the standard of care

The service treated people with kindness, empathy, and compassion and respected their privacy and dignity. However, women and birthing people's dignity was not consistently maintained by staff. Not all women had a positive experience or felt listened to.

We found dignity and privacy was not always maintained. For example, we found birth rooms in the birth centre did not have "do not enter" signs on the door when they were in use and staff relied on white boards to know if a room was occupied or not. This could have impacted on the dignity of service users as staff or visitors did not quickly know if a room was in use or not.

Data supplied by the trust highlighted that the main theme in complaints received from women and birthing people was staff were not communicating in a kind or compassionate way. It was unclear how many complaints this related to, and this was not reported by the people we spoke with during the inspection.

Multidisciplinary staff told us some initiatives had been carried out in recent years to improve communication and staff attitude to improve women and birthing people experience in the service.

The 2023 Wandsworth Health Watch report found a significant number of people felt that their

ethnicity had negatively influenced the maternity care they received, and experiences included feeling like they weren't being listened to.

During the inspection, we observed staff taking time to interact with women and birthing people and those close to them in a respectful and considerate way. Women, birthing people, and their families we spoke to felt they were treated with kindness, compassion, and dignity. One person told us staff were helpful, friendly, and caring. Women and birthing people felt that staff listened to them and communicated with them appropriately. A "15 steps" exercise was completed in the birth centre in March 2024 which found that staff seemed "unhurried, well supported and happy" and they were greeted with a smile.

We found there was a culture of kindness and respect between staff, women, and birthing people. Staff treated people with kindness and respect and were discreet when caring for women and birthing people. We observed women and birthing people receiving pain relief soon after requesting it. We saw staff close curtains and doors to protect patients' privacy and knock on doors before they entered.

We observed the multidisciplinary team treating women, birthing people, and their families as equal partners in the assessment, decision making and delivery of their care. In the Care Quality Commission (CQC) maternity survey published in 2024, service users gave an average score of 9.2 out of 10 (10 being the highest) to whether they were treated with respect and dignity during labour and birth. This was about the same when the score is compared with other trusts.

Treating people as individuals

Score

3. Evidence shows a good standard of care

The service made sure people's care, support, and treatment met people's needs and preferences. Staff took account of people's strengths, abilities, aspirations, culture, and unique backgrounds and protected characteristics.

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Staff made sure women and birthing people and those close to them understood their care and treatment. Women and birthing people we spoke with told us that staff treated them as individuals. Staff offered support and health promotion advice to manage long-term conditions, such as diabetes and hypertension. One person we spoke with reported that their cultural background was considered and their request to be treated by female staff was accommodated.

Results of the trust's friends and family test, give feedback on care survey and CQC 2024 maternity survey were mostly positive. In the CQC maternity survey, the trust scored "about the same" when compared to other trusts in all areas that service users were asked about. Feedback from women and birthing people who had used the specialist service for those who had an abnormally sited placenta between August and October 2024 showed that 100% either agreed or strongly agreed that they received adequate information and were adequately supported and 100% said they would recommend the service to a friend.

Staff we spoke with during the inspection understood the need to assess women and birthing people in a holistic way. Staff assessed individual needs and preferences to help ensure positive outcomes. From our observations and the records reviewed we saw that staff considered the individual, cultural, and communication needs of women and birthing people.

Staff were able to describe the multiple specialist teams and clinics within the service which helped them to tailor care to individual women and birthing people. For example, there was a multiple pregnancy clinic and a maternal medicine service. There was also an opportunity for joint clinics with other specialities such as cardiology and endocrinology to ensure the best care for individual women and birthing people using the service. There was a good level of support provided by the service to bereaved women, birthing people, and families following the loss of a baby.

However, analysis of complaint data showed themes of a lack of information and lack of time to ask questions. Common themes and learning from complaints are discussed at team meetings. Further improvements could be made to the service to ensure that all patients feel they were treated as individuals.

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Independence, choice and control

Score

3. Evidence shows a good standard of care

The service promoted people's independence, so people knew their rights and had choice and control over their own care, treatment, and wellbeing.

Women and birthing people said that they had choice and control over their own care. They reported that staff were flexible with appointments and did their best to accommodate their individual needs. We observed staff who supported and involved women and birthing people in assessments and encouraged them to make decisions about their care. The CQC maternity survey published in 2024 found that service users gave an average score of 8.3 out of 10 (10 being the highest) for being involved in decision making.

There were systems and processes in place to ensure that patient choice and control was promoted. Policies, such as the Entonox policy, included details to ensure patients were given adequate information to be able to make an informed choice about treatment options. Audits were completed to look at whether consent for treatment was documented within the patient notes. The November 2024 third stage of labour consent audit result showed 85% compliance which was above the trust's target. However, further improvement was needed as it was documented in the local care during labour guidelines that the decision for active management should be agreed with the woman or birthing person and must be documented. This audit was now part of the trust's routine documentation audit.

Staff talked with women and birthing people, families, and carers in a way they could understand, using communication aids where necessary. In the 2024 CQC maternity survey, people who had used the service gave a score of 8.5 out of 10 (10 being the highest) when asked about whether they had confidence and trust in the staff caring for them. This score was about the same as other trusts.

Women, birthing people, and their families could give feedback on the service and their treatment and staff supported them to do this. Staff supported women and birthing people to maintain relationships that were important to them.

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Responding to people's immediate needs

Score

2. Evidence shows some shortfalls in the standard of care

The service did not always listen to or understand people's needs, views, and wishes. Staff did not always respond to people's needs in the moment or act to minimise any discomfort, concern, or distress.

Staff told us they used risk assessment tools to identify when people need urgent help and to facilitate staff to respond to patients' needs. However, triage processes and phone triage documentation were inconsistent in and out of hours. This could make it difficult to identify repeat callers and could put women, birthing people, and babies at risk of harm and was not in line with national guidance. Gaps in documentation meant that staff did not have an accurate picture of the women and birthing people who were calling the service or the reasons for them calling. This could put them, and their babies, at risk of harm. This was not in line with the Royal College of Obstetricians and Gynaecologists (RCOG) 2023 maternity triage good practice paper. Following the warning notice that was issued as a result of this inspection, the trust made a number of improvements. The service introduced an electronic notes system which ensured contemporaneous notes are completed during working hours and out of hours with mandatory fields which ensure assessments are completed.

A Health Watch report, published in 2023 highlighted that those patients from black and ethnic minority backgrounds felt that their ethnicity had negatively affected the care they received by maternity services, and felt they were treated differently by health professionals because of their ethnicity. The report raised questions about whether there was an equitable level of care for everyone who use this service and whether all women and birthing people who use the service were protected from harm. The service had developed a maternity strategy and vision for the service which focused on meeting the needs of the local population and addressing health inequalities.

Consultants led twice daily ward rounds on all wards, including weekends. This was an improvement since the last inspection. Women and birthing people were reviewed by consultants depending on the care pathway they were on. Staff could call for support from

doctors and other disciplines, including mental health services and diagnostic tests, 24 hours a day, seven days a week.

Workforce wellbeing and enablement

Score

2. Evidence shows some shortfalls in the standard of care

The service did not always care about or promote the wellbeing of their staff. They did not always support or enable staff to deliver person-centred care.

Staff wellbeing was not a priority for leaders. There were ineffective resources and facilities for safe working in place, such as regular breaks for staff. Some staff we spoke to reported that they did not always get regular breaks due to high acuity and reduced staffing. Data received from the trust highlighted difficulties with the way the midwifery manager on-call duties rota were arranged and managers worked longer than permitted in the working time regulations (1998). The trust did not have an on-call policy which led to inconsistencies in payments and advice on compensatory rest required after working an on-call shift. This issue had been escalated and was included on the trust's risk register. Further work could be done by the trust to ensure staff wellbeing is promoted to ensure the best outcome for staff and people who use the service.

Staff felt valued but did not always feel listened to by their leaders. In a maternity safety champion report from May 2024 supplied by the trust following the inspection, it was reported that senior midwives were not consistently listened to and felt excluded from decision-making. The report also highlighted that some staff feared reprisals if they raised concerns. As a result of this an action plan was put in place.

Staff from black and ethnic minority backgrounds told us during the inspection that there were limited development opportunities and career progression. Therefore, further work to improve the culture is required to ensure equity and inclusivity.

The 2023 Staff Survey had a low response rate for maternity, which was 27% and lower than the trust average response rate of 38%. Morale was slightly lower than the trust score (5.5 out of 10,

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compared to 5.6). As a result of the survey, the trust put an action plan in place to improve the motivation and morale of staff, wellbeing and improving psychological safety.

The majority of staff we spoke with during the inspection felt they were able to give feedback, raise concerns, and suggest ways to improve the service. Staff reported feeling valued by their colleagues and their leaders. They reported a positive culture in the service because of the work done by the trust, with staff, to improve the service culture. Staff felt listened to and reported a culture of inclusivity. The service had programmes in place to assist staff to feel valued, for example long service awards.

The 2024 General Medical Council national trainee survey report showed an improvement in feedback given by trainee doctors regarding their placements in obstetrics and gynaecology at the trust since our last inspection. The majority of the feedback scores were within the normal range when compared to scores given to other services. Workload and induction scores were better than national average. However, the service scored below national average in educational supervision.

The trust had a 'raising concerns at work' policy which encouraged staff to raise concerns. It also contained contact details for the Freedom to Speak Up guardian. There were regular team meetings and safety champions who staff could raise concerns to. The trust had a guide to essential workplace adjustments to help managers to support staff to work effectively. There was also a recruitment and selection policy which described the reasonable adjustments that could be made and covered topics to ensure the selection process was equitable and free from discrimination.

There was a counselling service available to all staff and a dedicated wellbeing team. There was also an executive question time initiative which allowed senior leaders to respond to staff feedback.

There were 4 Professional Midwifery Advocates (PMA) in post and, as a team, they tried to ensure that there was one PMA present during day shifts (Monday – Friday) to support midwives.

Responsive

Rating Good

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We looked for evidence that people and communities were always at the centre of how care was planned and delivered. We checked that the health and care needs of people and communities were understood, and they were actively involved in planning care that met these needs. We also looked for evidence that people could access care in ways that met their personal circumstances and protected equality characteristics.

We did not rate this key question at our last inspection. This key question has been rated good.

Person-centred care

Score

2. Evidence shows some shortfalls in the standard of care

The service did not always make sure people were at the centre of their care and treatment choices and they did not always work in partnership with people, to decide how to respond to any relevant changes in people's needs.

Women and birthing people's records and birth plans did not fully reflect their physical, mental, emotional, and social needs, including those with protected characteristics under the Equality Act (2010). We found gaps in the assessments completed and in the documentation of assessments as part of the telephone triage service as staff did not always document the wellbeing, mental, and emotional needs of women and birthing people. The triage audit results for the period of January to September 2024 showed poor compliance in documentation of the time of patient interactions with midwives. Following the inspection, the trust made changes to improve their practice. A new electronic documentation system was introduced following the inspection with mandatory fields to ensure assessments are completed and timings are recorded.

An external maternity report found that the majority of women and birthing people from black and ethnic minorities experienced language barriers and felt judged by members of staff. They also felt that their ethnicity had a negative impact on the care they received. This showed that more could be done to ensure that all service users experienced patient-centred care and ensure there was an equitable service.

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Staff we spoke with understood the importance of person-centred care and could describe how they ensured women, birthing people, and their families were involved in planning and making decisions about their care. Staff told us they took the individual needs of their patients into account, especially those with additional needs for example mental health needs or learning disabilities. They did this by completing birth plans and personalised care plans.

Women and birthing people we spoke with felt involved in planning and making decisions about their care which was responsive to their needs. They reported staff worked together and supported them to plan their care and the birth of their baby. Women and birthing people knew how to access their health and care records and were able to decide which personal information was shared with their partners.

Care provision, integration and continuity

Score

3. Evidence shows a good standard of care

The service understood the diverse health and care needs of people and their local communities, to ensure care was joined-up, flexible, and supported choice and continuity.

Managers planned and organised services so they met the needs of the local population. The service delivered and co-ordinated services and care provision which considered the needs and preferences of different people, for example they offered halal, vegetarian, and vegan food options. Information was also available on the trust maternity website in a variety of different languages. Specialist antenatal clinics were also available for women and birthing people with high-risk conditions or with complications during pregnancy.

Women and birthing people we spoke with reported that the care and treatment they received took their diverse health and social needs into account.

The service had systems to help care for women and birthing people in need of additional support or specialist intervention following the birth of their baby. The service worked with

staff and leaders to set up a transitional care team within the maternity service to prevent babies who required more intensive medical treatment from being separated from their mothers. The recruitment process was ongoing at the time of our inspection to allow the service to remain open for 24 hours per day.

There was a high dependency unit (HDU) provision within maternity to provide additional medical care for women and birthing people. Staff who worked in this area received appropriate training to work on this unit. However, an audit published in October 2024 showed that there were often instances of short staffing with 13% of night shifts with insufficient staffing which did not meet local guidance. An action plan was put in place with a plan to recruit an additional HDU trained nurse.

Staff supported women and birthing people and babies when they were referred or transferred between services.

Managers worked to keep the number of cancelled appointments and operations to a minimum. However, when women and birthing people had their appointments or operations cancelled at the last minute, managers made sure they were rearranged as soon as possible. Managers ensured that women and birthing people who did not attend appointments were contacted.

Providing information

Score

3. Evidence shows a good standard of care

The service supplied appropriate, accurate, and up-to-date information about care, conditions, and maternity services in formats that were tailored to individual needs.

Women and birthing people knew how to access their health and care records and decide which personal information could be shared with others, for example their family.

People received information in a timely way that met best practice standards, legal

requirements, and was tailored to individual need. Staff gave women and birthing people verbal and written information and advice that was accurate and up to date. They also signposted women and birthing people to the maternity page of the trust website for further information. The information that was on the maternity page of the trust website was accessible and supported patient rights and choice.

During our inspection, staff told us about the digital transformation process to improve electronic records of patient notes which was planned for February 2025. They hoped that this would improve the trust's IT systems.

There were processes in place to ensure individual information needs were met and reviewed to support care and treatment and in line with the accessible information standard. On the maternity website, the service had included parent education resource videos on the first trimester of pregnancy which was available in English and five other languages including Urdu, Polish, and Arabic. Staff told us they also had other information leaflets that were available in some languages. There was ongoing work to ensure the service continued to meet the communication needs of its growing diverse population by ensuring leaflets were available in the top languages spoken by women and birthing people who accessed the service.

There were processes in place to ensure information about people that was collected and shared was kept safe in line with the data protection legislation requirements. There was a data protection and confidentiality policy which summarised these requirements for staff.

Listening to and involving people

Score

2. Evidence shows some shortfalls in the standard of care

The service made it easy for people to share feedback and ideas, or raise complaints about their care, treatment, and support. Staff involved people in decisions about their care and told them what had changed as a result. However, there were delays in the investigations of complaints.

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The service clearly displayed information about how to raise a concern and give feedback on care or experience of the service in patient areas. There were also leaflets asking for feedback in patient areas and there was a feedback section on the maternity page of the trust website. Women, birthing people, and their families felt that their complaint or concern would be explored thoroughly, and they would receive a response in good time and in an open and transparent way, with no repercussions. In the 2024 Care Quality Commission (CQC) maternity services survey, service users gave an average score of 8 out of 10 (10 being the highest) to whether concerns were taken seriously once they were raised. This score is about the same when compared with similar trusts.

Staff we spoke with described the processes in place to gather feedback from those who have used the service, for example the friends and family test. Feedback from women, birthing people, and their families was also captured during birth reflection clinic and incidents investigations.

Managers investigated complaints and identified themes. Managers shared feedback from complaints with staff and learning was used to improve the service. Generally, learning from incidents investigations, complaints and concerns was seen as an opportunity for improvement and staff gave examples of how use feedback to improve daily practice. Themes from complaints and investigations were discussed regularly in team meetings to improve practice. Data shared by the trust showed that from February to April 2024, 100% of complaints were acknowledged within 3 working days. This was above the trust target of 95%. However, from July to August 2024, 50% of complaints were resolved within 35 working days which was significantly below the trust target of 85% and meant that opportunities for learning and improving care were delayed.

Equity in access

Score

2. Evidence shows some shortfalls in the standard of care

The service did not always make sure that people could access the care, support, and treatment they needed when they needed it.

Acute services
Maternity

There was evidence that further improvements were needed to ensure equity in access for all. A report commissioned by the trust in 2023 found there was limited evidence of interpreter services being made available. Furthermore, the 2023 Health Watch report from the Wandsworth team found a significant number of people felt that their ethnicity had negatively influenced the maternity care they received. Women and birthing people who shared their experiences in the report felt that access to health services was not always equal, reported experiencing language barriers and felt that health professionals could do more to facilitate communication with those where English was their second language. This demonstrated that further work was required to ensure an equitable access for all.

Information provided by the trust following the inspection, identified that not all women and birthing people had an equal experience when accessing the service. The triage audit completed in September 2024 identified that 60.5% of women and birthing people had a medical review within a time frame which was in line with recommendations made by the Royal College of Obstetricians and Gynaecologists (RCOG). Medical review times were not always documented in records, and therefore it is hard to draw firm conclusions about how long people were waiting to see a doctor. However, this data shows that there was variation in access to maternity triage.

The triage telephone line was diverted during staff breaks during the day and out of hours from 8pm to 8am. This was not in line with guidance from the RCOG. Staff told us that midwifery staff working in areas other than triage were expected to answer triage calls, when the line was diverted, without specific training or completion of required competencies. This raised concerns about their ability to complete appropriate risk assessments and maintain records and we found inconsistency in the telephone triage assessment and documentation used during working hours and out of hours. This meant that women and birthing people who called out of hours did not receive the same level as care as those who called the service during normal working hours. Following the inspection, the trust changed its practice, and a 24-hour maternity triage telephone line was put in place to ensure women and birthing people can get help and advice when they need it, and calls are no longer diverted. There are also standardised assessments with mandatory fields and drop down boxes to improve the standard of documentation.

There have been instances where low staffing led to service suspensions, including 5 home-birth suspensions (July to November 2024) and multiple birth centre closures. These changes

impacted the individual birth choice of women or birthing people. There had also been delays for women and birthing people waiting for an induction of labour (IOL). Data showed that between 1 July 2024 and 4 November 2024, 23 women and birthing people had experienced a delay of 2 hours or more between admission and the start of the IOL. These delays could cause harm to the women, birthing people or their babies. However, there was an IOL pathway in place for staff to follow when delays occurred. This was an improvement since the last inspection.

Women and birthing people we spoke with during the inspection felt they had equal access to care, treatment, and support and reported their additional needs were supported by the service.

Staff we spoke with during the inspection were able to discuss ways in which the service ensured equity in access. For example, women and birthing people could access services without physical or digital barriers including out of normal hours and in an emergency. They were able to describe how women and birthing people were given support to overcome barriers to ensure equal access, for example information being available in some languages on the trust website.

The trust complied with legal equality and human rights requirements with appropriate processes and systems in place. The service prioritised, allocated resources, and provided opportunities as needed to tackle inequalities and achieve equity of access for women, birthing people, and babies.

The maternity service strategy included equity and highlight how the services planned to continue to tackle health inequality including working with the Maternity and Neonatal Voices Partnership (MNVP) to reach out to minority groups and hard to reach women and birthing people.

Equity in experiences and outcomes

Score

3. Evidence shows a good standard of care

Acute services
Maternity

Staff and leaders actively listened to information about people who are most likely to experience inequality in experience or outcomes and tailored their care, support, and treatment in response to this.

Leaders and staff were alerted to discrimination and inequality that could disadvantage different groups of people using their services. There were policies, systems, and processes in place to ensure people's care promoted equity, removed barriers, and protects their rights including those with protected equality characteristics. Equality impact assessments were considered in their policies and processes.

Multidisciplinary staff we spoke with understood the impact of discrimination and how inequity could disadvantage different groups of people using their service. Staff and leaders reported they proactively sought ways to address inequality barriers to improve experiences of those using the service and acted on feedback and outcomes. Leaders reported they allocated resources and opportunities to achieve equity. For example, the labour ward had a bariatric room that could be used to care for bariatric women and birthing people to ensure the service could respond to the needs of the people and ensure they had a good experience of care.

Staff were able to describe the multiple specialist teams and clinics within the service which helped them to tailor care to individual women and birthing people. For example, there was a multiple pregnancy clinic and a maternal medicine service. There were also opportunities for joint clinics to ensure women and birthing people received the individualised care they required. There was also a fetal medicine unit and a day assessment unit to support women and birthing people with long-term conditions or complications during their pregnancy. The service received tertiary referrals from other areas for women and birthing people who required input from the specialist services available.

The service utilised the together project maternity passport to allow staff, women, birthing people, and their families to work together to plan care and improve people's experience and outcome. The passport allowed women and birthing people to record how staff could best communicate with them and detailed any additional needs they may have. The service had a maternity strategy in place which focused on tackling health inequality and focused on improving experience and outcomes for all, which showed the service was aware of the diverse population it served.

Women and birthing people we spoke with as part of our inspection reported their care and

support were co-ordinated and everyone worked well together. They reported feeling they were in control of planning their care and treatment and the service took their diverse health and social needs into account.

Planning for the future

Score

3. Evidence shows a good standard of care

People were supported to plan for important life changes, so they could have enough time to make informed decisions about their future.

Women and birthing people could get information and advice that was accurate, up to date, and provided in a way they could understand to plan for their birth and future. The service supported women and birthing people to make informed choices about their care. This was achieved through health promotion information, antenatal classes, appointments with midwives, birth plan documents, information leaflets, and resources available on the maternity page of the trust's website.

Women and birthing people we met reported feeling supported to plan for important changes and reported being given verbal and written information. Women and birthing people reported that they had access to antenatal clinic appointments which never felt rushed, and they always felt they had enough time to discuss all their concerns with midwifery and obstetric staff.

Women and birthing people's decisions and what matters to them was recorded through personalised care plans that were shared with others who may need to be informed. Women and birthing people attended birth option clinics to discuss their birth options with staff. We were also told that, when changes needed to be made to a birth plan due to clinical reasons, staff communicated and managed this openly and sensitively.

Policies, processes, and systems were in place to assist staff with supporting women and birthing people to plan for their future care. There were "do not attempt cardiopulmonary resuscitation" (DNACPR), consent, and decision-making forms for different obstetric procedures to allow staff, women, and birthing people to plan for the future. There were also

Acute services
Maternity

multiple resources on the maternity page of the trust website with information regarding induction of labour, vaccinations, and other screening tests to help women, birthing people, and their families to start planning their future maternity care.

Well-led

Rating Requires improvement

We looked for evidence that there was an inclusive and positive culture of continuous learning and improvement that was based on meeting the needs of people who used services and wider communities. We checked that leaders proactively supported staff and collaborated with partners to deliver care that was safe, integrated, person-centred and sustainable, and to reduce inequalities.

At our last inspection we rated this key question inadequate. At this inspection, the rating has changed to requires improvement. This meant some aspects of the service were not always safe and there was limited assurance about safety despite some improvements. There was still a risk that people could be harmed.

Shared direction and culture

Score

2. Evidence shows some shortfalls in the standard of care

The service had a vision and a strategy, however there was a lack of evidence to show that the strategy had driven improvements in culture, equity, inclusion, and engagement. Leaders did not always understand the challenges and the needs of people and their communities.

The service had a vision for what it wanted to achieve and a strategy to turn it into action, however there was a lack of evidence to show how this strategy was being tracked to ensure progress was being made. The vision and strategy were focused on sustainability of services and aligned to local plans within the wider health economy. The maternity service strategy focused on improving care and staff wellbeing, promoting equality, diversity and inclusion, and

creating a workspace where all people feel valued and respected. However, no evidence was supplied by the trust to show how the success of the vision and strategy was being measured or what work has already been undertaken as a result.

The trust wide Workforce Race Equality Standard (WRES) 2024 report highlighted that the population of staff from black and ethnic minorities had continued to increase, however they were underrepresented at executive level. There had been an improvement in 7 out of 10 indicators on the WRES according to the data from 2024 and this showed an improvement from our previous inspection. The likelihood of staff from black and ethnic minorities entering a formal disciplinary process improved from 1.67 to 1.48 (the average for London in 2023 was 1.41). The percentage of staff from black and ethnic minorities who had experienced harassment, bullying or abuse from patients and staff had reduced. This showed an improvement from the previous inspection however, staff we spoke with reported further advancements were needed in this area. During the inspection, staff from the black and ethnic minority backgrounds told us that there were limited career development opportunities. Therefore, more could be done to improve the experiences of staff from black and ethnic minorities.

An external maternity report in 2023 highlighted that staff did not always feel supported, reported a blame culture, and felt their views were not valued when raising concerns. These findings were echoed in a maternity safety champion report from May 2024 which reported that senior midwives were not consistently listened to and felt excluded from decision-making. Staff we spoke with, during the inspection, understood equality, diversity, and human rights and felt that lessons learned from incidents or complaints were shared across sites in a proactive way.

Some work had been completed by the trust to improve the culture, for example, a Band 7 away day was introduced to improve working relationships among senior midwives. The staff we spoke with during our inspection reported an improvement in the service culture and reported no concerns regarding bullying and harassment. However, we received anonymous reports from members of staff detailing poor culture within the service following the inspection. Although the trust has started to introduce initiatives to improve the culture of the service, improvements were not fully embedded and further work was needed.

In the 2023 staff survey, staff in the maternity department gave an average score of 5.6 out of 10 (10 being the highest) when asked about whether they felt recognised and rewarded. Initiatives had started within the service to improve motivation of staff for example the introduction of the

E-pin board which contained praise for colleagues as well as announcements such as engagements or staff completing challenges for charity.

Capable, compassionate and inclusive leaders

Score

1. Evidence shows significant shortfalls in the standard of care

The service did not have inclusive leaders at all levels who understood the context in which they delivered care, treatment and support, or who embodied the culture and values of their workforce and organisation. There was no stable leadership team with high unplanned turnover of leaders. Leaders did not always understand and manage the priorities and issues the service faced.

There was a clear management structure in place with defined lines of responsibility and accountability. However, there had been a high turnover of leadership staff within the service, including multiple changes to head of midwifery. Post inspection, the Deputy Director of Midwifery and the Director of Midwifery had left their post in November and December 2024 with new staff appointed to interim posts. The trust also informed us, post inspection, that the Divisional Clinical Director post will be vacant from March 2025. These changes resulted in a lack of assurance regarding consistent direction and improvement, potentially affecting care quality.

Leaders we spoke with were not always fully aware of the issues or current challenges faced by the service to deliver high quality care such as the gaps in the documentation of risk assessments completed and the telephone triage cover out of hours not meeting the recommendations made by the Royal College of Obstetricians and Gynaecologists. Leaders did not take appropriate action when risks were identified such as areas of poor practice identified in audit results or the risk of baby abduction.

The service was supported by maternity safety champions and non-executive directors. The majority of the staff we spoke with knew who their maternity safety champions were, however, some did not. We observed display posters of the maternity safety champions in the maternity

areas during inspection. Further work was needed to ensure all multidisciplinary staff were aware of their maternity safety champions and their role and purpose.

Service leaders supported staff to develop their skills, take on more senior roles and take part in leadership development programmes to aid career progression. However, not all staff from ethnic and minority backgrounds felt supported in their career progression.

We found that leaders were well respected, approachable, and supportive. Staff we spoke with told us they were well supported by their line managers, ward managers, and matrons. Staff reported good access, visibility, and support from the divisional and trust leadership team.

Leaders understood how health inequalities affected treatment and outcomes for women, birthing people, and babies from ethnic minority and disadvantaged groups in their local population. The service utilised the together project maternity passport to allow staff, women, birthing people, and their families to work together to plan care and help highlight possible areas of inequality to ensure these could be addressed. The service had a maternity strategy in place which focused on tackling health inequality, however, there was a lack of evidence to demonstrate how effective the strategy was being to reduce inequalities.

Staff and Leaders had considered and understood national maternity specific recommendations such as the Ockenden report.

Freedom to speak up

Score

2. Evidence shows some shortfalls in the standard of care

People did not always feel they could speak up and that their voice would be heard.

The maternity improvement advisor team worked with the trust to improve the service. The maternity improvement advisor November 2023 report was reviewed and highlighted that the Freedom to Speak Up (FTSU) guardian had clear oversight of the service, but staff felt there was a blame culture which inhibited freedom to speak up. There were clear policies, systems, and

processes in place to promote FTSU and there are clear lines of feedback from the FTSU guardian to the maternity directorate. The FTSU report was presented to the trust board regularly.

Majority of staff we spoke to during inspection, reported an improved speaking up culture and felt able to raise concerns without fear of reprisals from senior staff. The safety champion report from May 2024, however, highlighted that some staff feared reprisals if they raised concerns. Staff we spoke to were aware of how to raise concerns and knew who their FTSU guardian was. Staff reported senior leaders were open when incidents occurred. However, post inspection, we received whistleblowing concerns from staff around under qualified staffing, low staffing levels, bullying, staff feeling unheard, undervalued, staff discouraged to report incidents, staff feeling stressed, low morale, and staff not feeling listened to.

The 2024 Care Quality Commission (CQC) maternity survey highlighted that women and birthing people gave an average score of 8.0 out of 10 (10 being the highest) when asked about whether they felt concerns were taken seriously once raised. This score was about the same as other trusts.

Workforce equality, diversity and inclusion

Score

2. Evidence shows some shortfalls in the standard of care

The service did not always value diversity in their workforce. Staff did not always work towards an inclusive and fair culture by improving equality and equity for people who work for them.

Staff from black and ethnic minorities told us that there were limited development and career progression opportunities, however they reported that there was a range of continuing professional development courses available. The service did not have anything in place to improve the development or career progression opportunities for staff from black or ethnic minority backgrounds. However, they did identify learning opportunities following the 2024 staff survey which discuss training and coaching opportunities for all staff.

Acute services
Maternity

Leaders did not actively ensure staff and leaders were representative of the population of people using the service. The trust completed a WRES report which included information for the whole trust including maternity. The 2024 report showed that the population of staff from black and ethnic minorities continued to increase. However, those from black and ethnic minorities were underrepresented at executive level. A report by the maternity improvement advisors found that more could be done in relation to equal opportunities in the workplace.

The Workforce Disability Equality Standard (WDES) report was also published by the trust covering the whole trust, not just maternity. The 2024 report showed that the number of people employed by the trust who view themselves as having a disability had increased. However, there was a higher number of these staff working in lower, non-clinical roles. The report also highlighted that staff with disabilities were underrepresented at executive and board levels.

Evidence provided by the trust following the inspection highlighted that, not all staff felt respected, supported, and valued. This was evidenced by the results of the 2023 staff survey which showed that more could be done to ensure staff felt recognised and rewarded for the work that they did.

There were systems in place to review and improve the culture of the organisation in relation to equality, diversity, and inclusion. The trust had 4 equality networks that staff were actively involved in. This included black and ethnic minority, women, LGBTQ+ and disability and wellness networks. These groups aimed to improve disparities in the experiences of staff with protected equality characteristics or those from excluded or marginalised groups.

The trust had systems in place to ensure reasonable adjustments were made to support staff with disabilities to carry out their roles well. There were policies, processes, and systems in place to prevent and address bullying and harassment at all levels and for all staff. However, leaders did not always take action to prevent and address bullying and discrimination at all levels for all staff.

Acute services
Maternity

Governance, management and sustainability

Score

1. Evidence shows significant shortfalls in the standard of care

The service did not have clear responsibilities, roles, systems of accountability, or good governance. Staff did not act on the best information about risk, performance, and outcomes.

There have been significant changes in the maternity leadership structure post inspection with the Director of Midwifery, Head of Maternity Governance, and Deputy Director of Midwifery roles becoming vacant. These changes in leadership will lead to a period of adjustment and the service will need to work hard to ensure current plans to drive improvements are maintained.

The service was previously inspected by the Care Quality Commission (CQC) in 2023 and a breach of regulation 12 (safe care and treatment) of the Health and Social Care Act 2008 was identified. A further breach of regulation 12 of the Health and Social Care Act 2008 was identified following this inspection with similar concerns identified, such as medicines management and low completion rates for mandatory training and appraisals. This demonstrates that governance processes need to be improved to ensure that women, birthing people, and their babies are protected from harm.

Some staff we spoke with found it difficult to locate policies on the intranet. They reported some elements are outlined in other policies rather than being a stand-alone policy which made them difficult to locate. For example, staff were unable to locate the baby abduction policy, and they were unclear about what the process was. The baby abduction policy was later found by the inspection team within the safeguarding policy.

The policies we reviewed as part of the inspection were current and were available for staff to access on the trust's intranet page. However, there was a lack of structure which meant that guidelines were found in different areas of the intranet and out of date policies were still available alongside the current policies. There were two policies seen by inspectors covering anticoagulation and thrombosis, one of which was out of date.

Acute services
Maternity

We found instances where staff were not following local guidance. For example, trust guidance stated that ST Analyser (STAN) terminology should be used when analysing cardiotocography (CTG) traces however, on inspection, we found a variety of systems used when analysing and discussing traces. Following the inspection, the trust introduced a new electronic notes system with drop down boxes which standardises the terminology used by staff.

The maternity service was unable to evidence their compliance with the Maternity Incentive Scheme for the past 2 years (years 4 and 5 of the programme), meaning they were unable to prove that the care the service provided met the list of key safety recommendations set out.

The trust had a risk register in place; however it failed to identify risks observed during our inspection, including appraisal target compliance, out-of-hours medical cover, and action plans for out-of-range fridge temperature. The breastmilk fridge temperature action plan submitted by the trust following the inspection, stated that the breastmilk fridge should be placed on the risk register following the May to October 2024 audit which found that the fridge temperature was outside the recommended range 52.3% of the time. By not including these risks on the maternity risk register, service leaders and trust board did not have full oversight of the risks within the department and appropriate actions were being missed. This could put people who use the service at risk of harm.

However, the trust had a risk management policy in place with a flow chart detailing the processes in place. The risk register included risks such as shortage of midwifery staffing and the multiple patient record systems. The risk register was discussed at clinical governance meetings and the quality committee meetings.

Since the last inspection, the service had improved the governance structure to strengthen the governance and trust board oversight, however further improvements were required. We saw evidence of more rigorous evidence gathering and analysis since the last inspection and leaders had established clearer accountability by implementing a new group accountability framework. Since the last inspection, the service had further strengthened their governance structure following internal and external review around their governance structure and processes. Incident and risks were discussed at various governance meetings and information was cascaded to staff through newsletters, handovers, and emails. However, there was a significant number of incidents which had not been investigated in a timely manner.

Staff understood their role within the wider team and took responsibility for their actions. Staff we spoke with knew how to escalate issues to leaders, the clinical governance and divisional management teams, however appropriate action was not always taken. Information was then shared back to sub-committees and all staff. We saw examples of how this learning was shared, for example the 5 facts shared learning emails sent to staff.

Staff reported there had been a change in how incidents were reviewed and graded particularly post-partum haemorrhage (PPH) of more than 1.5 litres and third- or fourth-degree tear. There was regular dissemination of information to ensure staff were aware of learning from incidents. Staff described a multidisciplinary team approach which was open to all. This was an improvement from the last inspection. However, further work was needed for training of staff around the grading of harm when reporting incidents within the service. The trust was able to evidence that all PPH and tear grading errors were corrected to ensure incidents were graded appropriately. However, evidence seen following the inspection demonstrates that further improvements in incident categorisation and grading are needed to ensure all learning opportunities are explored.

There were systems and processes in place for workforce planning. The Safer Staffing Paper, presented to the trust board in October 2024, recognised the complex staffing challenges that the maternity service had experienced, for example high sickness rates. A trust review into staffing was reported in May 2021, using data from the Birthrate Plus tool, and a further review was being completed at the time of the inspection. The May 2021 staffing review recommended one midwife to 24 births. The Safer Staffing Paper written by the trust reported that the service had 1 midwife to 23 births to ensure the safety of women and birthing people.

Partnerships and communities

Score

2. Evidence shows some shortfalls in the standard of care

The service understood their duty to collaborate and work in partnership; however, the service did not consistently demonstrate how it was actively improving to meet the needs of the community it serves.

Acute services
Maternity

The 2023 Wandsworth Health Watch report found a significant number of people felt that their ethnicity had negatively influenced the maternity care they received. At the time of the inspection, there was a lack of evidence that the service was actively working to improve the experiences of black and ethnic minority women and birthing people. Although a maternity vision and strategy were developed which discussed the issues of health inequalities, there was insufficient evidence to show that the trust was actively working towards this and that progress was being monitored.

Information was available in a select number of languages, which didn't reflect all the languages spoken in the communities which use the service. There was ongoing work to ensure the service continued to meet the communication needs of its diverse population to ensure information was available in the top languages spoken by women and birthing people who accessed the service.

There were processes in place to collaborate with external stakeholders and agencies to ensure joined up care was delivered and to share any learning to ensure continuous improvement. The service also collaborated with external stakeholders and agencies, for example the Maternity and Newborn Safety Investigations (MNSI) team and maternity services within their network to drive improvements in the care received by women, birthing people and babies. Senior staff members attended a wide range of meetings with different agencies for example the Local Maternity Neonatal System (LMNS). During the inspection we met with members of the safeguarding team who described the range of external meetings they attended to ensure all vulnerable people who used the service got the support they needed.

Leaders worked collaboratively with the Maternal and Neonatal Voices Partnership (MNVP) to keep women and birthing people at the centre of care. The MNVP held regular meetings which were attended by representatives from the leadership, obstetric, and governance teams as well as service users. We reviewed minutes from the MNVP meetings and there was a clear structure for feedback to allow service users to share their birth experiences to drive improvement. The trust actively engaged with the MNVP "Whose Shoes?" event in May 2024. This event was attended by staff from the trust, representatives of the MNVP as well as service users. There was no evidence of improvements that have been made in response to this. An action plan was developed between the trust and MNVP, which included working to engage with those from black and ethnic minorities, however there was no evidence to demonstrate meaningful action was being taken. The MNVP were involved in co-production of guidelines, information leaflets,

and engaged with charity organisations to improve the service.

Senior leaders had engaged with the Black Lives Matter organisation, undertaken unconscious bias training, and scheduled a leadership away day to further delve into equality and unconscious bias. The Public Health Consultant Midwife was leading an antiracism campaign with the aim to improve the service culture and the experience of people who used the service.

The service was enrolled in the Maternity Safety Support Programme (MSSP), and the service worked collaboratively with their maternity improvement advisors to address the areas for improvement which had been identified and received feedback to ensure continuous improvement. Staff and leaders recognised they were on an improvement journey.

The women and birthing people we spoke to during the inspection reported feeling involved in the planning of their care. Staff and leaders were open and transparent when we spoke to them as part of the inspection.

Learning, improvement and innovation

Score

2. Evidence shows some shortfalls in the standard of care

The service focused on innovation across the organisation and local system however there was a lack of oversight and governance. Staff did not always actively contribute to safe, effective practice. The service has repeatedly been found to be in breach of the Health and Social Care Act (2008).

Whilst the service was completing regular audits, results repeatedly showed areas for improvements in practice however appropriate actions had not been taken. The Maternity Early Warning Score (MEOWS) audits and the triage waiting time audits repeatedly showed that documentation needed to be improved however sufficient action was not taken. We found evidence that there had been incidents which had been associated with poor documentation meaning women, birthing people, and their babies were exposed to risk. In addition, there were often delays in responding to incidents which impacted on the ability of the service to

Acute services
Maternity

learn and improve as a result of incidents.

Local guidelines deviated from recommendations made in national guidelines in a number of areas. For example, trust policy required hourly CTG review and two hourly “fresh eyes”, deviating from the 2022 National Institute for Health and Care Excellence (NICE) guideline of hourly “fresh eyes”. Although this deviation was risk assessed and agreed by the trust board, appropriate measures were not taken to ensure that women, birthing people, and babies were safe from harm. There was insufficient oversight from senior leaders.

The trust was continuing to work to address some of the concerns raised at the last inspection. The percentage of staff with an appraisal remained significantly below the trust target particularly for non-medical staff. Mandatory training compliance levels were also low. Following the inspection, we saw an action plan to improve compliance. The service was previously found to have breached regulation 12 (safe care and treatment) of the Health and Social Care Act 2008 following the last inspection. A further breach of regulation 12 of the Health and Social Care Act 2008 was identified following this inspection with similar concerns identified, for example concerns around safe staffing levels. Although some actions were taken following the previous inspection, learning was not fully embedded.

Staff told us about the multiple innovation projects that have occurred within the service. For example, they were the first NHS trust to introduce ASPRE (Aspirin for Evidence-based Pre-eclampsia Prevention) screening in 2020 which aimed to reduce perinatal mortality and reduce ethnic disparities. There were multiple quality improvement projects underway at the trust and there were quality improvement boards around the wards to feedback to staff. For example, the midwives had completed a thematic review of “baby falls” which occurred on the post-natal ward and aimed to improve safety by introducing “safe sleeping rounds” to ensure safe sleeping advice was being followed.

The service involved the MNVP and people who used the service in developing and evaluating improvement and innovation initiatives. The service shared improvements and learning following incidents with other trusts in their LMNS.

The service continued to drive improvement by increasing the range of training available for staff, for example providing ‘make birth better’ courses and the birth trauma resolution training course for staff.

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Maternity

The service had processes in place to ensure that learning occurred when things went wrong. From October 2023 to October 2024, PPH exceeding 1.5 litres surpassed the 4% target for 5 months. This meant that more women and birthing people experienced significant bleeding following the birth of their baby. The service revised guidance to reduce PPH rates reflecting that women and birthing people who had given birth before tend to have a shorter second stage of labour.

The service took an active role in research and was involved in several research projects. The service was generally able to demonstrate learning from incidents and staff were able to describe how the emergency procedure was reviewed in the antenatal clinic following an incident. However, further improvements were needed around documentation and risk assessments.

Acute services
Surgery

Surgery

Overall	Requires improvement
Safe	Requires improvement
Effective	Good
Caring	Good
Responsive	Requires improvement
Well-led	Requires improvement

Our view of the service

Date of assessment: 28 January to 29 January 2025

We carried out an unannounced comprehensive inspection of surgical services on 28 and 29 January 2025 due to aged ratings and concerns regarding Never Events within the service. We inspected all quality statements across the five key questions: safe, effective, caring, responsive and well-led.

During our inspection we visited the following wards: Benjamin Weir, Brodie, Florence Nightingale, Gray, Gunning, Keate, Vernon and Major Trauma Unit. We also visited a selection of theatres and recovery; the surgical admissions lounge, day surgery unit (DSU) and the Nye Bevan unit - surgical same day emergency care (SSDEC). We spoke with over 40 members of staff including nursing and medical staff of all grades, pharmacists, healthcare assistants, housekeeping staff, and managers. We spoke with over 30 patients and their relatives. We rated the service as requires improvement overall. The risks to people had not been consistently assessed and mitigated and we were not assured that learning from previous incidents had been embedded fully. Care was not always delivered in line with national clinical guidance, and evidence-based best practice. The service was not always easy to

Acute services
Surgery

access and patient at times experienced long waits in the hospital for their surgery. The governance systems in place had failed to identify and rectify some of the concerns found at this assessment. However, staff were kind, caring and compassionate. Staff and teams worked together well to deliver good person-centred care.

The service was in breach of the legal regulation relating to safe care and treatment. We were not assured that the service appropriately assessed risks to the health and safety of patients receiving care or treatment and did all that was reasonably practicable to mitigate any such risks. Audit data showed the service did not always complete Venous Thromboembolism risk assessments in a timely manner and did not always comply with National Safety Standards for Invasive Procedures. We have asked the provider for an action plan in response to the concerns found at this assessment.

People's experience of the service

We spoke with 38 patients, family and carers. Patients, family, and carers we spoke with were all positive about the staff treating them with warmth and kindness and providing effective care and treatment. People said communication with them was generally good. However, some people said they would have appreciated more information about their discharge or when they would be called for surgery more often. Records showed people were monitored frequently, and they felt staff were on hand if they needed them for help or support. People said they did not feel anxious about raising concerns and praised staff for their care and consideration.

Safe

Rating Requires improvement

We looked for evidence that safety was a priority for everyone, and leaders embedded a culture of openness and collaboration. We checked that people were safe and protected from bullying, harassment, avoidable harm, neglect, abuse, and discrimination. We also checked people's liberty was protected where this was in their best interests and in line with legislation.

At our last assessment we rated this key question good. At this assessment, the rating has changed to requires improvement. This meant people were not always kept safe and protected from avoidable harm.

The service was in breach of legal regulations in relation to delivery of safe care and treatment and

premises and equipment within the service.

Learning culture

Score

2. Evidence shows some shortfalls in the standard of care

The service had a positive culture of safety, based on openness and honesty. Staff listened to concerns about safety and investigated and reported safety events. However, lessons were not always learnt to continually identify and embed good practice.

Between January 2024 and December 2024, the trust reported 7 Never Events in surgery at St George's Hospital. These are serious, preventable patient safety incidents that should never occur, if the available preventative measures are implemented. These incidents were thoroughly investigated with outcomes and learning points identified. Leaders described processes to share learning following incidents, improve the culture within theatres and gave examples of changes to practice because of incidents; however, it is not yet clear whether the mechanisms that were put in place will be fully effective at preventing future incidents. Staff told us that because of previous incidents protected teaching time was introduced each month to upskill staff. Staff also told us about initiatives to prevent incidents, for example consenting and marking patients with the assistance of full-length mirrors to allow patients to also confirm the location for their surgery and to reduce the risk of wrong site operations. However, the number of recurrent never events provided limited reassurance that the service has appropriate preventative measures in place to protect people from harm and suggests learning from previous incidents is not fully embedded.

The service managed patient safety incidents and made efforts to learn from incidents throughout the service. Staff recognised and reported incidents appropriately and knew how to raise concerns using the hospital's electronic incident reporting system in line with the hospital's incident reporting policy. Managers were responsible for investigating incidents and sharing the learning.

Most staff we spoke with were able to explain the duty of candour. When things went wrong,

staff apologised and gave patients honest information and suitable support, in line with the hospital's Duty of Candour (Being Open) policy. We saw examples of thorough investigations of incidents being performed and where duty of candour had been applied.

Managers debriefed and supported staff after a serious incident. We reviewed a selection of surgical team meeting minutes and saw that incidents and learning was routinely discussed. There were arrangements for identifying, recording, and managing risks, issues, and mitigating actions. We saw evidence that the service regularly reviewed safety, performance and risk through the Divisional Risk Review group and Divisional Governance Groups which reported key quality, safety and performance metrics to the trust's patient safety and quality group. We saw evidence that the service identified some risks through different sources such as audits, incidents, patient and staff feedback, and risk assessments. However, we found that not all risks identified within our inspection were identified and recorded on the service risk register, this meant that we could not be assured that all risks were managed appropriately such as poor audit compliance and low mandatory training compliance.

Safe systems, pathways and transitions

Score

3. Evidence shows a good standard of care

The service worked with people and healthcare partners to establish and maintain safe systems of care, in which safety was managed or monitored. Staff made sure there was continuity of care, including when people moved between different services.

We received positive feedback from staff regarding communication and multidisciplinary team working. We saw that the service worked collaboratively and in a joined-up approach regarding safety that involved patients along with staff and other partners. We observed that surgeons attend to inform patients of any on the day cancellations. Care and support were organised with patients and partners to ensure continuity; staff told us that for trauma surgery patients repatriation pathways to local pathways were performed quickly and are typically accepted within 24 hours.

As part of handover before shift changes, the nurse in charge read a safety briefing to the team.

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This was a briefing where staff were made aware of patients who were high risk such as those who were unstable, susceptible to falls or had a high national early warning scores (NEWS2) score. In addition, patients with known safety risks were highlighted so that staff allocations for the day were safe and appropriate.

Safeguarding

Score

3. Evidence shows a good standard of care

The service worked with people and healthcare partners to understand what being safe meant to them and the best way to achieve that. Staff concentrated on improving people's lives while protecting their right to live in safety, free from bullying, harassment, abuse, discrimination, avoidable harm, and neglect. The service shared concerns quickly and appropriately.

We reviewed the service's safeguarding adults and children policy. This was in date and available on the hospital intranet system. The policy detailed individual responsibilities, processes for reporting and escalation of concerns and who to contact.

All clinical staff were trained to level 2 and 3 safeguarding adults and level 2 and 3 safeguarding children. The service's compliance rates in safeguarding training exceeded the hospital's target of 85% for all staff groups.

Staff we spoke with could demonstrate a good understanding of safeguarding vulnerable adults and children and were able to articulate different forms of abuse such as domestic violence and female genital mutilation (FGM). Staff knew how to escalate concerns to their manager and safeguarding lead. We saw safeguarding posters around the wards and patient areas with information on how to raise safeguarding concerns.

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Involving people to manage risks

Score

2. Evidence shows some shortfalls in the standard of care

The service did not always work well with people to understand and manage risks. Staff did not always provide care to meet people's needs that was safe, supportive, and enabled people to do the things that mattered to them.

Monthly audits were undertaken to monitor Venous Thromboembolism (VTE) risk assessment completion and showed assessments were not always completed in a timely manner. Audit data we reviewed between October and December 2024 showed that improvement was required in all surgical wards to meet trust compliance targets of VTE assessed within 14 hours of admission. We saw a reminder to governance leads to complete VTE assessment for admitted patients was included as an action on the Divisional Governance Group action log in September 2024. However, the audit data did not show an improving trend, and we could not be assured that effective action was being taken to improve compliance.

We reviewed audit data for Local Safety Standards for Invasive Procedures (LocSSIPs) and National Safety Standards for Invasive Procedures (NatSSIPs 2) and found varied compliance in completion. Between July to September 2024, we found that of 21 specialties, 6 had below 95% compliance in overall surgical checklist completion and 7 had below 100% compliance. However, during our inspection we observed that the service used the World Health Organisation (WHO) five steps to safer surgery checklist effectively and saw that completion of the WHO checklist was consultant led and performed in line with national guidelines.

Staff informed us that they carried out risk assessments for patients having elective surgery preadmission in line with national guidance. The service used electronic risk assessments. The service had policies in place to improve care, for example suspected sepsis management pathways. Staff reviewed the risk assessments with the patient, which enabled appropriate provisions to be identified and put in place. Staff completed and updated risk assessments including manual handling, pain, water-low score, pressure ulcers, malnutrition during admission. Staff had access to translation services for patients whose first language was not

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English. From the records we reviewed we saw evidence that risk assessments had been completed with patients.

Staff were aware of and understood escalation protocols for deteriorating patients and the use of NEWS2. We checked patients' NEWS2 charts and found them to be correctly filled in. We also saw that appropriate action, such as increasing the frequency of observations in line with increasing scores was done at the right time. Staff understood the process for managing medical emergencies and the service had appropriate resuscitation equipment available if required.

People we spoke with felt able to give their views and we observed staff being educated about the roll out of Martha's rule across the hospital, which will empower patients, families, carers, and staff to ensure that their concerns are listened to and acted upon.

Safe environments

Score

2. Evidence shows some shortfalls in the standard of care

The service did not always detect and control potential risks in the care environment. Staff did not always make sure equipment, facilities and technology supported the delivery of safe care.

During the inspection we visited several theatres and 8 surgical wards, looked at the environment on each of them and randomly sampled the equipment in use in these areas. Limitations on space and storage of equipment in the corridors on some wards was previously assessed as posing a risk to evacuation in the event of fire. We saw that action plans available within fire risk assessments, however these actions were not signed or dated. During our inspection we also observed that some escape routes remained obstructed by equipment, indicating that the risk had not been addressed and appropriate action had not been taken to ensure safe escape routes in the event of a fire.

However, despite limited space within some wards, SSDEC and the waiting area of the SAL. We

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saw that storerooms were well-ordered and well stocked. Dirty utility rooms were clean and substances hazardous to health were well managed. The service generally had suitable premises and equipment and maintained them well and access to wards and theatres was by swipe card access locked doors.

Emergency trolleys were easily available within the service. We checked the emergency trolleys in the SAL, wards and theatre areas and found that they were secured with a plastic snap lock, so it was clear if someone had accessed the resuscitation equipment. Equipment in emergency trolleys was checked routinely. Record check sheets showed that checks had been signed to confirm compliance with national standards. We also checked various consumables and found they were sealed and in date.

Equipment we checked such as defibrillators and suction machines had up to date electrical safety tests. Staff kept substances which met the Control of Substances Hazardous to Health (COSHH) regulations in a locked cupboard in a room accessible by staff only. We saw these were stored appropriately.

Safe and effective staffing

Score

2. Evidence shows some shortfalls in the standard of care

Staff worked together well to provide safe care that met people's individual needs and made sure staff received effective support, supervision and development. However, the service did not always make sure there were enough qualified, skilled and experienced staff.

Staff received training appropriate to their role. New staff to the trust received an induction, which included mandatory training; the divisions compliance for this was 90%, which exceeded the trust target of 85%. The compliance rate for information governance mandatory training was 91%, which fell short of the trust target of 95% for this module. The topic with the poorest compliance rate of 61% was Resuscitation Immediate Life Support (ILS). Our review of evidence did not demonstrate that there was appropriate monitoring and mechanisms to ensure there

was always sufficient staff available with up-to-date ILS training. We saw that low ILS compliance was included in the service workforce report as a non-compliant challenge and improving mandatory training compliance was discussed in Divisional Governance Group meetings, however this was not reflected on the service risk register or governance action log to provide assurance that staff with appropriate resuscitation training were available to keep people safe. The trust data showed the worst compliance within the service for mandatory training was amongst medical staff who achieved 76% compliance. However, overall compliance with Advanced Life Support was 88% and Basic Life support was 85%. Mandatory training modules were a mixture of face to face and online training. Modules included but were not limited to, safeguarding adults and children, equality and diversity, Mental Capacity Act and the Deprivation of Liberty Safeguards, infection control, immediate life support, advanced life support and basic life support.

The service generally had enough medical staff with the right qualifications to keep patients safe, however leaders also described vacancies within the plastic surgery specialty. We saw that a shortage of neurology and cardiac anaesthetic consultants to deliver elective recovery and emergency cover was identified as an extreme risk on the service risk register, however we did not see evidence of any action taken to address this and it was not included in the divisional risk report. Nursing staff told us they could access medical staff when needed. Physician associates formed part of the team and were utilised well and appropriately throughout the service. There was a safe provision of physiotherapy, occupational therapy, and psychologist input where necessary for patients following surgery.

Staffing levels were reviewed and planned in a timely manner by ward managers. Staff generally reported good levels of staffing and use of bank staffing where there were shortfalls, with low to no use of agency staffing. Although staff in the SAL told us that there was not always sufficient staffing on the weekend and they felt that at times due to the complexity and number of patients, additional staff were needed.

During our inspection we saw there were appropriate staffing levels and skill mix allocated to theatres, recovery, and the surgical wards. The actual staffing levels largely met the planned levels.

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Infection prevention and control

Score

3. Evidence shows a good standard of care

The service assessed and managed the risk of infection. Staff detected and controlled the risk of it spreading and shared concerns with appropriate agencies promptly.

All the areas within the service we inspected were clean and had suitable furnishings, which were well-maintained. Cleaning records were up-to-date and demonstrated that all areas were cleaned regularly. Data requested showed that there was between 98% and 99.5% compliance against cleaning audits between October and December 2024, the trust target was 100%. Theatre areas were visibly clean. There was access to hand sanitisers throughout the hospital and good hand hygiene was promoted. Audits of staff hand hygiene consistently showed that the service exceeded the trust target of 95% compliance between October and December 2024.

We reviewed the infection control policy which was in date and accessible on the hospital intranet. The policy was comprehensive, and staff could easily access it. Staff had support from the site IPC team and medical microbiology to manage concerns, including over the weekend.

The service completed monthly infection control audits and monitored numbers of healthcare associated infections and surgical site infections (SSI). In the 12 months prior to the inspection, the service reported 28 healthcare associated infections. The service reported 6 cases of MSSA infection against a trust target of 0. The most recent SSI surveillance data showed the hospital was identified as an outlier nationally in inpatient and readmission SSI risk for reduction of long bone fractures, however between October and December 2024, the trust did not identify any SSIs in reduction of long bone fracture procedures. We saw evidence that the service was establishing a Task and Finish Group to review policies and practices, and the IPC team was reviewing the surgical site surveillance procedure to address this. Whilst we saw this was being addressed at board level, we did not see evidence of monitoring by the service. We did not see evidence of SSIs discussed in Divisional Governance Group minutes, included in directorate performance reviews, or identified on the service risk register.

There was easy access to personal protective equipment (PPE) such as gloves and aprons. Staff

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followed IPC principles and were bare below the elbow. We observed theatre staff wearing appropriate PPE in theatres. If a patient was infectious, a sign was put on the door of their room to indicate this to staff and visitors.

Waste management was handled in line with national standards, with different colour coding for general waste and clinical waste. All clinical bins were seen to be operated with pedal lids and were not overfilled. Most sharps bins were found to be correctly labelled and not filled above the maximum fill line, although temporary closure devices were not always used.

Medicines optimisation

Score

2. Evidence shows some shortfalls in the standard of care

The service did not always make sure that medicines and treatments were safe and met people's needs, capacities, and preferences. Staff did not always involve people in planning.

We saw from patient records there were some missed administration and delayed medicine doses. However, the service had a process for identifying and supporting people requiring time critical medicines and there was an improvement observed since our inspections of maternity in October 2024 and urgent and emergency care in November 2024. Staff generally provided patients with information about their medicines. Patients told us they received information about newly prescribed medicines and were given the opportunity to ask questions about them, however one patient commented that they were not always kept informed of changes in their medications. Pain audits undertaken from the last quarter showed mixed compliance with completion of pain scores. However, patient records we reviewed showed that patients' level of pain was assessed as part of their observation records. Most patients we spoke with told us their pain had been managed appropriately, and they generally received pain relief in a timely manner. We saw in records that patients had been prescribed and administered pain relief, and this had been recorded accurately.

Staff told us sometimes time critical medicines would not be administered on time as

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prescribed due to medicines not being available on the ward. Staff were encouraged to report medicine related incidents and learning from incidents was disseminated across the group. We saw evidence that medication incidents and learning was discussed at team meetings. Staff told us that they felt fully supported by the pharmacy team. Pharmacy staff were readily available in hours and out of hours, and the pharmacy on call service support was easily accessible.

We observed in the day surgery unit that staff would prepare syringes for medication for use during cases before the start of the operating list. We found that it was not always clear when they had been prepared as they were not labelled with the date and time of preparation. We highlighted the need to strengthen governance around the preparation of syringes in theatres in advance of cases to improve safety and prevent infection at the end of our inspection.

Medicines were generally stored safely and securely, and access was limited to authorised staff, however, we found on one ward that a cupboard was faulty and did not always lock. Staff told us they had previously raised concerns about unlocked fridges and medicines cupboards in anaesthetic and post anaesthetic rooms that were not in use during daily theatre lists. The provider told us a risk assessment was in place which stated anaesthetic drug cupboards could be left open during daily theatre lists; however, we emphasised the need for the trust to ensure that medicines are secure when theatres are not in use.

The service had a process for obtaining relevant patient history for medicines reconciliation on admission to the service. The trust had an electronic prescribing and medicines administration (EPMA) system in place.

Staff received training in medicines management and their competency was regularly assessed. Pharmacy staff told us they offered additional training for more complex areas of medicines management.

Controlled drugs were stored in line with legislation and records of administration were mostly completed in line with guidance. The most recent controlled drug audits across the service showed compliance above 90% for theatres, wards, and SSDEC.

Effective

Rating Good

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We looked for evidence that people had the best possible outcomes because their needs were assessed. We checked that people's care, support, and treatment reflected these needs and any protected equality characteristics, ensuring people were at the centre of their care. We also looked for evidence that leaders instilled a continuous culture of improvement.

At our last assessment we rated this key question good. At this assessment, the rating has remained good. This meant people's outcomes were good, and people's feedback confirmed this.

Assessing needs

Score

3. Evidence shows a good standard of care

The service made sure people's care and treatment was effective by assessing and reviewing their health, care, wellbeing, and communication needs with them.

People were involved in the assessment of their needs. People we spoke with told us their pain had been managed appropriately, and they generally received pain relief in a timely manner. There were appropriate arrangements to ensure patients' nutrition and hydration needs were met on the wards. The service used evidence-based tools to screen for malnutrition. We saw in patient records a malnutrition universal screening tool (MUST) tool was used for assessing patients' nutrition.

People's communication needs were assessed and met. Assessments considered the person's health, care, wellbeing, and communication needs, to enable them to receive care or treatment that has the best possible outcomes. People's needs were assessed using a range of assessment tools to ensure their needs were reflected and understood.

The trust had implemented the Oliver McGowan mandatory training on learning disability and autism. Staff we spoke with demonstrated a good understanding of how to assess the needs of autistic people, people with a learning disability and dementia. As part of handover before shift changes, nurses were made aware of patient's individual and holistic needs.

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Surgery

Delivering evidence-based care and treatment

Score

2. Evidence shows some shortfalls in the standard of care

The service planned and delivered people's care and treatment with them, including what was important and mattered to them. However, staff did not always follow current evidence-based good practice and standards.

We found some instances where audits such as VTE assessment completion and surgical safety checklist completions identified policies were not being followed. However, the trust's intranet contained a comprehensive range of policies and standard operating procedures which reflected evidence-based practice and standards practice. We reviewed a random sample of policies during our assessment and observed that polices were up to date and in line with national guidance.

Patients sometimes experienced long waiting times in the surgical admissions lounge. Staff told us that patient arrivals should be staggered but this did not always happen and there have been occasions when patients wait up to 12 hours; this meant that fasting times were not always minimised. In the SAL we observed that patient's hydration needs were not always met and did not always comply with guidance. On the first day of our inspection, we saw signage telling patients they could drink up to an hour before surgery, but several patients told us they had not had anything to drink since the previous night. On the second day of the inspection patient attendance was staggered in the SAL and there were less than 10 people waiting, we observed that all patients were given a bottle of water on arrival. We reviewed preoperative fasting data for the service and found that between January and December 2024 the average fasting time including fluids was approximately 4.5 hours, national guidelines state people may drink clear fluids until 2 hours before their operation. However, we observed that on surgical wards staff gave patients enough food and drink to meet their needs and improve their health.

We saw there was a formal annual clinical audit programme to evidence performance monitoring, quality measures or patient outcomes relating to surgical services. There was a corporate audit plan, which included national audits, which the trust was submitting data to, for example, the National Emergency Laparotomy Audit (NELA), National Joint Registry (NJR),

and the National Lung Cancer Audit (NLCA).

How staff, teams and services work together

Score

3. Evidence shows a good standard of care

The service worked well across teams and services to support people. Staff made sure people only needed to tell their story once by sharing their assessment of needs when people moved between different services.

We saw evidence of good multidisciplinary team (MDT) working. When people were due to move between services, all necessary staff, teams, and services were involved in assessing their needs to maintain continuity of care.

Staff informed us they worked well with other staff. Nursing staff told us medical staff were available for advice and support including overnight and on weekends and there were good working relationships between colleagues. Staff told us that they felt supported by pharmacy staff, and they were accessible out of hours via the pharmacy on call service. The outreach team were described as approachable and quick to attend. Theatre teams were observed to work well together for the safety of the patients. Recovery staff told us about the use of a secure messaging app that was used to improve communication with other teams and escalate problems to matrons and management.

Staff held daily handovers in the morning and evening. We observed the morning handover on the second day of our assessment, staff discussed patient care, concerns, staffing, and capacity. Staff also told us that medical teams worked well together across services to manage patient care, for example staff told us trauma and orthopaedic surgeons and orthopaedic geriatricians routinely performed ward rounds together to discuss care as a team.

We observed multidisciplinary approaches to planning care for patients. Patient records demonstrated input from the full clinical team of doctors, nurses, and allied health professionals. Regular team meetings take place to review updates for the service.

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Plans for transition, referral and discharge considered people's individual needs, circumstances, ongoing care arrangements and expected outcomes. Staff told us relevant teams, services and organisations were informed when people are discharged from the service. However, data for the service showed that between October and December 2024 only 53% of discharge summaries was sent to GPs within 24 hours. This was included in the service Divisional Quality and Safety Report, and showed leaders were seeking to review the data on discharge summaries sent to GPs within 24 hours data for each specialty to be followed up by care group leads.

Supporting people to live healthier lives

Score

3. Evidence shows a good standard of care

The service supported people to manage their health and wellbeing to maximise their independence, choice, and control. The service supported people to live healthier lives and where possible, reduce their future needs for care and support.

Health promotion was part of care provided to patients. Staff worked collaboratively to assess all aspects of general health, and to give advice and support to promote healthy lifestyles.

The service delivered preoperative information sessions for patients due to undergo major inpatient surgery, sessions provided dietary, physical, and psychological advice to support health promotion prior to surgery. People's health was assessed at pre-assessment and staff could make referrals relevant to the patients' needs e.g. smoking cessation at any point in the pathway. On discharge patients were signposted and given advice on where and when to seek help.

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Surgery

Monitoring and improving outcomes

Score

2. Evidence shows some shortfalls in the standard of care

The service routinely monitored people's care and treatment to continuously improve it. However, staff did not always ensure that outcomes were positive and consistent, or that they met both clinical expectations and the expectations of people themselves.

We were not assured that sufficient action was taken to improve outcomes in response to audit findings. We found that action to improve outcomes in VTE risk assessment compliance was not taken and audits showed a declining trend in compliance. VTE risk assessment compliance was 67% between April and June 2024, this reduced to 66.1% between July and September 2024 and 65% between October and December 2024. We also found that audits of compliance with surgical safety checklists did not feature action plans or learning points despite demonstrating areas of low compliance.

Metrics for anaesthesia and perioperative medicine as part of the Getting It Right First Time (GIRFT) programme showed that service performance did not comply with the GIRFT standard in most metrics. The service was also an outlier for wrong skin lesion surgery between April 2023 and March 2024; however, we saw evidence of improvements being implemented to address this and prevent future incidents. However, there were effective approaches to monitor people's care, treatment and their outcomes. Audit schedules were set up for 2024-2025 to assess a wide range of patient care.

Most of the national patient outcome data we reviewed was within national expectations. National patient outcome data showed that the hospital was an outlier in hip revision surgery rates, however management of the service explained that as St George's is a tertiary centre for specialist hip and knee procedures and as per an established pathway, they complete the most complex cases which means their outcomes are not comparative with other local services.

Acute services
Surgery

Consent to care and treatment

Score

3. Evidence shows a good standard of care

The service told people about their rights around consent and respected these when delivering person-centred care and treatment.

Written consent was sought from patients. We looked at completed consent forms in the patient records we reviewed; we saw that they were completed correctly and were signed in the correct places with documented risks to surgery.

People told us staff explained care and treatment options in a way they understood and gained verbal consent before carrying out assessments.

People's capacity and ability to consent was considered, and they, or a person lawfully acting on their behalf, were involved in planning, managing, and reviewing their care and treatment. Staff generally showed understanding of when and how to assess whether a patient had the capacity to make decisions about their care, and the Mental Capacity Act (MCA) 2005. Staff received training on the Mental Capacity Act and Deprivation of Liberty Safeguards, division compliance for level 1 of this module was compliant with the trust target but level 2 was 79% and therefore below the trust target of 85%.

Staff followed the trust policy and procedures when a patient could not give consent. We reviewed the consent policy, which was appropriate and next due for a review in December 2026.

People were supported to make their wishes about cardiopulmonary resuscitation known. We saw evidence that decisions around do not attempt cardiopulmonary resuscitation (DNACPR) were captured in patients' electronic care records.

Caring

Rating Good

We looked for evidence that people were always treated with kindness, empathy, and compassion. We

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checked that people's privacy and dignity was respected, that they understood that they and their experience of how they were treated and supported mattered. We also looked for evidence that every effort was made to take people's wishes into account and respect their choices, to achieve the best possible outcomes for them.

At our last assessment we rated this key question good. At this assessment, the rating has remained good. This meant people felt well-supported, cared for and were treated with dignity and respect.

Kindness, compassion and dignity

Score

3. Evidence shows a good standard of care

The service treated people with kindness, empathy and compassion and respected their privacy and dignity. We observed staff treated colleagues from other organisations with kindness and respect.

Feedback from patients we spoke with was positive and commented that they "were looked after pretty well." Relatives were happy with the communication and information given to them from staff and commented that staff "have gone above and beyond." We saw staff working to improve the experience of patients during their stay. Friends and family test results were often over 95% for the ward areas.

There was a strong, visible person-centred culture. All staff we spoke with were motivated to deliver care that is kind and promotes people's dignity. Staff understood and respected the personal, cultural, social, and religious needs of people using the services.

We saw staff explaining things to patients in a way they could understand. Staff involved patients and those close to them in decisions about their care and treatment. Patient's family and carers told us visiting times were flexible. Staff listened and acted upon people's needs including contacting family or friends. Staff locked patient records when they moved away from computer screens to maintain confidentiality.

We observed that there was a culture of kindness and respect between colleagues including

colleagues from other organisations. Staff collaborated with other colleagues to provide support for people including support with emotional wellbeing.

Treating people as individuals

Score

2. Evidence shows some shortfalls in the standard of care

The service did not always treat people as individuals or make sure people's care, support and treatment met people's needs and preferences. Staff did not always take account of people's strengths, abilities, aspirations, culture and unique backgrounds and protected characteristics.

People's communication needs were not always met to enable them to engage in their care and treatment and to support them to maximise their experience and outcomes. One patient's feedback shared with us showed the service did not account for their communications needs and they repeatedly received letters for telephone appointments, despite having no verbal speech.

Most people we spoke with told us the service took account of their individual needs and preferences. We saw in patient records that people's needs and preferences were reflected in plans for patient care. We observed that staff treated people as individuals, considering any relevant protected equality characteristics. People's personal, cultural, social, and religious needs were understood and met. The service had systems such as translation services to support communication and choice. We observed some posters on the walls of wards that had been translated into other languages.

Independence, choice and control

Score

3. Evidence shows a good standard of care

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The service promoted people's independence, so people knew their rights and had choice and control over their own care, treatment, and wellbeing.

People were supported to have choice and control in their own care and to make decisions about their care, treatment, and wellbeing. Patients were given a choice of food and drink to meet their cultural and religious preferences. People felt they were provided with adequate information relating to their procedures to allow them to make an informed choice. People told us they were offered chaperones.

People were supported to maintain relationships and networks that are important to them. People had access to their friends and family while they were using the service. There was a range of appropriate equipment to support and maximise people's independence and outcomes from care and treatment.

Responding to people's immediate needs

Score

3. Evidence shows a good standard of care

The service listened to and understood people's needs, views and wishes. Staff responded to people's needs in the moment and acted to minimise any discomfort, concern, or distress.

The service took account of patients' individual needs, preferences, and comfort. Patient records detailed people's additional needs such as mobility. Staff made reasonable adjustments to help patients access services.

People felt that staff would respond to their needs quickly and efficiently, especially if they were in pain. Patients also told us that there was a dedicated pain clinical nurse specialist (CNS) who could review them and help with pain management.

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Workforce wellbeing and enablement

Score

3. Evidence shows a good standard of care

The service cared about and promoted the wellbeing of their staff and supported and enabled staff to always deliver person-centred care.

Staff we spoke with were positive about their work and felt they were supported well. They told us managers were approachable, supportive and were visible and regularly visit clinical areas; throughout the inspection we observed managers visiting clinical areas and checking in with staff throughout the day.

The provider tried to recognise and meet the wellbeing needs of staff. These included providing the necessary resources and facilities for safe working, such as regular breaks. We observed that space was an issue and there was limited dedicated staff rest areas.

Staff have health and wellbeing offers, including staff networks, wellness action plans, and flexible working. The trust had staff recognition programmes such as employee of the month, we observed a member of theatre staff who had been appointed employee of the month and gifted a bouquet of flowers. Other team recognition awards included department accreditations and awards, with several departments and wards within the surgical service receiving gold and platinum awards. Such initiatives allow for recognition of both teams and individuals through nominations and good performance and staff we spoke to were proud of these achievements.

The health and wellbeing data from the national 2023 NHS Staff Survey showed a mixed picture, 47% of staff in the division agreed that the organisation takes positive action on health and well-being, moderately lower than the trust score of 50%. We saw evidence that leadership within the division had developed priorities for responding to staff survey data. One of the priorities identified was 'positivity and celebrating best practice' which included work to provide greater support for staff. We did not see timescales for the outlined priorities.

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Responsive

Rating Requires improvement

We looked for evidence that people and communities were always at the centre of how care was planned and delivered. We checked that the health and care needs of people and communities were understood, and they were actively involved in planning care that met these needs. We also looked for evidence that people could access care in ways that met their personal circumstances and protected equality characteristics.

At our last assessment we rated this key question requires improvement. At this assessment, the rating has remained requires improvement. This meant people's needs were not always met through good organisation and delivery.

Person-centred care

Score

3. Evidence shows a good standard of care

The service made sure people were at the centre of their care and treatment choices and they decided, in partnership with people, how to respond to any relevant changes in people's needs.

People could receive the most appropriate care and treatment for them, including through the provision of a post anaesthetic care unit (PACU), a dedicated 4 bedded cardiac HDU and a neurosurgery rehabilitation unit.

Staff were focused on delivering patient centred care and respected the individual needs of each patient. Patients were treated as individuals with treatment and care being offered in a flexible way and tailored to meet their individual needs. Staff could explain the additional support available for people with learning disabilities and dementia.

Staff understood how to meet the information and communication needs of patients with a disability. The patient records that we reviewed reflected that individual needs were assessed, and care planning was informed by this.

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The service had access to an interpreting service for patients whose first language was not English and sign language interpreters if needed. This was available by telephone and face to face. We observed some posters on walls in the wards that had been translated into other languages.

The hospital chaplaincy service was multi-faith and provided spiritual support 24-hours a day, seven days a week. Patients were given a choice of food and drink to meet their cultural and religious preferences.

Care provision, integration and continuity

Score

2. Evidence shows some shortfalls in the standard of care

The service understood the diverse health and care needs of people and their local communities; however, care was not always joined-up, flexible or supportive of choice and continuity.

Staff told us that there were not enough neurosurgery beds available, and that the neurosurgery rehabilitation unit was difficult to access due to the limited capacity. Staff also told us that patients sometimes stay overnight in recovery and the day surgery unit due to lack of capacity on wards and in the Intensive Therapy Unit (ITU), we saw this reflected on the service risk register. Leaders told us this negatively impacted their ability to increase capacity and theatre utilisation in the day surgery unit.

Leaders told us that theatre utilisation for inpatients was approximately 78%. Staff also told us that in some specialties, such as vascular surgery, there was not enough theatre capacity to manage elective cases, as there was only one vascular hybrid theatre. Leaders described ongoing work to monitor and improve theatre utilisation such as addressing issues that affect utilisation through regular specialty level theatre user group meetings and work to obtain new ITU beds in the next year.

Managers planned and organised services, so they met the needs of the local population

working in collaboration with system partners to analyse what people's needs were and how they could best meet them. We saw evidence of the service being evaluated with consideration of health inequalities, such as audits and research projects,

People's care and treatment was delivered in a way that met their assessed needs and was generally coordinated and responsive. The service had an established SSDEC with plans to increase capacity and utilisation improving flow from the emergency department. The service had also introduced patient-initiated follow up, which allows patients and carers who agree to this pathway to initiate their follow up appointments as and when required.

Providing information

Score

3. Evidence shows a good standard of care

The service supplied appropriate, accurate and up-to-date information in formats that were tailored to individual needs.

Most people's individual needs to have information in an accessible way were identified, recorded, and shared. These needs were met and reviewed to support their care and treatment in line with the Accessible Information Standard. People could expect information to be tailored to their individual needs. This included making reasonable adjustments for disabled people, interpreting and translation for people who did not speak English as a first language and for deaf people who use British Sign Language. People who have difficulty with reading, writing, or using digital services were supported with accessible information.

Staff made reasonable adjustments to help patients access services. There was a 24-hour telephone translation service available for patients and carers and in person interpreters or signers could also be requested.

We observed staff providing patients with appropriate information about their care and saw this reflected in patient records. Patients told us that communication with them was generally good, but some people said they would have appreciated more information about their discharge or when they would be called for surgery more often. The service also operated a

programme called 'Get Set 4 Surgery' providing information to help patients prepare for having an operation and understand what would happen at each stage of their journey.

Listening to and involving people

Score

3. Evidence shows a good standard of care

The service made it easy for people to share feedback and ideas, or raise complaints about their care, treatment, and support. Staff involved people in decisions about their care and told them what had changed as a result.

People we asked knew how to give feedback about their experiences of care and support including how to raise any concerns or issues. The service clearly displayed information about how to raise a concern in patient areas. We saw information on how to raise a complaint displayed around the service and ward areas.

Staff understood how to handle complaints, could provide examples of feedback from complaints and examples of changes made because of complaints. At the time of the inspection the complaints policy was out of date but has since been reviewed and reissued.

We were given examples of action that had been taken following a complaint. The service treated concerns and complaints seriously, investigated them and shared lessons learned with all staff. The main theme from the complaints was around delays. Friends and family test responses for the month of December 2024 showed 98% of patients felt the care they received was good. Positive feedback included praise for staff knowledge, care, and helpfulness.

Equity in access

Score

2. Evidence shows some shortfalls in the standard of care

Acute services
Surgery

The service did not always make sure that people could access the care, support, and treatment they needed when they needed it.

The trusts performance in referral to treatment times was mostly in line with the England average, however, both the trust performance and the England average were below national standards. Some specialties including neurosurgery were below the national average, figures for January 2025 showed 46% of patients on a neurosurgical pathway had treatment within 18 weeks versus the England average of 60%. Leaders described ongoing work to improve referral to treatment times. This included work to implement additional operating lists, introducing Saturday cover, and transferring lists to Queen Mary Hospital, Roehampton to increase capacity. Reports to Healthwatch showed people experienced delays to treatment which sometimes caused them significant distress, anxiety and in some instances resulted in people opting for private treatment but reported good care and treatment. One person we spoke to told us their surgery had been cancelled 4 times in 2 years.

Patients often experienced long waits in the SSDEC and SAL, waiting times in the SSDEC did not meet national targets. We observed that the waiting area in the SAL on the first day of the inspection was full, with some patients telling us they were waiting for over 6 hours. Staff told us patient arrivals should be staggered but this did not always happen.

Staff told us medical outliers on surgical wards negatively impacted surgical patient flow. However, staff also told us that systems in place for reviewing medical outlier patients were effective.

Managers worked to keep the number of cancelled appointments and operations to a minimum. Between 1 February 2024 and 31 January 2025, 3% of elective cases were cancelled on the same day as the scheduled procedure. The reasons for these cancellations included the patient not attending or the patient being unwell. The hospitals policy stated that cancelled patients should be rescheduled within 28 days. We asked to review data on this from the last 12 months, but this was not provided.

Managers and staff worked to make sure patients did not stay longer than they needed to. The service offered either day-case or inpatient surgical procedures. Day-case surgery did not require an overnight hospital stay. Staff told us that discharges were often delayed on the wards, and we observed that some patients who were ready for discharge were waiting for

discharge summaries and medications. We saw evidence that work was being done to improve flow such as implementing overnight stays in the discharge lounge for patients who are medically fit for discharge.

Managers monitored and took action to minimise missed appointments. For example, implementing a quality improvement proposal for reducing missed appointments in orthopaedic clinics.

Equity in experiences and outcomes

Score

2. Evidence shows some shortfalls in the standard of care

Staff and leaders listened to information about people who are most likely to experience inequality in experience or outcomes, however they did not always act on this information. This meant people's care was not always tailored in response to this.

We saw evidence that health inequalities were being considered throughout the service, however it was not always clear what action was being taken to address recommendations. For example, we saw that an assessment of health inequalities in medical oncology appointments found Black, Asian, younger, male patients and those in deprived areas are less likely to attend appointments. Recommendations had been identified to reduce DNA rates such as transportation assistance and community engagement and outreach; however, we did not see evidence that the recommendations had been implemented or were being actioned. We observed that people's care, treatment and support promoted equality and protected their rights. There was no indication that people experience any inequalities in experience and outcomes.

We saw evidence that feedback on patient experiences was taken seriously and changes to practice were considered and implemented as a result to remove barriers to care and improve people's experience.

Acute services
Surgery

Planning for the future

Score

3. Evidence shows a good standard of care

People were supported to plan for important life changes, so they could have enough time to make informed decisions about their future, including at the end of their life.

People are supported to make informed choices about their care and plan their future care while they have the capacity to do so. When people want to express their wishes about cardiopulmonary resuscitation, they were supported to do so and can change their mind if they wish. Staff had completed end of life care awareness training to manage such patients as part of mandatory training.

Well-led

Rating Requires improvement

We looked for evidence that there was an inclusive and positive culture of continuous learning and improvement that was based on meeting the needs of people who used services and wider communities. We checked that leaders proactively supported staff and collaborated with partners to deliver care that was safe, integrated, person-centred, and sustainable, and to reduce inequalities.

At our last assessment we rated this key question good. At this assessment, the rating has changed to requires improvement. This meant there was not always adequate service leadership and leaders and the culture they created did not always assure the delivery of high-quality care.

The service was in breach of legal regulation in relation to the governance of the service.

Acute services
Surgery

Shared direction and culture

Score

3. Evidence shows a good standard of care

The service had a shared vision, strategy, and culture. This was based on diversity and inclusion, engagement, and understanding challenges and the needs of people and their communities.

The surgical service had a clear vision which was focused on delivering safe, high quality, patient centred care. Leaders described their strategic direction as including developing a world class major trauma centre, investing in recruitment and retention, and maintaining their diverse workforce, improving their financial position, utilising theatres better and improving resourcing and training around managing mental health patients. This supported the trust's overall vision and strategy to provide 'outstanding care, together.'

The trust had developed a Green Plan to support the delivery of their overall strategy and become an environmentally sustainable organisation. Through this plan the trust aimed to take action to ensure the settings in which they provide care were as low carbon as possible, ensuring energy efficiency, and using renewable energy sources where possible. We saw that this was supported within the service in their development of SMART theatres which along with improving patient experience and efficiency aimed to improve sustainability and reduce theatre energy consumption through automation.

Staff and leaders were able to demonstrate a positive, compassionate, listening culture that promotes trust and understanding between them and people using the service and is focused on learning and improvement.

Staff throughout surgical services were welcoming and friendly and focused on providing high quality care for their patients. Leaders promoted a positive culture which supported and valued staff both formally and informally. As an example, in regular newsletters issued to staff we saw that staff achievements were celebrated, and professional development was promoted and encouraged.

Staff consistently told us they were proud to work at the hospital. They were passionate about

their work, and we saw this in our observations of positive and supportive relationships between staff at all levels.

Capable, compassionate and inclusive leaders

Score

2. Evidence shows some shortfalls in the standard of care

Leaders embodied the culture and values of their workforce and organisation and led with openness and honesty. However, leaders did not always demonstrate they had the appropriate oversight of risk to keep people safe.

Evidence we reviewed showed that leaders did not always have appropriate oversight of risks, for example we did not see that all risks identified on the service risk register were discussed or scheduled to be discussed in risk review meetings. However, there was a clear management structure with defined lines of responsibility and accountability. Care group leads were in post for most specialities who fed into a clinical director, general manager, and head of nursing for each triumvirate of the division. Local leadership was provided by matrons and ward managers. Leaders had the experience, capacity and capability to ensure that the organisational vision could be delivered, and risks were managed.

Staff we spoke with said that leaders were open, visible, and approachable. Staff felt leaders were engaged, they also told us they had access to training and regular appraisals, although some staff members described informal appraisal mechanisms, and the service had low appraisal rates across all staff groups.

Leaders were alert to any examples of poor culture that may affect the quality of people's care and have a detrimental impact on staff. They addressed this through listening events and tailored training and initiatives, although we were not provided with any evidence of the impact of this.

We saw evidence that the trust was looking to establish an inclusive talent management approach. We also saw evidence of development pathways for staff of all levels within the service. Staff across wards and theatres consistently told us how they were supported to access

courses and gain additional qualifications.

Freedom to speak up

Score

2. Evidence shows some shortfalls in the standard of care

People did not always feel they could speak up and that their voice would be heard.

We saw in the trust Freedom to Speak Up Report 8% of staff from the surgery service had raised concerns with the Freedom to Speak Up Guardian between April 2024 to September 2024. Overall, most concerns raised to the guardian were regarding bullying and harassment (53%) and inappropriate attitudes and behaviour (44%). We did not see evidence within the service of action taken to address concerns raised to the guardian.

Staff and leaders promoted staff empowerment to drive improvement. Staff were encouraged to raise concerns. The trust had a Freedom to Speak Up (FTSU) Guardian with whom staff could raise concerns about any issues.

Staff told us there was a culture of speaking up where staff actively raised concerns. We saw evidence of Freedom to speak up awareness included in protected teaching time and staff we spoke with told us they knew how to find contact details of freedom to speak up guardians should they need it.

The trust had an appropriate and up to date Raising Concerns at Work Policy.Staff and leaders promoted staff empowerment to drive improvement. Staff were encouraged to raise concerns. The trust had a Freedom to Speak Up (FTSU) Guardian with whom staff could raise concerns about any issues.

Staff told us there was a culture of speaking up where staff actively raised concerns. We saw evidence of Freedom to speak up awareness included in protected teaching time and staff we spoke with told us they knew how to find contact details of freedom to speak up guardians should they need it.

Acute services
Surgery

The trust had an appropriate and up to date Raising Concerns at Work Policy.

Workforce equality, diversity and inclusion

Score

2. Evidence shows some shortfalls in the standard of care

The service did not always promote diversity in their workforce. Staff did not always work towards an inclusive and fair culture by improving equality and equity for people who work for them.

The division workforce was made up of 62.2% people from ethnic minority groups, 35.8% white and 3.1% unknown. There was an under representation of people from ethnic minority groups in band 8 posts and in people from ethnic minority groups in very senior manager posts. We saw evidence that the trust had identified the overrepresentation of ethnic minority groups in lower bands and that this informed their plans to establish inclusive talent management, however we did not see evidence that the service was also working to address this. As part of the division's priorities for responding to staff survey data we saw that one of the priorities identified was 'career development opportunities'. As part of this the service planned to have an EDI representative for all roles band 6 and above and to establish developmental roles focussed on succession planning. However, we did not see evidence of a timeframe for the identified priorities to be addressed.

The trust had an in-date Equality, Diversity, and Inclusion in Employment Policy (EDI). Leaders told us about the introduction of a Justice, Equity, Diversity, and Inclusion programme (JEDI), which serves to promote EDI and ensure staff are heard in response to feedback from staff surveys.

Staff had access to multiple networks including:

- BAME Staff Network
- DAWN (Disability and Wellness) Staff Network

Acute services
Surgery

- LGBTQ+ Staff Network
- Women's Staff Network

Governance, management and sustainability

Score

1. Evidence shows significant shortfalls in the standard of care

The service did not have clear responsibilities, roles, systems of accountability and good governance. Staff did not act on the best information about risk, performance, and outcomes, or share this securely with others when appropriate.

There was a lack of effective systematic governance for the service. We reviewed the service risk register, and although all risks had recent updates. We found that not all risks identified within our inspection such as poor VTE assessment completion, missed medication administrations and low Immediate Life Support mandatory training compliance were identified and recorded on the service risk register. This did not provide the leadership with overall effective assurance and oversight of risk. Although each risk was given a risk rating and level and allocated a risk manager, we found that the risk register did not include actions, this meant it was not always clear what actions were being taken to address risks. We saw that the service produced divisional risk reports which provided control measures, actions, identified assurance in the effectiveness of control measures and gaps in assurance for some of the risks on their register. However, not all risks for example, the shortage of neuro and cardiac anaesthetic consultants identified as an extreme risk on the register were included in the divisional risk reports. We also found that some risks on the risk register were not scheduled to be discussed at the divisional risk review group meetings between January 2025 and March 2026.

From data we reviewed it was not clear that action was taken in response to risk assessments and audits. We reviewed risk assessments for fire safety on two wards where actions had been identified to address risks however it was not clear whether the risks had been addressed. During our inspection we observed that some obstructed escape routes identified as a risk in

fire risk assessments remained obstructed by equipment, indicating that the risk had not been addressed and we did not see this reflected on the service risk register. LocSSIP audit data we reviewed between April and September 2024 did not outline any actions or learning points despite most specialties performing below 98% overall and compliance in DSU general theatres as low as 50% in the debrief between April 2024 and June 2024.

Although we observed good practice within surgical theatres during the inspection, data showed that the service did not always comply with national safety standards. We were not assured by this data that the service had embedded learning from previous never events. We were informed of a never event which occurred within cardiac surgery in December 2024. Between October 2024 and December 2024 audit data showed that there was 65% compliance in the briefing element of safety checklists in cardiac theatres and 78% in the debrief, there was no audit data available for the consent and procedural verification, sign in, sign out and time out. The service also audited communication effectiveness, engagement, and attitude with NatSSIPs2, cardiac theatres demonstrated the poorest compliance of 73%, However, the data showed 98% compliance in cardiac theatres staff knowledge of NatSSIPS 2. We did not see that audit compliance or previous never events were included on the service risk register, the never event which occurred in cardiac surgery was also not included on the surgery learning response log. We did see that Never Events were routinely discussed at group board meetings.

Staff we spoke with had a good awareness of governance processes and knew how and where to escalate their concerns. Staff had access to a range of policies, procedures and guidance which was available on the provider's intranet. Ward and theatre teams held regular team meetings to discuss incidents, audit results, and safety alerts. We reviewed a sample of meeting minutes from teams within the surgical service and found most showed discussion of patient feedback, incidents, and learning. Part of the agenda of some of these meetings included welcoming new staff as well as recognising achievements.

The service established clear lines of accountability for governance processes and had an effective escalation process. The senior team told us that each surgical group had a care group meeting with representatives of their MDT joining monthly clinical governance meetings. Each care group had a consultant governance lead, ensuring good feedback mechanisms. Divisional teams held their own monthly meetings with the care groups or specialities in their divisions.

There was effective workforce planning including for managing major incidents or emergencies. The service had business continuity plans in place for various scenarios.

Acute services
Surgery

Partnerships and communities

Score

3. Evidence shows a good standard of care

The service understood their duty to collaborate and work in partnership, so services work seamlessly for people. Staff shared information and learning with partners and collaborate for improvement.

Staff and leaders engaged with people, communities, and partners to share learning, develop, and improve patient experience that results in continuous improvements to the service. They used these networks to identify new or innovative ideas that led to better outcomes for people. The service worked with other organisations for the benefit of service users. This included the citizens advice bureau, charities, and local system partners.

Learning, improvement and innovation

Score

2. Evidence shows some shortfalls in the standard of care

Staff encouraged creative ways of delivering equality of experience, outcome, and quality of life for people. The service had not embedded continuous learning, innovation and improvement across the organisation and local system. Staff did not always actively contribute to safe, effective practice and research.

Recurrent never events in the service suggest learning from previous incidents is not yet fully embedded. However, there were processes to ensure that learning happened when things went wrong. As part of learning from previous incidents leaders introduced theatre protected teaching time attended by all staff groups. Topics of learning included human factors, training in civility, consent, and NatSSIPs 2. Staff told us there were various learning opportunities available.

Acute services
Surgery

Staff we spoke with told us they were supported by their managers to access development opportunities and develop their leadership skills. The service was actively involved in research. Junior medical staff told us they were happy with research and trauma opportunities in the hospital.

Staff were involved in various quality improvement projects. The service was active in trying to improve and respond to individual patient care needs. The service had developed a patient initiated follow up pathway as well as a free initiative to provide access to programmes for individuals with joint pain in collaboration with an independent provider.

The service was innovative in their approach to patient care. The service has undergone a digital transformation project to implement the use of SMART theatres. We were told that in the weeks following the inspection there is an ambition to track the patient journey from the minute they arrive in the SAL to theatres and to recovery. This initiative aims to improve efficiency, patient experience and reduce energy consumption and improve sustainability.

Acute services

Urgent and emergency services

Urgent and emergency services

Overall	Requires improvement
Safe	Inadequate
Effective	Good
Caring	Requires improvement
Responsive	Requires improvement
Well-led	Requires improvement

Our view of the service

We carried out an unannounced focused assessment of the St. George's Hospital emergency department (ED) on 4 and 5 November 2024 due to aged ratings and ongoing patient safety concerns from previous assessments relating to IPC, poor documentation and records, incomplete risk assessments, and medicine management. We assessed 30 quality statements across the five key questions: safe, effective, caring, responsive and well-led.

St. George's Hospital in Tooting is a designated Major Trauma Centre. It serves as the hub for the south west London and Surrey Major Trauma Network, treating patients with severe, life-threatening injuries. This includes patients with injuries from incidents like stabbings, gunshot wounds, and serious road traffic accidents. During our assessment, we visited all areas of the emergency department including majors, the resuscitation area, paediatrics, the urgent treatment centre (UTC), the rapid assessment and treatment (RAT) area and the ambulance handover zone. We spoke with patients, family members and staff including nursing and medical staff across all grades, pharmacists, healthcare assistants, housekeeping staff and managers.

Acute services

Urgent and emergency services

We last carried out a focused inspection of the ED in March 2024 following incidents in the ED. The service wasn't re-rated during that assessment and maintained the previous rating of requires improvement from a wider assessment in July 2019. During this assessment, the rating has remained as requires improvement.

Since the last inspection in 2019 there were a few improvements. However, there were still concerns that had not been resolved from the previous assessment as well as new concerns:

- Medicines were not always managed safely.
- Staff did not always complete risk assessments and update them swiftly.
- Staff did not keep detailed records of patients' care and treatment and records were not always clear and up to date.
- The environment did not consistently support safe care. Some equipment was out of date and premises were not secure.
- Patients at risk of deterioration were not always promptly assessed and documentation was inconsistent.
- Overcrowding was an ongoing issue where privacy and dignity was not always maintained in corridors and triage areas.

The service was in breach of Regulation 12 (safe care and treatment) and Regulation 17 (good governance). We were not assured the service managed patient acuity appropriately during streaming and triage processes and medicine management, including delayed administration of time critical medicines. Breaches were also found around poor standards of documentation and information security. We have asked the provider for an action plan in response to the concerns found at this assessment.

People's experience of the service

We spoke with 10 patients and family members about their experience of care in the service. People described staff as friendly, approachable and compassionate. They told us staff took time to explain procedures and answer questions clearly, even when the service was busy. Staff were described as professionals and attentive and patients said the care they received was safe and appropriate. People

Acute services
Urgent and emergency services

said they were confident in raising concerns. However, some people told us they were confused about the queueing process. We observed privacy and dignity not always being maintained particularly for patients receiving care in corridors and during triage.

Safe

Rating Inadequate

We looked for evidence that safety was a priority for everyone, and leaders embedded a culture of openness and collaboration. We checked that people were safe and protected from bullying, harassment, avoidable harm, neglect, abuse and discrimination. We also checked people's liberty was protected where this was in their best interests and in line with legislation.

At our last assessment we rated this key question as requires improvement. At this assessment the rating has changed to inadequate. This meant people were not safe and were at risk from avoidable harm.

Learning culture

Score

2. Evidence shows some shortfalls in the standard of care

The service did not always have a proactive and positive culture of safety based on openness and honesty. They did not always listen to concerns about safety and did not always investigate and report safety events. Lessons were not always learnt to continually identify and embed good practice.

Staff knew how to report incidents, but we were not always assured that they were reporting incidents appropriately. We saw evidence of a high number of incidents being reported between July to September 2024. Staff raised concerns through an electronic incident reporting system and discussions with managers. We reviewed documents of lessons learned from incidents such as clinical governance newsletters and learning from incidents forms which highlighted key learning outcomes for staff.

Acute services

Urgent and emergency services

We reviewed trust responses to complaints and data showed 93 complaints were received between October 2023 and October 2024. Complaints were broken down between Green, Amber and Red categories to determine how many working days were allocated for a response. Data provided by the trust was not broken down by categories, we were not assured that all complaints were aligned with trust policy or investigated in a timely manner. The duty of candour (DoC) is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of certain 'notifiable safety incidents' and provide reasonable support to that person. We reviewed two trust responses and were not assured that the trust upheld its Duty of Candour obligations.

Safe systems, pathways and transitions

Score

1. Evidence shows significant shortfalls in the standard of care

The service did not work well with people and health system partners to establish and maintain safe systems of care. They did not manage or monitor people's safety. They did not make sure there was continuity of care, including when people moved between different services.

We were not assured that safety and continuity of care was consistent throughout patients care journey. There was not an effective system in place to manage patient acuity in the waiting room as we observed patients who arrived at the ED experiencing long waiting times before being assessed. This was a recurring theme during our conversations with patients. We observed the service lacked adequate clinical oversight, leading to long wait times for triage, sometimes exceeding 50 minutes, this was over the 15-minute national target for patients arriving at the ED. We observed patients with high-risk symptoms who should have been assessed urgently. We issued a section 29a warning notice as the service required significant improvements. The trust has now developed a standard operating procedure (SOP) to improve clinical oversight which was implemented 6 January 2025. This SOP outlines escalation procedures for wait times exceeding 15 minutes or when six or more service users are waiting.

Acute services
Urgent and emergency services

Patients expressed confusion around the queueing process, as there was no clear guidance or signage directing patients in the waiting room. While waiting times were visible in the waiting room, there was no information displayed about how to raise concerns. We reviewed data sent by the trust of multiple incidents relating to delays and overcrowding.

We reviewed data in August, September and October 2024 which showed a consistently high and increasing demand on the service which placed pressure on capacity, flow, and timely access to care. The service had a full capacity protocol which set out actions to take when the service was overcrowded including daily flow meetings and escalation to trust wide command. However, this was issued in early November 2024, during our assessment staff explained how the protocol was not yet fully embedded within the service

Data provided from the service showed 74% of patients met the 4 hour waiting target between August and October 2024. This fell below the 76% national standard. However, we found that because service users were not formally logged into the system until they reached the triage nurse, patients were not accurately recorded in the system, which inaccurately reflected their total wait time due to extended queuing periods. Staff reported significant queuing issues, with wait times sometimes exceeding an hour. This lack of clinical oversight and safety management systems resulted in delayed assessments, impacting patient care. Service users were not assessed by medical staff in a timely manner and were at risk of deterioration as a result until they were assessed by the streaming nurse, and their actual time of arrival was not recorded in this data. Therefore, we were not assured of the accuracy of these figures due to the issues identified regarding the triage and queuing processes.

Streaming to same day emergency care (SDEC) was considered during triage, using established criteria. However, this was restrictive having a very specific inclusion criteria for admission. Admission also required a discussion with a consultant before a patient could be sent to the SDEC. Staff told us the lack of flexibility in these protocols limited their ability to manage patient flow effectively. Additionally, there was no live quality or performance dashboard available for staff to view.

We reviewed 10 sets of electronic patient notes and found there were gaps in nursing documentation and a lack of detail within the notes, which meant there was an incomplete picture of patient care. There were delays in doctors completing their notes. For patients waiting in the ED for over 24 hours, there was a lack of detailed documentation, particularly

Acute services
Urgent and emergency services

regarding medication administration or patient updates.

There was also a lack of detailed documentation relating to mental health patients who absconded. Notes we reviewed of a patient who had absconded did not reflect that they had left the ED before being assessed. We issued a section 29a warning notice and received an action plan from the trust describing mitigation steps for these risks. The trust has developed written documentation standards for staff to adhere to and now undertake a daily audit in the service against basic documentation questions with outcomes shared with staff for improvement. A wider documentation audit was being developed to be available from April 2025 which will be monitored through ED quality and safety meetings. A documentation template is now being used across the service to ensure documentation standards are met.

Our review of ED morbidity and mortality meeting minutes demonstrated a proactive approach to risk management and escalation. During incident discussions, staff raised serious concerns around corridor care and formally escalated concerns to trust leaders and external regulators.

The service had a qualified streaming nurse and an additional consultant was sometimes available to support the streaming nurse by directly referring patients when needed. For patients who were offered a GP appointment, these were arranged by a dedicated navigator, allowing patients to leave the service without unnecessary delays.

The service had an SOP for paediatric referral services for children between 1 and 18 years old aiming to avoid hospital admission and ED attendances. However, this was only operational between 9am to 6pm and last referrals were at 4:30pm.

The service offered a hospital at home service, allowing patients to receive multidisciplinary support at home from nurses, therapists, and doctors. Clinicians worked closely with the hospital at home team to arrange follow-ups and personalised care at home.

Safeguarding

Score

2. Evidence shows some shortfalls in the standard of care

Acute services

Urgent and emergency services

The service did not always work well with people and healthcare partners to understand what being safe meant to them and how to achieve that. They did not always concentrate on improving people's lives or protecting their right to live in safety, free from bullying, harassment, abuse, discrimination, avoidable harm and neglect. They did share concerns quickly and appropriately.

We reviewed the ED risk register and saw a risk of harm to children and young people due to delays in formal radiology reporting and reviewing the reports. Data showed that there were 3 incident reports of missed injury or illness to date. This means that we could not be assured that children were appropriately safeguarded.

Although safeguarding policies were comprehensive and up to date. We were not assured that paediatric nurses routinely receive adult safeguarding or domestic violence training. We requested data on safeguarding training numbers for nurses; we did not receive this and therefore the trust was unable to provide assurances of adequate safeguarding training. However, training compliance data showed that 90% of medical staff had completed safeguarding training for adults at Level 2, with compliance for children's safeguarding at 94.7% for Level 2 and 89% for Level 3, exceeding the trusts target of 85%.

There was an understanding of safeguarding as staff described procedures and effective use of escalation processes. Staff generally identified and acted on safeguarding and domestic violence concerns, ensuring patients were supported appropriately. Staff told us they would raise safeguarding alerts or flag domestic violence concerns on the system for the assessment team to address in a private and secure area. During the assessment, we observed a streaming nurse identifying a potential domestic violence case, flagging it to the assessment team, and requesting further assessment. Patients benefitted from the proactive and collaborative approach taken by staff to address safeguarding concerns sensitively and appropriately.

Staff were able to articulate signs of abuse, neglect, or domestic violence and how they would respond, including referral to the safeguarding team. They demonstrated confidence in identifying safeguarding concerns and described clear processes for escalation. Staff reported receiving excellent responses and support from the safeguarding team, which they described as approachable and responsive. The trust demonstrated a commitment to taking action to keep people safe from abuse and neglect, including collaboratively working with partners. We reviewed data Between July 2023 and June 2024 that showed the service was making

appropriate referrals to the local authority. We saw 569 referrals for adults and 1,807 for children. This demonstrated compliance with trust safeguarding policies.

The service is supported by a multidisciplinary safeguarding team, including a health visitor liaison and a named consultant lead for safeguarding in the paediatric emergency department.

Involving people to manage risks

Score

1. Evidence shows significant shortfalls in the standard of care

The service did not work well with people to understand and manage risks. Staff did not provide care to meet people's needs that was safe, supportive and enabled people to do the things that mattered to them.

We reviewed the trust policy for NEWS 2, which stated that patients required hourly monitoring of NEWS scores between 0-8 hours. Nurses in the majors area monitored and entered NEWS scores into the electronic system. These scores appeared on the department tracking screen, but it didn't show when observations were last recorded. Staff escalated NEWS2 scores to the emergency department doctor. However, for patients awaiting a speciality bed, staff discussed escalated NEWS2 scores with the speciality doctor. This caused delays as bleep numbers were unavailable, resulting in physical searches for doctors on the medical assessment unit.

We reviewed the ED sepsis audit from April 2024 where 45 patients were audited. All patients should receive antibiotics within 3 hours, or within 1 hour of suspected neutropenic sepsis. Data showed that 1 patient that met the criteria for treatment via antibiotics waited 5 hours. Only 42.2 percent of patients received their antibiotics within 3 hours of arrival.

We requested PEWs audit which showed 100% compliance in June 2024, however there were no audits in July and August and in September only 80% of records showed completion of PEWS audit on admission. Therefore, we were not assured that PEWs audit were reviewed consistently due to the gaps in the data. In addition, we requested information regarding initial

triage of paediatric patients being conducted within 15 minute of arrival. This information was not provided and therefore we were not assured triage was completed in a timely way.

We requested VTE data for ED, however the data provided was trust wide VTE audit results which indicated poor performance across the whole hospital. We were not assured the ED had oversight over their own performance and any actions taken to manage poor VTE performance. This was not documented on the ED risk register.

We reviewed electronic patient notes and found that risk assessments were not always completed, particularly for mental health risks. The service completed risk assessments for patients presenting with mental health needs, but these often lacked detail. While they outlined steps to minimise risks, it was unclear how decisions were made to categorise risks as low, medium, high, or very high. In cases where patients left the unit before completing treatment or referrals and presented a risk of harm to themselves or others, the service contacted the police. There had been 30 such incidents in the last six months categorised as low harm.

Adults and young people frequently waited 3 to 5 days, exceeding national standards, for a mental health bed once assessed as requiring admission under the Mental Health Act (MHA). Staff escalated these extended waits to senior management.

However, staff told us they were confident in escalating concerns related to long mental health waits or other risk factors. We observed detailed patient handovers, which included discussions of care plans, outstanding tasks, administered medications, and risks including falls. These handovers were supported using electronic patient records, to ensure staff taking over a patient's care were fully informed of a patient's condition. However, observed a set of patients notes which had missing National Early Warning Scores (NEWS), which are essential for identifying deteriorating patients.

The service held monthly multidisciplinary meetings, involving ED staff, the psychiatric liaison team, police, ambulance services, and social workers, to discuss concerns and improve processes. Staff described these meetings as collaborative and productive, highlighting strong relationships with partner organisations. Staff were regularly involved in discussions about safety, risk, and service pressures. In governance and multidisciplinary meetings, staff raised concerns about mental health patient waits, resource constraints, and patient behaviour in the

waiting room. Notes from ED Morbidity and Mortality meetings demonstrated how staff contributed to incident review, action planning and scheduled follow-up reviews to support shared learning. Risk and performance updates were routinely shared with the team, and staff had opportunities to raise concerns through regular safety huddles and structured feedback routes.

We reviewed the trust's major incident plan, which was in date with the next review scheduled for December 2024.

Safe environments

Score

1. Evidence shows significant shortfalls in the standard of care

The service did not always detect and control potential risks in the care environment. They did not make sure that equipment, facilities and technology supported the delivery of safe care.

Patients were not always cared for in safe environments as we observed overcrowding within the service including patients on trolleys in the corridor who had been waiting several hours to see a doctor. Staff described significant delays in securing mental health beds, sometimes lasting up to 7 days.

Staff expressed concerns about the overcrowding in the service, which they felt compromised safe care.

During our assessment, we found that two adult mental health rooms were intended to be ligature free, however, although these rooms had fixed fitted beds included, each room had an additional hospital bed and hospital trolley, which introduced new ligature anchor points, and significantly restricted space. There was no CCTV in these rooms, but it was provided in the main ED majors area. Following the assessment, the trust advised that they had reviewed the fixed beds in these rooms and would be providing alternative appropriate furniture.

Acute services

Urgent and emergency services

There was an assessment room in the paediatrics ED which did not include a bed. Other rooms for both paediatric and adult mental health patients included ligature anchor points, not all of which could be removed such as taps and hooks. Patients at risk of self-harm could not be left in these areas without supervision, which impacted upon their privacy, particularly during long stays.

Within the paediatric emergency department, the service did not have bed areas specifically designed to minimise the risks presented by patients with mental health needs. If the patient presented a heightened risk, the service would need to place them in the adult mental health room within majors. There were no ensuite facilities available, but patients could access toilet and shower facilities on both the adult and paediatric ED.

The mental health assessment room and other rooms used for mental health patients were located centrally within the adult and children EDs, presenting safety management concerns for patients who had behaviours that challenged other patients with significant physical health problems.

Staff had access to a quiet room which was used for distressed patients, but this was located off the main majors area, and was not ligature free, which posed a risk to staff and patients. There was a nursing station located near this room, but we observed it to be frequently unattended.

We found examples of daily checks not completed in major B of resus trolleys along with out-of-date consumables. In the paediatric ED, we found trolleys had consumables that were found to be out of date including multiple non-adherent dressing.

We also found that the medicine cupboard in majors B and the control of substances hazardous to health (COSHH) cupboard in the dirty utility area were unlocked, despite signage indicating they should remain locked. Additionally, we found the dirty utility room door was left unlocked.

We reviewed meeting minutes where staff identified safety and dignity issues in shared spaces where privacy for procedures could not be maintained. Requests were made for additional equipment such as curtains and trolleys.

However, access to the service was secure, with a door buzzer system in place and staff carrying electronic passes to ensure controlled entry.

Acute services

Urgent and emergency services

Safe and effective staffing

Score

2. Evidence shows some shortfalls in the standard of care

The service did not always make sure there were enough qualified, skilled and experienced staff. They did not always make sure staff received effective support, supervision and development. They did not always work together well to provide safe care that met people's individual needs.

Staff reported that safe care and treatment were sometimes compromised due to the high numbers of patients waiting for admission, extended stays of mental health patients, and resuscitation area capacity being exceeded. Paediatric staff expressed concerns about insufficient staffing levels in their area. This was not documented in the service's risk registers. However, we did observe that the risk register documented a lack of radiology reporting for paediatric patients.

Staff also shared that they were not always given protected time for training, but overall compliance rates met the trust's target. Junior doctors told us they felt well-supported, with excellent clinical supervision and high-quality education. All resident doctors we spoke to told us they would recommend the service to friends and family.

Staff explained how they could not always provide one-to-one, or two-to-one observations for mental health patients as recommended following assessment by the psychiatric liaison team, due to having insufficient staff. During our assessment, there were sufficient staff to meet patient needs. Staff told us that the trust directly employed registered mental health nurses and mental health support workers on each shift and more could be called in when needed (although there could be a delay in additional staff arriving).

Leaders acknowledged the pressures faced by the team, including the sustainability of the consultant rota. While there was 24/7 consultant presence, several consultants had come off the night rota due to stress, putting additional pressure on the team. The Royal College of Emergency Medicine (RCEM) recommends at least 34 whole-time equivalent (WTE) consultants to provide 24/7 care in the service. Although the service maintained strong 24/7 consultant

coverage, the current number of WTE consultants fell short of this recommendation. We were not assured that the current staffing level was sustainable and presented long-term risks to staff well-being and service delivery.

Staff raised concerns about unsafe staffing levels at team meetings. Minutes recorded instances where only 3 medical assistants were available on shift, prompting escalation and review of rota fairness and staff wellbeing. During the inspection we spoke to an adult nurse working in paediatrics ED who had not had any additional training to look after children.

Registered general nurses within the EDs and agency RMNs did not carry out any restraint techniques on patients in line with trust policy. Only security staff were trained to do this. Staff said they would benefit from more de-escalation training, and more staff trained in physical restraints when needed. 69% of security staff had completed training in physical restraints of patients, with a further nine due to be trained in January 2025, bringing training compliance to approximately 94%.

Staff we spoke with did not report significant incidents of violence and aggression in the EDs over the last six months. Staff said that security staff were available when needed, and were needed more, since the police had introduced Right Care, Right Place, which meant police no longer stayed in the ED with mental health patients, unless they were detained under section 136 of the Mental Health Act.

Patients consistently described staff as competent, professional, and attentive to their needs. Patients described how staff followed established protocols and provided care that met their expectations. Despite pressures within the service, patients told us they felt the care they received was safe and appropriate.

The service was well-staffed at the resident doctor level, with 15 staff covering the early shift, 15 joining in the afternoon, and 9 on the night shift. Mandatory training compliance rates were high, with medical staff achieving 91.1% overall, including 96.2% for early warning scores, exceeding the trust target of 85%. Induction processes for doctors were thorough, and all doctors were required to undergo annual appraisals with 80.9% compliance at the time of the assessment. This was below the trust target of 90% and was not included on their risk register.

We reviewed meeting minutes where staffing risks were identified and discussed.

Acute services
Urgent and emergency services

Staff raised concerns about limited support staffing and the need for clearer role responsibilities, particularly for healthcare assistants. Concerns around flexible working were also noted as contributing to rota pressures. The trust was progressing workforce development through policies to extend roles including physician associates and nurse-led analgesia in paediatrics. Staffing risks linked to overcrowding and corridor care were escalated through governance structures.

Volunteers within the service underwent comprehensive recruitment checks and a trust-wide induction, and they were supported and supervised by the nursing team. Bank and agency staff, however, did not always have access to the same training as permanent staff, which created inconsistencies in care provision. Staff had access to trauma-informed care training and seminars, and 95% had completed conflict resolution training. Additionally, 89% of staff had completed Oliver McGowan training on supporting patients with autism or ADHD and 97% of staff had completed training in disability awareness.

Infection prevention and control

Score

2. Evidence shows some shortfalls in the standard of care

The service did not always assess or manage the risk of infection. They did not always detect and control the risk of it spreading.

Mandatory infection prevention and control (IPC) training compliance for medical staff was 85.5%, below the trust target of 90%.

During our inspection, we observed corridor care for patients with Methicillin-resistant Staphylococcus aureus (MRSA). Corridor care is the practice of providing medical attention to patients in hallways or other non-designated clinical areas due to overcrowding or resource shortages. This posed infection, prevention and control issues due to limited access to gloves, bins, and sinks. Moreover, corridor care made it difficult to maintain appropriate isolation for infectious patients, which increased the risk of transmission to other patients and healthcare staff. Patient isolation and infection was listed as a risk on the open risk register, gaps in

controls and assurance were documented however assurances and actions were left blank. This was recorded as an extreme risk on the open risk register.

It was reported on the open risk register that the ED would not meet IPC standards, which could lead to an increase in the prevalence of infection within the department and therefore impact patient safety and care, increasing Length of Stay (LOS), as well as staff sickness levels. Not all actions for this risk had been completed to mitigate this risk on the open risk register, this risk was recorded as a moderate risk.

Sewage leaks were regularly reported, most recently, week commencing 7 October 2024. This posed as a health and safety, and IPC risk to all patients and staff. A sewage leak would result in a short notice closure of the impacted areas of ED for maintenance. This would lead to increase space pressures within the department and a knock-on effect on admitted and non-admitted performance as well as considerable impact on staff morale and poor working conditions. This was documented on the risk register, with some actions competed but not all, this was recorded as a moderate risk.

However, in majors A, staff were observed practicing good hand hygiene by washing their hands after checking a patient's blood pressure, disposing of gloves, and wearing new personal protective equipment (PPE) before interacting with the next patient. During our assessment, we observed staff to be bare below the elbow.

In majors B, the treatment waiting area was visibly clean, with handwashing and sanitiser stations available. Curtains around beds were visibly well-maintained and had been changed regularly. Signage promoting good hand hygiene was displayed around hand washing basins. Facilities for mental health patients were also clean and well-maintained. We observed clinical areas had domestic and clinical waste bins and PPE was available.

Cleaning schedules and environmental audits for resus, paediatrics, majors A and majors B scored above the 98% compliance target. Hand hygiene audits from August to October 2024 demonstrated good compliance, with average scores above 98%. The latest PPE audit, conducted in May 2024, achieved 100% compliance. Isolation cleaning was also routinely completed prior to patient transfer. However, audits conducted in November 2024 identified some areas that failed but there were no action plans to address this. Areas that failed included hand wash dispensers and hand sanitisers.

Acute services
Urgent and emergency services

In majors B, we saw that equipment was regularly checked, with portable appliance testing (PAT) in date for various equipment and plugs. All equipment observed was visibly clean. “Last cleaned” stickers were visible on trolleys and other appliances, and all were in date. All furnishings, such as chairs and flooring, were wipeable and easy to clean.

We reviewed policies provided by the trust including business continuity plans outlining protocols for managing service disruptions. This included emergency cleaning arrangements, the use of PPE, and the handling of isolation needs in the event of premises being compromised. The plan made specific reference to maintaining patient safety and continuity of care through access to essential clinical supplies, cleaning arrangements, and safely relocating patients.

Medicines optimisation

Score

1. Evidence shows significant shortfalls in the standard of care

The service did not make sure that medicines and treatments were safe and met people’s needs, capacities and preferences.

We reviewed the records of 7 patients and found that medicines were not always given as prescribed, with some doses marked as not given retrospectively due to drug shortages. Medicines omitted included critical medicines such as inhalers, medicines for epilepsy and lithium. Staff told us that people did not always receive their medicine as the service often ran out of stock for medicines, requiring nurses to check other wards to obtain stock. Nurses told us that when they contacted the pharmacy for queries or support for obtaining stock or prescriptions, the response times were variable. Following our inspection, the trust has reviewed the medicines stock list to ensure it is up-to-date and reflect potential patient needs by conducting audits. The trust has updated and circulated the critical medicines list. The trust has also provided guidance to staff on how to access and obtain medicines that are not available in the service.

The service’s pharmacy support was inadequate and did not match the recommended support

outlined in the Royal College of Emergency Medicine (RCEM) guidelines. Pharmacists reported prioritising high-risk service users but were not able to review everyone in a timely manner. We saw that there was a pharmacist who was offering dedicated support to the whole emergency unit, including the acute medical unit (AMU). Following our inspection, the trust has conducted a risk assessment and has put mitigations in place including an additional interim pharmacist to increase support.

Staff highlighted how the resuscitation area of the service had regular discrepancies with controlled drugs (CDs). This was due to the acuity of the unit, and they did not always complete records as a result. Errors in CD record keeping books were crossed out which is not line with current legislation. Following our inspection, the trust has developed an improvement plan which is being monitored through weekly access meetings and governance meetings, including a spot check audit to review and manage concerns. The trust has increased the frequency of CD audits from quarterly to every other month to monitor progress with actions. Information on CD management has been displayed within the service and throughout the trust for staff.

Pharmacists told us they completed regular audits of antibiotic stewardship, venous thromboembolism (VTE) assessments and medicines management but improvement was inconsistent. This was in part due to constant rotation of resident doctors. Staff described seeing spikes in improvement but then a gradual decline. Therefore, we were not assured the audit process was effective.

Issues were identified with the electronic prescribing and administration record (EPMA) system, including weight-based prescribing errors, where incorrect weights were recorded in patient care records. Pharmacists identified prescribing errors linked to this issue. There was no system in place to flag overdue medicines or missed assessments, contributing to omitted doses and inconsistencies in medication administration. Following our inspection, the trust has provided assurances that mitigations are in place while this functionality is being developed, including drug check rounds twice a day to monitor missed doses.

The self-administration policy was not consistently applied across the service, leading to variation in practice. In majors A, patients self-administered medication without a formal assessment, while in majors B, medicines were stored in pod lockers, with administration prompted by nurses. Staff had different interpretations of how this was managed. Following our inspection, the policy for self-administration has been risk assessed and suspended.

Acute services
Urgent and emergency services

The service is now prescribing medication following an assessment by a clinician and this is being administered by nursing staff.

We issued a section 29a warning notice for medicine concerns and received an action plan from the trust describing mitigation steps for these risks.

We reviewed medicines optimisation group meeting minutes where staff raised governance risks around unlicensed medicines, highlighting delays and inappropriate reliance on junior doctors, reflecting staff awareness of prescribing safety.

During the inspection we observed a fridge beeping in Majors B, we witnessed staff ignoring this alarm. Therefore, we could not be assured that medications were kept within their optimum range.

Effective

Rating Good

We looked for evidence that people and communities had the best possible outcomes because their needs were assessed. We checked that people's care, support and treatment reflected these needs and any protected equality characteristics, ensuring people were at the centre of their care. We also looked for evidence that leaders instilled a culture of improvement.

At our last assessment we rated this key question as good. At this assessment the rating has remained as good. This meant people's outcomes were consistently good, and people's feedback confirmed this.

Assessing needs

Score

2. Evidence shows some shortfalls in the standard of care

The service did not always make sure people's care and treatment were effective because they did not always check and discuss people's health, care, wellbeing and communication needs with them.

Acute services

Urgent and emergency services

We observed patients being cared for in the corridor, which staff described as unsafe. According to trust policy patients should have observations recorded hourly for first 8 hours. This was not adhered to when we checked a patient record for patient receiving corridor care, we observed only 2 observations were recorded in these patients notes. We observed a patient that had arrived in an ambulance with shortness of breath with a pacemaker. This patient was placed on corridor care. The patient did not have an Echo Cardiogram (ECG) which is a type if ultrasound to visualise the heart and surrounding blood vessels. Inspectors reviewed the patient over 4 hours later and saw the patient had not been reviewed by a doctor. We reviewed further patient documentation and found there were three individuals identified as being at risk of falls who were receiving corridor care. Staff had no additional support or assistance to ensure safety with tasks such as administering medication. Patients in the corridor experienced a lack of privacy and dignity, as medical examinations were conducted in full view of passing members of the public. Privacy screens were not utilised, further compromising patient dignity.

Risk assessments for patients lacked documented mitigation steps or follow-up actions. For example, we observed an incident involving a patient at risk of falls, but the details were not recorded in the patient's notes, and there was no evidence of actions taken to mitigate the risk of further harm. Additionally, National Early Warning Scores (NEWS2) were not consistently recorded, limiting the ability to monitor patients effectively.

Staff reported that the falls risk assessment process in the service was subjective, with no clear guidance on when to implement specific interventions, such as slip socks, call buzzers, or bed rails. Similarly, the bed rail assessment process lacked clinical guidance, leaving staff uncertain about appropriate usage. This lack of clarity disrupted staff's ability to provide safe and effective care for patients at risk of falls.

Data submitted by the trust showed a significant increase in the length of time that patients waited to receive antibiotics due to suspected sepsis. Data showed that this was likely due to overcrowding in the ED as there was a direct correlation with the amount of time waiting to see a clinician.

We requested data on the initial assessment of paediatric patients being completed within 15 minutes of arrival, but we were only provided with the standard operating procedure (SOP). This means we were not provided with any assurance that children were being seen within their own SOP guidelines and triaged and escalated effectively.

Acute services
Urgent and emergency services

Trust level VTE assessments audits showed 63.9% compliance which was below trust target of 95%. In ED this compliance was being affected due to the new electronic patient record system which do not trigger a VTE assessment for patients.

The current triage system presented risks to acutely ill patients. The service recognised this risk and was planning to put mitigations in place. This mitigation was to introduce an E-triage system. This however poses risks for those patients with language barriers, with limited computer literacy skills, an economical gap, and can cause a digital divide.

Delivering evidence-based care and treatment

Score

3. Evidence shows a good standard of care

The service planned and delivered people's care and treatment with them, including what was important and mattered to them. Staff did this in line with legislation and current evidence-based good practice and standards.

Policies and procedures reviewed during the assessment were up to date and reflected current clinical standards including a policy for patients requiring enhanced care. Clinical staff contributed to the development and review of local policies and treatment protocols including updated guidance for stroke, agitation management, and prescribing in the service. We reviewed medicines optimisation group meeting minutes where standard operating procedures (SOPs) were regularly reviewed and updated with input from pharmacy, ED clinicians and specialist teams, supporting safe and consistent care. New SOPs were developed to guide safe prescribing for patients awaiting discharge and guidelines for nicardipine and thrombectomy care were adapted to reflect national standards.

The service reviewed Getting It Right First Time (GIRFT) reports, which provided clear actions and best practice recommendations to improve patient outcomes. For example, the service introduced a clinical pathway for assessing patients with back pain that aligns with GIRFT guidance including the use of red flag screening, early bladder scanning and a four-hour MRI target. Multidisciplinary meetings were held regularly, involving psychiatric liaison teams, ambulance services, and social workers, ensuring that complex cases were reviewed, and that

learning was shared across the service.

Supporting people to live healthier lives

Score

3. Evidence shows a good standard of care

The service supported people to manage their health and wellbeing to maximise their independence, choice, and control. The service supported people to live healthier lives and, where possible, reduce their future needs for care and support.

The service had relevant information promoting healthy lifestyles and support on the ED welcome boards across the department and electronic screens in the waiting area. This included videos and posters of national, regional, local and hospital campaigns. Information displayed covered large demographics and included physical and mental health. Information included cervical screening, smoking cessation, breast cancer screening, weight loss, bowel cancer screening, community pharmacy support, mental health services for LGTQ+ (lesbian, gay, bisexual, transgender, and queer or questioning) people, flu vaccines, stress and mood.

Patient information leaflets were readily available on the trust's website and available in larger print too.

Monitoring and improving outcomes

Score

2. Evidence shows some shortfalls in the standard of care

The service did not always routinely monitor people's care and treatment to continuously improve it. They did not always ensure that outcomes were positive and consistent, or that they met both clinical expectations and the expectations of people themselves.

Acute services
Urgent and emergency services

The service had established a comprehensive audit schedule for 2024 and 2025 to assess and enhance patient care across a range of clinical areas. This schedule included audits aligned with the National Institute for Health and Care Excellence (NICE) guidelines, Royal College of Emergency Medicine (RCEM) standards. The schedule including The Trauma Audit and Research Network (TARN). Whilst the trust told us they were doing national audits and provided an audit schedule, we were not provided with the data and actions from these audits. We requested data on participation of national audits, results and improvements made. However, the data shared did not evidence the trusts current performance and it was unclear which audits the trust had participated in 2023-2024. Therefore, we could not be assured that patient outcomes were routinely monitored and the service lacked evidence for effective improvement.

For people who frequently used the service, identified as high intensity users (HIU), the service had established a dedicated HIU group with a standard operating procedure (SOP) outlining detailed steps for managing HIUs effectively. This included a multi-disciplinary team (MDT) discussion and referrals.

The service had a detailed sepsis pathway document, providing clear guidance for managing sepsis. Staff we spoke with demonstrated an understanding of sepsis and were able to explain how they would recognise the symptoms and the actions that would be necessary once identified. This was in contrary to the audit data which showed that improvements needed to be made to keep patients with sepsis safe.

Consent to care and treatment

Score

3. Evidence shows a good standard of care

The service told people about their rights around consent and respected these when delivering person-centred care and treatment.

Patients told us that staff thoroughly explained care and treatment options and sought their consent before proceeding. This supported a clear understanding of their care and helped

Acute services
Urgent and emergency services

foster trust in the service provided.

The trust had a consent policy in place, which was in date and next due for review in June 2026. This outlined staff responsibilities in supporting patients with reduced capacity and confirmed that capacity assessments were guided by the Mental Capacity Act 2005 (MCA) with a clear framework for determining and documenting capacity. The policy also described strategies to support decision making including the use of accessible information, easy read leaflets and interpreters. The do not attempt cardiopulmonary resuscitation (DNACPR) policy was also in date and scheduled for review in February 2025.

Staff demonstrated a good understanding of MCA and least restrictive practices, which informed their approach to care. Staff also highlighted the availability of policies and training to support decision-making around consent and capacity.

Medicine and nursing staff achieved above 91% for level 1 training for Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS) which was above trust target. However, level 2 compliance was below trust compliance target at 81.3% for nursing staff. The trust had processes in place to ensure compliance was monitored, as the practice education team would review this monthly and staff who were not compliant would be flagged to leaders.

Caring

Rating Requires improvement

We looked for evidence that people were always treated with kindness, empathy and compassion. We checked that people's privacy and dignity was respected, that they understood that they and their experience of how they were treated and supported mattered. We also looked for evidence that every effort was made to take people's wishes into account and respect their choices, to achieve the best possible outcomes for them.

At our last assessment we rated this key question good. At this assessment the rating has changed to requires improvement. This meant people did not always feel well-supported, cared for and treated with respect.

Acute services
Urgent and emergency services

Kindness, compassion and dignity

Score

2. Evidence shows some shortfalls in the standard of care

The service treated people with kindness, empathy and compassion. However, privacy and dignity were not always maintained for patients being cared for in corridors. We did not see the use of privacy screens whilst medical examinations were being undertaken.

The area where the streaming nurse sat and took information from patients was in an open area of the department which meant information relayed to them by a patient could be overheard by those waiting to be seen in the queue and further compromised a patient's privacy.

In the paediatric ED on the day of the assessment, there were two mental health patients in cubicles next to each other separated by a curtain, one accompanied by police and one by a parent. This meant conversations could be overheard and it was difficult to maintain the dignity and privacy of the patient.

Patients reported prolonged waiting times up to 55 in the ED this including patient who were on end of life care.

However, staff expressed a commitment to maintaining professionalism and a caring attitude, even during busy periods to ensure patients felt supported despite raising concerns regarding patient safety in corridors. People we spoke with described staff as friendly, approachable, and compassionate.

Staff were compassionate and understanding towards people attending the ED with regards to their mental health. Staff expressed a strong commitment to helping patients recover. We observed staff interacting with patients in a kind and respectful manner, taking the time to explain procedures and answer questions clearly.

Acute services

Urgent and emergency services

Treating people as individuals

Score

3. Evidence shows a good standard of care

The service treated people as individuals and took account of people's strengths, abilities, aspirations, culture and unique backgrounds and protected characteristics. Children in the ED had access to some sensory equipment and a play specialist.

Staff demonstrated an understanding of diverse patient needs and made effective use of face to face or telephone interpretation services. This benefitted individuals whose first language was not English or those requiring British Sign Language.

The service has a chaplaincy and spiritual care team that provides support to patients and relatives, including on-call cover and regular visits. The team supports people of all faiths and those without a religious affiliation, speaking 27 languages and offering religious, emotional and spiritual care tailored to individual needs. The service employed the Butterfly Scheme to enhance care for patients with dementia, flagging patients on the electronic record system to identify these patients, prompting staff to provide individualised support.

Responding to people's immediate needs

Score

2. Evidence shows some shortfalls in the standard of care

The service did not always listen to and understood people's needs, views and wishes. Staff did not always respond to people's needs and did not always act to minimise any discomfort, concern or distress.

Patients requiring immediate interventions, such as pain relief, did not always receive timely assistance from streaming nurses at triage. Staff were able to provide analgesics while patients awaited further assessment, however, this was impacted due to long waits.

Acute services
Urgent and emergency services

We observed staff addressing physical and emotional needs of people even in challenging circumstances. However, some patients explained how staff did not respond as quickly, attributing this to long waiting times and overcrowding. We observed staff supporting relatives of patients who were emotionally distressed.

People's hydration needs were met in line with current guidance. Water dispensers were available in the waiting areas, and staff actively offered water to patients, particularly those experiencing extended waits.

Responsive

Rating Requires improvement

We looked for evidence that people and communities were always at the centre of how care was planned and delivered. We checked that the health and care needs of people and communities were understood, and they were actively involved in planning care that met these needs. We also looked for evidence that people could access care in ways that met their personal circumstances and protected equality characteristics.

At our last assessment we rated this key question requires improvement. At this assessment, the rating has stayed the same. This meant people's needs were not always met.

Person-centred care

Score

2. Evidence shows some shortfalls in the standard of care

The service did not always make sure people were at the centre of their care and treatment choices and they did not always work in partnership with people, to decide how to respond to any relevant changes in people's needs.

We were not assured that patients received person centred care. During our assessment we

observed multiple patients receiving poor care. For example, we observed a palliative patient on end-of-life care who had been left in the ED for 55 hours before being admitted to a ward. We observed a vulnerable elderly patient attempted to get off their trolley 3 times as observed by CQC staff.

The trust worked with a charity which provided support to young people aged 11–25 affected by violence or exploitation, ensuring they received safeguarding, psychological care, and referrals to specialist services. The service employed the 'George the Octopus' initiative to identify children with complex needs, flagging them on the electronic record system to ensure they were prioritised and allocated to appropriate areas. Play specialists and sensory equipment were available to support children and young people during their stay.

The service promoted awareness of non-visible needs using Hidden Disabilities Sunflower Lanyards, which helped staff identify and offer adjustments for people with less visible conditions including scoliosis, autism and anxiety.

The service employed a 'Think Family' approach to support holistic and safe care when working with children. This included recognising and responding to the needs of parents, carers and siblings as part of safeguarding.

Staff highlighted the service's collaboration with a charity which supported young people aged 11–25 who had experienced violence or exploitation, ensuring their needs were addressed promptly.

Care provision, integration and continuity

Score

1. Evidence shows significant shortfalls in the standard of care

There were significant shortfalls in how the service understood the diverse health and care needs of people and their local communities, so care was not joined-up, flexible or supportive of choice and continuity.

Acute services

Urgent and emergency services

The trust provided data between April 2024 and October 2024 that showed 4786 patients waited over 12 hours and 18304 patients waited over 4 hours to be seen. Analysis from the Royal College of Emergency Medicine revealed that there were more than 16,600 deaths associated with long ED waits before admission in England in 2024, this was a 20% increase compared to 2023. An estimated 16644 associated deaths were related to stays of 12 hours or longer before being admitted. The Office for National Statistics reported in January 2025 that patients who spent more than 12 hours in ED were more than twice as likely to die within 30 days compared to those who were seen within two hours.

The NHS England 2 year urgent and emergency care recovery plan published in January 2023 centred around patients being seen more quickly in emergency departments with an ambition to achieve 76% of patients being admitted, transferred or discharged with 4 hours by March 2024, with further improvements in 2024/2025. Between April and October 2024 data provided by the trust showed that over 42% of patients were not discharged within 4 hours of arrival. Data also revealed that 5% of patients waited over 12 hours for admission, in the same period. This equated to 4786 patients. This meant that there was strong evidence of significant patient risk and negative impact on staff.

Patients with mental health needs frequently experienced long waits for beds, resulting in extended stays in the service. The longest length of stay reported by the trust over the past 12 months was 270 hours (11 days) for an adult, with two other adults recorded 8 days. Staff identified waiting for mental health beds, placement arrangements, and care packages as the primary causes of these delays. The service regularly managed between 305 and 376 mental health patients each month, contributing to significant challenges in patient flow and care continuity.

However, the service used the Manchester Triage System linked to the electronic patient record, which streamlined patient assessments and referrals. Patients seen by the streaming nurse could be directly referred to alternative services, including the urgent treatment centre (UTC), same day emergency care (SDEC), GPs, or pharmacies, ensuring they received appropriate care outside the ED where possible. Where necessary, analgesics was also provided at the streaming window, ensuring patients received timely symptom management while awaiting further care.

The ED had a dedicated navigator who worked to arrange same-day GP appointments and timely access care in the community. This role enhanced integration with primary care services

and supported more efficient use of ED resources.

We reviewed escalation procedures and operational protocols for bed management which set out expectations for specialty response times and actions when delays occur, including escalation to the bronze command team. Staff had access to the patient flow coordinator and were instructed to request a review by senior clinicians when care needs exceeded department scope.

Staff in the waiting room and triage also highlighted the value of having a consultant which facilitated early diagnostics such as X-rays, CT scans, and MRIs. This enabled quicker identification of conditions, including respiratory issues, allowing for timely administration of treatments such as inhalers. Nurses in triage and the waiting room were able to ask the consultant for advice, improving patient outcomes and reducing unnecessary delays.

Providing information

Score

2. Evidence shows some shortfalls in the standard of care

The service did not always supply appropriate, accurate and up-to-date information in formats that were tailored to individual needs.

Patients had access to a range of information to support their understanding of their health and the services available. In the children's emergency department, health information was made accessible via QR codes, providing digital resources on children's health. Printable leaflets were also available although not in all languages, which limited accessibility for some service users. The trust did however display interpreter service information in different languages in the waiting areas.

Complaint information was displayed in the waiting rooms, ensuring patients were aware of how to raise concerns if needed. Complaint information was also displayed on the trust's website; however, we did not see this information offered in any other language. Waiting rooms also displayed real-time updates on waiting times, helping to manage patient expectations.

Acute services
Urgent and emergency services

Appropriate signage was displayed for toilets and pay phones were available for patients to use.

Children with sensory needs were supported in the paediatric ED where there was access to sensory lights, toys, and a play specialist, which enhanced their overall experience. However, the staffing board in the paediatric ED was not updated, which could leave patients and families unclear about who was providing care.

Staff had access to health promotion materials via QR codes and printable resources, which they could use to educate and inform patients. They reported that this approach allowed them to share up-to-date and relevant information efficiently.

Staff also highlighted the availability of interpreter services, for patients whose first language was not English and those requiring British Sign Language. This service was available in both adult and paediatric EDs and supported effective communication with patients from diverse backgrounds.

The trust's GDPR policy was in date, with the next review scheduled for November 2026.

Listening to and involving people

Score

2. Evidence shows some shortfalls in the standard of care

The service did not always make it easy for people to share feedback and ideas, or raise complaints about their care, treatment and support. They did not always involve people in decisions about their care and told them what had changed as a result.

The trust received 87 complaints between October 2023 and October 2024. Complaint numbers varied throughout the year with highest figures recorded in March and September 2024. Monthly totals ranged from 2 to 11. Most complaints related to concerns about care, clinical treatment and staff attitude. Additional themes included communication, wait times and respect for privacy and dignity. We were not assured of how effective the measures in place to

address these complaints were; as complaints were repetitive throughout a 12-month period. The complaints policy was in date as of November 2024, with the next review scheduled for December 2024.

We reviewed verbal resolution letters and found that the service prioritised resolving concerns and complaints by conducting thorough investigations, sharing lessons learned with staff, and providing clear and detailed responses to complainants. When things went wrong, the service apologised, outlined investigation steps, explained what went wrong, and provided assurances about actions taken to address the issues and prevent recurrence. The service listened to feedback and made changes in response to complaints and concerns. Through the service's 'you said, we did' plan, actions were taken to improve referral processes, clarify staff roles and address IT system issues. Complaints were acknowledged within 3 working days in line with the trust's policy but only 83% of complaints between October 2023 and October 2024 were closed within the agreed timeframe.

The results of the October 2024 FFT survey showed that 80% of the 1632 respondents would recommend the service, with 59% rating the service as very good and 21% as good. A total of 9% rated the service as very poor. The response rate for the survey in October 2024 was 90.67%. This was slightly above the national average for emergency departments where 77.9% of patients said they would recommend the service and 14.5% gave a negative rating.

Staff reported that feedback was shared through boards around the service and included in monthly updates between managers and staff. The leadership team placed strong emphasis on the importance of the FFT as a tool for understanding patient experiences and improving services. Leadership demonstrated this by involving staff in discussions about how to address patient concerns and implement improvements.

Patient partners and volunteers were involved in improvement discussions. Notes from governance meetings demonstrated patient partners meeting with ED consultants to discuss explore issues and opportunities for volunteers to support the department during periods of pressure.

Acute services
Urgent and emergency services

Equity in access

Score

2. Evidence shows some shortfalls in the standard of care

The service did not always make sure that people could access the care, support and treatment they needed when they needed it.

The ED operated 24/7 year-round, ensuring constant access for patients in need. However, people faced significant delays in accessing care, support, and treatment in the service. This was particularly challenging for those with additional physical and emotional needs, who were sometimes disadvantaged due to the pressures within the service. Staff were not always able to ensure that patients received timely care and support due to delays in access and ongoing capacity pressures. People often waited extended periods in the service due to overcrowding, with a total of 135 patients present during our on-site assessment, 35 of whom were waiting for a ward bed. The longest wait observed for a ward bed was 48 hours. Despite these challenges, patients reported being kept informed about delays, particularly regarding the availability of ward beds, which helped manage their expectations.

Data showed significant numbers of patients experiencing delays exceeding national targets. In August 2024, there were 2,285 waits of over four hours, increasing to 2,716 in September and 2,861 in October. The number of patients waiting over 12 hours also rose, from 643 in August to 669 in September and 798 in October, reflecting growing pressure on capacity and flow. Data showed two patient harms were recorded in the same period. Long waiting periods exceeding 40 hours were considered the norm, with staff reporting that waiting periods exceeding 5 hours is unusual as patients wait for much longer lengths of time.

Although there were over 40 patients waiting for hospital beds in the ED during the assessment, there were no long ambulance queues or prolonged handover delays, reflecting efforts to minimise backlogs at the service's entrance.

The service had 24/7 access to a psychiatric liaison team. Staff in the ED described the team as responsive to mental health patients in terms of the timeliness of assessments. However, patients waiting for a mental health bed was an issue which often had significant delays of up

to 7 days. To support this registered mental health nurses were appointed to provided 1 to 1 care for these patients.

The service had a pain team which operated from Monday to Friday, 9am to 5pm, where staff could refer patients with chronic pain to. However, we observed a patient with chronic back pain who had not had their pain managed and would have benefited from a referral. Also, we were not assured how patients with chronic pain were referred to the pain team outside of the operational hours, including over the weekend.

The service did not have a specific frailty team based in the ED. There was however a dedicated ED frailty link nurse. This meant that there was limited capacity to conduct comprehensive assessments or manage complex needs of multiple frail patients in a busy ED environment. This also meant that there was a lack of multidisciplinary input into the care of frail patients.

Equity in experiences and outcomes

Score

3. Evidence shows a good standard of care

Staff and leaders actively listened to information about people who are most likely to experience inequality in experience or outcomes and tailored their care, support and treatment in response to this.

People's care, treatment, and support promoted equality and protected their rights. There was no indication that people experienced any inequalities in outcomes or access to care, the trust had systems in place to support patients at risk of experiencing inequitable care including people with learning disabilities, autism or language needs, including a liaison service, use of interpreters and staff training. Discharge summaries and results were shared with patients' GPs, ensuring continuity of care. The service made reasonable adjustments to support diverse patient needs, including hearing loops and interpreter services for individuals with communication barriers. Patients had access to digital information with QR codes displayed around the service for easy access to advice leaflets. For those unable to access digital resources, leaflets could be printed upon request. Staff actively signposted patients and carers

to additional services, including community pharmacies and dentists.

Psychology support services were available for patients treated for major trauma, ensuring that those experiencing emotional distress were not overlooked. Trauma psychologists worked with patients to create personalised care plans, including ongoing therapy and referrals to mental health services.

Planning for the future

Score

3. Evidence shows a good standard of care

People were supported to plan for important life changes, so they could have enough time to make informed decisions about their future, including at the end of their life.

Advanced Life Support (ALS) training compliance for medical staff was 93.8%. For nursing staff, ALS compliance was at 88.89% with Basic Life Support (BLS) training at 100%. The services aimed to reach 100% compliance in the next 12 months.

Patients had access to a digital application offered by the service which provided digital tools to monitor recovery, access physiotherapy exercises and included mental health resources and general wellness advice to ensure ongoing support.

The service secured a grant from the Royal College of Emergency Medicine (RCEM) to trial facial scanning technology for remote vital sign monitoring. The project aimed to explore how digital innovation could enhance patient safety and monitoring capabilities.

Well-led

Rating Requires improvement

We looked for evidence that there was an inclusive and positive culture of continuous learning and improvement that was based on meeting the needs of people who used services and wider communities. We checked that leaders proactively supported staff and collaborated with partners to deliver care that was safe, integrated, person-centred and sustainable, and to reduce inequalities.

Acute services

Urgent and emergency services

At our last inspection we rated this key question good. At this inspection the rating has changed to requires improvement. This meant there was not always adequate service leadership and leaders and the culture they created did not always assure the delivery of high-quality care.

The service was in breach of legal regulation in relation to the governance of the service.

Shared direction and culture

Score

2. Evidence shows some shortfalls in the standard of care

The service did not have a clear shared vision, strategy and culture which was based on transparency, equity, equality and human rights, diversity and inclusion, and engagement. They did not always understand the challenges and the needs of people and their communities.

St George's University Hospital had a values-based behavioural framework under the tagline "We Are St George's: Outstanding People, Outstanding Care." This framework was structured around four domains: Excellent, Kind, Responsible, and Respectful. It outlined expectations under categories of "What we expect to see," "What we love to see," and "What we don't want to see." These values were displayed throughout hospital corridors. The trusts strategy was refreshed for 2023-2028. The St Georges University Hospitals ED Strategic Plan 2018- 2023 listed 6 core strategic objectives which were:

1. Continue to provide safe, timely, outstanding quality urgent and emergency care for an ever changing population
2. Build an ambitious, resilient and happy workforce.
3. Stay at the forefront of emergency care through identifying, fostering and adopting clinical and service innovation.
4. Build our research activity to a world class level

Acute services
Urgent and emergency services

5. Work in partnership with other organisation to create a strong local and national health and care system.
6. Create a building and physical infrastructure fit for an outstanding emergency department and major trauma centre.

Each objective had actions to help achieve the objective and success indicators to measure this achievement.

Despite the trust values being around for some time staff could not describe them and reported a lack of involvement in the development of the trust values. When questioned staff had basic knowledge of the trusts values but did not have an awareness of the hospital or department values or strategy

Staff reported positive feelings about working in the ED, although they did describe and acknowledge the difficulties and pressures they faced in delivering the service in line with the values. Staff survey results indicated that although 85% of staff had a support network amongst colleagues, over 75% of staff had considered leaving their role in the last year.

Staff felt there were appropriate forums to raise concerns and discuss challenges they faced in their roles. They described a listening culture within the organisation but noted that while issues were acknowledged, actions to resolve them were not always achieved quickly, if at all.

The trust received a warning notice section 29a on 19 December 2024. The trust's leadership team did not share the findings of warning notice with the senior leadership team in a timely manner. Consequently, staff did not receive information of this breach until after 9 January 2025. The senior leadership team were hesitant regarding the importance of breaches unrelated to patient care in corridors or patient flow. Though these breaches were still acknowledged. This demonstrated a narrow focus over a comprehensive understanding that whilst patient safety was paramount other breaches can still impact the overall quality of care and the well-being of both patients and staff.

We requested data on the ED Workforce Disability Equality Standard and Workforce Race Equality Standard, data provided was at trust level. The Workforce Disability Equality Standard (WDES) was introduced in 2019 and is designed to improve the experiences of people with a disability working in or seeking employment within the NHS. The mandated collection of

evidence-based metrics helps an organisation understand more about the experience of its staff. At St George's 3.7% of the workforce had shared they have a disability on the staff record systems; staff surveys indicated that this figure was closer to 6% of the workforce. It was reported that there was a higher number of staff with a disability in lower bands. Staff with a disability were under-represented at executive and board level within non voting groups, they were positively represented in voting and non-executive director groups. Applicants without a disability was 1.26 times more likely to be appointed compared to applicants with a disability.

The Workforce Race Equality Standard (WRES) is an NHS initiative introduced in 2015 to address racial inequalities within the NHS workforce. All NHS providers are required to complete an annual WRES report. Results from this report showed that Black, Asian and Minority Ethnic workforce had increased year on year since 2019 to be representative of the local communities served by the hospital. For clinical staff there was an increase in the percentage of Black, Asian and Minority Ethnic (BME) staff across 7 of the 11 Agenda for Change bands. There was also an increase in diversity with consultant groups from 38% in 2022 to 47% in 2024. The lowest representation remains band 8a to 8d. For example, of the 25 band 8d and above posts, only 20% were held by a BME member of staff compared to 80% being held by a white member of staff.

Capable, compassionate and inclusive leaders

Score

3. Evidence shows a good standard of care

The service had inclusive leaders at all levels who understood the context in which they delivered care, treatment and support and embodied the culture and values of their workforce and organisation. Leaders had the skills, knowledge, experience and credibility to lead effectively. They did so with openness and honesty.

The trust followed the South West London Acute Provider Collaborative recruitment and selection policy. The policy provided clear processes and standards to follow. Recruitment Inclusion Specialists (RIS) were required to be available to advice interview panels on diversity. Leaders were appointed following a thorough assessment and selection

process, ensuring that they met the necessary specification criteria to perform their roles effectively. Offers of employment were made subject to satisfactory references, medical clearance, checks of qualifications, right to work checks and disclosure and barring service checks. Fit and Proper Persons checks were conducted for director-level appointments.

The clinical leadership team followed a structured job planning matrix that outlined non-clinical responsibilities, enabling the service to align leadership roles with the skills, experience, and ambitions of its staff.

The trust promoted opportunities for staff to change roles to gain broader experience and develop leadership resilience. Several members of the consultant team had previously taken on roles such as care group lead and governance lead, allowing them to offer peer support and provide cover during leave.

Staff benefitted from leadership courses and regular senior leadership teaching sessions from the trust. Career breaks and personal job planning were encouraged and facilitated wherever possible, supporting staff in balancing professional growth with personal commitments.

Staff spoke positively about their experience of working for the trust and described a strong sense of teamwork within the service. Staff highlighted that their colleagues were very supportive and that they felt well supported in their roles by their seniors. The 2024 Staff survey results showed that 82% of staff described the level of friendship amongst staff in the ED as excellent or good.

We reviewed respect in the workplace steering group meeting minutes where leaders took an active role in discussions, recognised positive contributions from reception and clinical teams and acknowledged the emotional impact of workplace pressures. Meetings were used to reinforce the service’s aim to ensure all staff felt part of a supportive, inclusive environment.

The service had taken steps to recognise and respond to variation in staff experience. Leaders acknowledged challenges around inclusivity for newer and lower-banded staff. Team building events and staff development days were planned across multiple bands. Leaders recognised representation gaps including the over-representation of black staff in lower pay bands and committed to improving workplace culture and fairness.

Resident doctors reported feeling well supported in their training and development. ED

consultants explained that they had regular meetings with the senior leadership team and described good communication and engagement with leaders. Nursing staff also reported that they were supported in their professional development, with opportunities available to progress their skills through additional courses.

Patients described staff as kind, respectful and took time to explain their care thoroughly. Feedback from patients highlighted attentiveness shown by staff. The department responded to patient feedback by reinforcing expectations around communication and behaviour, demonstrating a commitment to delivering care in line with the trust's values.

However senior staff reported being unsure of what training bank staff received. Senior staff reported limited protected time for mandatory training and no additional training time given.

We could not review competencies for leadership staff or the skills that demonstrated competency within the ED. We requested data on evidence of leadership competency, but the trust provided documentation pertinent to a general ward, not the Emergency Department's specific needs. Additionally, the submitted Competency Assessment Document (CAD) and responsibilities for the Nurse in Charge (NIC) of inpatient Wards competency checklist was blank, and the trust did not provide other leadership competency assessments for the ED's diverse leadership roles. This meant that we were unable to review competencies for leadership staff, and was unable to review the skills measured to demonstrate competency within the ED.

Reception staff reported feeling unsupported by managers and leaders, who they felt were not visible and did not routinely check on the team during busy periods. They described the environment as high-pressure when managing large numbers of patients, despite the presence of security staff.

Freedom to speak up

Score

3. Evidence shows a good standard of care

The service fostered a positive culture where people felt they could speak up and their

voice would be heard.

Staff felt encouraged to raise concerns and reported that leaders were supportive when they did so. Staff expressed confidence that actions were taken to address issues they raised, contributing to an open and transparent culture. The trust had a freedom to speak up guardian who engaged with staff regularly, providing an accessible route for raising concerns. Staff could access the freedom to speak up guardian whenever needed, ensuring that issues could be escalated through a structured process.

The trust also had an in-date raising concerns at work policy, with the next review scheduled for March 2025**.** This policy provided a clear framework for staff to report concerns and reinforced the trust's commitment to supporting a speaking-up culture.

Workforce equality, diversity and inclusion

Score

2. Evidence shows some shortfalls in the standard of care

The service showed limited diversity in their workforce for senior staff. Staff work towards an inclusive and fair culture by improving equality and equity for people who work for them.

Leaders took steps to ensure that some staff and leadership positions reflected the diverse population of people using the service. As of October 2024, the ED workforce was made up of 45.68% BME staff, 52.87% white staff. This indicated a diverse workforce, however, there was an underrepresentation of BME staff in clinical posts at Band 7 and above. The trusts Workforce Race Equality Standard (WRES) and Workforce Disability Equality Standard (WDES) data showed that while the ED workforce was diverse, staff from minority ethnic backgrounds and those with disabilities were underrepresented at senior levels. Senior representation was not representative of the patient demographic using the ED. Staff survey results highlighted concerns around workload and inclusion, with only 47% of ED staff saying they would recommend the trust as a place to work.

Acute services
Urgent and emergency services

The gender distribution in the service was 67% female and 33% male.

However, the trust had an ED respect forum, a proactive initiative designed to promote workforce equality, diversity, and inclusion (EDI). This forum provided an open platform for discussing Black, Asian, and Minority Ethnic (BME) representation, workforce demographics, and career progression transparency. Staff described the forum as a positive initiative that had contributed to improving staff experience, particularly for overseas nurses and doctors adjusting to working in the NHS. The forum had expanded to engage specific staff groups, including receptionists and international staff, ensuring that wider workforce perspectives were considered in discussions about inclusivity and representation.

Staff had access to multiple staff networks, including networks for BME, disability and wellness, LGBTQ+, and women's networks, supporting an inclusive and representative workplace.

The trust demonstrated a commitment to EDI through initiatives such as an internship programme designed for young adults aged 18–24 with autism and/or learning difficulties. This programme provided opportunities for young adults to develop skills and gain work experience, further reinforcing the trust's inclusive approach to workforce development.

Governance, management and sustainability

Score

1. Evidence shows significant shortfalls in the standard of care

The service did not have clear responsibilities, roles, systems of accountability and good governance. They did not act on the best information about risk, performance and outcomes, or share this securely with others when appropriate.

The governance systems in place did not always identify or address risks in a timely way. This was reflected in concerns outlined in the warning notice including poor documentation, unsafe medicines management, triaging processes and information security concerns.

There was a lack of systems and processes in place to support the confidentiality of people

using the service. During our assessment, we observed staff did not always store and treat service user identifiable information in line with General Data Protection Regulations (GDPR). Staff did not recognise the need to lock computer screens or remove service user sensitive information from public view. We observed five computers where staff had left their Smart Cards inserted into the Smart Card readers. NHS Smart Cards are essential for healthcare professionals to securely access patients' information and IT systems. This created a data security breach and meant that patient data could have been accessed by the public. We observed a computer had been left unattended with a staff smart card still in place in majors B for ten minutes. We issued a section 29a warning notice and received an action plan from the trust describing mitigation steps for these risks. The time a computer remains unlocked before automatic lock-out has been reduced from 10 minutes to 3 minutes. Concerns were also communicated at daily safety huddles to remind staff to lock computer screens immediately and not to rely on the automatic screen lock.

We requested information on cyber security, and we were provided with the trusts Information Governance Management Framework and Policy. Whilst there was reference made to cyber security, we expected to review a policy for how digital information and systems were protected from digital threats. Therefore, we could not be assured that the importance of digital patient data was understood nor was it being protected at all times.

The governance structure of the ED included monthly governance meetings where key risks, incidents and issues were reviewed. The service maintained two risk registers tracking both new and open risks.

We reviewed the two ED risk registers, one for current open risks and another for new risks. At the time of the assessment, there were eight risks recorded in the new risks register and nine in the open risks register. We found the use of two risk registers had the potential to introduce confusion and operational inefficiencies. Preventing a single comprehensive overview of all potential and active risks in ED. One of the risks on the open risk register had been inputted in December 2021 with a due date of December 2022, but there was no further documentation to action this risk.

Safe care and treatment were compromised due to several factors; including high numbers of down to admit (DTA), exit blocks caused by lack of capacity for inpatients and staffing levels. 20 DTAs in the ED had been normalised which had peaked to 50 DTAs. Exit blocks had an impact on

the level of care within the ED department but also had a knock-on effect with ambulance off load delays and delays to 999 response times. A research paper in the Emergency Medical Journal 2022 stated an association between delays in ED admissions and all cause 30-day mortality. The authors concluded that for every 82 patients delayed between 8 and 12 hours from time of arrival, there is 1 extra death. This meant that in 2022, for this ED service the 30-day excess mortality for May was 40, June 47 and July 42. This was an excess mortality of over one patient per day every day.

During our assessment we observer a high number of mental health patients with extended stays and exceeding resus capacity. This had been documented on the open risk register in August 2022, as an extreme risk. The full capacity protocol was a documented control however the approved full capacity protocol was only circulated in November 2024. This meant that there was a 3 year delay to inform staff on what to do when operating at full capacity.

Risks identified during our assessment were not always recorded on the risk register. We reviewed mental health patients on the risk register with a RAG status of extreme however, we saw no documentation on mitigation around ligature assessment and hazards in the ED that could protect mental health patients.

VTE audits were not on the risk register despite poor performance indicated across the whole trust.

Senior staff lacked understanding and knowledge of environmental sustainability. When questioned staff were unable to describe what it meant to their role and did not see this as a priority. In April 2024 there was a Green ED week but senior staff were not able to recall what happened or how this impacted the ED department. However, staff were aware that becoming paper light and using recycling bins enhanced environmental sustainability.

We asked to review the last 3 months of clinical governance meetings minutes, but we were sent a blank agenda for the meeting. We also received 3 files tiled Action Log ED for 3 separate months in 2024; September, October and November. However, each log had a meeting date of 1 November 2023 and two of these logs were identical, despite being a log for two different months. The logs were brief and lacked detail. Although the department assigned a responsible officer to each of the two issues and recorded a mitigation action, the logs did not document the outcome or previous issues from other months. This prevented effective trend analysis and

reflected poor governance processes. Consequently, the logs offered no robust audit trail to demonstrate proper risk management, action implementation, or outcome achievement.

Staff understood their roles and responsibilities within the ED and reported that governance and management structures were well defined. The ED had a monthly governance meeting where governance leads for adults and paediatrics reported on key issues. Additionally, divisional governance meetings were held monthly, where leaders reviewed key performance indicators, complaints, risks, and workforce challenges. Governance meetings were well-structured and attended by a multidisciplinary team. We observed key topics such as mortality, safety alerts, and the trust's risk register being discussed. Outcomes from the meetings were shared through the departmental newsletter.

The service promoted a proactive incident reporting culture, with incident report submissions encouraged and reviewed weekly. Complaints and PALS (patient advice and liaison service) handling were well structured, with the assistant service manager overseeing all complaints. Regular divisional complaints meetings took place to ensure timely responses, and consultant governance leads for adults and paediatrics played a role in supporting complaint resolution.

ED leadership demonstrated a commitment to using audits to drive service improvements. Patient flow data was reviewed to measure waiting times and inform the implementation of a digital triage. Feedback from major trauma audits was also used to refine trauma response processes and improve patient outcomes.

We reviewed policies including the initial assessment of children and young people in the emergency department policy, which was in date, with the next review scheduled for September 2026. The information governance management framework and policy were in date, with a review planned for November 2026. The emergency preparedness, resilience, and response (EPRR) policy were also in date, with the next review due in August 2025.

Governance meetings were well-structured and attended by a multidisciplinary team, covering performance measures, safety incidents and learning opportunities. We reviewed meeting minutes where issued were actively followed up and managers responding to concerns.

Acute services
Urgent and emergency services

Partnerships and communities

Score

3. Evidence shows a good standard of care

The service understood their duty to collaborate and work in partnership, so services work seamlessly for people. Staff share information and learning with partners and collaborate for improvement.

The ED actively collaborated with Epsom and St Helier University Hospitals NHS Trust to share best practice and solutions, including the implementation and sharing of a full capacity protocol. This partnership aimed to improve patient flow and response strategies during periods of high demand.

Leaders within the ED engaged with local schools to promote understanding of emergency care. A consultant, matron, and deputy general manager visited three separate schools to educate young children about the role of the service and what to expect when accessing urgent care.

The service was in the process of establishing an ED voice group, which was a quality improvement initiative designed to engage with patients and gather feedback on their experiences using a survey. The responses would be used to invite patients to attend a session at the trust, where they would meet members of the ED team face-to-face and participate in structured focus groups. These focus groups would allow patients to discuss their experiences in different areas of the ED, helping to shape improvements in service structure, processes, and patient outcomes.

The trust homelessness inclusion team played a significant role in supporting vulnerable patients by promoting health equity and advocating for individuals at risk of exclusion from healthcare services. The team engaged in various external boards and forums, including the Violence Reduction Network for Allied Healthcare Professionals and the Mayor of London's Violence Reduction Unit (VRU). These partnerships enabled the trust to work alongside external organisations to develop strategies to address health inequalities, improve access to services, and provide targeted support for high-risk patient groups.

Acute services
Urgent and emergency services

The service worked in partnership with local GPs and community services to support safe streaming and referral including collaboration with regional retrieval teams for paediatric critical care transfers and with community paediatric and safeguarding services.

Staff described strong collaborative relationships with external partners, including the psychiatric liaison team and child and adolescent mental health services (CAMHS). These partnerships were critical in providing comprehensive care and ensuring smooth pathways for patients with mental health needs.

Learning, improvement and innovation

Score

3. Evidence shows a good standard of care

The service focused on continuous learning, innovation and improvement across the organisation and local system. Staff encouraged creative ways of delivering equality of experience, outcome and quality of life for people. Staff actively contribute to safe, effective practice and research.

Leaders encouraged staff to contribute ideas for improvement and innovation, fostering a culture of continuous learning and service development. Staff were supported in identifying areas for enhancement, and the service actively pursued technological advancements to improve patient care and operational efficiency.

Consultants in the service were responsible for both clinical and non-clinical duties, with additional leadership roles incorporated into their job planning. These responsibilities were rotated to support professional development, broaden expertise, and ensure a diverse skill set within the team. The trust encouraged consultants to take on leadership positions within the service and across the organisation, allowing them to contribute to service development and advance their professional growth. Examples of consultant leadership roles included the clinical director, who oversaw the overall management, strategic planning, and leadership of the service alongside the head of nursing and general manager. The care group lead was responsible for providing leadership and management support to the consultant and medical

workforce, ensuring high-quality care, adherence to protocols, and the effective day-to-day operation of the service.

Following our inspection, a new e-triaging system has been introduced in the service to improve access and flow. For service users who do not have access to a smart phone, devices are situated at the entrance for accessibility. For service users who are unable to use the device or English is not their first language, a streaming clinician assists with this using translation services.

The service also conducted weekly incident reviews to identify recurring themes and areas for safety improvements. These reviews played a crucial role in learning from incidents, mitigating risks, and driving continuous service enhancement.

LAP assessment report

Queen Mary's Hospital

LAP Assessment Report ID : lap-01860

Inspection visit date(s): 11 February 2025

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Queen Mary's Hospital
Location findings

Ratings for this location

Overall	Requires improvement
Safe	Requires improvement
Effective	Requires improvement
Caring	Good
Responsive	Requires improvement
Well-led	Good

Overall location summary

Date of assessment: 11 February 2025. Queen Mary's Hospital provides outpatient and surgical services. This assessment looked at surgical services due to aged ratings and concerns regarding Never Events within the service. We inspected all quality statements across the five key questions:, which we rated as good. The rating from surgery has been combined with ratings of outpatients from the last inspection. See our previous reports to get a full picture of all other services at Queen Mary's Hospital. The rating of Queen Mary's Hospital remains requires improvement. In our assessment of surgery services we found there was a good safety culture where incidents were investigated, and learning was embedded to promote good practice. Staff provided safe care and treatment, they followed evidence-based practice and there was effective team work to support positive patient outcomes. Staff were kind, caring and compassionate. The service planned care to meet the needs of people, took account of patients' individual needs, and made it easy for people to give feedback. The service and staff were well-led by strong leaders who supported staff to develop their skills. Staff were committed to continually learning and improving services.

Queen Mary's Hospital
Location findings

Safe

Rating Requires improvement 

Our overall rating of safe at Queen Mary's Hospital remains requires improvement

Effective

Rating Requires improvement 

Our overall rating of effective at Queen Mary's Hospital remains requires improvement.

Caring

Rating Good 

Our overall rating of caring at Queen Mary's Hospital remains good.

Responsive

Rating Requires improvement 

Our overall rating of responsive at Queen Mary's Hospital remains requires improvement.

Well-led

Rating Good 

Our overall rating of well-led at Queen Mary's Hospital is now good. We looked at surgery services only and rated well-led as good.

Acute services
Surgery

Surgery

Overall	Good
Safe	Good
Effective	Good
Caring	Good
Responsive	Good
Well-led	Good

Our view of the service

Date of assessment: 11 February 2025

We carried out an unannounced comprehensive inspection of surgical services at Queen Mary's Hospital due to aged ratings and concerns regarding Never Events within the service. We inspected all quality statements across the five key questions: safe, effective, caring, responsive and well-led.

During our inspection we visited the surgical treatment centre. This included 4 theatres, patient assessment rooms, patient waiting and changing areas and the recovery room. We also visited staffing areas within the centre. We spoke with over 18 members of staff including nursing and medical staff, healthcare assistants, housekeeping staff, and managers. We spoke with 8 patients. We rated the service as good overall. There was a good safety culture where incidents were investigated, and learning was embedded to promote good practice. Staff provided safe care and treatment, they followed evidence-based practice and there was effective team work to support positive patient outcomes. Staff were kind, caring and compassionate. The service planned care to meet the needs of people, took account of patients' individual needs, and made it easy for people to give feedback. The

Acute services
Surgery

service and staff were well-led by strong leaders who supported staff to develop their skills. Staff were committed to continually learning and improving services.

People's experience of the service

Patients were all positive about the staff treating them with warmth and kindness and providing effective care and treatment. They said they were generally seen quickly after arrival for pre-operative review by anaesthetic staff.

Records showed they were appropriately assessed and monitored throughout their treatment and care at the surgical treatment centre. They felt staff were on hand if they needed them for help or support. People said they did not feel anxious about raising concerns.

Some feedback from patients included they sometimes had to wait longer than expected between arrival and surgery. They appreciated that staff tried to manage the flow of patients by staggering arrival times and most said communication with them was good.

Safe

Rating Good

We looked for evidence that safety was a priority for everyone, and leaders embedded a culture of openness and collaboration. We checked that people were safe and protected from bullying, harassment, avoidable harm, neglect, abuse and discrimination. We also checked people’s liberty was protected where this was in their best interests and in line with legislation.

At our last assessment we rated this key question good. At this assessment the rating has remained good. This meant people were safe and protected from avoidable harm.

Acute services
Surgery

Learning culture

Score

3. Evidence shows a good standard of care

The service had a proactive and positive culture of safety, based on openness and complete honesty. Staff actively listened to concerns about safety and thoroughly investigated and reported safety events. Lessons were always learnt to continually identify and embed good practice.

Patient safety incidents were managed well. Staff understood how to identify, report and record incidents and recognised the importance of using information to support learning and improvement.

Between January 2024 and December 2024, the trust reported 7 Never Events in surgery, this included a wrong site skin surgery never event at Queen Mary's Hospital surgical treatment centre. Managers investigated when things went wrong and worked together with staff and colleagues to identify improvements. We saw examples of learning and staff were involved in this. This included the development of a new safety checklist. Improved safety actions included the use of mirrors, photographs and additional checks with the patient and staff to ensure the correct lesion was removed.

Staff were consistently able to give examples of discussions, learning and improvement. They understood the requirement for openness and honesty in relation to the Duty of Candour, informing patients when things went wrong and involving them in investigations. We viewed an example where an apology letter was sent to a patient because their surgery had been postponed due to a lack of available equipment. Staff informed the patient of the reason for the error and the action taken to prevent it from happening again.

We reviewed surgical treatment centre team meeting minutes and saw that incidents were routinely discussed. This included incidents that had occurred at other hospital sites.

Acute services
Surgery

Safe systems, pathways and transitions

Score

3. Evidence shows a good standard of care

The service worked with people and healthcare partners to establish and maintain safe systems of care, in which safety was managed or monitored. Staff made sure there was continuity of care, including when people moved between different services.

Staff told us there was good multidisciplinary team working within the service. We observed a collaborative approach and staff working well together to manage safety.

There was good communication with patient's GPs and, where indicated, with other services for patients with enhanced needs. Staff reviewed patient records 1 to 2 days ahead of surgery. This ensured suitability for day of surgery and identify any potential concerns.

There was good continuity of care when patients moved between services. For example, on occasion, where a patient's recovery indicated they required additional support in emergency situations or where their condition was deteriorating, they would be transferred to St George's Hospital accident and emergency (A&E) department by emergency ambulance. There was a clear deteriorating patient policy in place for this and an anaesthetist accompanied the patient to provide enhanced care during transfer and to provide a thorough handover on arrival at A&E.

Safeguarding

Score

3. Evidence shows a good standard of care

The service worked with people and healthcare partners to understand what being safe meant to them and the best way to achieve that. Staff concentrated on improving people's lives while protecting their right to live in safety, free from bullying, harassment,

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abuse, discrimination, avoidable harm and neglect. The service shared concerns quickly and appropriately.

Staff understood how to access the service's safeguarding adults and children policy which was up to date and available on the hospital intranet system. The policy included clear guidance on reporting and escalation of safeguarding concerns. Staff told us they could raise safeguarding concerns with senior staff and felt these were taken seriously. They also felt confident accessing the trust's safeguarding team for advice and support.

All clinical staff were trained to level 2 and 3 safeguarding adults and children. The service's compliance rates in safeguarding training exceeded the hospital's target of 85%.

Safeguarding posters were visible on the unit and included information on how to raise safeguarding concerns. Staff we spoke to had a good understanding of the different types of safeguarding risk and concerns.

Involving people to manage risks

Score

3. Evidence shows a good standard of care

The service worked with people to understand and manage risks by thinking holistically. Staff provided care to meet people's needs that was safe, supportive and enabled people to do the things that mattered to them.

Patients were assessed as to their suitability to receive treatment at the centre and as a day surgery patient. Staff completed individual patient risk assessments including pain, pressure ulcer risk, and moving and handling. From the records we reviewed we saw evidence that assessments had been appropriately completed with patients.

Action was taken to work with patients about specific risks to their health. For example, on the day of our visit to the treatment centre, a patient with an allergy to latex was undergoing surgery. A risk assessment had been undertaken in discussion with the patient. Actions were

put in place, including adapting the theatre schedule to mitigate against any interruptions and signage on theatre doors reminding staff of the risks. Other assessments included pain, skin integrity and where appropriate due to the nature of the surgery, venous thromboembolism risks.

Staff monitored the stability of patients using the national early warning scores (NEWS2). In addition, level of consciousness scores was used in relation to assessment of the level of sedation of patients, including during their recovery. We saw that monitoring of patients post operatively included frequent observations, starting at 5-minute intervals for the first 30 minutes post operatively then moving to every 15 minutes. Staff we spoke with were aware of escalation protocols for deteriorating patients. They routinely increased the frequency of observations when NEWS2 scores indicated this.

There was an additional anaesthetist working within the surgical treatment centre, known as a 'floating' role to assist with any unwell or deteriorating patients. When necessary, patients requiring additional support post operatively were sometimes transferred to St George's Hospital. They were transferred by emergency ambulance and accompanied by an anaesthetist to ensure continuity and a sufficient handover of care. The service recorded transfers using their incident reporting system. We saw that 7 transfers had occurred since April 2024. These were for issues such as managing patients' airway, pain, blood pressure and abnormal blood results and cardiac concerns.

The service used the World Health Organisation (WHO) five steps to safer surgery checklist effectively; this was used in line with national guidelines and embedded into practice. We reviewed audit data for Local Safety Standards for Invasive Procedures (LocSSIPs) and National Safety Standards for Invasive Procedures (NatSSIPs 2) and found that all specialties at Queen Mary's Hospital achieved 100% safer surgery compliance in relation to the required checks, with the exception of urology that achieved 98%.

Safe environments

Score

3. Evidence shows a good standard of care

Acute services
Surgery

The service detected and controlled potential risks in the care environment. Staff made sure equipment, facilities and technology supported the delivery of safe care.

During the inspection we visited the surgical treatment centre. We looked at the environment which included, a staff room, changing areas, waiting areas, consultation rooms, theatres and anaesthetic rooms, preparation rooms, scrub areas, utility areas and the recovery room. The treatment centre had been constructed in 2021 and had recently had a refurbishment of the ventilation system. The service had suitable premises that were well maintained. However, managers told us there had been some challenges with the premises relating to the use of a generator and 2 episodes of generator failure. Risk assessments had been carried out and there were appropriate business continuity arrangements in place to reduce the impact of this. There were longer term plans to build an electricity sub-station.

Environmental risk assessments were carried out, for example, in relation to health and safety and fire safety. There were appropriate checks in place that included fire alarm testing and water safety testing.

The environment was free from clutter and well ordered with good use of storage space. There were no environmental hazards identified during out visit. Fire escapes and exits were free from clutter and easily accessible. Substances hazardous to health were stored in a locked Control of Substances Hazardous to Health (COSHH) cupboard in a clinical area only accessible to staff.

The environment was suitably secure. Theatres were accessed using no touch sensors and the treatment centre was accessible using allocated swipe cards or through the manned reception area.

Emergency trolleys were easily available within the service. We checked the emergency trolleys in the theatre and recovery areas and found that they were secured with a plastic snap lock, so it was clear if someone had accessed the resuscitation equipment. Equipment in emergency trolleys was checked either daily or monthly and we saw evidence of these checks. We also checked consumable items such as defibrillator pads, needles and syringes and found they were sealed and in date.

Electrical equipment such as defibrillators and suction machines had up to date electrical safety tests.

Acute services
Surgery

Safe and effective staffing

Score

3. Evidence shows a good standard of care

The service made sure there were enough qualified, skilled and experienced staff, who received effective support, supervision and development. Staff worked together well to provide safe care that met people's individual needs.

Managers planned and reviewed staffing levels. Staff told us that staffing was good, with appropriate levels and mix of skills. Nursing and theatre staffing was planned to ensure 2 qualified and 1 operating department assistant or healthcare assistant covered each theatre and there were 6 registered nurses and additional nurse associates planned to ensure 8 or 9 staff working in recovery. We reviewed rotas and saw that planned staffing was consistently achieved. There was minimal use of bank or agency staff.

There were sufficient medical staff to keep people safe and meet their individual needs. Theatres were staffed by 3 anaesthetists, 2 participating in theatre lists and a third who was available to support recovery and in the event of a deteriorating patient. There were no medical staff vacancies impacting the Queen Mary's Hospital surgical treatment centre.

New staff undertook competency-based training and assessment. There were 2 practice educators providing support across 2 days a week. This included supporting healthcare assistants to complete the care certificate and mentor and assessor support to all staff. We viewed competency frameworks for staff in relation to scrub practitioners, recovery practitioners and leadership roles. These incorporated induction programmes and learning agreements.

Staff received training appropriate to their role. Mandatory training rates exceeded the trust's 85% target. The surgical division achievement rate was 90%. Mandatory training included safeguarding, infection control, resuscitation, moving and handling and information governance.

Staff told us they had opportunities to develop their skills and complete training outside of mandatory training requirements. Staff we spoke with told us they had received an appraisal in

the last year. Achievement rates for appraisals across the theatres and anaesthetics division were 85% for non-medical staff and 84% for medical staff. This was below the trust target of 90% but we saw there was close monitoring of compliance. Appraisal completion for staff working within the surgical treatment centre at Queen Mary's Hospital was 100%. Team leaders at Queen Mary's Hospital told us all non-medical staff had received an appraisal in the last year.

Infection prevention and control

Score

3. Evidence shows a good standard of care

The service assessed and managed the risk of infection. Staff detected and controlled the risk of infectionspreading and shared concerns with appropriate agencies promptly.

The environment of the surgical treatment centre was clean and well maintained, with suitable furnishings. One of the theatre nurses was the lead for infection prevention and control (IPC). There were up to date cleaning records demonstrating regular cleaning of the environment. Cleaning audits were carried out and showed 100% compliance in November and December 2024.

We observed staff appropriately washing their hands and there were relevant hand hygiene posters at hand washing areas. There was access to hand sanitisers throughout the service. Monthly audits of staff hand hygiene were carried out. These consistently showed that the service exceeded the trust target of 95% compliance between October and December 2024.

The trust infection control policy was in date and accessible on the hospital intranet. Staff had support from the site IPC team to help manage any IPC issues. Staff told us there were regular IPC walk arounds and microbial testing on the theatre air quality.

There were no reported surgical site infections (SSI) at the surgical treatment centre. Audits of the intra and post operative SSI prevention was carried out in the centre biannually. Records showed that SSI prevention compliance was 100%.

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There was easy access to personal protective equipment (PPE) such as gloves and aprons. We observed staff wearing appropriate PPE in theatres.

Equipment was decontaminated and cleaned as appropriate in line with trust policy. We saw the use of 'I am clean' stickers that indicated equipment had been cleaned after use.

Waste management was handled in line with national standards. Recognised colour coding was used. Waste bins were foot pedal operated and used appropriately. Sharps bins were labelled and not overfilled.

Medicines optimisation

Score

3. Evidence shows a good standard of care

The service made sure that medicines and treatments were safe and met people's needs, capacities and preferences. Staff involved people in planning, including when changes happened.

Patients were given appropriate information about their medicines in relation to the treatment they received. This included pre-operative information about changes to their usual medicines and post operative information about issues such as pain control. There were processes for assessing patients on admission to the surgical treatment centre and this included a review of their medicines and relevant medical history.

The trust pharmacy team were available to support safe and secure management of medicines. We saw that medicines were stored safely, within locked cupboards where the keys were only accessible to authorised staff. Controlled drugs were stored in line with legislation and records of administration were completed appropriately.

Monthly audits of medicines were carried out in theatres and recovery. Performance was consistently at 100% for the surgical treatment centre. Variance in November 2024 included that records of fridge temperature checks were not recorded on the appropriate form and that a medicines cupboard was not appropriately secured. We did not observe these issues during

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our inspection and records were appropriately maintained of fridge temperatures.

Effective

Rating Good

We looked for evidence that people and communities had the best possible outcomes because their needs were assessed. We checked that staff and leaders delivered care and treatment in line with legislation and evidence-based guidelines. People's care, support and treatment reflected their needs and any protected equality characteristics, ensuring people were at the centre of their care. We looked for evidence that processes around consent were in line with national guidance. Leaders instilled a culture of improvement, where understanding current outcomes and exploring best practice was part of their everyday work. Staff worked well together to ensure the best possible care for patients.

At our last assessment we rated this key question requires improvement. At this assessment the rating has changed to good. This meant people's outcomes were consistently good, evidence-based guidelines were followed and staff worked well together.

Assessing needs

Score

3. Evidence shows a good standard of care

The service made sure people's care and treatment was effective by assessing and reviewing their health, care, wellbeing and communication needs with them.

People were assessed prior to booking as to their suitability and eligibility for day surgery. Patients undergoing surgery under general anaesthetic had a pre-operative assessment. Team leaders reviewed patient records prior to the day of surgery to identify any additional risks or needs as part of an overall assessment. This included the identification of wellbeing and communication needs. For example, we saw that a patient with a learning disability had their needs assessed and adjustments were made, including enabling them to have their carer with them prior to surgery and in recovery. We saw that 87% of staff had completed training in

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learning disability and autism awareness and 95% had completed training in dementia awareness, this was above the trust target of 85%. Staff we spoke with demonstrated an understanding of the assessment needs of individuals and options for adjustments to ensure their needs were met.

On arrival to the unit patients were checked in by anaesthetic staff. There were clear assessment processes. This included a review of patients past medical history, medication and physical observations. In addition, as part of discharge planning, staff assessed any additional needs to ensure appropriate arrangements were in place.

Delivering evidence-based care and treatment

Score

3. Evidence shows a good standard of care

The service planned and delivered people's care and treatment with them, including what was important and mattered to them. Staff did this in line with legislation and current evidence-based good practice and standards.

Treatment and care were delivered in line with legislation, national guidance and evidence-based practice. Staff had access to trust policies through the intranet system. Staff knew how to access policies and those we reviewed were up to date and based on nationally recognised standards.

We saw that National and Local Safety Standards for Invasive Procedures (NatSSIPs and LocSSIPs) were embedded in practice. We reviewed audit data from December 2024 and saw that safety measures generally demonstrated compliance of between 96% and 100% across surgical specialities within Queen Mary's Hospital.

Staff followed national guidance on pre-operative fasting. Staff staggered admission times to reduce waiting and minimise fasting times for people. We reviewed preoperative fasting data visible in the department and found that in December 2024 between 50% and 60% of patients fasted up to 4 hours, with 15% to 20% fasting for up to 2 hours. This meant that the majority of

patients fasted for longer than national guidelines that state people may drink clear fluids until 2 hours before their operation.

People were discharged post operatively when their condition was stable, and they had managed to eat and drink.

We saw there was a formal annual clinical audit programme to evidence performance monitoring, quality measures or patient outcomes relating to surgical services. There was a corporate audit plan, which included national audits, which the trust was submitting data to.

How staff, teams and services work together

Score

3. Evidence shows a good standard of care

The service worked well across teams and services to support people. Staff made sure people only needed to tell their story once by sharing their assessment of needs when people moved between different services.

We observed good multidisciplinary working in theatres and recovery. Staff worked well together to support people. Staff told us that medical staff were easily accessible and there were clear arrangements for escalating concerns, including a 'floating' anaesthetist should the need arise. Staff met regularly prior to starting theatre lists, to discuss risks and issues and organise themselves.

Staff told us they received support from additional multidisciplinary team members and departments. This included safeguarding, practice education and other specialist services when needed.

Because people accessing day surgery were expected to be discharged following their recovery, it was unusual for people to move between different services. However, in the event of complications where further treatment or care was needed, patients may be transferred to St George's accident and emergency department. This was always done with a medical escort and

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relevant patient notes so that the assessment of their needs was shared with the receiving medical team.

Discharge summaries were sent to the patient's GP following surgery.

Supporting people to live healthier lives

Score

3. Evidence shows a good standard of care

The service supported people to manage their health and wellbeing to maximise their independence, choice and control. The service supported people to live healthier lives and where possible, reduce their future needs for care and support.

People's health needs were assessed as part of pre-operative processes, including in relation to their appropriateness for day surgery. Assessments helped staff to identify people's support needs, and this included lifestyle factors and their recovery from surgery. Staff gave advice that included the promotion of healthy lifestyles. For example, patients undergoing vascular day surgery were encouraged to do gentle walking and increase the amount daily.

Monitoring and improving outcomes

Score

3. Evidence shows a good standard of care

The service routinely monitored people's care and treatment to continuously improve it.

There were effective approaches to monitor people's care and treatment and their outcomes. The trust operated a schedule of national audits relating to a broad range of issues relevant to surgery. However, these were not all relevant to the day surgery undertaken at Queen Mary's Hospital.

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Trust wide metrics for anaesthesia and perioperative medicine as part of the Getting It Right First Time (GIRFT) programme showed that service performance did not comply with the GIRFT standard in most metrics. The service was also an outlier for wrong skin lesion surgery between April 2023 and March 2024, which included surgery at Queen Mary's Hospital; however, we saw evidence of improvements being implemented to address this and prevent future incidents. However, there were effective approaches to monitor people's care, treatment and their outcomes. Audit schedules were set up for 2024-2025 to assess a wide range of patient care.

Local audits were undertaken to monitor and improve patient outcomes. These included monitoring of areas such as fasting times and audits of local safety standards. We saw that between August 2024 and February 2025 fasting times averaged just over 2.5 hours within the surgical treatment centre, with most people fasting for between 2 and 4 hours pre-operatively. Audits of safety standards showed consistently high adherence to safety requirements. Improvements were made when safety issues were identified, including a 'no photo, no surgery' amendment to local standards in relation to removal of skin lesions to minimise the risk of the incorrect lesion being removed.

The trust also monitored incidents where patients had to return to theatre due to complications. There had been no reported incidents relating to day surgery at Queen Mary's Hospital surgical treatment centre.

Consent to care and treatment

Score

3. Evidence shows a good standard of care

The service told people about their rights around consent and respected these when delivering person-centred care and treatment.

Written consent was appropriately sought from patients in line with guidance and recorded on consent forms. Forms included the identification of risks and a record these had been discussed with people before signing them. We reviewed written consent forms and saw these were completed and signed appropriately.

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People told us staff explained care and treatment to them in a way they understood, and we observed staff requesting consent to undertake assessments and post operative monitoring.

Staff understood the process and requirements for assessing whether a patient had the capacity to make decisions about their care in relation to the Mental Capacity Act (MCA) 2005. Staff received training on the Mental Capacity Act and Deprivation of Liberty Safeguards, compliance across anaesthetic, scrub and recovery teams at Queen Mary's Hospital was at 100% which was above the trust target of 85%.

Staff followed the trust policy and procedures when a patient could not give consent. We reviewed the consent and Mental Capacity Act (2005) policies, which was based on recognised guidance and appropriately up to date and reviewed.

Caring

Rating Good

We looked for evidence that people were always treated with kindness, empathy and compassion. We checked that people's privacy and dignity was respected, that they understood that they and their experience of how they were treated and supported mattered. We also looked for evidence that every effort was made to take people's wishes into account and respect their choices, to achieve the best possible outcomes for them.

At our last assessment we rated this key question good. At this assessment the rating remained good. This meant people felt well-supported, cared for and treated with dignity and respect.

Kindness, compassion and dignity

Score

3. Evidence shows a good standard of care

The service always treated people with kindness, empathy and compassion and respected their privacy and dignity. Staff treated colleagues from other organisations with kindness

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and respect.

Feedback from patients we spoke with was consistently positive. This included comments that the 'care has honestly been fantastic, I can't fault it' and 'have been so kind, caring and friendly which has made all the difference'. Other patients told us they had received treatment at the centre more than once and did not want to go anywhere else because the care had been so good.

We reviewed Friends and family test results and saw these were consistently higher than average, between 99% and 100%.

There was a strong, visible person-centred culture. Staff understood and respected the personal, cultural, social and religious needs of people using the services. They respected people's privacy and dignity and took action to preserve this.

Staff told us there was a positive culture within the surgical treatment centre. Staff were observed to be kind and respectful to each other and those we spoke to consistently told us there was a supportive culture. There was a clear focus on the emotional wellbeing of patients.

Treating people as individuals

Score

3. Evidence shows a good standard of care

The service treated people as individuals and made sure people's care, support and treatment met people's needs and preferences. Staff took account of people's strengths, abilities, aspirations, culture and unique backgrounds and protected characteristics.

Staff treated people as individuals and considered any relevant protected characteristics. We saw examples of this during our inspection. This included where patients with a learning disability or dementia were able to be accompanied by a family member.

Staff took account of people's individual communication needs. Translation and interpreting

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services were available, and information was available in different formats.

Patients consistently told us that staff explained things to them in a way they could understand. They involved patients in decisions about their care and treatment. One patient said, 'I appreciate that the staff answered my questions, and I had many questions', another said 'they explained things in a way that helped me understand.'

Independence, choice and control

Score

3. Evidence shows a good standard of care

The service promoted people's independence, so people knew their rights and had choice and control over their own care, treatment and wellbeing.

Staff worked to ensure that information was shared, and patients were informed of benefits and risks associated with treatment, so that they could make informed choices and control over their own care.

Information leaflets were available to patients about their procedure and treatment. This included information relating to post operative care at home and how to care for any wound. Patients we spoke with told us the information they were given was provided in a way that was easy to understand and enabled them to have control over their post operative care.

Responding to people's immediate needs

Score

3. Evidence shows a good standard of care

The service listened to and understood people's needs, views and wishes. Staff responded to people's needs in the moment and acted to minimise any discomfort, concern or

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distress.

We observed staff responding quickly to people's needs. Patients in recovery were closely monitored and staff acted to minimise discomfort and concerns.

Assessment processes included the identification of individual needs. In addition, team leaders reviewed patient records prior to the day of surgery to ensure additional individual needs were met.

Patients told us their pain was well managed, and staff ensured a calm and peaceful environment in recovery which was appreciated.

Workforce wellbeing and enablement

Score

3. Evidence shows a good standard of care

The service cared about and promoted the wellbeing of their staff and supported and enabled staff to always deliver person-centred care.

Staff were consistently positive about the support they received from managers and service leads. They had regular breaks, and their break room was well equipped, and they were provided with bottles of water throughout their shift.

Managers organised team events for staff. This included a beach day and Christmas party. Managers and staff participated in fundraising events to fund staff wellbeing activities. This included skydiving and abseiling activities, as well as cake sales and raffles.

A trust wide staff survey was carried out, with comparative results collated by division and directorate. We saw that results for theatres and anaesthetics were generally higher than the trust average. One area that was below at 46% compared to a division score of 50%, related to opportunities for career progression and we saw that this was addressed as part of the divisional priorities developed These included protected time for high value activities such as training and research, focusing on celebrating success and improving collaboration across the

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division. We saw specific action had been taken to make these improvements. This included a protected learning session held monthly for theatre staff, away days and team activities for staff, and the development of regular divisional bulletins for staff.

The trust had staff and team recognition awards. There were also staff networks and support systems.

Responsive

Rating Good

We looked for evidence that people and communities were always at the centre of how care was planned and delivered. We checked that the health and care needs of people and communities were understood, and they were actively involved in planning care that met these needs. We also looked for evidence that people could access care in ways that met their personal circumstances and protected equality characteristics.

At our last assessment we rated this key question requires improvement. At this assessment the rating has changed to good. This meant people's needs were met through the organisation and delivery of responsive services.

Person-centred care

Score

3. Evidence shows a good standard of care

The service made sure people were at the centre of their care and treatment choices and they decided, in partnership with people, how to respond to any relevant changes in people's needs.

There were processes in place to ensure that people could receive the most appropriate care and treatment for them. This included a clear criteria for patients receiving treatment at the surgical treatment centre (STC). Pre-operative assessment processes ensured that patients

added to the STC lists met the required parameters and were fit for surgery as a day case.

Staff gave us examples of where they had responded to changes in people's needs. This included where people were unwell following surgery or where their recovery took longer than anticipated.

We observed staff delivering patient centred care and saw they respected the individual needs of each patient. Pre and post operative care and support was planned by taking account of people's individual needs. This included people requiring additional support, for example, for people with a learning disability or dementia.

Staff understood how to meet the information and communication needs of patients with a disability. The service had access to interpreting and signing support services by telephone or face to face for patients who needed it.

Care provision, integration and continuity

Score

3. Evidence shows a good standard of care

The service understood the diverse health and care needs of people and their local communities, so care was joined-up, flexible and supported choice and continuity.

Managers planned and organised services, so they met the needs of the local population. Trust leads worked collaboratively with local partners to meet people's needs. For example, the surgical treatment centre was developed in 2021 in response to issues around longer wait times for patients to receive surgery across Southwest London. Surgical lists were provided for other Southwest London NHS trusts as well as those for internal trust day surgery.

People's care and treatment was delivered in a way that met their assessed needs and was well coordinated. The service was not equipped to deal with medical emergencies, therefore, patients who experienced complications during surgery or in recovery were transferred to the

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St George's accident and emergency department by emergency ambulance. Follow up was then arranged by the consultant surgeon. Systems were integrated across the trust to ensure continuity of care in the event of complications.

Providing information

Score

3. Evidence shows a good standard of care

The service supplied appropriate, accurate and up-to-date information in formats that were tailored to individual needs.

Assessment processes ensured that people's individual information needs were identified. Staff made reasonable adjustments to help patients access services. Information was provided in different formats and in line with the Accessible Information Standard. This included people who required support with translation, interpreting and signing.

We observed staff sharing information with patients and checking their understanding. This included post operative information leaflets about wound care, ongoing recovery at home and when it was safe for them to start normal daily activities. Patients were also given information on how to escalate concerns within normal hours and out of hours.

Listening to and involving people

Score

3. Evidence shows a good standard of care

The service made it easy for people to share feedback and ideas, or raise complaints about their care, treatment and support. Staff involved people in decisions about their care and told them what had changed as a result.

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There were opportunities for people to feedback about their care and experience of the service. Patients were given feedback surveys to complete. Results were collated by service leads and feedback was shared with staff by way of governance reports and meetings. Feedback reports we viewed were consistently positive.

Patients were informed of how to make a complaint should they need to, with information displayed. There were processes in place where managers investigated complaints, identified learning and shared this with staff to ensure improvements were made and embedded where necessary. Patients we spoke with understood how to complain and felt confident giving feedback should they need to. However, all patients told us they were happy with the service, with only one comment about the time they waited to go into theatre.

Feedback from compliments was also shared with staff.

Equity in access

Score

2. Evidence shows some shortfalls in the standard of care

The service did not always make sure that people could access the care, support and treatment they needed when they needed it.

Performance in relation to referral to treatment times was in line with the England average, yet below national standards. There was ongoing improvement work in relation to this.

Patients were added to the surgical treatment centre day surgery lists based on them meeting the criteria for accessing day surgery. Surgical lists included dermatology, cataract surgery, plastics, urology, vascular, renal, gynaecology and orthopaedics. Surgical treatment centre staff checked the patient records prior to their surgery day to identify any issues, which on occasion may lead to cancellation of their surgery.

The trust monitored cancellation rates, theatre utilisation, late starts and delays. We reviewed cancellation data for October 2024 and saw that 92% of planned surgeries went ahead. Of

those that did not go ahead 23% were unfit for surgery, 18% did not arrive and 18% were due to clinical decision making. In addition, 18% of those that did not go ahead were due to service error or rescheduling or due to the theatre list being overbooked or delayed. Theatre utilisation was between 63% and 67% between October and December 2024, against a target of 85% and there was a theatre utilisation group focused on increasing utilisation. We were told that delays and cancellation data was reviewed as part of theatre utilisation reviews.

Staff staggered patients' arrival times to reduce the amount of time they waited for. Patients we spoke with were aware of this and appreciated the efforts staff made to reduce waiting. One patient told us they were happy with the care they received but felt communication around waiting times could be better. We reviewed data about days to surgery start times and saw that most of these were due to medical staff delays that were classed as appropriate. Other causes included theatre overrunning or delays due to patient issues.

Staff worked to ensure people did not stay longer than they needed to. Because of the nature of day surgery all patients were discharged home on the day of surgery, unless unexpected medical needs necessitated an acute transfer. We were told that delays to patient discharge were minimised. The main cause was due to lists over running, delays in patients being fit for discharge and issues with transport. However, we were told that staff were flexible and would stay to support patients until transport arrived, and they were fit to go home. Staff reported issues with transport delays as incidents and managers followed up to promote improvements going forward.

Equity in experiences and outcomes

Score

3. Evidence shows a good standard of care

Staff and leaders actively listened to information about people who are most likely to experience inequality in experience or outcomes and tailored their care, support and treatment in response to this.

People’s care, treatment and support promoted equality and protected their rights. Staff demonstrated a good understanding of individual people’s needs and took action to make

Acute services
Surgery

reasonable adjustments so they would not be disadvantaged. Examples included patients with additional needs being able to be accompanied in the waiting area and recovery, whereas usually patients attending for day surgery were not able to be accompanied.

Planning for the future

Score

3. Evidence shows a good standard of care

People were supported to plan for the future.

Staff took account of people's decisions about their future, however, due to the nature of the day surgery service, staff did not generally have discussions with patients about their future, including at the end of their life. The trust had a clear 'do not attempt cardiopulmonary resuscitation' (DNACPR) policy. Staff had received training in end of life care and compliance was 93%.

Well-led

Rating Good

We looked for evidence that there was an inclusive and positive culture of continuous learning and improvement that was based on meeting the needs of

people who used services and wider communities. We checked that leaders proactively supported staff and collaborated with partners to deliver care that was safe, integrated, person-centred and sustainable, and to reduce inequalities.

At our last assessment we rated this key question requires improvement. At this assessment, the rating was good. This meant leaders of the service created and fostered a culture that ensured the delivery of high-quality care and operated effective governance processes.

Acute services
Surgery

Shared direction and culture

Score

3. Evidence shows a good standard of care

The service had a shared vision, strategy and culture. This was based on transparency, equity, equality and human rights, diversity and inclusion, engagement, and understanding challenges and the needs of people and their communities.

There was a clear trust vision which was focused on high quality, safe and individualised care. Priorities included working in collaboration and partnerships, sustainability, improved patient outcomes and empowered and engaged staff.

Priorities relevant to the surgical treatment centre at Queen Mary's Hospital included improving sustainability of the estate the service operated from, improved utilisation of theatres and continuing to build an inclusive culture.

The trust had developed a Green Plan to support the delivery of their overall strategy and become an environmentally sustainable organisation. Through this plan the trust aimed to take action to ensure the settings in which they provide care were as low carbon as possible, ensuring energy efficiency, and using renewable energy sources where possible.

Leaders and staff working at the surgical treatment centre demonstrated an inclusive, listening, caring and patient focused culture. There was a strong focus on learning and improvement.

Leaders promoted a positive culture that was focused on effective collaboration and teamwork. Staff worked well together and undertook team building activities. This included days out and working together on fundraising for staff wellbeing.

Staff we spoke with consistently spoke of a working culture that was enjoyable and supportive. Leaders demonstrated that they valued staff, and we saw that professional development was encouraged.

Acute services
Surgery

Capable, compassionate and inclusive leaders

Score

3. Evidence shows a good standard of care

The service had inclusive leaders at all levels who understood the context in which they delivered care, treatment and support and embodied the culture and values of their workforce and organisation. Leaders had the skills, knowledge, experience and credibility to lead effectively. They did so with integrity, openness and honesty.

There was a clear structure of leadership and accountability within the service. Within the theatres and anaesthetics directorate there were care group leads that included a matron for Queen Mary's Hospital Day surgery. Team leaders worked within theatres, taking responsibility for the day to day running of the service, including staffing.

Staff told us that leaders were open, approachable and visible within the service, including trust senior leaders. They told us they felt supported and able to raise concerns directly with line managers. They said leaders cared about staff wellbeing and encouraged wellbeing activities and support to maintain good working relationships.

Leaders demonstrated a good understanding of issues relating to culture and potential poor performance and took action to manage these areas effectively.

Freedom to speak up

Score

3. Evidence shows a good standard of care

The service fostered a positive culture where people felt they could speak up and their voice would be heard.

We saw in the trust Freedom to Speak Up Report 8% of staff from the surgery service had raised

Acute services
Surgery

concerns with the Freedom to Speak Up Guardian between April 2024 to September 2024. Overall, most concerns raised to the guardian were regarding bullying and harassment (53%) and inappropriate attitudes and behaviour (44%). We did not see evidence of this during our assessment of surgery at Queen Mary's Hospital and staff we spoke with consistently told us they felt supported by managers.

Staff we spoke with understood how they could raise concerns. They told us they felt able to discuss issues with their line manager but knew how to access the Freedom to Speak Up (FTSU) guardian. They had received awareness training in raising concerns and accessing the FTSU guardian and we saw evidence of this.

There was a clear speaking up policy and staff were able to access this and the contact details required if they needed to raise concerns. There were processes for involving staff in investigations into their concerns and identifying solutions. Staff we spoke with did not have examples of concerns they had raised, telling us there was an open culture within the service and issues were discussed in team meetings and with line managers when they arose.

Workforce equality, diversity and inclusion

Score

3. Evidence shows a good standard of care

The service valued diversity in their workforce. Staff work towards an inclusive and fair culture by improving equality and equity for people who work for them.

The trust had an up-to-date equality, diversity and inclusion (EDI) policy. There were EDI networks open to staff. These included disability, BAME, women's and LGBTQ+ staff networks. Staff working at the surgical treatment centre were involved in some of these networks.

The trust took action to ensure the workforce were representative of the population using the service. They recognised an imbalance in the proportion of staff in the most senior roles from ethnic minority groups in comparison with those in more junior roles. As a result, they had identified talent management and leadership development as a key strategic priority. This included an equality, diversity and inclusion working group within the trust's talent strategy

implementation plan delivery group. In addition, a pilot project for inclusive positive action was developed, creating opportunities for underrepresented groups to learn, develop and shadow executive and senior leaders for real life, practical work experience. At service level we found that staff from ethnic minority groups were employed, including in senior positions.

Governance, management and sustainability

Score

3. Evidence shows a good standard of care

The service had clear responsibilities, roles, systems of accountability and good governance. Staff used these to manage and deliver good quality, sustainable care, treatment and support. Staff act on the best information about risk, performance and outcomes, and share this securely with others when appropriate.

There was a clear governance framework for theatres across the trust that included Queen Mary's Hospital. There were clear lines of accountability. The theatres and anaesthetics directorate had consultant, management and nursing governance leads. Operationally there were care group leads, deputy and associate managers and matrons. This included a matron dedicated to theatres at Queen Mary's hospital. Divisional teams held their own monthly meetings with the care groups or specialities in their divisions. There was a theatres transformation board that met monthly to review performance and theatre utilisation, this included where surgical lists were provided for other Southwest London NHS trusts. Monthly governance meetings were held to review issues such as mandatory training compliance, incidents and risks. Other meetings included directorate meetings, care group meetings and monthly protected teaching for staff.

Policies and procedures were available on the trust intranet and staff knew how to access them. Policies and procedures we viewed were up to date and based on relevant legislation and guidelines. There were business continuity plans, for example, in the event of IT or power failures.

Staff were aware of governance processes and accountabilities. There were regular team

meetings where issues such as incidents, safety alerts, key performance indicators and audit results were discussed. We reviewed a sample of meeting minutes and saw that these included evidence of discussions and reviews of theatre performance, risks and feedback processes.

Risks were managed effectively through a risk register system where risk ratings were attributed to each risk and managers were identified as responsible for their risk management. We saw that risks were regularly reviewed in leadership and governance meetings.

Workforce planning was undertaken by service and senior leaders. We saw that information about staffing was reviewed as part of governance meetings. Staff reported that leaders had worked to support the development of staff into roles, and we saw that practice educators worked within the department to support this process.

We viewed data that was collated by the trust relating to quality and performance of the service. Information was visible within the surgical treatment centre including that relating to theatre utilisation and cancellation rates. There was evidence that data was reviewed at both governance and staff meetings, including feedback data from both patients and staff.

Partnerships and communities

Score

3. Evidence shows a good standard of care

The service understood their duty to collaborate and work in partnership, so services work seamlessly for people. Staff share information and learning with partners and collaborate for improvement.

There was a theatre users' group where relevant stakeholders and surgical teams utilising the surgical treatment centre met to discuss operational matters regularly. This was to collaborate on theatre use to maximise utilisation and productivity and improve access and patient pathways.

Staff and leaders shared examples of learning through collaboration. This included working with other trusts and services on reviewing the use of surgical drapes in relation to the impact

on potential skin damage.

Learning, improvement and innovation

Score

3. Evidence shows a good standard of care

The service focused on continuous learning, innovation and improvement across the organisation and local system. Staff actively contribute to safe, effective practice.

Staff we spoke with told us there were good learning and development and continuous learning opportunities available. Practice educators were based at the surgical treatment centre 2 days a week. They supported the continuous learning of staff by delivering education and conducting competency-based assessments. We saw that other development opportunities were available for staff, including themed education sessions.

We saw examples of innovative approaches to patient care. The trust had pursued a digital transformation project to implement SMART theatres with initiatives to improve patient experience, efficiency and sustainability while reducing theatres energy consumption.

We saw there were clear priorities for improvement at Queen Mary's Hospital. This included improving theatre utilisation which was between 63% and 67% between October and December 2024, against a target of 85%. A surgical treatment centre working group was working together to improve utilisation. We saw action taken as a result of this collaborative working across surgical teams included reducing under utilised theatre sessions and exploring additional sessions to improve efficiency.

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NHS
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University Hospitals and Health Group

Group Board

Meeting on Friday, 05 September 2025

Agenda Item	2.3
Report Title	**Group Maternity Services Quality Report** **March, April and May 2025 data**
Executive Lead(s)	Professor Arlene Wellman, Group Chief Nursing Officer and Director of Infection Prevention and Control Jacqueline Gabriel-King, Interim Director of Midwifery and Gynaecology and Nursing (Outpatients), SGUH Emily Kaliwoh, Lead Midwife for Governance SGUH Annabelle Keegan, Director of Midwifery and Gynaecology Nursing, ESTH Laura Rowe, Lead Midwife for Clinical Governance and Assurance ESTH
Report Author(s)	Natilla Henry, Group Chief Midwifery Officer
Previously considered by	gesh Quality Group 10 July 2025 Quality Committees 31 July 2025
Purpose	**For Assurance**

Executive Summary

1.0 Purpose

The Board is receiving this report in line with the requirements of the Maternity and Perinatal Incentive Scheme (MIS) and the NHS England Perinatal Quality Surveillance Model (PQSM, December 2020). Its purpose is to support regular review and discussion of maternity key performance indicators (KPIs) by the designated sub-committee of the Group Board. It was reviewed by the Quality Committees in July

The report includes, as appendices 1, 1a, 2, and 2a, **the mandated** PQSM data submissions for March, April, and May 2025, and the Perinatal Mortality Review Tool report, as required under the NHS England Perinatal Quality Oversight Model.

The KPIs presented include maternity outcomes, perinatal mortality data, training compliance, and key risks recorded on the corporate and maternity risk register. Together, these metrics offer an overall view of maternity and neonatal safety across the Group.

The report is structured in three sections, focusing on the following areas:

- **Section one - Quality, Safety, and Outcomes:** Summary of PQSM data and key performance indicators (refer to appendices 1 and 1a).
- **Section two - Regulatory Oversight and Compliance:** Updates on inspections, notifications, progress against action plans, and status toward CNST compliance across both Trusts.
- **Section three - Local Service Updates:** Specific developments, issues and concerns from ESTH and SGUH, including the bi-monthly update from the Maternity Safety Support Programme (MSSP).

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2.0 Key risks and issues for escalation

- **SGUH maternal death (section 1, pgs. 7 & 8, 3.1.3):** There was one extreme harm event in March of a sad maternal death, which has been reported to all appropriate stakeholders and statutory bodies e.g., the Care Quality Commission. An internally led after-action review (AAR) with a multi-disciplinary attendance was undertaken. The AAR report is being finalised and will then be shared at relevant governance meetings at directorate and divisional level, and actions monitored at Divisional Governance meeting. The Patient Safety Incident Investigation (PSII) is being carried out by the Maternity and Newborn Safety Investigations (MNSI) team, which is external to the Trust and who investigate all maternal deaths that meet their criteria. The immediate actions from the maternal death and the steps taken to address them, were presented at April's meeting of the Quality Committee and were also shared with the CQC. An inquest into this mothers death is pending.

- **SGUH Maternity Incentive Scheme (MIS) year 6 (section 2, pg. 9, 4.2):** On 2 April 2025, NHS Resolution advised SGUH they were non-compliant for year 6 of MIS, specifically due to not meeting Safety Action 1: Perinatal Mortality Review Tool (PMRT) requirements. An appeal and a separate application for discretionary funding to support MIS Year 7 were submitted. The appeal was not upheld, and therefore SGUH is not expected to receive the 10% rebate. A decision on the discretionary funding application is pending.

- **SGUH PMRT Safety Action 1 (section 2, pg. 10, 4.2.1):** PMRT compliance at SGUH has been affected by late reporting of cases, which contributed to the Trust not achieving full compliance for Year 6 of MIS. In response, a more robust reporting process was implemented to reduce the risk of missed cases in future. While this improves reliability, it is acknowledged that human factors may still impact adherence. This has been borne out by a further incident of two cases being notified late for the MIS year 7 reporting period. NHS Resolution and MBBRACE have been notified of the circumstances that resulted in the delay, and their response is that this will be considered as part of the verification process at the end of the MIS period. To mitigate further misses, the governance team now conducts bi-weekly monitoring checks to identify and address any missed cases promptly. However, due to the new cases that were reported late, the Trust is **at risk of not meeting compliance for year 7**, if the mitigations are not accepted by MBBRACE.

- **SGUH National Maternity and Perinatal Audit (section 3, pg. 15, 5.5)**: The NMPA team advised that SGUH was identified as an **alarm-level outlier** for post-partum haemorrhage (PPH) **≥1500ml**. The Trust's submission of organisational and other mitigating factors was not upheld, and the report will be published as originally drafted, with an appended page on the improvements being undertaken by the Trust. Although publication has been delayed, the revised release date is expected to be **14 August 2025**. SGUH continues to work through the improvement actions identified, and PPH of 1500ml or above is now trending below the target and the mean since May 2025, with sustained focus on further improvement.

- **ESTH training compliance (section 1, pg. 8, 3.1.4):** Training compliance for PROMPT remain below the 90% target between March-May for all staff groups except midwives. Trainee and staff grade obstetricians are particularly low at 79%. Cardiotocograph (CTG) training compliance for consultant obstetricians is 89%, which is 1% below the target in April and May. All other training requirements across all staff groups remain above the 90% standard (see Appendix 1, Slide 11). To support improvement and maintain compliance for medical staff, the service has introduced a projected attendance list.

- **Both Trusts, MBRRACE 2021 external review (section 2, pgs. 9-10, 4.1):** This review focused on perinatal deaths reported to MBRRACE between January and December 2021, providing

another opportunity to reflect on our progress in improving perinatal outcomes. A total of 46 perinatal deaths (31 stillbirths, 11 neonatal deaths, and 4 late fetal losses) were reviewed.
A key area of concern highlighted in the report is the decision by SGUH to deviate from the *Saving Babies' Lives Care Bundle* (SBLCB) and NICE guidance by not routinely performing symphysis-fundal height (SFH) measurements in low-risk women for fetal growth surveillance. The concern is that fetal growth restriction and placental dysfunction may go undetected in this cohort, as SFH measurement is one method used to identify potential growth issues that would prompt further assessment, such as a growth scan and uterine Doppler.
SGUH currently offers low-risk women routine scans at 12, 20, and 36 weeks. If risk factors are identified at the 12- or 20-week scan, women are commenced on aspirin until 36 weeks and receive an additional scan at 28 weeks. SGUH maintain that this approach is evidence-based and, in their view, exceeds the standards of SBLCB and NICE in recognising and appropriately managing risk—citing favourable outcomes such as stillbirth rates as supportive evidence.
In contrast, ESTH practice remains aligned with the SBLCB and NICE recommendations.

- **Both Trusts, iClip issues (section 3, pgs. 16-17, 5.6):** Since the implementation of iClipPro at SGUH in February and at ESTH in May 2025, several challenges have arisen post-implementation. These are mainly linked to the following areas:
  SGUH: (1) data migration did not take place at go-live, meaning staff must view the old system alongside iClip during patient care, (2) inaccurate MEWS scoring, affecting appropriate and timely escalation of concerns, (3) Lack of electronic VTE assessment, staff using paper instead, (4) Lack of mandatory fields causing data quality issues, which impacts among other aspects, the accurate and full reporting of the Maternity Services Data Set (MSDS). **This places the Trust at risk of not being compliant with Safety Action 2 of MIS year 7.**
  ESTH: iPads are used by community midwives, however, iClipPro is not available on iPads so midwives are unable to access clinic lists, referral platforms or outcome appointments when away from the units. This means there is a delay in uploading the patient contact in real time. This is being mitigated by admin support outcoming attendances and care provided retrospectively.

- **Both Trusts, Birthrate Plus workforce assessment (section 3, pg. 17-18, 5.7): SGUH** received its birthrate plus report in April 2025. The data shows a fall in the birth rate by 990 since the 2021 report, however, the level of complex births remains high, with over 50% in the two highest Birthrate+ categories. It also shows an over-establishment of 7.54WTE but recommend this is considered against a backdrop of growth in some services, such as community care, safeguarding, diabetes and maternal medicine and the requirement for midwifery resource to support these areas.
  ESTH last Birthrate plus report was in July 2022, and a new review has been commissioned to start September 2025, in line with the three yearly recommended cycle (**see staffing reports for ESTH, appendix 4 and SGUH appendix 4a**)

Action required by Group Board

The Board is asked to:

a) Note the maternity service updates and the key risks and points for escalation

b) Consider any aspects where further assurance is required

c) Working with MSSP to adopt standard format for reporting

Appendices

Appendix No.	Maternity

Appendix 1	ESTH Perinatal Quality Surveillance Model data (PQSM)
Appendix 1.1	SGUH Perinatal Quality Surveillance Model Data (PQSM)
Appendix 2	ESTH Perinatal Mortality Review/ Board report
Appendix 2.1	SGUH Perinatal Mortality Review/Board report
Appendix 3	ESTH CNST / Maternity Incentive Scheme Year 7 progress update
Appendix 3.1	SGUH CNST / Maternity Incentive Scheme Year 7 progress update
Appendix 4	ESTH bi-annual safer staffing report
Appendix 4.1	SGUH bi-annual safer staffing report, including April 2025 birthrate plus report highlights
Appendix 5	Executive and Non-Executive Board Safety Champions report
Appendix 6	MSSP gesh bi-monthly (March – April 2025) report
Appendix 7	**READING ROOM –** ESTH Appreciative Inquiry
Appendix 8	**READING ROOM –** SGUH 2nd response to the National Maternity Perinatal Audit
Appendix 9	**READING ROOM –**SGUH Birthrate Plus report April 2025
Appendix 10	**READING ROOM** – Letter from CEO and CNO at NHS England

Implications

Group Strategic Objectives

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

Risks

As set out in the report.

CQC Theme

☒ Safe	☒ Effective	☒ Caring	☒ Responsive	☒ Well Led

NHS system oversight framework

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

Financial implications

ESTH:
ESTH declared full compliance with the CNST Maternity and Perinatal Incentive Scheme (MIS) Year 6 through its Board declaration form submitted on 3 March 2025. NHS Resolution has since confirmed that full compliance has been achieved. As a result, ESTH is eligible for a minimum 10% rebate on its CNST contribution.

SGUH:
SGUH declared compliance with 9 out of 10 safety actions for MIS Year 6 in its Board declaration

submitted on 3 March 2025. On 2 April 2025, NHS Resolution confirmed that SGUH was non-compliant, specifically due to not meeting Safety Action 1: Perinatal Mortality Review Tool (PMRT) requirements.
An appeal and a separate application for discretionary funding to support MIS Year 7 were submitted. The appeal was not upheld, and therefore SGUH is not expected to receive the 10% rebate. A decision on the discretionary funding application is pending.

Legal and /or Regulatory implications

ESTH and SGUH: There is an ongoing requirement to achieve compliance in the MUST and SHOULD Do actions issued by the CQC 2023 inspections across gesh maternity services in line with the Health and Social Care Act 2008 (Regulations 2014) and CQC Registration Regulations.

SGUH: In January 2025, SGUH maternity received a section 29A following their CQC inspection in October 2024. Maternity have completed an action plan, which is being monitored via the maternity oversight group.

ESTH: Within the Maternity Service, the issue around maternity manager on-call arrangements that contravene the Working Time Regulations 1998/AFC has been resolved following a grievance and a subsequent appeal hearing that was held on 7th May 2025.

Equality, diversity and inclusion implications

ESTH and SGUH have signed up to implement the themes of the Royal College of Midwives (RCM) Anti-Racism Framework, which is a strategic initiative developed by the RCM to tackle racism and promote equity within midwifery in the United Kingdom (UK). It was launched in 2022 in response to persistent racial inequalities experienced by both staff and service users in maternity care.

Environmental sustainability implications

ESTH: There are several environmental issues which have an impact on service development and business continuity, which were highlighted in the most recent CQC inspection report (please see risk register section, slide 4 of appendix 1).

SGUH: One or more of the two patient lifts in the Lanesborough Wing is frequently out of service and for prolonged periods. This impacts fast and safer transfer of patients during an emergency. The contingency in place is the use of the service lift.

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Group Maternity Services Quality Report

Group Board, 05 September 2025

1.0 Purpose of paper

1.1 The Board receives this report in line with the requirements of the Maternity and Perinatal Incentive Scheme (MPIS) and the NHS England Perinatal Quality Surveillance Model (PQSM, December 2020). Its purpose is to support regular review and discussion of maternity key performance indicators (KPIs) and was reviewed in detail by the Quality Committee, the designated sub-committee of the Group Board.

The KPIs presented include maternity outcomes, perinatal mortality data, training compliance, and key risks recorded on the corporate and maternity risk register. Together, these metrics offer an overall view of maternity and neonatal safety across the Group.

1.2 This report also informs the Board of significant changes, emerging safety concerns, new risks and successes within gesh maternity services, and provides assurance that there are robust plans with monitoring processes in place to make any identified improvements required or address any concerns.

1.3 In addition, the report includes **the mandated** data sets that were reviewed by the Quality Committee, as required as part of the NHS England Perinatal Quality Oversight Model – Perinatal Quality Surveillance Model.

2.0 Background

2.1 The PQSM report data covers the position for March, April and May 2025, and includes:

Mandated reporting requirements at least quarterly:

- The perinatal quality surveillance model (PQSM), appendices 1 and 1a
- The maternity quality and safety dashboard trend data in relation to outcomes for birthing people and babies (appendices 1 and 1a, slide no.3)
- Perinatal mortality by exception (appendices 1 and 1a ESTH and SGUH respectively)
- The Board Safety Champions Report

Key updates include:

- The bi-monthly gesh Maternity Safety Support Programme report
- CQC MUST and SHOULD DO actions from the 2023 inspection for ESTH and SGUH
- Status towards CNST compliance for both Trusts
- Issues and risks, post iClip go-live at ESTH and SGUH
- SGUH response to National Maternity Perinatal Audit outlier status notification
- Bi-annual safer staffing report for both Trusts

SECTION ONE

3.0 QUALITY, SAFETY AND OUTCOME (Perinatal Quality Surveillance Model, PQSM)

3.1 Perinatal Quality Surveillance Model (PQSM) data for March, April and May 2025

3.1.1 Outcomes

ESTH and SGUH: The outcome dashboard trend data presented in the standard process chart (SPC), shows that most outcomes have remained stable or improved, except for a significant reduction in fill rate for ESTH in May, which was mitigated with temporary staffing. However, some shifts operated with less than the agreed numbers but did not result in any adverse outcomes for women or babies (appendices 1 and 1a, slide 3).

3.1.2 Risk register

ESTH: There are three extreme (red) risks on the risk register, which is an increase by one, since the last report in April 2025: (1) the absence of a second operating theatre at Epsom, (2) general environmental concerns identified during the 2023 CQC inspection and, (3) (**new risk**), where cardiotocograph records are not being auto stored. While work is ongoing to address all three risks and some positive changes have been made, e.g., conversion of the Rose Room into a 2nd theatre is complete, the delivery of an anaesthetic machine is now awaited before it can be used. Works to soundproof the bereavement room at STH is also complete (see Appendix 1, Slide 4).

SGUH: There are two extreme (red) risks on the risk register. The first concerns the laser stack, which is beyond its intended lifespan and no longer covered by a manufacturer maintenance contract. A replacement stack was ordered and delivered on 10 April. The replacement laser component remains outstanding due to challenges in sourcing a suitable device and the requirement for clinical trials prior to adoption. Following a review of the risk on 7 July by the service and medical physics, it has been agreed that the risk can be reduced since the stack has been replaced. However, it should be noted that the risk related to the laser remains, as it is still unreliable and has failed about once every 6 months. Staff manage these failures by restarting the machine, which resolves the issue, but it is not a sustainable solution.

The second extreme risk relates to the service not meeting regulatory standards, following a CQC inspection in October 2024, which resulted in the issuing of a Section 29A notice. This risk was formally added to the risk register in February 2025. The service has addressed all immediate actions, which are overseen by the Maternity Oversight Group, chaired by the Site Managing Director. The CQC inspection report has still not been received (see Appendix 1a slide 4)

3.1.3 Moderate and above harm cases

ESTH: had a total of 26 moderate harm outcomes across March (5), all have been closed, April (9), one is closed with all others under review of which one will be investigated as a PSII and May (12), one is closed, with the others currently under review (appendix 1 slide 7)

- **SGUH:** A total of 61 incidents were reported as moderate harm outcomes across March (26), April (19) and May (16). There was **one extreme harm event in March of a sad maternal death**, which has been reported to all appropriate stakeholders and statutory bodies e.g., the Care Quality Commission. An internally led after-action review (AAR) with a multi-disciplinary attendance was undertaken. The AAR report is being finalised and will then be shared at relevant governance meetings at directorate and divisional level, and actions monitored at

Divisional Governance meeting. The Patient Safety Incident Investigation (PSII) is being carried out by the Maternity and Newborn Safety Investigations (MNSI) team, which is external to the Trust and who investigate all maternal deaths that meet their criteria. MNSI have carried out interviews with staff involved in the event, staff were offered and have attended debrief sessions with the psychologist from the Trust Staff Support services, as well as individual sessions with educational supervisors, a Professional Midwifery Advocate (PMA), the practice support team and or their line manager.

The immediate actions from the maternal death were presented at April's meeting of the Quality Committee.

All other cases have been or are scheduled to be reviewed through the moderate cases review meetings, and lessons learned will be disseminated accordingly (see Appendix 1a, slide 8)

3.1.4 Training Compliance

ESTH: Training compliance for **PROMPT remain below** the 90% target between March-May for all staff groups except midwives. Trainee and staff grade obstetricians are particularly low at 79%. Cardiotocograph (CTG) training compliance for consultant obstetricians is 1% below the target of 90% in April and May. All other training requirements across all staff groups remain above the 90% standard (see Appendix 1, Slide 11). To support improvement and maintain compliance for medical staff, the service has introduced a projected attendance list.

SGUH: Training compliance for **PROMPT is above** the 90% target for all staff groups except maternity support workers, who are 84% March, 85% April and 87% May. MSWs have been forward booked unto the next available sessions to ensure compliance is met. All other training is at or above the 90% target for all staff groups.

ESTH: Midwifery fill rate: the fill rate at EGH and STH was between 92-96% during this reporting period, against a target of >94%. Staffing gaps are mitigated by levelling staff across the units or support from temporary staffing such as bank is utilised.

SGUH: Midwifery fill rate: the improvement seen in overall fill rate for midwifery staffing in the last report in April continues through this reporting period. However, it should be noted that Carmen Birth Centre experienced challenged fill rates in March and April for some shifts with fill rate of 66% (MSWs) and 63% (registered midwife, night shift). Gaps are mitigated as far as possible with levelling of staff across the unit, closure of the Birth Centre to support staffing in the delivery suite, use of bank and use of the escalation policy (see Appendix 1a slide 14).

3.1.5 Claims and inquests

ESTH: new claims – one new claim opened in May 2025 relating to disclosure of medical records. **Closed Claims:** one claim successfully defended with no damages awarded. One claim settled out of court for £3 million, relating to a 2021 birth incident involving a brain injury following a failed ventouse delivery. The passage of time significantly impacted the Trust's ability to defend.

Inquests: No new inquests opened or closed in May 2025**.**

SGUH: new claims – one new claim opened in April relating to failure to investigate, and two in May 2025, (1) poor care and treatment and (2) failure to undertake treatment to an appropriate standard.

Inquests: One inquest into the maternal death in March 2025 is pending

SECTION TWO

4.0 Sources of Assurance

4.1 Review of MBRRACE findings 2021 - Perinatal Mortality External Report

An external review of MBRRACE 2020 and 2021 cases was commissioned by the Quality Committees in Common (QCiC) to assess perinatal data and outcomes at gesh Maternity services and gain an understanding of whether there are any issues that may be negatively contributing to babies who were stillborn or where a neonatal death occurred. It was also to ascertain where good practice occurs that results in good outcomes for newborn babies.

The review follows a previous assessment of MBRRACE cases from 2020, by the same reviewing team. This review focusses on cases reported to MBRRACE during January to December 2021 and provides another opportunity to reflect on our progress in improving perinatal outcomes. Forty-six (46) perinatal deaths, (31 stillbirths, 11 neonatal deaths and 4 late fetal losses) were reviewed.

The review commenced in July 2024, with the Trust receiving the report March 2025. However, the report was returned to the reviewers for factual accuracy check. Following that process, the report was returned to the Trust in April 2025.

Key Findings

- **Grading of Care:**
    - SGUH: 6/21 stillbirths (28.5%) and 2/10 neonatal deaths had care issues graded as a ‘C’ or ‘D’ that may/likely impacted outcome.
    - ESTH: 5/13 stillbirths (38.5%) had similar care concerns, where cases graded a ‘C’ or ‘D’.
- **Neonatal deaths** at SGUH often related to **preterm birth management**; a preterm birth clinic has since been introduced.
- **Common themes across sites:**
    - Inconsistent or delayed maternity triage; no use of BSOTS tool.
    - Deviation from NICE and SBLCB guidance on fetal growth surveillance at SGUH (no symphysis fundal height measurements).
    - Use of interpreting services inconsistent; gaps in documentation of language needs.
    - Parental questions missing in 52% of cases, despite PMRT guidance.
    - Lack of external representation on 46% of PMRT panels

A key area of concern highlighted in the report is the decision by SGUH to deviate from the Saving Babies’ Lives Care Bundle (SBLCB) and NICE guidance by not routinely performing symphysis-fundal height (SFH) measurements in low-risk women for fetal growth surveillance. The concern is that fetal growth restriction and placental dysfunction may go undetected in this cohort, as SFH measurement is one method used to identify potential growth issues that would prompt further assessment, such as a growth scan and uterine Doppler.

SGUH currently offers low-risk women routine scans at 12, 20, and 36 weeks. If risk factors are identified at the 12- or 20-week scan, women are commenced on aspirin until 36 weeks and receive an additional scan at 28 weeks. SGUH maintain that this approach is evidence-based and, in their view, exceeds the standards of SBLCB and NICE in recognising and appropriately managing risk—citing favourable outcomes such as stillbirth rates as supportive evidence.

In contrast, ESTH practice remains aligned with the SBLCB and NICE recommendations

Next Steps and Governance

The report and all recommendations have been shared with the directorate, divisional leadership, and senior leadership team (SLT). All recommendations have been incorporated into the Unified Maternity Improvement Plan, which is monitored and updated through existing governance processes, with formal closure once actions are complete.

Ongoing oversight and thematic discussion will also take place via the Morbidity and Mortality Group (MMG). This ensures alignment with broader maternity safety and quality improvement programmes.

4.2 Clinical Negligence Scheme for Trusts, Year 6 and 7 Maternity Incentive Scheme (MIS)

ESTH: ESTH declared full compliance with the CNST Maternity and Perinatal Incentive Scheme (MIS) Year 6 through its Board declaration form submitted on 3 March 2025. NHS Resolution has since confirmed that full compliance has been achieved. As a result, ESTH is eligible for a minimum 10% rebate on its contribution to the Maternity Incentive Scheme of CNST.

SGUH: SGUH declared compliance with 9 out of 10 safety actions for MIS Year 6 in its Board declaration submitted on 3 March 2025. On 2 April 2025, NHS Resolution confirmed that SGUH was non-compliant, specifically due to not meeting Safety Action 1: Perinatal Mortality Review Tool (PMRT) requirements.
An appeal and a separate application for discretionary funding to support MIS Year 7 were submitted. The appeal was not upheld, and therefore SGUH is not expected to receive the 10% rebate. A decision on the discretionary funding application is pending.

MIS Year 7 was published on 2 April 2025. Both ESTH and SGUH are actively reviewing and disseminating the updated safety actions to the relevant teams. Updates will be provided to QCiC throughout the reporting period (see appendices 3, and 3a).

4.2.1 Improving timely reporting of Maternity Incentive Scheme (MIS) year 7 safety actions

The Maternity Incentive Scheme (MIS) Year 7 safety actions are coordinated by the Lead Midwife for Governance at both Trusts. Given the volume of actions, approximately 90, responsibility for individual safety actions is delegated to relevant subject matter experts.

Despite this structure, challenges have been identified with **Safety Action 1 (PMRT)** at SGUH, due to delays in reporting cases, and with **Safety Action 4 (clinical workforce)** and **Safety Action 8 (training compliance)** across both Trusts.

Specifically, PMRT compliance at SGUH has been affected by late reporting of cases, which contributed to the Trust not achieving full compliance for Year 6 of MIS. In response, a more robust reporting process was implemented to reduce the risk of missed cases. While this improves reliability, it is acknowledged that human factors may still impact adherence. This has been borne out by a further incident of two cases being notified late for the MIS year 7 reporting

period. NHS Resolution and MBBRACE have been notified of the circumstances that resulted in the delay, and their response is that this will be considered as part of the verification process at the end of the MIS period. To mitigate further misses, the governance team now conducts bi-weekly monitoring checks to identify and address any missed cases promptly. However, due to the new cases that were reported late, the Trust is **at risk of not meeting compliance for year 7**, if the mitigations are not accepted by MBBRACE.

To mitigate this, the governance team now conducts **bi-weekly monitoring checks** to identify and address any missed cases promptly.

4.3 Maternity Safety Support Programme (MSSP)

MSSP continues its support of gesh maternity services. It should be noted that the bi-monthly report has external authorship, it is written by the maternity improvement advisor based on their visits and meetings with maternity staff. The report is then provided to be included as part of the maternity reports the Quality Committee and Board are required to review. It is available at Appendix 6.

The next stage of the support provided by MSSP is for *a 'review and reset meeting'*, which is planned to take place on 08 August 2025, with attendance from GCNO, GCMO, SLTs, maternity directorate and divisional teams, and the NHSE London Regional Maternity Leadership Team. It is expected that discussions around an exit strategy will also form part of the discussion.

4.4 Care Quality Commission (CQC) Inspection 2023

Position against CQC MUST and SHOULD Do's for ESTH and SGUH as of 25 June 2025. All CQC actions are reviewed at the monthly Evidence Assurance Panel (EAP), for evidence of assurance that the actions have been met and are sustainable.

ESTH: all actions have been approved, however, considering the estate challenges, this action will return quarterly to track progress.

SGUH: All SHOULD DO actions are complete. Of the fifteen MUST Do actions, five actions (in yellow highlight to right of table on page 10 below) are still pending approval, all of which have been to the EAP at least once but require further evidence in some aspects of the MUST DO requirement, e.g., evidence of sustained compliance with audits over at least 3 months, before they can be signed off as achieving sustainable improvements. The deadline for all to be signed off has been extended to September 2025.

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St George's				25-Jun-25
MUST DO	**CQC Wording - MUST DO Actions**	**Presented at EAP**	**Comments**	**Evidence status**
1	The service must ensure staffing levels are safe and there are effective processes in place to escalate and mitigate safe staffing concerns. (Regulation 12)	31July 2024 & 27 September 2024	further evidence required 31 July 2024	Action signed off 27 September 2024
2	The service must ensure that triage processes are safe, risk assessments are carried out, and women and birthing people have access to parity of service at any time of day or night. (Regulation 12 (2) (a) (b))	02/12/2024 26 March 2025 **29 May 2025**	not approved not approved 26/03/25 **Not approved 29 /05/25 to return Sept**	02/12/24 Need a plan for medical cover for triage 26/03/25 To return in three months - (June 2025) 29/05/2025 - Not approved as Division to device a plan to fund BC for SHOs
3	The service must ensure adequate and up-to-date policies, pathways and guidance are in place, including implementation of a standard operating procedure in maternity triage and clear, effective escalation pathways to mitigate for risks of short staffing on women, birthing people, babies and staff. (Regulation 12)	02 December 2024		Action approved 2 December 2024
4	The service must ensure safe care of women in labour especially in relation to fetal monitoring. (Regulation 12 (2) (a) (b)	04 November 2024		Action approved 4 November 2024
5	The service must ensure that all staff groups complete mandatory training in a timely way. (Regulation 12)	**29 May 2025**	26/03/25 not approved	Service still below target. Return in June 2025 29/05/25 approved
6	The service must ensure non-compliant audits are acted upon and improvement plans put in place. (Regulation 17 (2) (a))	02 December 2024		Action approved 2 December 2024
7	The service must ensure medicines are stored safely and there are effective systems and processes in place to manage medicines safely, including regular reviews of risk assessments. (Regulation 12 (2) (g))	26/02/2025 **29 May 2025**	not approved **to return September 2025**	Fridge temperature targets not compliant still work to do on missed doses to embed practice presentation did not cover the clinical areas such as delivery suite - needs to cover all clinical areas. 29/05/2025 - Revision of audits is required within the next two weeks
8	The service must ensure incidents are managed well, including but not limited to effective sharing of learning, using learning to effect change and improvement in practice, ensuring incidents are categorised, harm rated, investigated, referred for external review and reported accurately and appropriately. (Regulation 17 (2) (a) (b))	04 February 2025		Action approved 4 February 2025
9	The service must ensure clinical areas are clean, fit for purpose and equipment is properly serviced and maintained in a timely way, including but not limited to emergency trolleys, resuscitaires and appropriate, timely portable appliance testing. (Regulation 15 (1) (a) (c) (d))	04/02/2025 26/03/2025	04/02/25 not approved 26/03/25 approved	04/02/25 Requested further evidence 26/03/25 - Approved
10	The service must ensure governance processes are effective including but not limited to communication between staff, service leaders and trust executives, clear and up-to-date guidelines in place, acting on audit results, and appropriate incident management. (Regulation 17 (1))	04 February 2025		Action approved 04 February 2025
11	The service must ensure all staff are provided with annual developmental appraisals. (Regulation 12)	26/02/2025	not approved **to return July 2025**	To be presented again as compliance is below target. Return June 2025 25/06/2025 - not presented as not all information available
12	The service must ensure that adequate documentation takes place including but not limited to triage arrival times and assessments, perineal repair, consistent use of SBAR and MEOWS, sepsis risk assessments for babies, consistency and accuracy over several record-keeping systems. (Regulation 17 (2))	26/02/2025 25/06/2025	not approved 26/2 not approved 25/06 **to return in September 2025**	Further information requested 1.Routine audits regularly done. 2.Evidence audit outcomes are shared widely - feedback to division and site leadership team, what the cycle looks like 3.That there is a schedule for sharing audits, and action plans and monitoring are in place if non-compliant
13	The service must ensure maternity safeguarding processes are strengthened, including timely staff training, consideration of a maternity safeguarding policy, adequate availability of staff trained in safeguarding concerns, and timely actions to implement safe measures to reduce the potential for baby abduction. (Regulation 13	27 September 2024	approved	Action approved 27 September 2024
14	The service must ensure that women and birthing people experiencing delays in induction of labour are managed and monitored safely, there are effective pathways in place, and that staff follow them. (Regulation 12)	27/09/2024 **25/06/2025**	not approved 27/09/24 not approved 25/06/25 **to return in**	further evidence required : seek women's views and demonstrate improvements and share with staff as audit or presentation. Return June 2025 audit users who were delayed - return September 2025
15	The service must ensure that documentation in the bereavement suite is completed contemporaneously and in full. (Regulation 17 (2) (c))	31 July 2024 & 27 September 2024	Not Approved 31/7/24 approved 27/09/2024	Action signed off 27 September 2024
SHOULD DO	**CQC Wording - SHOULD DO Actions**			
1	The service should ensure continued monitoring and risk assessment of the effectiveness of the fetal growth pathway to ensure the safety of unborn babies. (Regulation 12	26 March 2025	approved	approved pending presentation of the governance processes followed in an email to MH
2	The service should ensure that national screening targets are met, in particular carbon monoxide monitoring and antenatal screening tests are performed in a timely way. (Regulation 12)	26 March 2025	approved	approved
3	The service should ensure it takes account of the Workforce Race Equality Standards to provide equity for staff from ethnic minority groups. (Regulation 17 (2) (d) (e)	26/03/2025 28/04/2025	deferred to April 2025 28/04/2025 approved	approved 28/04/2025
4	The service should formalise a second consultant ward round on the labour ward to ensure adequate medical oversight of patient safety, in line with national recommendations. (Regulation 12)	26/03/2025 28 April 2025	deferred to April 2025 28/04/25 approved	approved 28/04/25
5	The service should examine its culture and involve staff in improving it, including staff members with protected characteristics under the Equality Act 2010.	28 April 2025	28 April 2025	approved 28/04/2025
6	The service should improve executive knowledge of and involvement in maternity services, including but not limited to growth of the maternity safety champion role, and health inequalities for women and birthing people who use the service.	28 April 2025	28 April 2025	approved 28/04/2025

SECTION THREE

5.0 LOCAL ISSUES AND SERVICE UPDATES

ESTH local issues and service updates

5.1 CTG Storage Failure – STAN Machines

An IT issue has been identified whereby cardiotocography (CTG) traces from the STAN machines are not being downloaded or stored as expected. The absence of these recordings presents a clinical and legal risk, as CTG traces often form key evidence in the investigation and defence of clinical negligence claims, particularly in determining breach of duty.

This issue has been reported to both the manufacturer, Neoventa, and to the MHRA via the Yellow Card Scheme. The manufacturer has since confirmed that this is related to a failure in their third-party software agreement, and that the problem is affecting other local providers and is now understood to be a wider issue impacting South West London, and potentially beyond. Neoventa is actively working to resolve this.

In the interim, a temporary solution has been agreed with the IT department, involving manual transfer of data from the STAN machines using an unencrypted USB stick. While this is not an ideal workaround, it is being carefully managed to ensure data integrity and availability.

This risk has been formally recorded on the Trust's Risk Register, and the situation is being closely monitored by the service in collaboration with the manufacturer.

5.2 Screening KPI ST2 (Timeliness of Antenatal Screening) – Performance and Mitigations

In Q3 2024, ESTH's ST2 KPI fell to **52%**, below the **50% acceptable threshold set by NHSE and >75% being the achievable threshold**. The primary issue was lack of midwifery booking availability. Immediate mitigations included additional weekend booking clinics, which were successful. These were later stood down after monitoring showed unfilled slots and resolution of backlog.

On **30 April 2025**, ESTH were notified of a further drop in **Q4 ST2 to 39.2%**, triggering renewed mitigations:

- Escalation to Operations Team to support the POD in their workload and to the Divisional Director of Ops to inform and discuss at the Vacancy Control Panel requirements for the recruitment of staff for the POD.
- Weekly reporting on outstanding bookings and USS appointments.
- Review and adjustment of midwifery booking capacity.

Impact: April data showed recovery to **62%**, which is above the acceptable threshold.

The **Director of Midwifery** attended the screening meeting on **3 June 2025** to support assurance and articulate mitigations, which were accepted. The potential short-term impact of the recent **iClip system change**, which is being actively monitored was also discussed. It was confirmed that there may be a temporary reduction in the target but by undertaking the monthly

and weekly review, along with POD support (including both short- and longer-term recruitment), will help to keep on track.

Assurance:

- No missed screenings for **sickle cell, thalassaemia, or Prenatal Diagnosis (PND)**.
- No related **clinical incidents**.
- **3 complaints** received in early May regarding lack of appointment communication; all resolved.

This issue remains under close review with continued POD and recruitment support.

5.3 Appreciative inquiry

An Appreciative Inquiry (AI) was conducted (Dec 2023–Mar 2024) to understand why long-standing operational and professional concerns in midwifery services remained unresolved, despite repeated escalation. The AI provided confidential space for staff to share honest feedback. Overwhelmingly, staff expressed pride in the care they deliver but highlighted that this often comes at personal cost (report available in the READING ROOM)

Key themes and risks identified

- **Service fragmentation and tensions between clinical areas**, e.g., Lack of clarity on clinical competencies required across areas (especially for covering Labour Ward). Specialist midwives feel undervalued due to not "counting in numbers"
- **Impact of Personal Relationships on Professional Culture**, e.g., friendship groups (often linked to long tenure) seen to influence decisions, with perceived nepotism in rota allocation and recruitment.
- **Inconsistencies in Accountability and Escalation**, e.g., concerns over preferential treatment, tolerance of poor behaviour, and lack of visible consequences.
- **Failures in HR Process**, e.g., repeated examples of poor recruitment and secondment practices, and unaddressed grievances.
- **Leadership Gaps and Team Dysfunction**, e.g., the Midwifery Leadership Team is pivotal but divided, with acknowledged tension and poor collective functioning. Lack of Triumvirate visibility and shared responsibility; focus remains solely on DoM.

There was a delay in the midwifery team receiving the report, mainly due to personnel changes. However, this is now resolved and in response to the issues highlighted, an action plan has been drafted by the midwifery senior leadership team and engagement sessions commenced in June 2025 with all Band 7 midwives to assist in the development and collective ownership of the actions. The engagement sessions will then be rolled out to all staff over the next 2-3 months.

SGUH local issues and service updates

5.4 Proposed closer of SGUH Birth Centre

SGUH are working through a proposal to close the Birth Centre. This is influenced by several factors including, the overall fall in the number of women giving birth at SGUH, which is 990 births less than four years ago, the year-on-year underutilisation of the birth centre, with fewer births taking place there each year and the financial cost of maintaining a service that is underutilised against a backdrop of the significant financial challenges facing the Trust. This has raised concern from staff, service users and other key stakeholders such as the Maternity and Neonatal Voices Partnership (MNVP). The directorate and division are working closely with the Site Leadership Team (SLT) and Trust Communications Team to address these concerns and to progress the changes that are required, with an expected completion date of first week of September 2025. The committee will be updated on the outcome at the next meeting.

5.5 St George's response to the National Maternity and Perinatal Audit (NMPA) outlier alert for Post Partum Haemorrhage

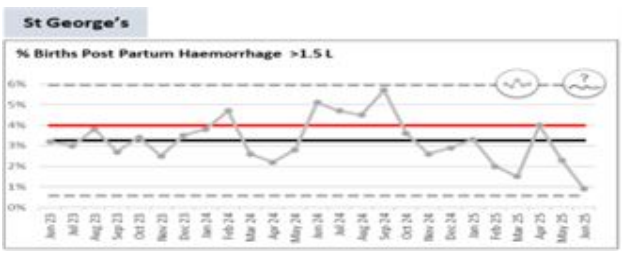
The NMPA team wrote to SGUH on 19 February 2025, advising that the trust may be a potential alarm-level outlier in the forthcoming National Maternity and Perinatal Audit (NMPA) report for postpartum haemorrhage of greater than or equal to 1500mL, which covers births over 2023.

The Trust was invited to respond to the alert with any evidence of organisational or service level issues that may have contributed to the alarm level status, as well as any evidence of improvement actions. This was submitted on 1 April 2025. The NMPA responded to the submission advising that following their review, the alarm level status will be upheld and published as part of their report. However, they advised the Trust they could do the following:

''You will have the opportunity to provide details of the actions you have taken in response to this outlier alert, to be published alongside the report and data, as an appendix. This could describe the quality improvement activity taken in response to this outlier notification or provide local context that may help users to interpret it''

Subsequently, the Trust prepared and sent a reply on 2 July 2025 (available in the READING ROOM, Appendix 8), which will be published alongside the NMPA 'State of the Nation' report covering 2023 data. Publication of the report was expected mid-July, however, NMPA wrote to SGUH on 3 July, advising the report is delayed and the new publication date is expected to be 14th August 2025.

SGUH continues to work through the improvement actions identified, and PPH of 1500ml or above is now trending below the target and the mean, with continued focus to further improve



Service updates applicable to both Trusts

5.6 Electronic Patient record – update on current risks and mitigations

The digital maternity transformation, involving the transition from Euroking E3 to iClipPRO at SGUH and implementation of Cerner at ESTH, went live at SGUH February 2025 and at ESTH May 2025.

Several challenges have arisen post-implementation as the system undergoes optimisation. These issues have been appropriately escalated by the directorates to the IT project team, as well as to the Divisional and Site Leadership teams. At SGUH, these issues have also been discussed and solutions explored at the Maternity Oversight Group chaired by the Site Managing Director.

Key issues - SGUH

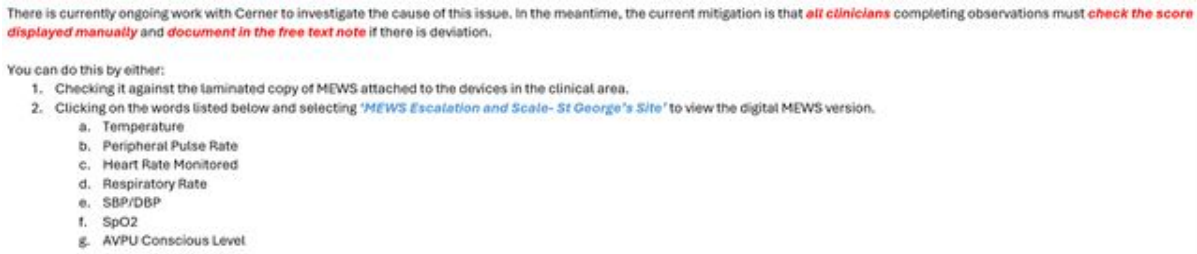
Lack of data migration at go-live: 2673 records were not migrated, this means clinicians currently need to access and work across two systems to get a full picture of a woman's pregnancy history, which increases the risk of missing important clinical information. The outstanding records to be migrated now sits at 1680, with a plan for staff to migrate 300-400 records each month, thereby completing the migration by November 2025. **Mitigation:** all staff are reminded to view the old system when providing care for women and babies, which has been effective, since the new system doesn't hold the information, it acts as a prompt for staff to search the old system.

Inaccurate calculation of the MEWS score: it has emerged that the system set-up in the demonstration model did not translate to the real-life environment, and the Maternity Early Warning Scores (MEWS) are not only incorrect, but the system is also displaying National Early Warning Scores (NEWS, used in nursing) rather than MEWS, despite changing the "Assigned EWS type" to MEWS, the "EWS Type" is displayed as NEWS, which could lead to lack of appropriate and timely escalation of a mother who is deteriorating.



The senior midwifery team and the digital midwifery team are working with the IT change team to resolve the issue. **Mitigation:** paper copies of the MEWS chart along with instructions on when, how and who to escalate to are in all delivery rooms and in the ward areas.

The midwifery bulletin has also been used to communicate the issue and mitigation with all staff – see screenshot on next page, page 16.



There is currently ongoing work with Cerner to investigate the cause of this issue. In the meantime, the current mitigation is that ***all clinicians*** completing observations must ***check the score displayed manually*** and ***document in the free text note*** if there is deviation.

You can do this by either:

1. Checking it against the laminated copy of MEWS attached to the devices in the clinical area.
2. Clicking on the words listed below and selecting *'MEWS Escalation and Scale- St George's Site'* to view the digital MEWS version.
    a. Temperature
    b. Peripheral Pulse Rate
    c. Heart Rate Monitored
    d. Respiratory Rate
    e. SBP/DBP
    f. SpO2
    g. AVPU Conscious Level

VTE is still paper based: a resolution is expected with a broader (Trust) system fix; however, the completion date is not yet known. **Mitigation** – staff continue to use paper based VTE as they did prior to iClipPro.

Lack of mandatory fields: there is a lack of mandatory fields in iClipPro, which causes data quality issues and challenges in retrieving data and or completing audits. It also makes it harder to find information due to the volume of free texting that is occurring. Lack of mandatory fields also adversely imapct the accurate and full reporting of the Maternity Services Data Set (MSDS). **This places the Trust at risk of not being compliant with Safety Action 2 of MIS year 7.** A group has been stood up to urgently address these issues, which will be chaired by the Site Chief Operating Officer, with directorate, divisional and IT change team attendance and input**. Mitigation:** there are no robust mitigations at present, however, reminders on how to document in iClip are sent out frequently to staff, until this is rectified.

Keys issues – ESTH

Community midwife access: community midwives at ESTH were previously allocated iPads to access the maternity EPR (Badgernet). iClipPro is not available on iPads so midwives are unable to access clinic lists, referral platforms or outcome appointments when away from the units. This has been mitigated by admin support out coming retrospectively, however continues to have an impact on midwifery workload with admin tasks having to be added to the end of the working day once back in the units.

5.7 Workforce review – Birthrate Plus and bi-annual staffing report

Following the birthrate plus review at SGUH, the report was received in April 2025 (available in the READING ROOM Appendix 9). The data shows a fall in the birth rate by 990 since the 2021 report, however, the level of complex births remains high, with over 50% in the two highest Birthrate+ categories. It also shows an over-establishment of 7.54WTE but recommend this is considered against a backdrop of growth in some services, such as community care, safeguarding, diabetes and maternal medicine and the requirement for midwifery resource to support these areas.

ESTH last Birthrate plus report was in July 2022, and a new review has been commissioned to start September 2025, in line with the three yearly recommended cycle.

The bi-annual staffing report, which is mandated by NHS England as part of the perinatal mortality surveillance reporting requirement is available at appendices 4 (ESTH) and 4a (SGUH). Each service provides assurance within their report of the processes and procedures in place to ensure safe staffing, escalation and monitoring to keep women and babies safe. They

both highlight the challenges with keeping sickness and other absences within the required target and the impact it can have on staff allocation from shift to shift, which is mitigated by strong underpinning policies and midwifery leadership. Maintaining training compliance for all staff groups in line with the competency framework, Trust mandatory training and CNST requirements is also challenging, and requires continued focus.

5.8 Commitment to the RCM Anti-Racism Framework

Both ESTH and SGUH have formally committed to implementing the Royal College of Midwives (RCM) Anti-Racism Framework, a strategic initiative launched in 2022 to address systemic racism and promote equity within maternity services across the UK.

The framework was developed in response to longstanding disparities in maternal outcomes and staff experience, including:

- Disproportionately higher maternal mortality rates among Black and Asian women.
- Inequitable access to and experience of care for ethnic minority service users.
- Workplace discrimination and barriers to progression for midwives and maternity support workers from ethnic minority backgrounds.

The framework is structured around five core pillars: Leadership, Culture, Education, Accountability, and Partnership.

In signing up to the framework, both Trusts have committed to embedding anti-racist principles in maternity improvement plans and workforce development strategies. However, both Trusts are in the very early implementation stages and needs more traction and engagement to achieve these ambitions.

With progress, this approach will help address recommendations within the letter dated 23 June 2025 from the Chief Executive Officer (CEO) and Chief Nursing Officer (CNO) of NHS England advising that the Secretary of State has announced a rapid independent investigation into maternity and neonatal services, and for Boards with responsibility for maternity services to take several actions, including to *'retain a laser focus on tackling inequalities, discrimination and racism within your services, including tracking and addressing variation and putting in place key interventions'* (letter available in READING ROOM, APPENDIX 10)

6.0 Actions and what success will look like

6.1 Completion of all MUST and SHOULD dos that were issued to ESTH and SGUH by the CQC in the 2023 inspection of maternity services by September 2025 (deferred from the original deadline of 31 March 2025).

7.0 Recommendations

7.1 Group Board is asked to:

a) Note the maternity service updates and the key risks and points for escalation

b) Consider any aspects where further assurance is required

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Glossary of Terms and Acronyms

Term / Acronym	Meaning
AAR	After Action Review
CNST	Clinical Negligence Scheme for Trusts
CQC	Care Quality Commission
EAP	Evidence Assurance Panel MDT group of Trust, ICB and User representatives to oversee completion of maternity CQC actions
KPI	Key Performance Indicator
KPI ST2	One of six key performance indicators underpinning antenatal screening This KPI relates to: The proportion of pregnant women having antenatal sickle cell and thalassaemia screening for whom a screening result is available before or at 10 weeks plus 0 days gestation to maximise the opportunity of informed choice related to further decisions about the pregnancy.
MBRRACE	Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries
MEWS	Maternity Early Warning Score
MIA	Maternity Improvement Advisor Advisor who supports maternity services as part of the Maternity Safety Support Programme
MIS	Maternity Incentive Scheme (10 Safety Actions which is part of CNST), currently in Year 7 of the Scheme, which begins in April each year.
MMG	Morbidity and Mortality Group
MNSI	Maternity and Newborn Safety Investigations (national programme in England focussed on improving safety within maternity care by independently investigating specific patient safety incidents)
MNVP	Maternity and Neonatal Voices Partnership (service user group), a NHSE mandated group for all perinatal services.
MSDS	Maternity Services Data Set Data collection system that captures information about all activity related to a mother and baby within NHS funded maternity services, from the first booking appointment to discharge.
MSSP	Maternity Safety Support Programme
NEWS	National Early Warning Score
NICE	National Institute for Health and Care Excellence
NMPA	National Maternity and Perinatal Audit

PMA	Professional Midwifery Advocate An experienced midwife with additional training, who offer a confidential and supportive environment for staff, women and families. Support includes restorative clinical supervision and a safe space for discussion
PMRT	Perinatal Mortality Review Tool It is a reporting and reviewing tool for perinatal deaths (past of CNST)
PND	Prenatal Diagnosis
POD	Patient Outpatient Department (ESTH)
PQSM	Perinatal Quality Surveillance Model NHS England and Maternity Incentive Scheme mandated requirement for maternity services to support regular review of key performance indicators by the Trust Board or its designated committee
PSII	Patient Safety Incident Investigation
RCM	Royal College of Midwives
SBLCB	Saving Babies Lives Care Bundle A national NHS initiative aimed at reducing stillbirths and early neonatal deaths by improving care in key areas such as **smoking cessation, fetal growth surveillance, fetal monitoring, reduced fetal movements, and preterm birth prevention.**
SLT	Site Leadership Team
SPC	Standard Process Chart
USS	Ultrasound scan

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Appendix 1

ESTH - Perinatal Quality Surveillance Model Data
March, April and May 2025

Quality Committees in Common – July 2025

Presented by:
Natilla Henry
Group Chief Midwifery Offer

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Background and Overview

In 2020, NHSE implemented the revised Perinatal Quality Oversight Model. As part of this, in partnership with their LMNS and Regional Maternity Team, local Maternity Units are required to report on a defined set of agreed measures, including as a minimum those defined by NHSE and the LMNS.

As a requirement of the Maternity and Neonatal Incentive Scheme (Safety Action 9), these defined measures should be shared with the Trust Board (or delegated sub-committee) quarterly.

These slides include the agreed Perinatal Quality Surveillance Model measures in line with the requirements of the LMNS and NHSE.

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CQC Maternity Ratings	Overall	Safe	Effecti	Caring	Well-Led	Responsive
	Requires Improvement	Requires Improvement	Good	Good	Requires Improvement	Outstanding

Maternity Safety Support Programme	Yes

	2025											
	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
Findings of review of all perinatal deaths using the real time data												
Findings of review all cases eligible for referral to MNSI.												
Report on:												
The number of incidents logged graded as moderate or above and what actions are being taken, serious incidents declared, serious incidents closed and progress on action plans												
Training compliance for all staff groups in maternity related to the core competency framework and wider job essential training												
Minimum safe staffing in maternity services to include Obstetric cover on the delivery suite, gaps in rotas and midwife minimum safe staffing planned cover versus actual												
Service User Voice feedback												
Staff feedback from frontline champions and walk-abouts												
HSIB/NHSR/CQC or other organisation with a concern or request for action made directly with												
Coroner Reg 28 made directly to Trust												
Progress in achievement of CNST 10												

Proportion of midwives responding with 'Agree or Strongly Agree' on whether they would recommend their trust as a place to work or receive treatment (Reported annually)	59%
Proportion of specialty trainees in Obstetrics & Gynaecology responding with 'excellent or good' on how would they would rate the quality of clinical supervision out of hours (Reported annually)	70%

RAG Rating	Explanation
Green	All parameters within normal limits, progress being made with action plan within anticipated time period, or action plan created
Amber	Progress with action plans not within anticipated time limit
Red	Issues identified, new reports available

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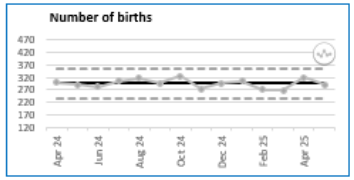


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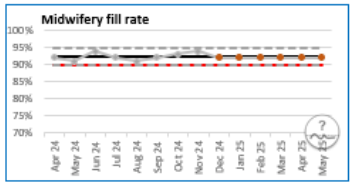
Outcomes Dashboard

Maternity overview ESTH

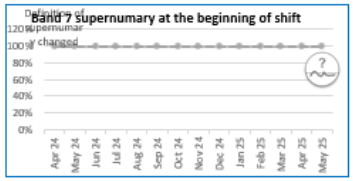
Latest month 01/05/25
Number of births 291
No significant change



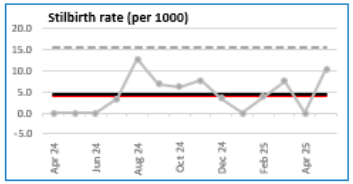
Latest month 01/05/25
Midwifery fill rate 90%
Significant deterioration



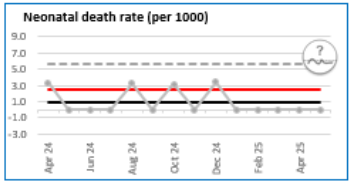
Latest month 01/05/25
Supernumary status 100%
No significant change



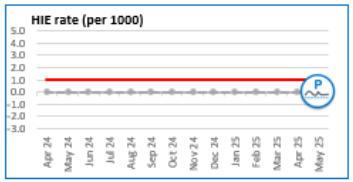
Latest month 01/05/25
Still birth rate/1(10.3
No significant change



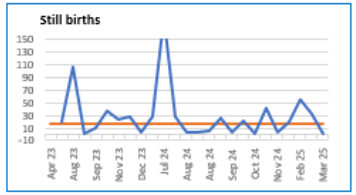
Latest month 01/05/25
Neonatal Death 0.0
No significant change



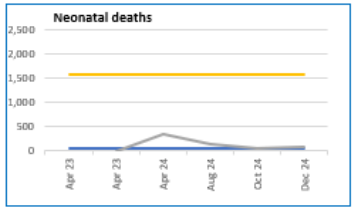
Latest month 01/05/25
HIE rate/1000 0.0
No significant change



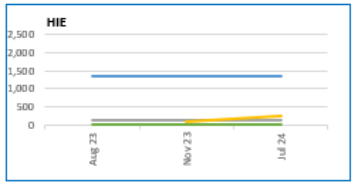
Date of last stillbirth 14/03/25
Average days between 16.1
No significant change



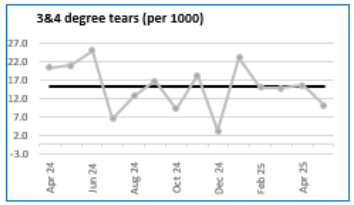
Date of last neonatal death 29/12/24
Average days between 69.2
No significant change



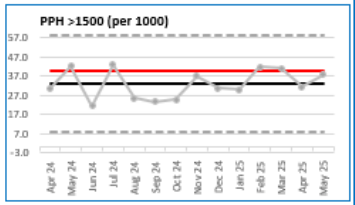
Date of last HIE ######
Average days between HIE 148.7
No significant change



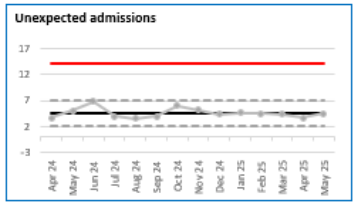
Latest month 01/05/25
3&4 degree tears (per 1000) 10.3
No significant change



Latest month 01/05/25
PPH >1500 (per 1000) 37.8
No significant change



Latest month 01/05/25
Unexpected admissions to NNU ATAIN 4.5
No significant change



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Risks – High and Extreme (10 and above)

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Description of Risk	Review Date	Update	Current Risk Level	Risk Owner
Lack of 2nd obstetric operating theatre at Epsom	30/092025	Work has now finished to convert Rose Room into a 2nd theatre; the delivery of an anaesthetic machine is now awaited before it can be used.	Extreme	Annabelle Keegan
General environmental issues were highlighted during the 2023 CQC inspection	31/07/2025	Work to sound-proof the STH bereavement room has been completed; work to increase the unit footprint to accommodate triage is planned.	Extreme	Kathryn Hughes
We have discovered that some cardiotocograph records have not be auto-stored; this has been raised with the manufacturer and has also been reported to the MHRA via the Yellow Card Scheme. Other local units have also been affected.	31/07/2025	It has provided a secure USB and currently all data from the machine is being manually downloaded and uploaded to the storage area on a weekly basis. An update is awaited from MHRA as the manufacturer has been unable to resolve the issue.	Extreme	Annabelle Keegan
Maternity lift breakdowns restricting access to labour and maternity wards and risk of entrapment for staff and patients	31/07/2025	An external lift was installed at STH but this does not give access to the main building (main theatres) as does not go down to basement level. At EGH contingency measures are in place through SWLEOC.	High	Annabelle Keegan
Nitrous Oxide exposure on Labour Ward	31/07/2025	The second round of room testing is currently underway. The HoM has provided details of the rooms in which Entonox is used to Estates for further action.	High	Annabelle Keegan
Our current staffing establishment only allows backfill for 23 hours of mandatory training and this is not sufficient to cover essential and nationally mandated training. SGUL by contrast have 34 hours per year.	31/07/2025	This is currently unresolved due to financial constraints.	High	Natilla Henry
The maternal assessment unit (MAU) at EGH is located in a separate building to Labour Ward	31/07/2025	There is a SOP and process in place to control the risk. Work to increase the unit footprint to accommodate MAU is planned.	High	Annabelle Keegan

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Perinatal Mortality

- **ESTH Data from the PMRT data tool**

May 2024 – Apr 2025	May 2024 – Apr 2025	May 2024 – Apr 2025	Jun 2024 – May 2025
Antepartum stillbirths	14	14	17
Intrapartum stillbirths	0	0	0
Stillbirth (unknown timing	1	1	1
Early neonatal death	4	3	3
Late neonatal death	1	1	1
	(20)	(19)	(22)
<24 weeks	2	2	2
24 – 27 weeks	5	5	6
28 – 31 weeks	2	2	2
32 – 36 weeks	7	6	7
37 – 41 weeks	4	4	5
≥ 42 weeks	0	0	0

- **Cases discussed, themes and open actions**

PMRT Panel	Cases reviewed Mar/Apr 2025	Emerging Themes/Learning	Open Actions from previous reviews, year to date
ESTH: 3 panel meetings held 14/03/2025, 25/04/2025 and 16/05/2025. There was an external panel member at the panel in March 2025.	INC-166116 INC 168996 INC-170805 INC-170865	No new clear emerging themes identified to date that contributed to the deaths, but the panel has noted that there is a trend of not completing partograms/observations in labour for cases of intrauterine death and 2 incidents highlighted issues with following up result (unrelated to the outcomes).	There are 2 open actions: • Placental histology to be added to i-Clip Pro (outside of our gift but the request is being progressed) • Action to discuss the need to document cervical assessment prior to Misoprostol (31/04/2025)

The latest ***MBRRACE-UK*** Perinatal Mortality Report for 2023 birth has shown that ESTH are average when compared with similar Trusts for neonatal death (up to 5% higher or up to 5% lower) and high than average for stillbirth (more than 5% higher). This shows a worsened position from the 2022 report.

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MNSI Cases

- There are currently no cases open with MNSI and no cases were closed during March – May 2025.
- There are 2 current open actions as follows:
- A review of the Birth Centre guidance is currently underway, with a view to simplifying the admission criteria.
- We are currently reviewing the antenatal CTG guidance to make it clearer when to apply Dawes-Redman criteria during induction of labour.

Trust top recommendations*

MNSI Maternity & Newborn Safety Investigations

25 completed reports:
7 reports *did not have* recommendations for the primary healthcare provider.
18 reports *did have* recommendations for the primary healthcare provider.



*Based on the year of report publication. The number of top recommendations listed may vary depending on their frequency.
**2025/26 has no current cases at the time of presentation

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Moderate and above Harm Outcomes

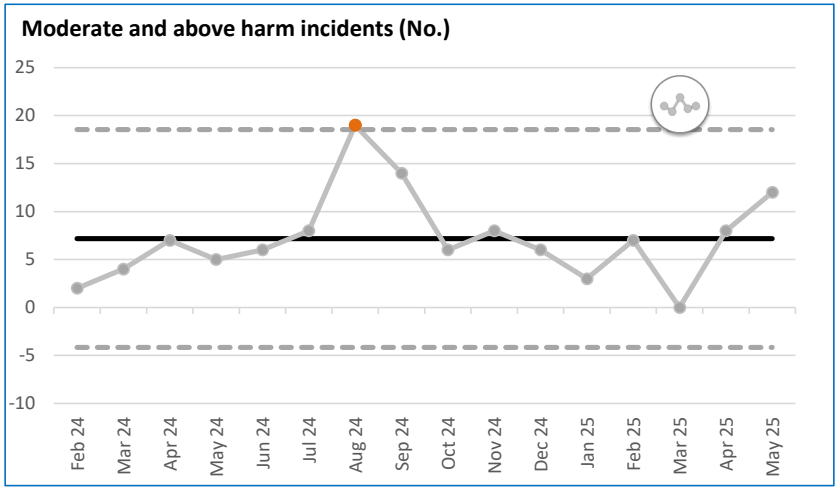
In March 2025 there were 5 moderate harm outcomes reported and all have been closed. Two related to stillbirth and one related to a neonatal death following a termination of pregnancy; all 2 incidents were graded as death in line with the Trust requirement following CQC inspection. There were also 2 3rd degree tears.

In April 2025, we have had 9 moderate harm outcomes reported. Only one has been closed:

- Neonatal death at 16+5 weeks gestation (late miscarriage). Whilst there was no patient safety incident identified which led or contributed to the death this has been graded as 'incident causing death'

The other incidents are all currently under review; one incident will be progressing to a PSII and others may be downgraded following review if no patient safety incident occurred. These related to:

- Massive obstetric haemorrhage (MOH) (5 (inc 3rd degree tear))
- 3rd/4th degree tear (2)
- Out of area woman discharged to the Croydon area had no community visits; the baby was admitted to St George's NICU with weightloss, dehydration and sever jaundice. The baby has since made a full recovery, but the division is progressing a PSII as there is significant learning in this case.



In May 2025, there were 12 Moderate harm incidents reported; 1 case (late miscarriage) has been closed. The other incidents are all currently under review may be downgraded following review. These related to:

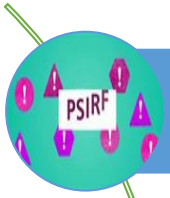
- 3rd/4th degree tear (3 cases)
- Obstetric haemorrhage (4 cases)
- Pressure damage
- Stillbirth (3 cases)

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PSIIs/Learning/Themes



There are currently no open actions from PSIIs/legacy SIs. The action from the most recently completed PSII (guidance for uterine inversion) has been completed and the guidance is awaiting upload to VICTOR.



During March, April and May 2025, 8 investigations were closed; 5 were closed through review by the PMRT panel (see separate PMRT report on the CNST update slides) and 3 were closed following an After Action Review.



There are currently 5 open investigations/learning responses; 4 cases are being reviewed by the PMRT panel and 1 is undergoing a PSII; this relates to a woman who was discharged to Croydon area and then did not receive any postnatal care resulting in a NNU admission for the baby.



We have found that the SWARM and rapid AAR approach does not always fit well with the Maternity Specialty as, in order to undertake a meaningful review for learning, we need to look back over the whole of the antenatal care. Whilst this means our AARs may take longer, this is the right thing to do to gain a meaningful outcome and learning.

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Incident themes (PSIRF)

Top 5 Incidents March 2025

The majority of incidents reported in Maternity Services fall under the maternity and neonatal category. The top 5 reported within this category in March 2025 were:

- Readmission of baby (15)
- Term baby admitted to the neonatal unit (10)
- Blood loss >1500mls (7)
- Maternal readmission (7)
- Postnatal delay in procedure (6)
- Guidelines not followed (7)
- 3rd or 4th degree perineal tear (4)

This indicates a relatively stable position over time and further information is included on the Outcomes Dashboard (slide 3). Detailed information is provided monthly to the Trust PSIR Panel via the specialty's DIRG Report.

Top 5 Incidents April 2025

- Blood loss >1500mls (15 – includes 6 not reported in March 2025)
- Readmission of baby (10)
- Term baby admitted to the neonatal unit (10)
- Maternal readmission (5)
- Antenatal delay in care or procedure (5)
- 3rd of 4th degree perineal tear (5)

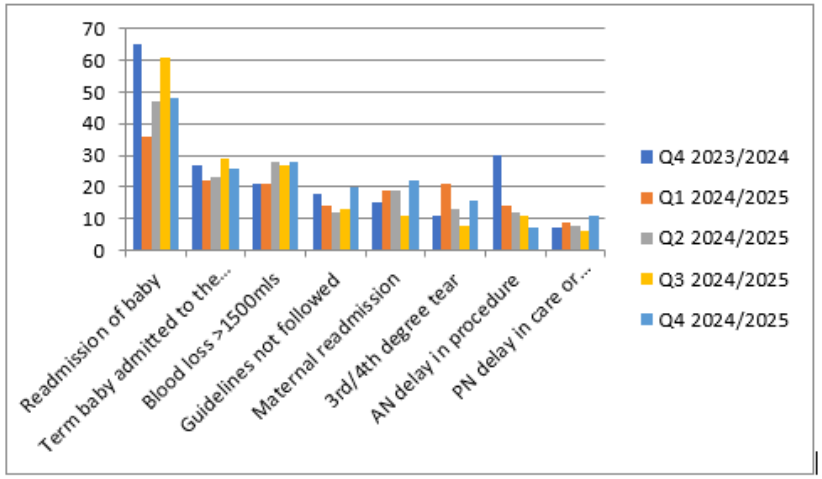
Top 5 incidents May 2025

- Readmission of baby (15)
- Term baby admitted to the NNU (11)
- Blood loss >1500mls
- Maternal readmission (5)
- Postnatal delay in care (5)
- Guidelines not followed (5)

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Incident themes Quarterly analysis/QI (PSIRF)



As readmission of babies has consistently been our most frequently reported incident and has a significant impact on both families and the service, we have commenced a deep dive audit and will present the findings and recommendations when the audit has been completed.

We are currently progressing a maternity-specific PSIRP; an-depth analysis of incidents has been undertaken to inform this, and this will include readmission of babies as one of the areas for local focus. The drafted has been completed and is awaiting local sign-off.

Our current PSIRP (areas for local focus below) now needs to be updated in response to our on-going analysis of incident themes:

1. PPH >1500mls has shown consistency over the last 15 months; we have only showed as above the national average on 2 of the last 15 months (National Maternity Dashboard).
2. CTG – we have well-embedded processes associated with audit, training and review with a specialist midwife and consultant in post.
3. There have been low numbers of maternal admissions to HDU with no themes or trends identified.

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Training Compliance

Type of Training and % compliance	Staff Group	ESTH Mar 25	ESTH Apr 25	ESTH May 25
PROMPT 90%	Midwifery Staff	96%	94%	92%
	Maternity Support Workers	95%	86%	88%
	Consultant Obstetricians	97%	89%	89%
	Trainee and Staff Grade Obstetricians	71%	83%	79%
	Anaesthetics	97%	100%	100%
CTG Training 90%	Midwifery Staff	93%	91%	90%
	Obstetricians	83% Cons/96% MG	89% Cons/94% MG	89% Cons/94% MG
NLS (Newborn Life Support) 90%	Midwifery Staff	96%	94%	92%
NLS (Newborn Life Support) 90%	Neonatal Nursing Staff	100%	100%	100%
NLS (Newborn Life Support) 90%	Neonatal Medical Staff	100%	100%	100%

There has been an increase in non-attendance from obstetric medical staff from the beginning of 2025 – compliance is expected to increase through the projected attendance list.

All new starters (obstetric medical staff) attend CTG and PROMPT training within 3 months of their start date. Neonatal medical staff attend NLS/BLS as part of their induction when they start.

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Safe Staffing

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Staff Group	Measure	Mar 2025		Apr 2025		May 2025	
Midwifery	Fill rate (target >94%)	ESTH STH	ESTH EGH	ESTH STH	ESTH EGH	ESTH STH	ESTH EGH
		92%	92%	88%	95%	88%	96%
Obstetric	Expected v Fill	100%		100%		100%	
Band 7 supernumerary MW allocated at start of shift	Shift allocation 100%	100%		100%		100%	
Triage Staff 1 wte per shift	Shift allocation 100%	100%		100%		100%	
Neonatal Nursing		89%	96%	97%	96%	96%	94%
Neonatal Medical		96%	98%	97%	99%	96%	98%

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Service User Feedback (complaints, FFT, PALS, MNVP and actions)

COMPLAINTS
We received 1 complaint in March 2025, 1 complaint in April 2025 and 6 complaints in May 2025. There are no clear themes, but issues identified include;

- Management of retained placenta (1)
- Attitude of the sonographer (2)
- Management of Birth (2)
- Antenatal care (3)

PALS
Between March and May 2025 there were 63 contacts; 10 contacts were regarding care concerns and 3 contacts are included in complaints above. 2 contacts were regarding staff attitude. Other recurring themes included positive comments about care (7), admin/notes requests (6), appointment/referral queries (20) and requests for results/MatB1a (3), Badger App (2). There was contact from a family member which was referred to the Safeguarding Team due to concerns around coercive control.

FFT responses in Quarter 4 - latest) - positive:

- ✓ Wanting to give a donation due to the excellence of care
- ✓ Positive comments about community midwives
- ✓ General comments about the excellence of the service and staff
- ✓ Positive comments about sonographers and reception staff

FFT - YOU SAID/WE DID:

There were comments around visiting hours, community midwifery care, waiting times in MAU.

We are reviewing MAU to ensure there is medical cover in place to reduce waiting times. Staff have been reminded to ensure woman are give the ***'Welcome to the Maternity Unit'*** leaflet which explains the visiting policy.

ACTIONS – There have been a number of general reminders issued to staff in response to complaints.

Other action have been taken around the management of ectopic pregnancy and staff attitude.

MNVP – Positive feedback themes included kind, caring and supportive midwives. Women felt listened to and respected and commented positively on continuity of care.

There was a lack of support on the postnatal ward (focussed on a lack of feeding support) which is a common theme throughout the region and concerns were raised around induction of labour and provision of information.

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Safety Action 7: Concerns

There is a requirement for ICBs to commission and fund MNVPs, to cover each Trust within their footprint, and reflecting the diversity of the local population.

It is important that we have an adequately funded, employed, trained and supported team in place.

- We currently do not have an adequate provision to meet the requirements of the MNVP being a quorate member of all Maternity Service Governance Meetings; our current MNVP lead is only funded for 6 hours per week and as she also has another employer, she does not have the flexibility to attend the meetings if they do not fall on her MNVP day(s).
- We currently have a vacancy in our MNVP lead team (funded by Surrey Heartlands).
- We have reached out to the ICB to confirm what funding is necessary to meet the requirement and how they will be ensuring the MNVP leads are trauma trained to facilitate attendance at PMRT panels.
- If the ICB cannot commission or fund the service to meet the current standard required, we need to agree and action plan with them to work towards.
- **It is a requirement of PMRT that this is noted in the PQSM report to the Board.**

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Concerns (MNSI/NHSR/CQC/Regulation 28)

There are no current MNSI letters of concern

There are no current NHSR concerns

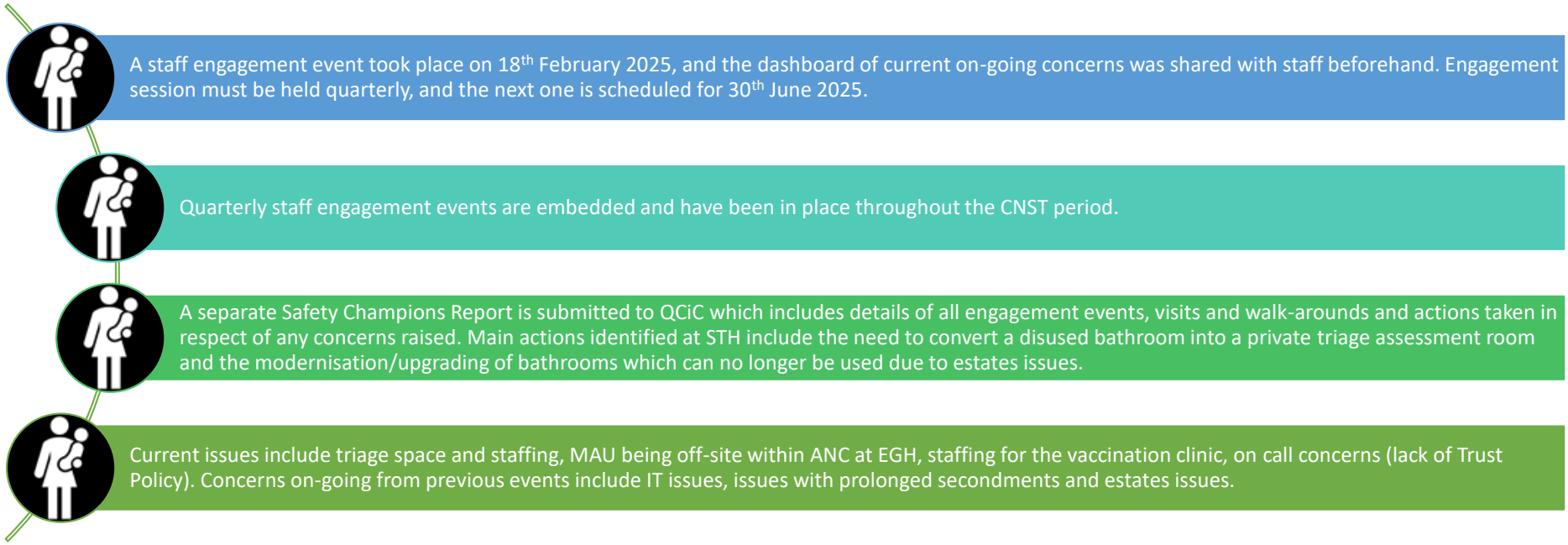
The CQC rating for the Maternity Service is 'Requires Improvement' and an action plan has now been completed, and reviewed through the Evidence Assurance Panel – ESTH alongside SGUH have entered onto the Maternity Support Programme. There is a meeting in August 2025 to discuss an Exit plan

There are no current Regulation 28 Reports (reports to prevent future deaths issued by a Coroner)

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Safety Champions (staff engagement/feedback/walk-arounds etc.)



A staff engagement event took place on 18th February 2025, and the dashboard of current on-going concerns was shared with staff beforehand. Engagement session must be held quarterly, and the next one is scheduled for 30th June 2025.

Quarterly staff engagement events are embedded and have been in place throughout the CNST period.

A separate Safety Champions Report is submitted to QCiC which includes details of all engagement events, visits and walk-arounds and actions taken in respect of any concerns raised. Main actions identified at STH include the need to convert a disused bathroom into a private triage assessment room and the modernisation/upgrading of bathrooms which can no longer be used due to estates issues.

Current issues include triage space and staffing, MAU being off-site within ANC at EGH, staffing for the vaccination clinic, on call concerns (lack of Trust Policy). Concerns on-going from previous events include IT issues, issues with prolonged secondments and estates issues.

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Cultural improvement plans/survey/SCORE survey



Proportion of specialty trainees in Obstetrics & Gynaecology responding with 'excellent or good' on how would they would rate the quality of clinical supervision out of hours (Reported annually) – ***70% (2023)***

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Thank you.

For any other information, please see:

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SGH Perinatal Quality Surveillance Model Data, March - May 2025

Presented by:
Natilla Henry
Group Chief Midwifery Officer

July 2025

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Background

In 2020, NHSE implemented the revised Perinatal Quality Oversight Model. As part of this, in partnership with their LMNS and Regional Maternity Team, local Maternity Units are required to report on a defined set of agreed measures, including as a minimum those defined by NHSE and the LMNS.

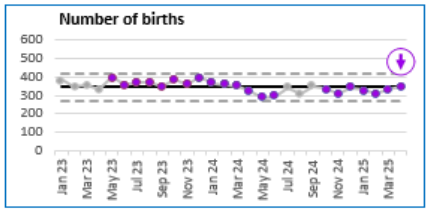
As a requirement of the Maternity and Neonatal Incentive Scheme (Safety Action 9), these defined measures should be shared with the Trust Board (or delegated sub-committee) at every meeting.

These slides include the agreed Perinatal Quality Surveillance Model measures in line with the requirements of the LMNS and NHSE.

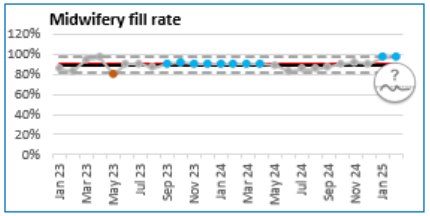
Outcomes dashboard

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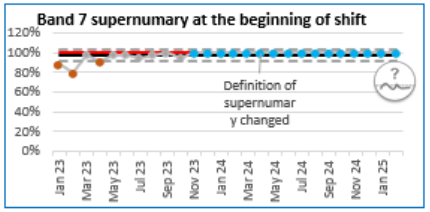
Latest month 01/04/25
Number of births 345
Significant reduction



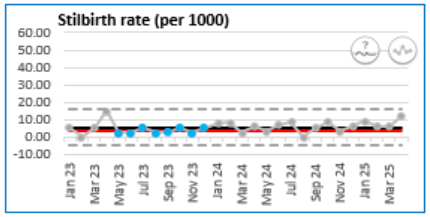
Latest month 01/02/25
Midwifery fill rate 90%
Significant Improvement



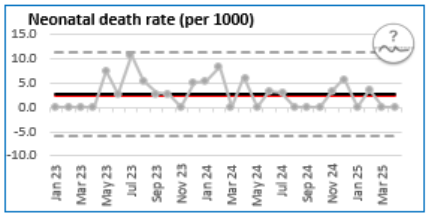
Latest month 01/02/25
Supernumary status 100%
Significant Improvement



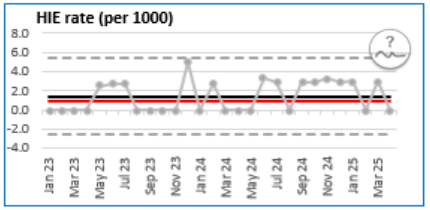
Latest month 01/04/25
Still birth rate/1000 11.6
No significant change



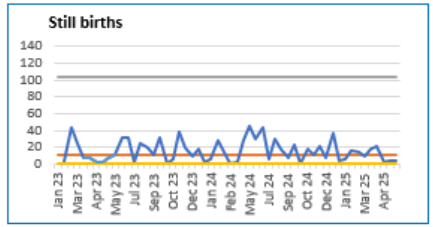
Latest month 01/04/25
Neonatal Death rate/1000 0.0
No significant change



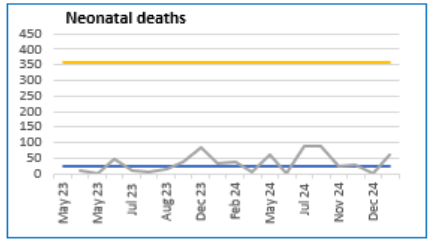
Latest month 01/04/25
HIE rate/1000 0.0
No significant change



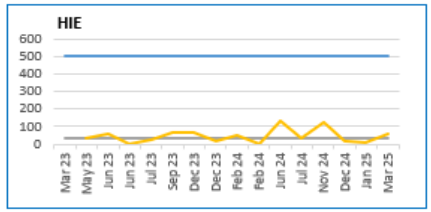
Date of last stillbirth 25/04/25
Average days between stillbirths 11.5
No significant change



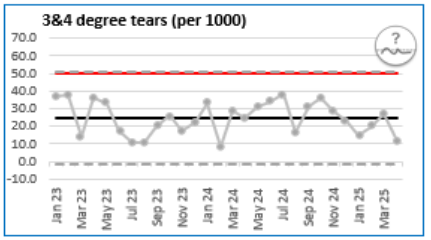
Date of last neonatal death 23/02/25
Average days between deaths 22.3
No significant change



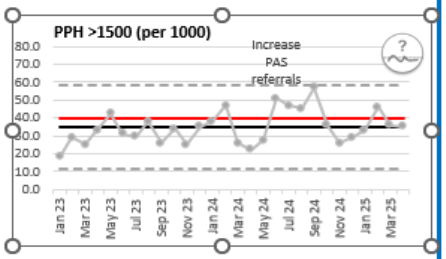
Date of last HIE 04/03/25
Average days between HIE 34.5
No significant change



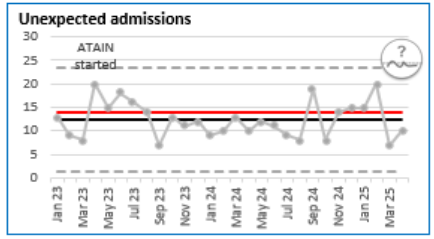
Latest month 01/04/25
3&4 degree tears (per 1000) 11.6
No significant change



Latest month 01/04/25
PPH >1500 (per 1000) 35.0
No significant change



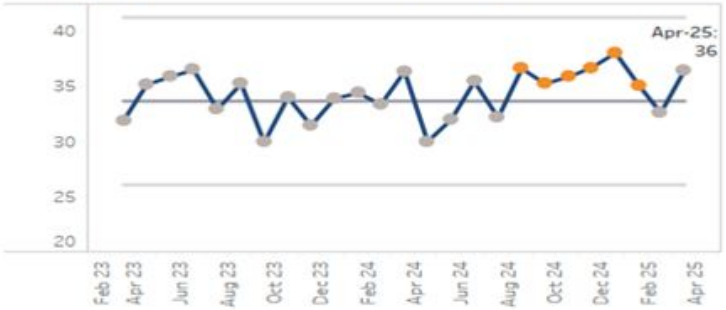
Latest month 01/04/25
Unexpected admissions to NNU ATAIN 10.0
No significant change



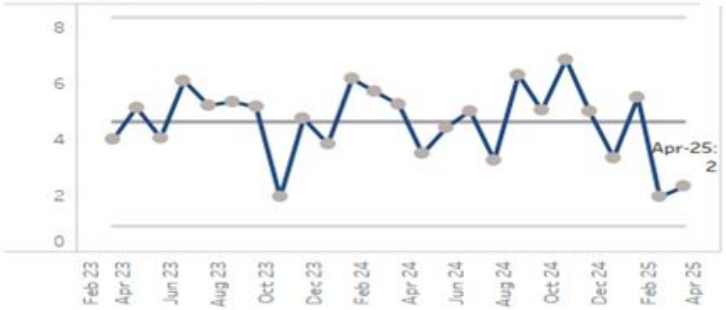
Maternity Dashboard
Data Source - E3

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Deliveries by Caesarean Section: % of Total



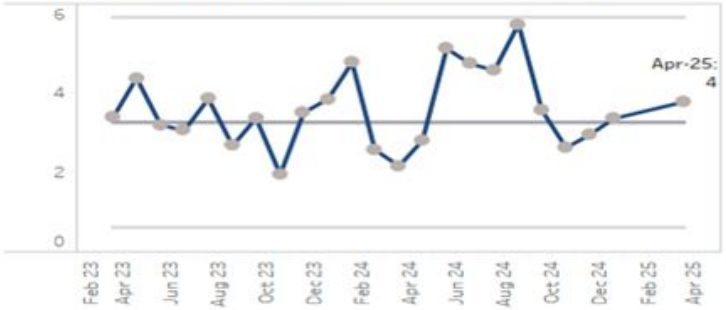
Deliveries by Emergency C-Section: % of Total



Births with 3rd or 4th Degree Tear: % of Total



Births with Life-Threatening PPH >1.5L: % of Total



KPI	Latest month	Previous Month Measure	Latest Month Measure	Target	Variation	Assurance	Benchmark
% Births with 3rd or 4th degree tear	Apr 25	3.0%	1.2%	5.0%			3.0%
% Births Post Partum Haemorrhage >1.5 L	Apr 25	3.6%	3.8%	4.0%			3.2%
Stillbirths per 1,000 births	Apr 25	8.7	2.2	2.0			3.5
Neonatal deaths per 1,000 births	Apr 25	5.8	0.0	2.0			1.6
HIE (Hypoxic ischaemic encephalopathy) per 1,000 births	Apr 25	2.9	2.2	-			1.0

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Risks – High Risk and Above

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SGH-Title of Risk	Update	Current Risk Level
FMU laser stack	Risk for de-escalation as the stack now ordered	Extreme
Meeting patients, mother and/or baby safety in line with regulatory standards	Newly approved risk following CQC Section 29a	Extreme
Infrastructure damage/sewerage flooding on the maternity unit	Action plan in place with Estates. Escalation for any issues logged with estates	High risk
Shortage of staff within FMU Sonography service due to national shortage of highly trained specialised obstetric sonographers	Continue to recruit. Trainee sonographer post approved to start training in Sept 25	High Risk
Maternity iClip problems relating to missing information and some relevant documentation fields not being completed or in place	All raised concerns have been collated and added to an action plan for IT to review and work through solutions. Additional digital midwife in place until end June who has trained staff in clinical areas to use system.	High Risk
Maternity records not migrated from Euroking to iClip	2000+ notes still to be migrated to iClip from E3. Staff continue to work on migration but no additional staff to support.	High Risk
Perinatal Mental Health service provision	Team short staffed and activity high. Currently recruiting	High Risk
Multiple Information Systems Migrating to a single digital platform. Project underway.	New IT single documentation system went live on 8th February 2025. Risk score for review	High risk
Provision of Home Birth service	Risk for de-escalation at next Divisional Governance	High risk
Closure of Birth Centre	Risk for de-escalation at next Divisional Governance	High risk
Viewpoint 5 servers and application out-of-support IDT is working with Med Physics and clinical services to transition to V6 Viewpoint and integrate this with iCLIP. Risk description updated to add risk and impact; controls added.	Awaiting transition to V6 Viewpoint	High Risk
Diabetes team seeing 500+/year women with GDM in the same clinic for women with pre-existing diabetes. Provision of pregnancy care for women with pre-existing diabetes in an MDT clinic although this patient group forms a minority within the clinic which includes gestational diabetics and other endocrine patients	This service being reviewed with the MDT as currently no facility to expand the clinic. Weekly MDT meeting prior to clinic to support focused care	High Risk

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Risks – Moderate

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SGH-Title of Risk	Update	Current Risk Level
No emergency bells fitted in DAU/FMU	Staff using emergency bleep in the event of an emergency. Alerting colleagues within the FMU/DAU vocally. Facilities to review as part of infrastructure	Moderate
Onboarding time laps for recruited midwives	Recruitment and retention midwives to have 2 touch base meetings with new recruits whilst they are waiting for the pre-employment checks to be completed	Moderate
Maternity Unit Security System	Not approved during this year's establishment review, will reassess in the establishment review in 2025. Establishment review to include 7/7 security and 7/7 reception cover on the PNW.	Moderate
Midwifery Manager on call rota	Ongoing optimisation of the Midwifery Manager on call roster. Work with division and HR to understand role of MMoC and expand team through HR processes	Moderate

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Incident themes (Datix)

Top 5 Incidents March 2025

Most incidents reported in Maternity Services fall under the maternity and neonatal category. The top 5 reported within this category in March 2025 were:

- Postpartum haemorrhage
- Delayed/inappropriate referral or patient care
- Test results
- Staffing issues
- Admission to NNU

Top 5 Incidents April 2025

Most incidents reported in Maternity Services fall under the maternity and neonatal category. The top 5 reported within this category in April 2025 were:

- Postpartum haemorrhage
- Patient access, appointment, transfer
- Staffing issues
- Third degree tear
- 2 instruments used for delivery

Top 5 Incidents May 2025

Most incidents reported in Maternity Services fall under the maternity and neonatal category. The top 5 reported within this category in May 2025 were:

- Delayed/inappropriate referral or patient care
- Staffing issues
- Postpartum haemorrhage
- Admission to NNU
- Third degree tear

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Moderate Harm and above cases

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In **March** 2025 there was –
1 Extreme case / maternal death during CS (baby delivered and discharge home). Case has been referred to MNSI and AAR undertaken. Immediate action plan in place and identified immediate actions have been undertaken.

There were **26 moderate** harm outcomes identified; these related to:

- Postpartum Haemorrhage (12)
- 3rd degree tear (9)
- 2 x instruments for delivery (1)
- Medication Error (1)
- Staff fall (1)
- Baby fall (1)
- Intra-abdominal bleed following CS (1)

1 maternal death during CS referred to MNSI and AAR undertaken.

During March, April and May 3 SWARM, 1 AAR and MDT were completed meetings and actions will be made as appropriate.

PSIIs/Learning/Themes

There is 1 open action from an SI. An extension was requested.
There is currently 3 open investigations, 3 PSII and 2 MDT

In **April** 2025 there were **19 moderate** harm and above outcomes identified; these related to:

- Post-partum haemorrhage (11)
- 3rd degree tear (3)
- Baby fall (1)
- Ureteric injury (1)
- Stillbirth > 37 weeks: High (2) < 37 weeks (1)
- Complications Twin laser (1)
- Complication CS (1)

In **May** 2025 there were **16 moderate** harm and above outcomes identified; these related to:

- Adm NNU (1)
- Failure to act on test results (1)
- Accreta hysterectomy (1)
- Neonatal Death 23+6 (1)
- 3rd degree tear (6)
- Post-partum haemorrhage (5)
- Adm to ITU: maternal collapse at home: High (1)

The above incidents are being reviewed through our moderate cases review meetings and actions will be made as appropriate.

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Perinatal Mortality

- **SGH Data from the PMRT data tool**

	April 24- March 25	May 2024- April 25	June 2024- May 2025
Antepartum stillbirths	19	22	22
Intrapartum stillbirths	2	2	2
Stillbirth (unknown timing	3	4	4
Early neonatal death	8	8	9
Late neonatal death	6	6	4
	(38)	(42)	(41)
<24 weeks	10	10	12
24 – 27 weeks	7	8	7
28 – 31 weeks	4	4	1
32 – 36 weeks	8	9	9
37 – 41 weeks	9	11	9
≥ 42 weeks	0	0	0

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Perinatal Mortality

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- **Cases discussed, themes and open actions**

PMRT Panel	Cases reviewed March-May 2025	Emerging Themes/Learning	Open Actions from previous reviews, year to date	
During the period of March- May 2025, SGH held 6 meetings in which 14 cases were discussed. Out of the 6 meetings, an external panel member was present for 3 meetings.	• ID:95964-IUD • ID:96360-IUD • ID:96929-IUD • ID:97000-IUD • ID:97122-IUD • ID:93292-IUD • ID:97655-IUD • ID:97828-IUD • ID:97627-IUD • ID:96002-NND • ID:96172-NND • ID:96558-NND • ID:96600-NND • ID:96755-NND To help us achieve Safety Action 1c. I have joined NHS future platform: A plea for PMRT to ask other Trust to be an external panel member for our meetings.	No new clear emerging themes were identified to date that contributed to the deaths of the cases reviewed. Case ID: 95964 was reported as a PSII case and the report still pending. This case was discussed in March; however, we are waiting for the actions to be completed from the relevant teams and for the recommendations. Cases ID: 96002 and 96600 were discussed at the meetings on March and April, however both cases were not supported by CNST as both babies died after 28 days of birth. Case ID:93292 was reported to MNSI, this case was discussed in April. All recommendations and actions were implemented and closed. Cases ID: 97122 and 96755 were discussed at last meeting in April, however report still pending.	The actions from the cases discussed for the period of December 2024 to present	Actions: ID:96172- Development of a Delivery Room Normothermia Guideline for Preterm Infants at St George's Hospital. To be completed by August 2025. All remaining actions are closed.

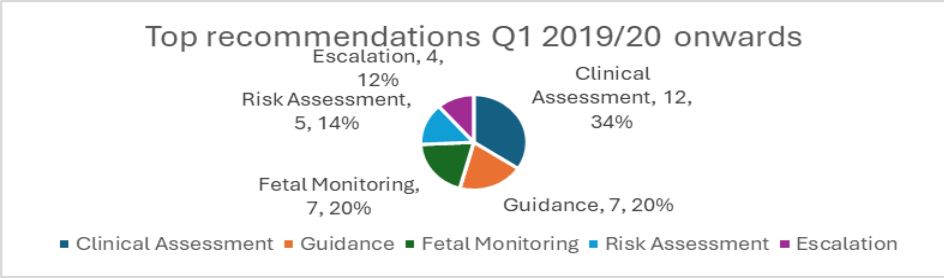
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Perinatal Mortality (MBRRACE-UK Perinatal Mortality Report)

The latest ***MBRRACE-UK*** Perinatal Mortality Report for 2023 birth has shown that SGUL are average when compared with similar Trusts for stillbirth (up to 5% higher or up to 5% lower) and lower than average for neonatal death (more than 5% and up to 15% lower). These are the same findings that were published in the 2022 report.



MNSI Maternity & Newborn Safety Investigations

8 open cases with MNSI

Case Number	Date	Referral Criteria	Case Status
MI-037842/DW213326	28/07/2024	HIE/cooled	Completed: Awaiting sign off action plan DIRG
MI-038558/DW215544	23/09/2024	Maternal Death	Active: Waiting for input from respiratory clinical advisor
MI-038731/DW211153	23/06/2024	Maternal Death	Active: Awaiting final sign off at MNSI before sharing for factual accuracy.
MI-038732/DW211153	23/06/2024	Neonatal Death	Active: Awaiting final sign off at MNSI before sharing for factual accuracy.
MI-039186/DW220116	20/12/2024	HIE/cooled	Active: Delays with Neonatal team interviews
MI-039196/DW220592	02/01/2025	HIE/cooled	Active: Draft report shared for factual accuracy return 19th June
MI-040236/DW223760	03/03/2025	Maternal Death	Active: Awaiting second panel discussion
MI-040278/DW225886	04/03/2025	HIE/Cooled	Active: Interviews underway

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Training Compliance

Type of Training and % compliance	Staff Group	SGH Feb 25	SGH March 25	SGH April 25	SGH May 25
PROMPT 90%	Midwifery Staff	88%	87%	94%	94%
	Maternity Support Workers	93%	83%	85%	87%
	Consultant Obstetricians	89%	89%	95%	100%
	Trainee and Staff Grade Obstetricians	92%	83%	96%	97%
	Anaesthetics	94%	92%	100%	100%
CTG Training 90%	Midwifery Staff	93%	92%	92%	95%
	Obstetricians	91%	95%	93%	99%
NLS (Newborn Life Support) 90%	Midwifery Staff	92%	94%	94%	94%
NLS (Newborn Life Support) 90%	Neonatal Nursing Staff	89.04%	90%	90%	90%
NLS (Newborn Life Support) 90%	Neonatal Medical Staff	100%	100%	100%	100%

Marked improvement with all training compliance over April and May.
For PROMPT overall compliance at 90% has been achieved for the MDT, except for MSW's who are all booked to attend future dates.

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Staff Staffing

St George's University Hospitals NHS Foundation Trust

Safer Staffing-March 2025

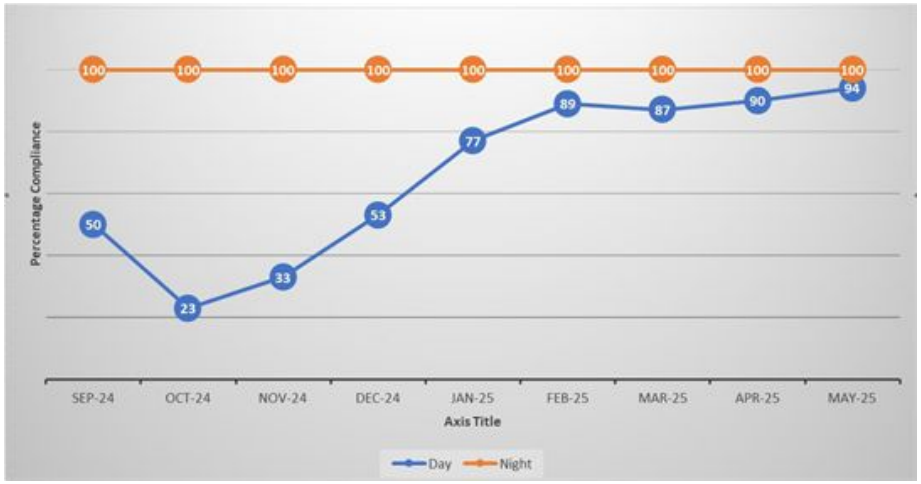
	Day						Night					
Ward Name	Registered Nurse / Midwives		Average fill rate registered staff	Care Staff		Average fill rate care staff	Registered Nurse / Midwives		Average fill rate registered staff	Care Staff		Average fill rate care staff
	Total planned staff hours	Total actual staff hours	Registered Staff Day %	Total planned staff hours	Total actual staff hours	Care Staff Day %	Total planned staff hours	Total actual staff hours	Registered Staff Night %	Total planned staff hours	Total actual staff hours	Care Staff Night %
Carmen Suite	740	645	87%	377	248	66%	712	614	86%	356.5	357	100%
Delivery Suite	5096	4528	89%	1126	898	80%	4880	4559	93%	1070	1059	99%
Gwillim Ward	2293	2009	87.50%	777	648	83%	1426	1351	95%	713	691	97%
			Day Qualified			**Day HCA**			**Night Qualifies**			**Night HCA**
			88%			**76%**			**91%**			**99%**
Trust Total	121,270	118,484	**98%**	52,273	50,109	**96%**	97,639	97,654	**100%**	44,157	44,559	**100%**

Safer Staffing-Apr 2025

	Day						Night					
Ward Name	Registered Nurse / Midwives		Average fill rate registered staff	Care Staff		Average fill rate care staff	Registered Nurse / Midwives		Average fill rate registered staff	Care Staff		Average fill rate care staff
	Total planned staff hours	Total actual staff hours	Registered Staff Day %	Total planned staff hours	Total actual staff hours	Care Staff Day %	Total planned staff hours	Total actual staff hours	Registered Staff Night %	Total planned staff hours	Total actual staff hours	Care Staff Night %
Carmen Suite	735	534	72.50%	344	322	93.50%	679	431	63%	345	345	100%
Delivery Suite	4970	4293	86%	1005	948	94%	4727	4272	90%	1022	1022	100%
Gwillim Ward	2157	2052	95%	735	677	92%	1380	1348	97.50%	679	679	100%
			Day Qualified			**Day HCA**			**Night Qualifies**			**Night HCA**
			85%			**93%**			**84%**			**100%**
Trust Total	116,751	114,050	**98%**	50,855	49,425	**97%**	93,921	92,890	**99%**	41,970	42,239	**100%**

Safe Staffing

Triage Staffing



Triage budgeted staffing -
2 midwives and one MSW on a day shift
1 midwife and one MSW on a night shift

- As the helpline is diverted to triage overnight, the coordinators allocate 2 midwives to Triage during the night shift (taken from delivery suite staffing) to maintain safety.
- Staffing in Triage has continued to improve from February to May as the team have worked to ensure appropriate day time staffing.

Band 7 supernumerary MW allocated at start of shift

March 2025	April 2025	May 2025
100%	100%	96.8%

One to One in Established Labour

	March	April	May
Birth Centre	100%	100%	100%
Labour Ward	100%	100%	100%

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Service User Feedback (complaints, FFT, PALS,MNVP and actions)

COMPLAINTS
There were 20 complaints received in March & April 2025 for Maternity.
6 of the 20 complaints relate Clinical Treatment.
5 relating to Cancelation
5 relating to care
2 relating to other
1relating to Request for Information
1 relating to Attitude

FFT positive feedback

- ✓ Caring and compassionate staff
- ✓ Being seen by the same team of midwives
- ✓ Staff described as amazing
- ✓ Care in labour

FFT - YOU SAID/WE DID

The value of face-to-face classes –

Every team in the community now provides their own antenatal classes.

ANC and the Birth Centre are now launching their own face to face classes to create and equitable opportunity.

ACTIONS

A new MNVP Lead appointed – Mrs Amena Ahmed started in Feb 25.

Working with SLW core connector to prioritise communities to direct targeted classes – language/deprivation/greatest risk

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March to April 2025

- **PALS Numbers**
- There were 12 PALS Maternity enquiries received in March and April 2025.
- 6 Concerns
- 6 Concerns

PALS Themes
1) APPOINTMENT - serveley anemic patient waited 4 hours to be seen that only lasted 2 minutes
1) CARE - Experience of antenatal clinic
1) CLEAN - Poor housekeeping on Gwillim Ward
4) COMMUNICATION - Request for translator; request for medical report for travel; request of proof apt; confirming time of apt;
2) INFORMATION - guidance to make formal complaint; letter needed for home office regarding high risk of miscarriage
3) LOST PROPERTY - missing jewellery; missing clothing; missing baby box

Maternity Neonatal Voices Partnership (MNVP)						
Action No.	Date of Meeting	Action	Lead Officer	Timescale/Deadline	Comment/Feedback from Lead Officer	Progress
MNVP 1	17/12/2024	Meeting to be arranged for CLW, M Montagna, G Green and L Tufari to discuss and schedule an education day for midwives and doulas	CLW	25/02/2025	Doula day arranged for in February at the Tooting Health Centre. Event attended by 18 doulas. See doula day pledges.	complete
MNVP 2	17/12/2024	K Ramdass to arrange for a meeting with L Tufari to discuss if doulas can not be seen as a plus one but support staff	KR		Amena to contact KR to help organise the meeting.	in progress
MNVP 3	12/02/2025	Amena to arrange for a potential face-to-face meeting for June's MNVP	AA	07/03/2025	June MNVP meeting booked at Maternity Education room.	complete
MNVP 4	12/02/2025	Encourage staff to recruit people into the MNVP	CLW	Ongoing	Email to be sent to all midwives.	in progress
MNVP 5	04/07/2025	Post-natal ward WTP report to be shared with staff so necessary actions can take place if needed.	AA	04/06/2025	Amena to share document with Angela that will be included circulated ahead of next MNVP meeting in June	in progress
MNVP 6	04/07/2025	Chelone to collate feedback from debrief clinic.	CLW/PH	06/11/2025		in progress
MNVP 7	04/07/2025	A service user at this meeting had some negative feedback from her recent birthing experience. Service user to be contacted and offered options of what she can do next.	AA	06/11/2025	Amena to contact the service user and arrange for potential meeting with KR as KR said in the last meeting she would be happy to speak with her.	in progress
MNVP 8	04/07/2025	It was mentioned in the meeting (teams chat box) that service users had raised concerns with regards to the delay in responding to call bells. They asked if there was any plan of action to monitor and improve this.	KR	06/11/2025	Amena to contact KR to help answer this query.	in progress

Appendix 2

PMRT - Perinatal Mortality Reviews Summary Report

This report has been generated following mortality reviews which were carried out using the national Perinatal Mortality Review Tool

Epsom and St Helier University Hospitals NHS Trust

Report of perinatal mortality reviews completed for deaths which occurred in the period:

1/2/2024 to 31/5/2025

Summary of perinatal deaths*

Total perinatal* deaths reported to the MBRRACE-UK perinatal mortality surveillance in this period: *23*

Summary of reviews**

Stillbirths and late fetal losses

Number of stillbirths and late fetal losses reported	Not supported for Review	Reviews in progress	Reviews completed and published ***	Grading of care: number of stillbirths and late fetal losses with issues with care likely to have made a difference to the outcome for the baby
23	5	4	14	0

Neonatal and post-neonatal deaths

Number of neonatal and post-neonatal deaths reported	Not supported for Review	Reviews in progress	Reviews completed and published ***	Grading of care: number of neonatal and post-neonatal deaths with issues with care likely to have made a difference to the outcome for the baby
7	3	0	4	0

*Late fetal losses, stillbirths and neonatal deaths (does not include post-neonatal deaths which are not eligible for MBRRACE-UK surveillance) – these are the total deaths reported and may not be all deaths which occurred in the reporting period if notification to MBRRACE-UK is delayed. Termination of pregnancy are excluded. All other perinatal deaths reported to MBRRACE-UK are included here regardless of whether a review has been started or is published.

** Post-neonatal deaths can also be reviewed using the PMRT

*** If a review has been started, but has not been completed and published then the information from that review does not appear in the rest of this summary report

Report Generated by: Laura Rowe
Date report generated: 02/07/2025 11:06

Table 1: Summary information for the babies who died in this period and for whom a review of care has been completed – number of babies (N = 18)

Perinatal deaths reviewed	Gestational age at birth						
	Ukn	22-23	24-27	28-31	32-36	37+	Total
Late Fetal Losses (<24 weeks)	0	0	--	--	--	--	0
Stillbirths total (24+ weeks)	0	0	5	2	5	2	14
Antepartum stillbirths	*0*	*0*	*5*	*2*	*5*	*2*	*14*
Intrapartum stillbirths	*0*	*0*	*0*	*0*	*0*	*0*	*0*
Timing of stillbirth unknown	*0*	*0*	*0*	*0*	*0*	*0*	*0*
Early neonatal deaths (1-7 days)*	0	1	0	0	1	1	3
Late neonatal deaths (8-28 days)*	0	0	0	0	0	1	1
Post-neonatal deaths (29 days +)*	0	0	0	0	0	0	0
Total deaths reviewed	0	1	5	2	6	4	18
Small for gestational age at birth:							
IUGR identified prenatally and management was appropriate	0	0	0	1	2	0	3
IUGR identified prenatally but not managed appropriately	0	0	0	0	0	0	0
IUGR not identified prenatally	0	0	0	0	2	0	2
Not Applicable	0	1	5	1	2	4	13
Mother gave birth in a setting appropriate to her and/or her baby's clinical needs:							
Yes	0	1	5	2	6	3	17
No	0	0	0	0	0	1	1
Missing	0	0	0	0	0	0	0
Parental perspective of care sought and considered in the review process:							
Yes	0	1	5	2	6	4	18
No	0	0	0	0	0	0	0
Missing	0	0	0	0	0	0	0
Booked for care in-house	0	1	0	0	1	2	4
Mother transferred before birth	0	0	0	0	0	0	0
Baby transferred after birth	0	0	0	0	0	0	0
Neonatal palliative care planned prenatally	0	0	0	0	0	0	0
Neonatal care re-orientated	0	1	0	0	1	1	3

*Neonatal deaths are defined as the death within the first 28 days of birth of a baby born alive at any gestational age; early neonatal deaths are those where death occurs when the baby is 1-7 days old and late neonatal death are those where the baby dies on days 8-28 after birth. Post-neonatal deaths are those deaths occurring from 28 days up to one year after birth

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Table 2: Placental histology and post-mortems conducted for the babies who died in this period and for whom a review of care has been completed – number of babies (N = 18)

Perinatal deaths reviewed	Gestational age at birth						
	Ukn	22-23	24-27	28-31	32-36	37+	Total
Late fetal losses and stillbirths							
Placental histology carried out							
Yes	0	0	5	2	5	2	14
No	0	0	0	0	0	0	0
Hospital post-mortem offered	0	0	5	2	5	2	14
Hospital post-mortem declined	0	0	1	1	4	0	6
Hospital post-mortem carried out:							
Full post-mortem	0	0	3	1	1	2	7
Limited and targeted post-mortem	0	0	0	0	0	0	0
Minimally invasive post-mortem	0	0	0	0	0	0	0
External review	0	0	1	0	0	0	1
Virtual post-mortem using CT/MR	0	0	0	0	0	0	0
Neonatal and post-neonatal deaths:							
Placental histology carried out							
Yes	0	1	0	0	1	1	3
No	0	0	0	0	0	1	1
Death discussed with the coroner/procurator fiscal	0	0	0	0	1	2	3
Coroner/procurator fiscal PM performed	0	0	0	0	0	2	2
Hospital post-mortem offered	0	1	0	0	1	0	2
Hospital post-mortem declined	0	1	0	0	0	0	1
Hospital post-mortem carried out:							
Full post-mortem	0	0	0	0	1	0	1
Limited and targeted post-mortem	0	0	0	0	0	0	0
Minimally invasive PMpost-mortem	0	0	0	0	0	0	0
External review	0	0	1	0	0	0	1
Virtual post-mortem using CT/MR	0	0	0	0	0	0	0
All deaths:							
Post-mortem performed by paediatric/perinatal pathologist*							
Yes	0	0	4	1	1	2	8
No	0	0	0	0	0	0	0
Placental histology carried out by paediatric/perinatal pathologist*:							
Yes	0	0	4	1	1	2	8
No	0	0	1	1	4	0	6

*Includes coronial/procurator fiscal post-mortems

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Table 3: Number of participants involved in the reviews of late fetal losses and stillbirths without resuscitation (N = 13)

Role	Total Review sessions	Reviews with at least one
Chair	19	92% (12)
Vice Chair	18	92% (12)
Admin/Clerical	0	0%
Ambulance Team	0	0%
Bereavement Team	18	100% (13)
Community Midwife	0	0%
External	5	38% (5)
Management Team	6	38% (5)
Midwife	117	100% (13)
MNVP Lead	0	0%
Neonatal Nurse	0	0%
Neonatologist	3	23% (3)
Obstetrician	41	100% (13)
Other	0	0%
Risk Manager or Governance Team	39	100% (13)
Safety Champion	0	0%
Sonographer or Radiographer	0	0%

Table 4: Number of participants involved in the reviews of stillbirths with resuscitation and neonatal deaths (N = 5)

Role	Total Review sessions	Reviews with at least one
Chair	5	100% (5)
Vice Chair	5	100% (5)
Admin/Clerical	0	0%
Ambulance Team	0	0%
Bereavement Team	4	40% (2)
Community Midwife	0	0%
External	6	100% (5)
Management Team	5	80% (4)
Midwife	35	100% (5)
MNVP Lead	0	0%
Neonatal Nurse	1	20% (1)
Neonatologist	4	60% (3)
Obstetrician	13	100% (5)
Other	3	40% (2)
Risk Manager or Governance Team	17	100% (5)
Safety Champion	0	0%
Sonographer or Radiographer	0	0%

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Table 5: Grading of care relating to the babies who died in this period and for whom a review of care has been completed – number of babies (N = 18)

Perinatal deaths reviewed	Gestational age at birth						
	Ukn	22-23	24-27	28-31	32-36	37+	Total
STILLBIRTHS & LATE FETAL LOSSES							
Grading of care of the mother and baby up to the point that the baby was confirmed as having died:							
A - The review group concluded that there were no issues with care identified up the point that the baby was confirmed as having died	0	0	4	0	2	1	7
B - The review group identified care issues which they considered would have made no difference to the outcome for the baby	0	0	1	1	3	0	5
C - The review group identified care issues which they considered may have made a difference to the outcome for the baby	0	0	0	1	0	1	2
D - The review group identified care issues which they considered were likely to have made a difference to the outcome for the baby	0	0	0	0	0	0	0
Not graded	0	0	0	0	0	0	0
Grading of care of the mother following confirmation of the death of her baby:							
A - The review group concluded that there were no issues with care identified for the mother following confirmation of the death of her baby	0	0	3	2	4	2	11
B - The review group identified care issues which they considered would have made no difference to the outcome for the mother	0	0	2	0	1	0	3
C - The review group identified care issues which they considered may have made a difference to the outcome for the mother	0	0	0	0	0	0	0
D - The review group identified care issues which they considered were likely to have made a difference to the outcome for the mother	0	0	0	0	0	0	0
Not graded	0	0	0	0	0	0	0
NEONATAL AND POST-NEONATAL DEATHS							
Grading of care of the mother and baby up to the point of birth of the baby:							
A - The review group concluded that there were no issues with care identified up the point that the baby was born	0	0	0	0	0	1	1
B - The review group identified care issues which they considered would have made no difference to the outcome for the baby	0	1	0	0	1	0	2
C - The review group identified care issues which they considered may have made a difference to the outcome for the baby	0	0	0	0	0	1	1
D - The review group identified care issues which they considered were likely to have made a difference to the outcome for the baby	0	0	0	0	0	0	0
Not graded	0	0	0	0	0	0	0
Grading of care of the baby from birth up to the death of the baby:							
A - The review group concluded that there were no issues with care identified from birth up the point that the baby died	0	1	0	0	1	2	4
B - The review group identified care issues which they considered would have made no difference to the outcome for the baby	0	0	0	0	0	0	0
C - The review group identified care issues which they considered may have made a difference to the outcome for the baby	0	0	0	0	0	0	0
D - The review group identified care issues which they considered were likely to have made a difference to the outcome for the baby	0	0	0	0	0	0	0
Not graded	0	0	0	0	0	0	0
Grading of care of the mother following the death of her baby:							
A - The review group concluded that there were no issues with care identified for the mother following the death of her baby	0	1	0	0	1	2	4
B - The review group identified care issues which they considered would have made no difference to the outcome for the mother	0	0	0	0	0	0	0
C - The review group identified care issues which they considered may have made a difference to the outcome for the mother	0	0	0	0	0	0	0
D - The review group identified care issues which they considered were likely to have made a difference to the outcome for the mother	0	0	0	0	0	0	0
Not graded	0	0	0	0	0	0	0

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Table 6: Cause of death of the babies who died in this period and for whom a review of care has been completed – number of babies (N = 18)

Timing of death	Cause of death
Late fetal losses	**0 causes of death out of 0 reviews**
Stillbirths	**14 causes of death out of 14 reviews**
	The cause of death was undetermined
	The cause of death was undetermined
	The cause of death was undetermined
	The cause of death was undetermined
	Intra-uterine death of an appropriately grown and developed late trimester male fetus, the cause of which is attributed to the placental findings of acute chorioamnionitis (infection) with fetal inflammatory response (necrotising funisitis) and high grade fetal vascular malperfusion.
	Placental abruption and possible FNAIT as documented in the postmortem result: Intra-uterine death of a late second trimester male baby a few days prior to delivery with acute hypoxic changes and evidence of a large subarachnoid haemorrhage; screening for fetal and neonatal alloimmune thrombocytopaenia is advised. Placental examination showed a long umbilical cord with high-grade fetal vascular malperfusion and a large retroplacental clot, the latter raising the possibility of acute abruption
	Placental Abruption
	The PM report found features of an acute hypoxic mode of death, the cause of which is attributed to cord entanglement, which corresponds to the clinical findings at delivery where the cord was around Raed's neck twice.
	Placental abruption
	The post-mortem found acute hypoxia. But the panel concluded it is unclear whether the fetal anaemia which was diagnosed at birth was a contributory factor to the placental issues found on post-mortem.
	Intra-uterine death of an early third trimester female baby at up to one week prior to delivery attributed to confirmed trisomy 21, associated congenital abnormalities and placental pathology
	The cause of death was undetermined
	Acute twin to twin transfusion syndrome
	The cause of death was undetermined
Neonatal deaths	**4 causes of death out of 4 reviews**
	Respiratory failure secondary to multiple dysmorphic facial features and undiagnosed congenital abnormalities as described by the post mortem examination.
	Late miscarriage and extreme prematurity (22+0).
	1a. Acute perinatal asphyxia. 1b. Maternal ascending genital tract infection. The placenta was of normal weight. Histology showed acute chorioamnionitis with fetal inflammatory response, in keeping with a maternal ascending genital tract infection.
	Sudden Unexpected Death in Infancy
Post-neonatal deaths	**0 causes of death out of 0 reviews**

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Table 7: Issues raised by the reviews identified as relevant to the deaths reviewed, by the number of deaths affected by each issue* and the actions planned

Issues raised which were identified as relevant to the deaths	Number of deaths	Actions planned
During resuscitation the baby required intubation but this was not achieved	1	No action entered
During this mothers's labour maternal observations, commensurate with her level of risk and national guidelines, were not carried out	1	Ongoing intermittent auscultation audit, to now include maternal observations also. A message of the week was circulated on 09.09.24 regarding appropriate intermittent auscultation in labour and maternal pulse.
The type of fetal monitoring used in established labour was not appropriate	1	Ongoing intermittent auscultation audit, to now include maternal observations also. A message of the week was circulated on 09.09.24 regarding appropriate intermittent auscultation in labour and maternal pulse.
This mother and/or her baby had an intrapartum complication(s) which was not managed appropriately	1	A special edition of the Maternity Risk Newsletter focusing on the management and escalation of pink/ blood stained liquor was published on the 19.09.24.
This mother had a placental abruption during her pregnancy and there was a delay in the diagnosis	1	The learning regarding the management of pregnant women with abdominal pain is to be shared at the monthly Clinical Risk Meeting, at daily labour ward safety huddles and an item to be placed in the risk newsletter. In addition, the learning will be shared with the Midwives at the Call a Midwife triage line.
This mother had a placental abruption during her pregnancy which was not managed according to national or local guidelines	1	The learning regarding the management of pregnant women with abdominal pain is to be shared at the monthly Clinical Risk Meeting, at daily labour ward safety huddles and an item to be placed in the risk newsletter. In addition, the learning will be shared with the Midwives at the Call a Midwife triage line.
This mother had other during her pregnancy which was not managed according to national or local guidelines	1	Guideline for the management of antenatal antibodies to be updated to include a flow chart for ease of interpretation.
This mother's risk status was not formally assessed at the start of her care in labour to ensure that her intended place of care in labour was appropriate	1	Working party to be established to review and update the guidance. This should include the Labour Ward Lead Consultants, the Matrons and the Birth Centre Leads. The updated guidance should include the process for developing OOG plans, the process for reviewing birth plans and the process for reviewing birth plans when women attend triage.

*Note - depending upon the circumstances in individual cases the same issue can be raised as relevant to the deaths reviewed and also not relevant to the deaths reviewed.

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Table 8: Top 10 issues** raised by the reviews which are of concern but not directly relevant to the deaths reviewed, by the number of deaths in which this issue was identified* and the actions planned

Issues raised which were identified as not relevant to the deaths	Number of deaths	Actions planned
The baby had to be transferred elsewhere for the post-mortem	9	No action entered
		No action entered
		No action entered
		No action entered
		No action entered
		No action entered
		No action entered
		No action entered
		No action entered
Placental histology was performed but was not carried out by a perinatal/paediatric pathologist	7	No action entered
		No action entered
		No action entered
		No action entered
		No action entered
		No action entered
		No action entered
This mother's progress in labour was not monitored on a partogram	4	No action entered
		Clinicians to be reminded that the partogram gives an overview of progress in labour and maternal wellbeing. When caring for a mother with an intrauterine death who is in labour, maternal observations must be documented in the labour assessment on BadgerNet, (this should include an hourly pulse) so the partogram is populated. If the mother has commenced analgesia and/or is contracting this information must also be documented on the partogram. All antenatal inpatient women must have 4 hourly observations. On daily ward round the frequency of observations must be reviewed. This will be highlighted at daily labour ward huddle, Band 7 meetings and be circulated as message of the week.
		This will be highlighted at daily labour ward huddle, Band 7 meetings and be circulated as message of the week.
		An audit is to be carried out to assess compliance with partograms overall. The importance of completing a partogram in IUD case is to be added to the bereavement mandatory training.
During this mothers's labour maternal observations, commensurate with her level of risk and national guidelines, were not carried out	3	Article in risk newsletter to outline PCA observations. Huddle and handover reminder of observations in labour.

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		Observations should be 4 hourly for every woman who is admitted with an IUD/ threatened miscarriage. These women are high risk for sepsis. Once women are in labour our guideline is for hourly pulse in addition to four hourly observations. This will be highlighted in a message of the week circulated to all staff, via the handovers and huddles and in the band 7 meetings.
		Clinicians to be reminded that observations should be 4 hourly for every woman who is admitted with an intrauterine death/threatened miscarriage. These women are high risk for sepsis. Once women are in labour our guideline is for hourly pulse in addition to four hourly observations. This will be highlighted at daily labour ward huddle, message of the week, at Band 7 meetings.
A completed bereavement checklist was not in the notes	2	The process for uploading the bereavement documentation to BadgerNet requires review and strengthening.
		A review of the process for scanning and uploading the bereavement documentation to BadgerNet is required.
During the early bereavement period the baby was not cared for in a cold cot because the cold cot was not offered	2	The Bereavement Midwife to highlight at yearly mandatory training, the importance of using a cold cot.
		No action entered
Induction of labour or a caesarean section was indicated but not carried out and it is not clear from the notes why not	2	No action entered
		The guideline is to be updated to include a flow chart for ease of interpretation. An email was sent to the fetal medicine team and all sonographers to highlight the learning and include the flow chart outlined above on 14th January 2025.
This mother booked late. Are there any organisations to consider in relation to her booking late?	2	No action entered
		No action entered
This mother booked late. Did this affect her care?	2	No action entered
		No action entered
During resuscitation of the baby blood was transfused , this was indicated, but the volume of blood given was incorrect	1	No action entered

*Note - depending upon the circumstances in individual cases the same issue can be raised as relevant to the deaths reviewed and also not relevant to the deaths reviewed.

** There are further issues which can be downloaded directly as a spreadsheet using the Extract Issues/Factors button

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Table 9: Top 5 contributory factors related to issues identified as relevant to the deaths reviewed, by the frequency of the contributory factor and the issues to which the contributory factors related

Issue Factor	Number of deaths	Issues raised for which these were the contributory factors
Task Factors - Guidelines, Policies and Procedures	1	This mother's risk status was not formally assessed at the start of her care in labour to ensure that her intended place of care in labour was appropriate
		During this mothers's labour maternal observations, commensurate with her level of risk and national guidelines, were not carried out
		The type of fetal monitoring used in established labour was not appropriate
Education and Training - Competence	1	This mother had a placental abruption during her pregnancy and there was a delay in the diagnosis
		This mother had a placental abruption during her pregnancy which was not managed according to national or local guidelines
Task Factors - Procedural or Task Design	1	During resuscitation the baby required intubation but this was not achieved
Task Factors - Decision making aids	1	This mother and/or her baby had an intrapartum complication(s) which was not managed appropriately
Staff Factors - Cognitive Factors	1	This mother had other during her pregnancy which was not managed according to national or local guidelines

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PMRT - Perinatal Mortality Reviews Summary Report-Q1

This report has been generated following mortality reviews which were carried out using the national Perinatal Mortality Review Tool

St George's Hospital, St George's University Hospitals NHS Foundation Trust

Report of perinatal mortality reviews completed for deaths which occurred in the period:

1/1/2025 to 31/5/2025

Summary of perinatal deaths*

Total perinatal* deaths reported to the MBRRACE-UK perinatal mortality surveillance in this period: 12

Summary of reviews**

- There were twelve cases reviewed in this quarter three neonatal deaths, and nine stillbirths.
- There were two cases that did not meet the criteria for the Clinical Negligence Scheme for Trusts (CNST); however, one has been discussed at the PMRT meeting and the other case will be discussed in July 2025.
- There was one case referred to Maternity and Newborn Safety Investigation (MNSI). The investigation for this case has been completed.
- There was one case referred as a Multidisciplinary Team review (MDT). The investigation has been completed and the actions has been completed.

Now in its seventh year of operation, NHS Resolution's Maternity (Perinatal) Incentive Scheme (MIS) continues to support safer maternity and perinatal care by driving compliance with ten Safety Actions, which support the national maternity ambition to reduce the number of stillbirths, neonatal and maternal deaths, and brain injuries from the 2010 rate by 50% before the end of 2025.
The MIS applies to all acute Trusts that deliver maternity services and are members of the Clinical Negligence Scheme for Trusts (CNST). As in previous years, members will contribute an additional 10% of the CNST maternity premium to the scheme creating the CNST MIS fund.
The original ten safety actions were developed in 2017 and have been updated annually by a Collaborative Advisory Group (CAG) including NHS Resolution, NHS England, Royal College of Obstetricians and Gynaecologists (RCOG), Royal College of Midwives (RCM), Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries (MBRRACE-UK), Royal College of Anaesthetists (RCoA), the Neonatal Clinical Reference Group (CRG), the Care Quality Commission (CQC), the Maternity and Newborn Safety Investigation Programme (MNSI) and service user representatives.
Trusts that can demonstrate they have achieved all ten of the safety actions in full will recover their trust's element of the contribution relating to the CNST MIS fund and this will be returned to the source of the initial CNST payment. They will also receive a share of any unallocated funds.
Trusts that do not meet the ten-out-of-ten threshold will not recover their contribution to the CNST MIS fund but may be eligible for a smaller discretionary payment from the scheme to help to make progress against actions they have not achieved. Such a payment would be at a lower level than the 10% contribution to the MIS fund and is subject to a cap decided annually by NHS Resolution. The balance of unallocated funds will be shared with the trusts who have achieved all ten safety actions.

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a) All eligible perinatal deaths should be notified to MBRRACE UK within seven working days.	We are **compliant** with this standard. 100% of the supported cases for review were notified to MBRRACE within seven working days. Surveillance information was completed within one calendar month of the death in 100% of the cases.
b) For at least 95% of all the deaths of babies in your Trust eligible for PMRT review, Trusts should ensure parents are given the opportunity to provide feedback, share their perspectives of care and raise any questions and comments they may have from 1 December 2024 onwards.	We are **compliant** with this standard (100% of the parents have their perspectives of care and any questions they have sought)
c) For deaths of babies who were born and died in your Trust multi-disciplinary reviews using the PMRT should be carried out from 1 December 2024. 95% of reviews should be started within two months of the death, and a minimum of 75% of multi-disciplinary reviews should be completed and published within six months. For a minimum of 50% of the deaths reviewed an external member should be present at the meetings and documented within PMRT.	We are **NOT compliant** with this standard. (89% of the reviews were started within two months of the death, 100% of multidisciplinary cases reviews had a report published within six months) We are compliant with the external panel member as she was present for 78% of the deaths reviewed.
d) Quarterly reports should be submitted to the Trust Executive Board from 1 December 2024	We are **compliant** with this standard (there is no time scale on this standard)

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Grading of Care: case by case

Neonatal Death Cases ID:	Grading of the care of the mother and baby up to the point of birth of the baby	Grading of care of the baby from birth up to the death of the baby	Grading of care of the mother following the death of the baby
97447	A	A	A
97639 (Not for CNST)	B	A	A
97634(Not for CNST) Meeting pending-23/07/25			

Stillbirth Cases ID:	Grading of care of the mother and baby up to the point that the baby was confirmed as having died	Grading of care of the mother following confirmation of the death of her baby
96929	A	A
97000	A	A
97122 (PSIRF-MDT)	C	A
97355	A	A
97627	A	A
97688	A	A
97828	A	A
98001 (Pending discussion)		
93292 (MNSI)	B	A

A: The review group concluded that there were no issues with care identified up to the point that the baby was born/ baby was confirmed as having died.

B: The review group identified care issues which they considered would have made no difference to the outcome of the baby.

C: The review group identified care issues which they considered may have made a difference to the outcome of the baby.

D - The review group identified care issues which they considered were likely to have made a difference to the outcome for the mother

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Issues arising:

- The anomaly scan was performed at a later gestational age than the recommended guideline. However, local guidelines state that the anomaly scan can be performed up to 22 w+6 days.
- The progress of labour was not documented in the partogram; however, it was documented on the labour notes. Action plan and escalation re issues with documentation since digital transformation.
- Carbon Monoxide reading not taken at booking appointment. Booking appointment was in DAU staff unaware where to find carbon monoxide reader. DAU staff now all aware and reminder sent in maternity comms.

Actions:

Case ID:	Issue	Action taken
97639	Patient self-referred originally to another Trust; she only had an early pregnancy ultrasound; and did not receive antenatal care locally; this could be due to language barriers as she was a Portuguese speaker. The patient was booked at St Georges when she transferred her care at 24 weeks of gestation.	Local Trust to update the team in regard to their DNA policy and to confirm if this was followed up for this patient.
97122-MDT	No follow up by GP following GDM pregnancy. Responsible lead: Maternal Medicine. Started: May 2025.	Referral patients with GDM to diabetes prevention service post pregnancy. This includes 18 months of one-to-one counselling re prevention, monitoring and action to prevent diabetes.
	No consideration given to earlier delivery based on several risk factors. Responsible Lead: Maternal medicine lead and specialist consultant for diabetes. To be completed by: 30/10/2025	Review diabetes guidelines specifically model of care for GDM appointments to include individual risk stratification and consideration for earlier delivery when multiple risk factors are

	USS pathway for GDM not in line with NICE guidance. Responsible Lead: FMU and diabetes specialist consultants. To be completed by: 30/10/2025	present. New diabetes consultant to run separately from GDM clinic. Explore possibility of MDT meeting for complex GDM patients. To increase index of suspicion when care planning for complex GDM patients. Discussion between FMU and diabetes team to explore possibility of bringing USS care pathway for GDM in line with NICE guidance.
93292-MNSI	Delay in conducting initial assessment in Delivery Suite Triage due to staffing levels and activities of the unit. The computerised record of contact with the maternity helpline was not reviewed.	**MNSI Recommendations:** The Trust to ensure that safe staffing levels are prioritized in maternity triage in order to support the service being provided in line with national good practice paper (RCOG, 2023). Trust to review the handover of information between the maternity helpline and other patient Areas to ensure safe and timely assessment of maternal and fetal wellbeing. **Immediate actions:** Following CQC inspection in 2023 the Trust Board supported investment in the maternity

		establishment which included Midwifery staffing in triage. Appointment of dedicated band 7 triage midwife August 2024. Funding for two midwives in triage in the day since April 2024. Monthly triage audits (staffing, and time arrived/to time seen by midwife and then time seen by doctor) presented at Governance meetings and reported on QCiC Group Maternity Report. Introduction of dedicated obstetric SHO in triage Feb 2025. Maternity digital transformation and introduction of triage patient outcome electronic whiteboard.

Stillbirths and late fetal losses

Number of stillbirths and late fetal losses reported	Not supported for Review	Reviews in progress	Reviews completed and published ***	Grading of care: number of stillbirths and late fetal losses with issues with care likely to have made a difference to the outcome for the baby
9	0	1	8	0

Neonatal and post-neonatal deaths

Number of neonatal and post-neonatal deaths reported	Not supported for Review	Reviews in progress	Reviews completed and published ***	Grading of care: number of neonatal and post-neonatal deaths with issues with care likely to have made a difference to the outcome for the baby
3	0	2	1	0

*Late fetal losses, stillbirths and neonatal deaths (does not include post-neonatal deaths which are not eligible for MBRRACE-UK surveillance) – these are the total deaths reported and may not be all deaths which occurred in the reporting period if notification to MBRRACE-UK is delayed. Termination of pregnancy are excluded. All other perinatal deaths reported to MBRRACE-UK are included here regardless of whether a review has been started or is published.

** Post-neonatal deaths can also be reviewed using the PMRT

*** If a review has been started, but has not been completed and published then the information from that review does not appear in the rest of this summary report

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Table 1: Summary information for the babies who died in this period and for whom a review of care has been completed – number of babies (N = 10)

Perinatal deaths reviewed	Gestational age at birth						
	Ukn	22-23	24-27	28-31	32-36	37+	Total
Late Fetal Losses (<24 weeks)	0	3	--	--	--	--	3
Stillbirths total (24+ weeks)	0	0	1	2	0	2	5
Antepartum stillbirths	*0*	*3*	*1*	*2*	*0*	*0*	*6*
Intrapartum stillbirths	*0*	*0*	*0*	*0*	*0*	*2*	*2*
Timing of stillbirth unknown	*0*	*0*	*0*	*0*	*0*	*0*	*0*
Early neonatal deaths (1-7 days)*	0	0	0	1	1	0	2
Late neonatal deaths (8-28 days)*	0	0	0	0	0	0	0
Post-neonatal deaths (29 days +)*	0	0	0	0	0	0	0
Total deaths reviewed	0	3	1	3	1	2	10
Small for gestational age at birth:							
IUGR identified prenatally and management was appropriate	0	0	0	0	0	0	0
IUGR identified prenatally but not managed appropriately	0	0	0	0	0	0	0
IUGR not identified prenatally	0	0	0	0	0	0	0
Not Applicable	0	3	1	3	1	2	10
Mother gave birth in a setting appropriate to her and/or her baby's clinical needs:							
Yes	0	3	1	3	1	2	10
No	0	0	0	0	0	0	0
Missing	0	0	0	0	0	0	0
Parental perspective of care sought and considered in the review process:							
Yes	0	3	1	3	1	2	10
No	0	0	0	0	0	0	0
Missing	0	0	0	0	0	0	0
Booked for care in-house	0	0	0	1	0	0	1
Mother transferred before birth	0	0	0	0	0	0	0
Baby transferred after birth	0	0	0	0	1	0	1
Neonatal palliative care planned prenatally	0	0	0	0	0	0	0
Neonatal care re-orientated	0	0	0	1	1	0	2

*Neonatal deaths are defined as the death within the first 28 days of birth of a baby born alive at any gestational age; early neonatal deaths are those where death occurs when the baby is 1-7 days old and late neonatal death are those where the baby dies on days 8-28 after birth. Post-neonatal deaths are those deaths occurring from 28 days up to one year after birth

Table 2: Placental histology and post-mortems conducted for the babies who died in this period and for whom a review of care has been completed – number of babies (N = 10)

Perinatal deaths reviewed	Gestational age at birth						
	Ukn	22-23	24-27	28-31	32-36	37+	Total
Late fetal losses and stillbirths							
Placental histology carried out							
Yes	0	3	1	2	0	2	8
No	0	0	0	0	0	0	0
Hospital post-mortem offered	0	3	1	2	0	2	8
Hospital post-mortem declined	0	1	0	1	0	2	4
Hospital post-mortem carried out:							
Full post-mortem	0	2	0	1	0	0	3
Limited and targeted post-mortem	0	0	1	0	0	0	1
Minimally invasive post-mortem	0	0	0	0	0	0	0
External review	0	0	0	0	0	0	0
Virtual post-mortem using CT/MR	0	0	0	0	0	0	0
Neonatal and post-neonatal deaths:							
Placental histology carried out							
Yes	0	0	0	1	1	0	2
No	0	0	0	0	0	0	0
Death discussed with the coroner/procurator fiscal	0	0	0	0	1	0	1
Coroner/procurator fiscal PM performed	0	0	0	0	0	0	0
Hospital post-mortem offered	0	0	0	1	1	0	2
Hospital post-mortem declined	0	0	0	1	1	0	2
Hospital post-mortem carried out:							
Full post-mortem	0	0	0	0	0	0	0
Limited and targeted post-mortem	0	0	0	0	0	0	0
Minimally invasive PMpost-mortem	0	0	0	0	0	0	0
External review	0	0	0	0	0	0	0
Virtual post-mortem using CT/MR	0	0	0	0	0	0	0
All deaths:							
Post-mortem performed by paediatric/perinatal pathologist*							
Yes	0	2	1	1	0	0	4
No	0	0	0	0	0	0	0
Placental histology carried out by paediatric/perinatal pathologist*:							
Yes	0	3	1	2	0	2	8
No	0	0	0	0	0	0	0

*Includes coronial/procurator fiscal post-mortems

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Table 3: Number of participants involved in the reviews of late fetal losses and stillbirths without resuscitation (N = 8)

Role	Total Review sessions	Reviews with at least one
Chair	0	0%
Vice Chair	0	0%
Admin/Clerical	1	12% (1)
Ambulance Team	0	0%
Bereavement Team	4	50% (4)
Community Midwife	0	0%
External	9	75% (6)
Management Team	0	0%
Midwife	30	100% (8)
MNVP Lead	3	37% (3)
Neonatal Nurse	5	37% (3)
Neonatologist	7	50% (4)
Obstetrician	23	100% (8)
Other	12	100% (8)
Risk Manager or Governance Team	9	62% (5)
Safety Champion	0	0%
Sonographer or Radiographer	0	0%

Table 4: Number of participants involved in the reviews of stillbirths with resuscitation and neonatal deaths (N = 2)

Role	Total Review sessions	Reviews with at least one
Chair	1	50% (1)
Vice Chair	0	0%
Admin/Clerical	0	0%
Ambulance Team	0	0%
Bereavement Team	1	50% (1)
Community Midwife	0	0%
External	4	100% (2)
Management Team	0	0%
Midwife	6	100% (2)
MNVP Lead	1	50% (1)
Neonatal Nurse	1	50% (1)
Neonatologist	8	100% (2)
Obstetrician	5	100% (2)
Other	3	100% (2)
Risk Manager or Governance Team	2	100% (2)
Safety Champion	0	0%
Sonographer or Radiographer	0	0%

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Table 5: Grading of care relating to the babies who died in this period and for whom a review of care has been completed – number of babies (N = 10)

Perinatal deaths reviewed	Gestational age at birth						
	Ukn	22-23	24-27	28-31	32-36	37+	Total
STILLBIRTHS & LATE FETAL LOSSES							
Grading of care of the mother and baby up to the point that the baby was confirmed as having died:							
A - The review group concluded that there were no issues with care identified up the point that the baby was confirmed as having died	0	2	1	2	0	0	5
B - The review group identified care issues which they considered would have made no difference to the outcome for the baby	0	1	0	0	0	1	2
C - The review group identified care issues which they considered may have made a difference to the outcome for the baby	0	0	0	0	0	1	1
D - The review group identified care issues which they considered were likely to have made a difference to the outcome for the baby	0	0	0	0	0	0	0
Not graded	0	0	0	0	0	0	0
Grading of care of the mother following confirmation of the death of her baby:							
A - The review group concluded that there were no issues with care identified for the mother following confirmation of the death of her baby	0	3	1	2	0	2	8
B - The review group identified care issues which they considered would have made no difference to the outcome for the mother	0	0	0	0	0	0	0
C - The review group identified care issues which they considered may have made a difference to the outcome for the mother	0	0	0	0	0	0	0
D - The review group identified care issues which they considered were likely to have made a difference to the outcome for the mother	0	0	0	0	0	0	0
Not graded	0	0	0	0	0	0	0
NEONATAL AND POST-NEONATAL DEATHS							
Grading of care of the mother and baby up to the point of birth of the baby:							
A - The review group concluded that there were no issues with care identified up the point that the baby was born	0	0	0	1	0	0	1
B - The review group identified care issues which they considered would have made no difference to the outcome for the baby	0	0	0	0	1	0	1
C - The review group identified care issues which they considered may have made a difference to the outcome for the baby	0	0	0	0	0	0	0
D - The review group identified care issues which they considered were likely to have made a difference to the outcome for the baby	0	0	0	0	0	0	0
Not graded	0	0	0	0	0	0	0
Grading of care of the baby from birth up to the death of the baby:							
A - The review group concluded that there were no issues with care identified from birth up the point that the baby died	0	0	0	1	0	0	1
B - The review group identified care issues which they considered would have made no difference to the outcome for the baby	0	0	0	0	1	0	1
C - The review group identified care issues which they considered may have made a difference to the outcome for the baby	0	0	0	0	0	0	0
D - The review group identified care issues which they considered were likely to have made a difference to the outcome for the baby	0	0	0	0	0	0	0
Not graded	0	0	0	0	0	0	0
Grading of care of the mother following the death of her baby:							
A - The review group concluded that there were no issues with care identified for the mother following the death of her baby	0	0	0	1	0	0	1
B - The review group identified care issues which they considered would have made no difference to the outcome for the mother	0	0	0	0	1	0	1
C - The review group identified care issues which they considered may have made a difference to the outcome for the mother	0	0	0	0	0	0	0
D - The review group identified care issues which they considered were likely to have made a difference to the outcome for the mother	0	0	0	0	0	0	0
Not graded	0	0	0	0	0	0	0

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Table 6: Cause of death of the babies who died in this period and for whom a review of care has been completed – number of babies (N = 10)

Timing of death	Cause of death
Late fetal losses	**3 causes of death out of 3 reviews**
	Placenta findings: long and hyper coiled umbilical cord. -High-grade fetal vascular malperfusion -Early Acute chorioamnionitis
	Please see PM and placental findings.
	See Placenta findings
Stillbirths	**5 causes of death out of 5 reviews**
	See PM and placenta findings
	MCDA twin placenta Three inter-twin vascular anastamoses identified. complex umbilical cord entanglement high grade fetal vascular malperfusion features of maternal vascular malperfusion
	See Placenta findings
	- Late second trimester male fetus showing mild maceration. - External body morphometry appropriate for gestation. - No dysmorphic features nor external structural abnormalities. - No evidence of ante-mortem anaemia or hydrops. -Placenta showing scattered foci of avascular Villi.
	Placenta Findings: -Changes of maternal vascular malperfusion (small placenta, accelerated villous maturation, agglutination). -Early acute chorioamnionitis. -Chronic deciduitis
Neonatal deaths	**2 causes of death out of 2 reviews**
	Hypoxic Ischaemic Encephalopathy Spontaneous Uterine Rupture
	Pulmonary hypoplasia and heart failure Skeletal dysplasia and congenital heart disease (coarctation of the aorta) Prematurity (29 weeks gestation)
Post-neonatal deaths	**0 causes of death out of 0 reviews**

Table 7: Issues raised by the reviews identified as relevant to the deaths reviewed, by the number of deaths affected by each issue* and the actions planned

Issues raised which were identified as relevant to the deaths	Number of deaths	Actions planned
This mother had gestational diabetes during her pregnancy and there was a delay in the diagnosis	1	New system for tracking GTT referrals and results: Pilot scheme for home GTT: more effective and more convenient.
This mother had poor/no English and language line was used to interpret during her labour and birth	1	Language line was used as no face to face interpreter available.

*Note - depending upon the circumstances in individual cases the same issue can be raised as relevant to the deaths reviewed and also not relevant to the deaths reviewed.

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Table 8: Top 10 issues** raised by the reviews which are of concern but not directly relevant to the deaths reviewed, by the number of deaths in which this issue was identified* and the actions planned

Issues raised which were identified as not relevant to the deaths	Number of deaths	Actions planned
This mother booked early enough but her mid-trimester anomaly scan was carried out after 20+6 weeks	5	Following local guidelines, anomaly scans can be performed up to 22+6 weeks of gestation.
This mother booked late. Are there any organisations to consider in relation to her booking late?	4	Booking appointment given at the next available.
This mother's progress in labour was not monitored on a partogram	4	Progress in labour documented on labour notes.
This mother booked late. Did this affect her care?	3	Late booker, booking completed on admission to St George's Hospital.
NICE guidance recommends carbon monoxide testing for all mothers at booking; this mother was not screened	2	Not clear documentation on the notes that this was done. Booking completed after patient had delivered.
A completed bereavement checklist was not in the notes	1	Remind all staff to complete Bereavement check list.
From information identified earlier in the tool this mother met met the national guideline criteria for screening for gestational diabetes but this does not appear to have been identified and she was not offered screening	1	IUD diagnosed prior to GTT screening.
It is not possible to assess from the notes whether the clotting & general haematological management of the baby during the first 24 hours on the neonatal unit was appropriate	1	NNU Team present during delivery and admission to NNU.

It is not possible to assess from the notes whether the time from the request for neonatal transfer to the transport arriving was within the expected timescale	1	Inform team to document the time of discussions with the specialist teams and NTS.

*Note - depending upon the circumstances in individual cases the same issue can be raised as relevant to the deaths reviewed and also not relevant to the deaths reviewed.

** There are further issues which can be downloaded directly as a spreadsheet using the Extract Issues/Factors button

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Table 9: Top 5 contributory factors related to issues identified as relevant to the deaths reviewed, by the frequency of the contributory factor and the issues to which the contributory factors related

Issue Factor	Number of deaths	Issues raised for which these were the contributory factors
Task Factors - Guidelines, Policies and Procedures	1	This mother had gestational diabetes during her pregnancy and there was a delay in the diagnosis
Communication - Communication Management	1	This mother had poor/no English and language line was used to interpret during her labour and birth

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Appendix 3

Maternity and Neonatal Incentive Scheme (CNST) – Year 7 ESTH

Compliance update for the Quality Committee in Common – July 2025

Presented by:
Natilla Henry, Group Chief Midwifery Officer

31st July 2025

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Background/Overview

- NHS Resolution's Maternity (Perinatal) Incentive Scheme (MIS) aims to support safer maternity and perinatal care by driving compliance with ten Safety Actions, which support the national maternity ambition to reduce the number of stillbirths, neonatal and maternal deaths, and brain injuries from the 2010 rate by 50% before the end of 2025. The MIS applies to all acute Trusts that deliver maternity services and are members of the Clinical Negligence Scheme for Trusts (CNST). As in previous years, members will contribute an additional 10% of the CNST maternity premium to the scheme creating the CNST MIS fund; where Trusts can demonstrate they are meeting all 10 safety actions they will be eligible for this part of the premium to be reimbursed.

- ESTH declared full compliance with Year 6 of the Maternity and Perinatal Incentive Scheme (MIS); evidence was reviewed and signed-off by the Trust Board and the ICB and the Board Declaration Form was submitted on 3rd March 2025. Confirmation of the outcome is awaited from NHSR

- Year 7 Technical Guidance was published on 2nd April 2025 and the launch event was held on 28th April 2025. Year 7 of the scheme will run from 2nd April 2025 until 30th November 2025 (with the exception of Safety Action 1 and Safety Action 9 which are on-going throughout the year).

- The Board Declaration Form for Year 7 must be submitted to NHSR by 12 noon on 3rd March 2026.

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Background/Overview

*Mandated Safety Action Requirements:

Safety Action	Red	Amber	Green	Blue	Total Requirements
1	0	7	0	0	7
2	0	2	0	0	2
3	4	0	2	0	6
4	15	3	1	0	19
5	12	0	0	0	12
6	9	0	0	0	9
7	4	0	0	0	4
8	20	0	1	0	21
9	9	0	0	0	9
10	0	9	0	0	9
Total	73	21	4	0	98

Key:

Red	Not compliant
Amber	Partial compliance - work underway
Green	Full compliance - evidence not yet reviewed
Blue	Full compliance - final evidence reviewed

*Non-mandated sections will not be included in this table.

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Safety Action 1:

"All eligible perinatal deaths should be notified to MBRRACE-UK within seven working days."

- Since the last report in April 2025 there have been 3 eligible perinatal deaths which required reporting to MBRRACE-UK.

Case ID:	Date of Death	Date Reported	Supported for PMRT Review Y/N
98546	12/05/2025	13/05/2025	Y
98777	28/05/2025	29/05/2025	Y
98788	29/05/2025	30/05/2025	Y

"For at least 95% of all the deaths eligible for PMRT review, Trusts should ensure parents are given the opportunity to provide feedback, share their perspectives of care and raise any questions and comments they may have; 95% of reviews should be started within two months of the death, and a minimum of 75% of multi-disciplinary reviews should be completed and published within six months. For a minimum of 50% of death which occurred from 02/04/2025, and external panel member should be present at the MDT review"

Case ID	Review Started	Review Complete	Parents Informed	External (Year 7)	Notes
96154	Y	Y	Y	N/A	***Standard met***
96468	Y	Y	Y	N/A	***Standard met***
97230	Y	N	Y	N/A	***Standard on track***
97760	Y	N	y	N/A	***Standard on track***
97773	Y	N	y	N/A	***Standard on track***
98546	Y	N	Y	Not yet reviewed at panel	***Standard on track***
98777	Y	N	Y	Not yet reviewed at panel	***Standard on track***
98788	Y	N	Not yet formally informed	Not yet reviewed at panel	***Standard on track***

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Themes and action plans

Please refer to the Board Report generated from the PMRT (Appendix 1)

- During March, April and May 2025, 3 review meetings were held on 14/03/2025, 25/04/2025 and 16/05/2025. Four cases were discussed/finalised at these meetings.
- There have been no new clear emerging themes identified to date that contributed to the deaths, but the panel has noted that there is a trend of not completing partograms in labour for cases of intrauterine death and 2 incidents highlighted issues with following up results (unrelated to the outcomes).
- There are 2 open actions; Placental histology to be added to i-Clip Pro (outside of our gift but the request is being progressed) and an action to discuss the need to document cervical assessment prior to Misoprostol (31/04/2025).
- All actions are monitored via a tracker by the risk team.
- ***Quarterly reports are discussed with the maternity safety champions through presentation at SLT/Triangulation meetings, Perinatal meetings and QCiC.***

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Overview of cases reported to MBBRACE-UK

Deaths of babies who died within your trust/health board Filtered

23 deaths between 01/04/2024 and 09/06/2025 | 2020 | 2021 | 2022 | 2023 | 2024 | YTD | 1m | 3m | 6m | 1y | 2y | 3y | 4y | 5y | 435 days (~ a year)

Days between deaths | Totals | Trends | Tabular data | Settings | Help | Show advanced settings

Number of deaths by Type of death | **Time units** Auto | Year | Half-year | Quarter | Month

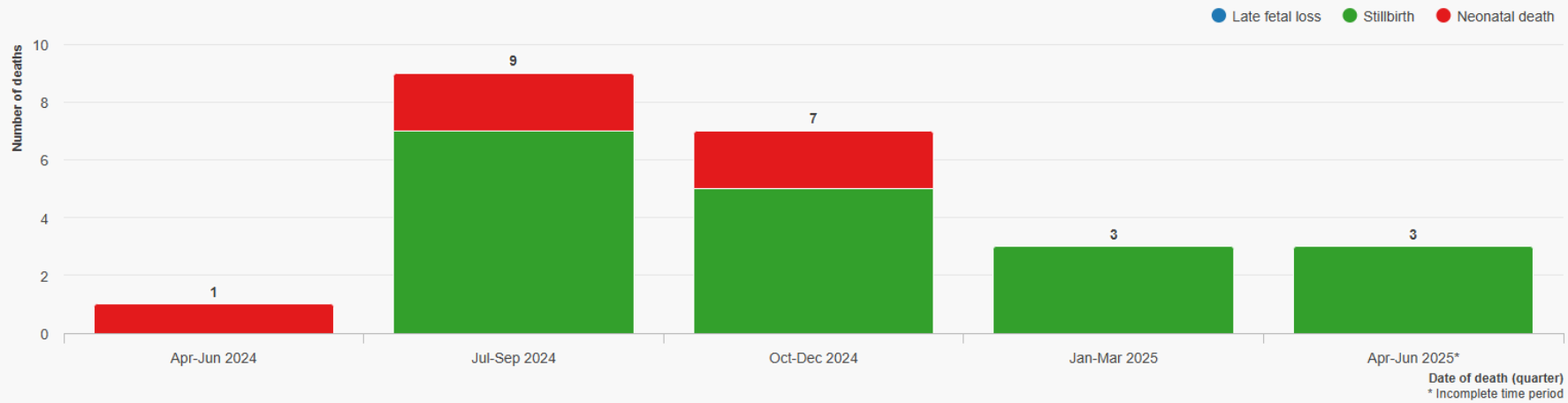
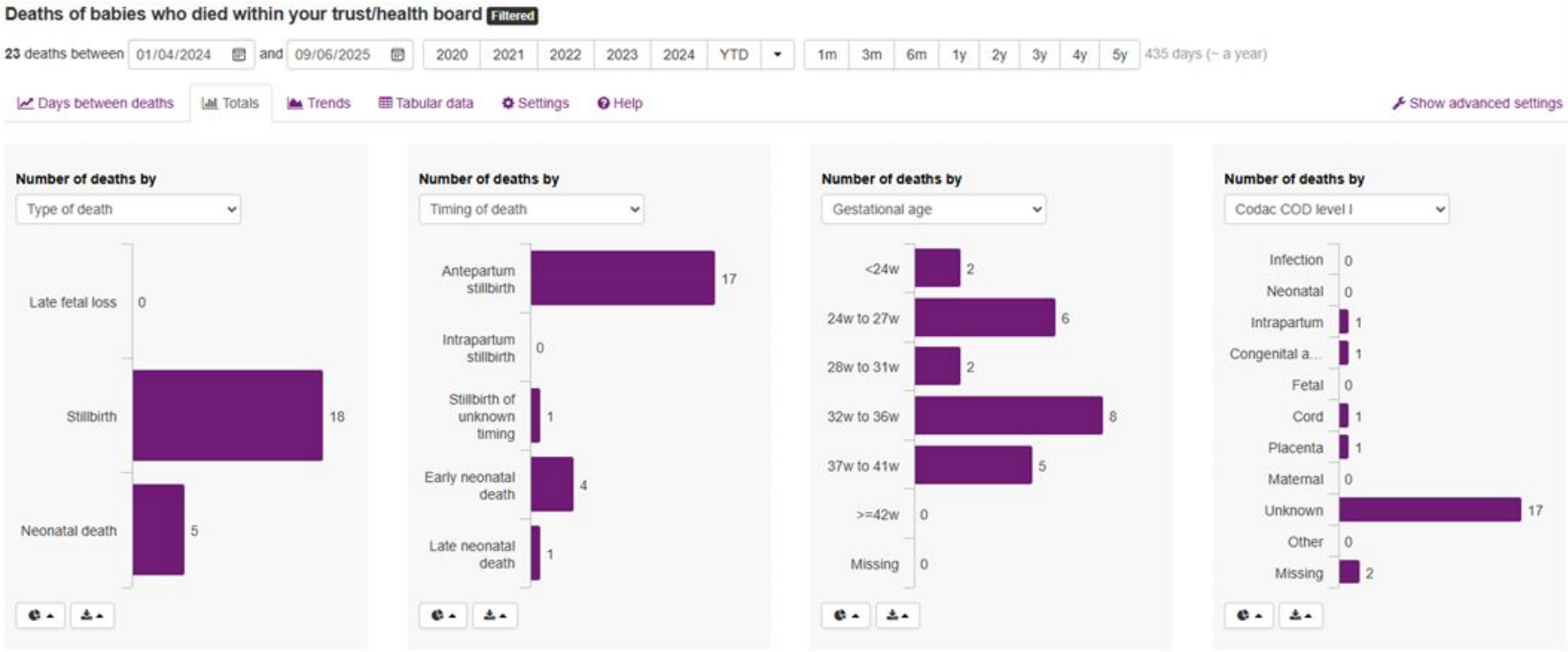


Chart type | Download

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Overview of cases reported to MBBRACE-UK



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Safety Action 2: *Are you submitting data to the Maternity Services Data Set (MSDS) to the required standard?*

Compliance will be assessed externally based on submission of our July data.

The results will be published in October 2025.

Safety Action 3: *Can you demonstrate that you have transitional care (TC) services in place and undertaking quality improvement to minimise separation of parents and their babies?*

This Safety Action is lead by the Neonatal Service.

There is a requirement for a Quality Improvement project to be registered by ***02/09/2025 or and update provided for a project registered in Year 6.*** **The progress update has been provided on the following slide.**

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MIS Year 7 – 2025/6 Safety Action 3

St Helier:

St Helier implemented Phase 1 of the new Neonatal Transitional Care model in 2024/5 and demonstrated a 91% reduction in ward attenders. To demonstrate full compliance with BAPM standards for transitional care, Phase 2 commenced in Q1 2025/6, and Band 5 Registered Nurses are being recruited as part of the Neonatal Workforce to work in Transitional Care to enable more babies to remain with their mothers and minimise separation by reducing admission and length of stay to the Neonatal Unit. The Quality Improvement Project for Transitional Care at St Helier will focus on ensuring all staff working in the area are trained and competency assessed to care for babies requiring nasogastric feeding in line with BAPM standards to further minimise separation. This will be a new quality improvement project and has been registered with the Trust Clinical Audit and Effectiveness Team, support for the Senior Sister for Special Care and Transitional Care will be provided by the Trust Continuous Senior Project Manager. It is anticipated that an update will be provided to the SWL LMNS and Trust Safety Champions in December 2025 (subject to dates being available). Evidence of success will be quantitative and qualitative data.

Epsom

In MIS Year 6 Epsom and St Helier had a joint QI to minimise separation of parents and babies and although some progress was made this was delayed and the Senior Sister role to lead on SCBU / Transitional Care was not recruited to until December 2024 and staff engagement work with the team to implement the new model. This resulted in only a 16% reduction in ward attenders to SCBU (based on Q2 & Q3 data). The QI project for Epsom will therefore be a continuation of the project from Year 6 with the aim to reduce ward attenders by 60%. The project initiation template has been updated and submitted to the Trust Clinical Audit and Effectiveness Team, support for the Senior Sister for Special Care and Transitional Care will be provided by the Trust Continuous Senior Project Manager. It is anticipated that an update will be provided to the Surrey LMNS and Trust Safety Champions in December 2025 (subject to dates being available). Evidence of success will be quantitative and qualitative data, the previous years data was quantitative only, however this year we are also keen to obtain parents views on the care that they have received in the Transitional Care area.

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Safety Action 4: *Can you demonstrate an effective system of clinical workforce planning to the required standard?*

This safety action is being led by the obstetric, anaesthetic and neonatal teams. Confirmation of leads for each area is awaited.

Safety Action 5: *Can you demonstrate an effective system of midwifery workforce planning to the required standard?*

BirthRate+ (the 3-yearly process used to calculate midwifery staffing establishment) is due to take place in September 2025 and we will need to demonstrate that we meet the establishment requirements in order to declare compliance with CNST. If we are not compliant, we must submit an agreed plan around when full establishment will be achieved and what the Trust are doing to mitigate shortfalls in the meantime. This plan must be shared with our commissioners.

The 6 monthly staffing report is due to be presented to QCiC in July 2025.

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Safety Action 6: *Can you demonstrate that you are on track to achieve compliance with all elements of the Saving Babies Lives Care Bundle Version Three?*

We are continuing to have quarterly review meetings of progress with the ICB and we have currently achieved 99% compliance.

A new V3.2 has now been issued alongside a new implementation tool; a regional meeting has been arranged to review the revised requirements.

Safety Action 7: *Listen to women, parents and families using maternity and neonatal services and coproduce services with users?*

The MNVP Lead needs to be a quorate member of all governance, business, patient safety, and guidelines meeting and is also required to be a quorate member of PMRT panels.

This is currently not achievable as our MNVP Lead is only commissioned for 6 hours per week and also has a job alongside MNVP work.

Concerns have been raised with the regional teams who have confirmed that other units have also shared these concerns.

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Safety Action 8: *Training Compliance*

Type of Training and % compliance	Staff Group	ESTH Mar 25	ESTH Apr 25	ESTH May 25
PROMPT 90%	Midwifery Staff	96%	94%	92%
	Maternity Support Workers	95%	86%	88%
	Consultant Obstetricians	97%	89%	89%
	Trainee and Staff Grade Obstetricians	71%	83%	79%
	Anaesthetics	97%	100%	100%
CTG Training 90%	Midwifery Staff	93%	91%	90%
	Obstetricians	83% Cons/96% MG	89% Cons/94% MG	89% Cons/94% MG
NLS (Newborn Life Support) 90%	Midwifery Staff	96%	94%	92%
NLS (Newborn Life Support) 90%	Neonatal Nursing Staff	100%	100%	100%
NLS (Newborn Life Support) 90%	Neonatal Medical Staff	100%	100%	100%

There has been an increase in non-attendance from obstetric medical staff from the beginning of 2025 – compliance is expected to increase through the projected attendance list. We have held a drill in the clinical area so we have met this part of the safety action.

All new starters (obstetric medical staff) attend CTG and PROMPT training within 3 months of their start date. Neonatal medical staff attend NLS/BLS as part of their induction when they start.

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Safety Action 9: *Can you demonstrate that there is clear oversight in place to provide assurance to the Board on maternity and neonatal safety and quality issues?*

We are submitting a Perinatal Quality Surveillance Model (PQSM) to the Board on a quarterly basis.

Engagement sessions chaired by the Board Level Safety Champions have continued since Year 6 of the scheme and the next session is due to take place on 30th June 2025.

There is a requirement for the claims scorecard to be reviewed quarterly (twice between April and November 2025) against out incident and complaints data and this has been included on the following slide.

There is a requirement for the Safety Champions are meeting with the Perinatal leadership team and the MNVP at least every 2 months; this is currently covered by the Maternity Triangulation Meetings and the SLT Meetings, but the MNVP Lead is not currently attending these meetings as a quorate member. We have highlighted the needs for the ToRs of this meeting to be updated to reflect this.

Safety Action 10: *Have you reported 100% of qualifying cases the MNSI and to NHS Resolution's Early Notification Scheme from 01/12/2024?*

To date, during MIS Year 7 we have not had any reportable cases.

Safety Action 9:

ESTH Claims Scorecard April 2014 – March 2024

Top injuries by volume: • Unnecessary pain (8) • Fatality (8) • Adtnl/unnecessary operation (7) • Psychological damage (6) • Brain damage (5)	**Top injuries by value:** • Brain damage (5) • Cerebral Palsy (3) • Wrongful birth (2) • Erb's palsy (2) • Fatality (8)
Top causes by volume: • Fail – antenatal screening (7) • Failure/delay treatment (6) • Fail to act on abnrl test result (5) • Fail to monitor 1st stage labour (5) • Fail to recognise complication (4)	**Top causes by value:** • Fail antenatal screening (7) • Fail to monitor 1st stage labour (5) • Fail to recognise complication (4) • Fail to act on abnrl test result (5) • Forceps delivery (2)

Complaints Q3 and Q4 2024-2025 (21 complaints)

Postnatal/community Care (4)
Management of miscarriage (including management in the ED) (3)
Management of early pregnancy/ED (3)
Wound infection (1)
Staff attitude (1)
Management of jaundice (1)
Care in the early pregnancy unit (1)
Care in the Maternal Assessment unit (1)
Other (5)

Incidents Q3 and 4 2024-2025 (moderate and above harm outcomes)

PPH (14)
3rd/4th degree tears (6)
Baby admission to NNU/readmission (2)
Bladder injury (1)
Still birth/Neonatal death (10)

There is a requirement for a review of Trust's claims scorecard alongside incident and complaint data and discussed by the maternity, neonatal and Trust Board level safety champions at a Trust level (Board or directorate) quality meeting

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Themes Q3 and Q4 2024-2025

- There are no obvious themes emerging in response to incidents, complaints and claims when correlated with the claims scorecard, although several complaints relate to the management of early pregnancy in the ED.

Learning Q3 and Q4 2024-2025

- Labelling babies
- Intermittent auscultation
- Management of the latent phase of labour
- Management of jaundice
- Security

Key Actions in progress

Review of the homebirth service/2nd on-call	On-going	
Increasing the in-patient staffing template	Completed	
Review of readmissions (neonatal)	On-going and draft PSIRP	
Review of Escalation Guidance	On-going	

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Thank you.

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Appendix 3a

Maternity and Neonatal Incentive Scheme (CNST) – Year 7 SGH

Compliance update – July 2025

Presented by:
Natilla Henry, Group Chief Midwifery Officer

July 2025

Background/Overview

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- The Technical Guidance for Year 7 of the Maternity and Perinatal Incentive Scheme (MIS) was published on 4th April 2025. There are 96 separate requirements that must be evidenced and signed-off by the Trust Board and the ICB after the end of the MIS period (30th November 2025). The deadline date for the Board Declaration Form to be sent to NHS Resolution will be 12:00 midday on 3rd March 2026.
- The following slide shows an overview of the current compliance status. Most requirements cannot be assessed as complete until after the end of the MIS period. For the purposes of this report 'red' indicates that we have not yet received any assurance or evidence that we are compliant, 'amber' indicates that work is in progress and on track, 'green' indicates that the action is complete, and evidence has been received and 'blue will be completed once the evidence has been reviewed and signed-off.

Overview of progress on MIS year 7 safety action requirements

*Mandated Safety Action Requirements:

Safety Action	Red	Amber	Green	Blue	Total Requirements
1	1	0	6	0	7
2	0	1	1	0	2
3	3	0	1	0	4
4	15	4	0	0	19
5	9	2	0	0	11
6	0	9	0	0	9
7	2	0	2	0	4
8	7	1	13	0	21
9	1	6	2	0	9
10	0	0	9	0	9
Total	38	23	34	0	95

Key:

Red	Not compliant
Amber	Partial compliance - work underway
Green	Full compliance - evidence not yet reviewed
Blue	Full compliance - final evidence reviewed

*Non-mandated sctions will not be included in this table.

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Background/Overview - SGH

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	Safety Action Detail	RAG (June 2025)	Projected Submission RAG
1	*Are you using the National Perinatal Mortality Review Tool (PMRT) to review perinatal deaths from 1 December 2024 to 30 November 2025?*	1 case reported late due to individual error Triplet case 98006 under review	
2.	*Are you submitting data to the Maternity Services Data Set (MSDS) to the required standard?*	On track. Compliant with April data. Digital midwives inputting any missing data manually	
3	*Can you demonstrate that you have transitional care (TC) services in place and are undertaking quality improvement to minimise separation of parents and their babies?*	Compliant- TC services in place since March 2025.QI project in place	
4	*Can you demonstrate an effective system of clinical workforce planning to the required standard?*	On track-Action plan in place for Neonatal Nursing.	
5	*Can you demonstrate an effective system of midwifery workforce planning to the required standard*	On track	
6	*Can you demonstrate that you are on-track to achieve compliance with all elements of the Saving Babies Lives Care Bundle Version Three?*	121 in care labour audit data difficult to extract for this due to iclip documentation issues	
7	*Listen to women, parents and families using maternity and neonatal services and coproduce services with users.*	On track with mitigations	
8	*Can you evidence of 90% attendance for the relevant staff groups at fetal monitoring training, multi-professional 1 day emergencies training and Neonatal Life Support training?*	Bank and agency training oversight	
9	*Can you demonstrate that there is clear oversight in place to provide assurance to the Board on maternity and neonatal safety and quality issues?*	Safety champions actions log not shared widely with staff before 1st July 2025	
10	*Have you reported 100% of qualifying cases to MNSI and NHSR Early Notification Scheme?*	On track.	

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Safety Action 1:

Use the National Perinatal Mortality Review Tool to review perinatal deaths from 1 December 2024 to 30 November 2025 to the required standard?

Since the last report in April 2025 there have been 11 eligible perinatal deaths which required reporting to MBRRACE-UK.

Case ID:	Date of Death	Date Reported	Supported for PMRT Review
98250	15/04/2025	22/04/2025	Reviewing
98234	17/04/2025	22/04/2025	Reviewing
98252	21/04/2025	22/04/2025	Reviewing
98304	25/04/2025	25/04/2025	Reviewing
98383	28/04/2025	30/04/2025	Reviewing
98412	03/05/2025	03/05/2025	Reviewing
98497	07/05/2025	09/05/2025	Review cancelled duplicate referral
98497	09/05/2025	09/05/2025	Reviewing
98635	17/05/2025	19/05/2025	Reviewing
98953	08/06/2025	11/06/2025	Review not supported
98905	08/06/2025	08/06/2025	Reviewing

Case ID	Review Started	Review Complete	Parents Informed	External (Year 7)	Notes
96929	Yes	Review complete	Yes	N/A	*Standard Met*
97000	Yes	Review complete	Yes	N/A	*Standard Met*
97122	Yes	Writing report	Yes	N/A	*Standard on track: draft report published*
97355	Yes	Review complete	Yes	N/A	*Standard Met*
97447	Yes	Reviewing	Yes	N/A	*Standard on track: draft report published*
97627	Yes	Reviewing	Yes	N/A	*Standard on track: draft report published*
97639	Yes	Reviewing	Yes	N/A	*Standard on track: draft report published*
97634	Yes	Reviewing	Not answered	N/A	*Standard on track: draft report published*
97688	Yes	Reviewing	Yes	N/A	*Standard on track: draft report published*
97828	Yes	Review complete	Yes	N/A	*Standard Met*
98001	Yes	Reviewing	Yes	N/A	*Standard on track: draft report published*
98250	Yes	Reviewing	Not answered		*Standard on track: draft report published*
98234	Yes	Reviewing	Yes		*Standard on track: draft report published*
98252	Yes	Reviewing	Yes		*Standard on track: draft report published*
98304	Yes	Reviewing	Not answered		*Standard on track: draft report published*
98412	Yes	Reviewing	Yes		*Standard on track: draft report published*
98635	Yes	Reviewing	Not answered		*Standard on track: draft report published*
98905	Yes	Reviewing	Not answered		*Standard on track: draft report published*

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Themes and action plans

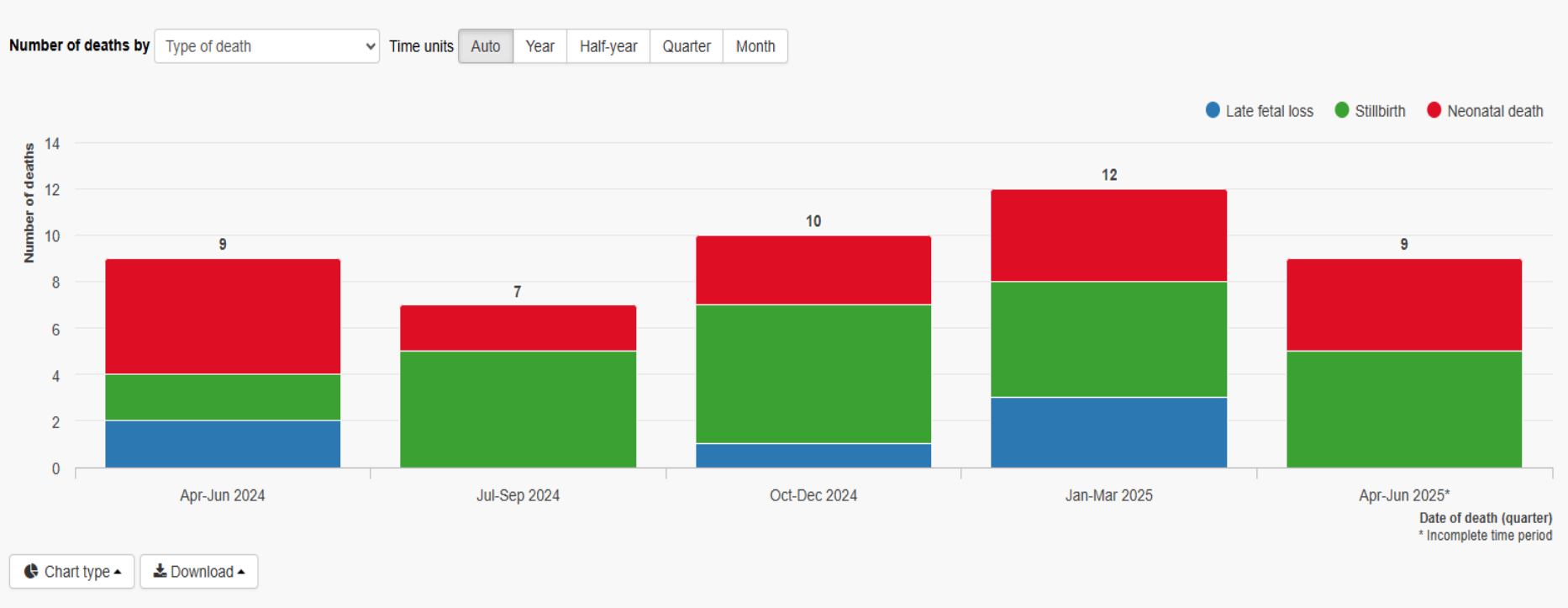
Please refer to the Board Report generated from the PMRT

- During March, April , May and June 2025, review meetings were held on 12/03/2025, 26/03/2025, 09/04/2025, 23/04/2025, 14/05/2025 ,28/05/2025 and 11/06/2025. 19 cases were discussed/finalised at these meetings.
- The panel has identified issues with care in triage, antenatal CTG interpretation, Diabetes team and test result review.
- There are open actions for three cases and no overdue actions.
- All actions are monitored via a tracker by the risk team.
- ***Quarterly reports are discussed with the maternity safety champions through presentation at SLT/Triangulation meetings, Perinatal meetings and QCiC.***

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Overview of cases reported to MBBRACE-UK SGH



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Overview of cases reported to MBBRACE-UK SGH

Deaths of babies who died within your trust/health board Filtered

47 deaths between 01/04/2024 and 09/06/2025 | 2020 | 2021 | 2022 | 2023 | 2024 | YTD | 1m | 3m | 6m | 1y | 2y | 3y | 4y | 5y | 435 days (~ a year)

Days between deaths | Totals | Trends | Tabular data | Settings | Help | Show advanced settings



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Safety Action 2 and 3

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Safety Action 2:

Are you submitting data to the Maternity Services Data Set (MSDS) to the required standard?

GAPS

iClipPro for maternity launched on 8th February 2025. Emerging issues re; data quality as not all relevant fields have been made mandatory. Data migration did not take place at go-live, system not scoring MEWs correctly

Action Plan

Digital midwives working on missing data issues to ensure compliance with Safety Action 2 - MSDS. Digital midwives manually inputting missing data for ethnicity and birthweight to mitigate. Compliant with April data

Safety Action 3:

Can you demonstrate that you have transitional care (TC) services in place and undertaking quality improvement to minimise separation of parents and their babies?

GAPS

No GAPS identified. On track to be compliant with this. TC continuing with the QI project already registered and will present their progress to Safety champions at the end of MIS reporting period.

Safety Action 4- Clinical Workforce

Can you demonstrate an effective system of clinical workforce planning to the required standard?

Obstetric Medical Workforce-Locum obstetric staff rota and ACRP currently under staff bank.

General Management team to request this information from bank staff so this is available, and audits to be carried out.

Anaesthetist Medical workforce- Compliant, evidence of rotas submitted.

Neonatal medical workforce- Awaiting evidence of rotas.

Neonatal Nursing workforce- Neonatal Staffing on risk register. Currently at 65% and there is an action plan in place from MIS Year 6. Targeting to be 70% by the end of this year to meet BAPM standards. Action plan shared previously, and an update will be shared for this reporting year.

Safety Action 5- Midwifery Staffing

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Can you demonstrate an effective system of midwifery workforce planning to the required standard?

- A formal Birth Rate Plus midwifery workforce assessment was completed in April 2025.
- As part of the Birth rate plus review the maternity workforce, annual birth rate and case mix of the women attending St George's was analysed along with the midwifery staffing budget to assess whether this accurately reflected the establishment as calculated by Birth rate plus.
- It was noted that the annual birth rate had steadily decreased over the past 5 years (↓990 women) although there has been an increase in Category V (most complex) women 51.4% (↑3.8%).
- The 6 monthly safe staffing report is due to be presented to QCIC in July 2025.

Compliant with midwifery coordinator at beginning of shift. Escalation process in place through SITREP.

GAPS identified- Issues with obtaining audit data for 121 care in labour. This is due to the data quality issues that have emerged since implementation of iClipPro on 8 February 2025.

Safety Action 6- Saving Babies Lives

Can you demonstrate that you are on track to achieve compliance with all elements of the Saving Babies Lives Care Bundle Version Three?

Quarterly review meetings take place with the ICBs quality team, and all elements of Saving Babies Live Care bundle is reviewed for compliance and improvement.

Q4 data to be reviewed. Currently 80% compliant, with ongoing work to achieve full compliance in all elements.

V3.2 SBL tool has now been launched and available in the Futures platform. A meeting took place on 19th June with the ICB to review and identify all updates/ changes.

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Safety Action 7- MNVP

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Listen to women, parents and families using maternity and neonatal services and coproduce services with users?

The MNVP Lead needs to be a quorate member of all governance, business, patient safety, and guidelines meeting and is also required to be a quorate member of PMRT panels.

Our MNVP lead unable to attend all meetings due to limited hours within the role, and this has been raised with the ICB and NHS Resolution as a concern. MIS have advised to raise all mitigation during submission.
MNVP lead from the ICB joined June's PMRT meeting and will be attending these meetings going forward.

Gaps identified

Action plan to be reviewed by MNVP

Actions

Review of 2024 plan in progress by MNVP Lead and awaiting free text feedback, if any from Group Patient Experience Lead, WD.

Safety Action 8: MDT Training

Training Compliance



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Type of Training and % compliance	Staff Group	SGH Feb 25	SGH March 25	SGH April 25	SGH May 25
PROMPT 90%	Midwifery Staff	88%	87%	94%	94%
	Maternity Support Workers	93%	83%	85%	87%
	Consultant Obstetricians	89%	89%	95%	100%
	Trainee and Staff Grade Obstetricians	92%	83%	96%	97%
	Anaesthetics	94%	92%	100%	100%
CTG Training 90%	Midwifery Staff	93%	92%	92%	95%
	Obstetricians	91%	95%	93%	99%
NLS (Newborn Life Support) 90%	Midwifery Staff	92%	94%	94%	94%
NLS (Newborn Life Support) 90%	Neonatal Nursing Staff	89.04%	90%	90%	90%
NLS (Newborn Life Support) 90%	Neonatal Medical Staff	100%	100%	100%	100%

Continued improvement with all training compliance over April and May.
For PROMPT overall compliance at 90% has been achieved for the MDT , except MSWs who are all booked to attend future dates.
No assurance re: bank staff and agency staff training. To liaise with staff bank as line managers re: process for ensuring staff have completed required training.
Plan in place for training dates once the rotational doctors commence working for the Trust

Safety Action 9- PQSM

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Can you demonstrate that there is clear oversight in place to provide assurance to the Board on maternity and neonatal safety and quality issues?

A review has taken place at the Maternity Services Oversight Meeting of all maternity reports that are required to reach the Board for review.

CQC Evidence Assurance and CQC Action plan is included in an Integrated Action Plan including all maternity action plans to give oversight at board level of progress with all actions.

Board Level Safety Champion walk-around of clinical areas and engagement with staff occur bi-monthly, and feeds back to the Board.

The claims scorecard to be reviewed quarterly against maternity incident and complaints data. Summary is reported to the Board.

Safety Action 10- MNSI and ENS

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Have you reported 100% of qualifying cases the MNSI and to NHS Resolution's Early Notification Scheme from 01/12/2024?

All cases have been reported

Case Number	Date	Referral Criteria	Case Status
MI-037842/DW213326	28/07/2024	HIE/cooled	Completed: Awaiting sign off action plan DIRG
MI-038558/DW215544	23/09/2024	Maternal Death	Active: Waiting for input from respiratory clinical advisor
MI-038731/DW211153	23/06/2024	Maternal Death	Active: Awaiting final sign off at MNSI before sharing for factual accuracy.
MI-038732/DW211153	23/06/2024	Neonatal Death	Active: Awaiting final sign off at MNSI before sharing for factual accuracy.
MI-039186/DW220116	20/12/2024	HIE/cooled	Active: Delays with Neonatal team interviews
MI-039196/DW220592	02/01/2025	HIE/cooled	Active: Draft report shared for factual accuracy return 19th June
MI-040236/DW223760	03/03/2025	Maternal Death	Active: Awaiting second panel discussion
MI-040278/DW225886	04/03/2025	HIE/Cooled	Active: Interviews underway

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SGUH claims Scorecard April 2014 – March 2024

Top injuries by volume: Unnecessary Pain (5) Fatality (4) Brain Damage (4) Stillborn (4) Cerebral palsy (3)	**Top injuries by value:** Brain damage (4) Cerebral palsy (3) Incontinence (2) Bowel Damage/Dysfunction (2) Erb's palsy (1)
Top causes by volume: Fail/Delay Treatment (10) Fail to monitor 2nd stage Labour (5) Fail to monitor 3rd Stage Labour (5) Fail/Delay Diagnosis (3) Fail To make Respond to Abnormal FHR (3)	**Top causes by value:** Fail to monitor 1st Stage Labour (5) Fail/Delay Treatment (10) Fail to Monitor 2nd stage of Labour (5) Fail to make Respond to Abnormal FHR (3) Inadequate Nursing Care (1)

Complaints Q4 2024-2025 (complaints)

Appointment (1)
Communication (6)
Care issues (6)
Request for information (1)

Incidents Q4 2024-2025 (moderate and above harm outcomes)

PPH > 1.5 litres
3rd/4th degree tears
Term NNU admission
IUD
Maternal death

There is a requirement for a Quarterly review of Trust's claims scorecard alongside incident and complaint data and discussed by the maternity, neonatal and Trust Board level safety champions at a Trust level (Board or directorate) quality meeting

Themes Q4 2024-2025

- There are no obvious themes emerging in response to incidents, complaints and claims.

Learning Q4 2024-2025

- Escalation of deteriorating patient
- Escalation of fetal monitoring concerns
- Documentation of perineal protection

Key Actions in progress

SIMS and PROMPT training on CCOT escalation	Ongoing
CTG training twice weekly with one happening on Delivery Suite every Friday	Ongoing
OASI care bundle training for staff	Ongoing

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Thank you.

For any other information, please see:

Group Board

Meeting on Friday, 05 September 2025

Agenda Item	2.3.4	
Report Title	**ESTH Bi-annual midwifery workforce review 2024/25**	
Executive Lead(s)	Arlene Wellman, Group Chief Nursing Officer	
Report Author(s)	**Annabelle Keegan, Director of Midwifery and Gynaecology Nursing**	
Previously considered by	Choose an item.	
Purpose	**For Assurance**	

Executive Summary

The purpose of this report is to provide assurance that ESTH has an effective system of midwifery workforce planning and provide assurance regarding existing contingencies to cover staffing shortfalls or address peaks in activity.

This report covers the period from 1st September 2024 to 31st February 2025. This is a requirement of the Maternity Incentive Scheme Year 7 - Safety Action 5: **Can you demonstrate an effective system of midwifery workforce planning to the required standard?** And includes detail on:

Table 1.

A	A systematic, evidence-based process to calculate midwifery staffing establishments is complete
B	The midwifery coordinator in charge of delivery suite has supernumerary status (defined as having a rostered planned supernumerary coordinator at the start of every shift).) to ensure there is an oversight of all birth activity and support for all midwives within the service
C	All women in active labour receive one to one midwifery care
D	A six-monthly midwifery staffing report that covers the staffing/safety issues is submitted to the Trust Board

In addition, the report highlights the following:

- ESTH remains unable to implements BSOTS at present within maternity triage
- Triage audits show there are doctor review delays when reviewing women within the timeframe as required by NICE (2015)
- Birthrate Plus® establishment review is scheduled to take place in September 2025
- Provides an accurate account of the current workforce status and includes an update from recommendations within the paper presented in December 2024

Action required by Group Board

The Board is asked to:

a. Note the content of this report for assurance that ESTH has an effective system of midwifery workforce planning to meet CNST safety action 5 compliance
b. Note the highlights as outlined above

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

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

Implications

Group Strategic Objectives

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

Risks

Failure to deliver safe staffing levels can result in an increase in incidents, reduced efficiency and increased litigation costs

CQC Theme

☐ Safe	☐ Effective	☐ Caring	☐ Responsive	☒ Well Led

NHS system oversight framework

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

Financial implications

As above

Legal and / or Regulatory implications

To ensure the Trust meets all regulatory requirements described in the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, as well as CQC Key Lines of Enquiry (Safe, Effective and Responsive).

To ensure Trust's compliance with NICE Safety Staffing Quality Standards (NG4).

Equality, diversity and inclusion implications

Environmental sustainability implications

ESTH Bi-annual midwifery workforce review 2024/25

Quality Committees-in-Common, 31 July 2025

1.0 Purpose of paper

1.1 This paper provides the committee with a bi-annual appraisal of the Trust's maternity services current status for the provision of midwifery staffing levels, and assurance of the work in progress to monitor and manage safe staffing levels of midwifery and support staff. In addition, it highlights the maternity and neonatal staffing requirement needed to achieve CNST safety actions 3 (transitional care) and 5 (effective midwifery workforce planning).

2.0 Background

2.1 The National Institute of Health and Clinical Excellence (NICE) published its guideline for safe midwifery staffing in maternity settings in February 2015. The requirement to ensure midwifery and support staffing levels are safe and sufficient to meet the needs of women, babies and families is clearly an imperative. The Francis enquiry (2013) and subsequent government response 'Hard Truths' (2014) have emphasised the need to get staffing levels right, with seminal papers from Keogh (2013) and Berwick (2013) clearly linking staffing levels to patient safety, outcome, and experience. Inadequate staffing has been a recurring theme in organisations where patient care has been found to be substandard Ockenden (2020 & 2022).

2.2 The most effective and safe way to provide maternity care is to ensure sustainable and productive staffing of maternity services. The NQB's model recommends that NHS providers must ensure that care is delivered by the right staff, with the right skills, in the right place at the right time (National Quality Board, 2016). Maternity services nationally, use the Birth-rate Plus ® (BR+), workforce planning tool, to determine the required total midwifery workforce establishment for all hospital and community midwifery services.

2.3 In July 2022, a review of midwifery staffing took place at ESTH maternity department using Birthrate Plus® in which a birth ratio of 1:19 (1 midwife to 19 births) at STH and 1:20 (1 midwife to 20 births) at EGH was recommended.

3.0 Key issues for consideration

3.1 Safer staffing

It is a requirement that NHS providers continue to have the right people with the right skills in the right place at the right time to achieve safer nursing and midwifery staffing in line with the National Quality Board (NQB) requirements. (NICE 2017) states that midwifery staffing establishments must develop procedures to ensure that a systematic process is used to set the midwifery staffing establishment to maintain continuity of maternity services and to always provide safe care to women and babies in all settings.

Safe staffing can contribute to a calmer and more controlled environment in maternity care settings therefore reducing stress and anxiety among both patients and healthcare providers, which positively impacts the overall birthing experience and care outcomes.

The framework used in the Maternity unit at ESTH to support safe staffing is Birth-rate Plus ® (BR+), which is used to support workforce planning and decision-making in UK maternity units since 1988 and is endorsed by The Royal College of Midwives (RCM) and NICE. At ESTH a formal Birthrate Plus assessment was undertaken in July 2022. This reviewed the acuity of all women who used the maternity services at Epsom and St. Helier University NHS Trust. The review at this time recommended a birth to midwife ratio of 1:19 (1 midwife to 19 births) at STH and 1:20 (1 midwife to 20 births) at EGH. NICE (2017) recommend that a workforce assessment is carried out every three years as a minimum, so the next BR+ review is expected to take place in September 2025.

A midwifery red flag event is a warning sign that something may be wrong with midwifery staffing (NICE 2015). If a midwifery red flag event occurs, the midwife in charge of the service is notified. The midwife in charge will then determine whether midwifery staffing is the cause and the action that is needed. Red flags are collected through the live Birthrate Plus acuity tool and reported through the Trusts incident reporting system (Datix). They are then reviewed by the maternity governance team and appropriate action and learning is taken.

The Maternity unit at ESTH is supported by a leadership team that comprises a Director of Midwifery, Head of Midwifery, four Clinical Matrons, three Consultant Midwives, and Specialist Midwifery roles. These roles support safe staffing, safety, and quality on a daily basis. Additionally, the service receives support from obstetric, medical and operational colleagues.

3.2 Capacity

The maternity service has 86 inpatient beds across two sites as follows:

Table 2 Maternity service bed capacity

St Helier Labour Ward Inc Triage beds	13
St Helier Birth Centre	3
Postnatal & Antenatal Ward	38 including 6 Transitional Care beds
Epsom Labour Ward Inc Triage	8
Epsom Birth Centre	3
Postnatal & Antenatal Ward	19 including 4 Transitional Care beds
Total	86

Antenatal activity is delivered on the two sites, and at a number of satellite clinics in the SW London and Surrey locality, in addition to two maternity assessment units and two early pregnancy units which run Monday- Friday. Inpatient areas are currently staffed to 8 day/9-night midwives at Epsom and 11 at St Helier per shift. After a community staffing consultation in Q1 2024, midwifery continuity of care teams (where care is delivered from antenatal booking, through intrapartum until discharge from postnatal care) were reduced to 1 in total, with this team (based in Roundshaw, Wallington) focusing on delivering continuity to families living in the areas of highest social deprivation. This is alongside the well-established Homebirth team covering both geographical areas. The remaining community workforce continues to provide care under a 'traditional' model with antenatal and postnatal care delivered by teams in specific geographical areas.

3.3 Current birth data

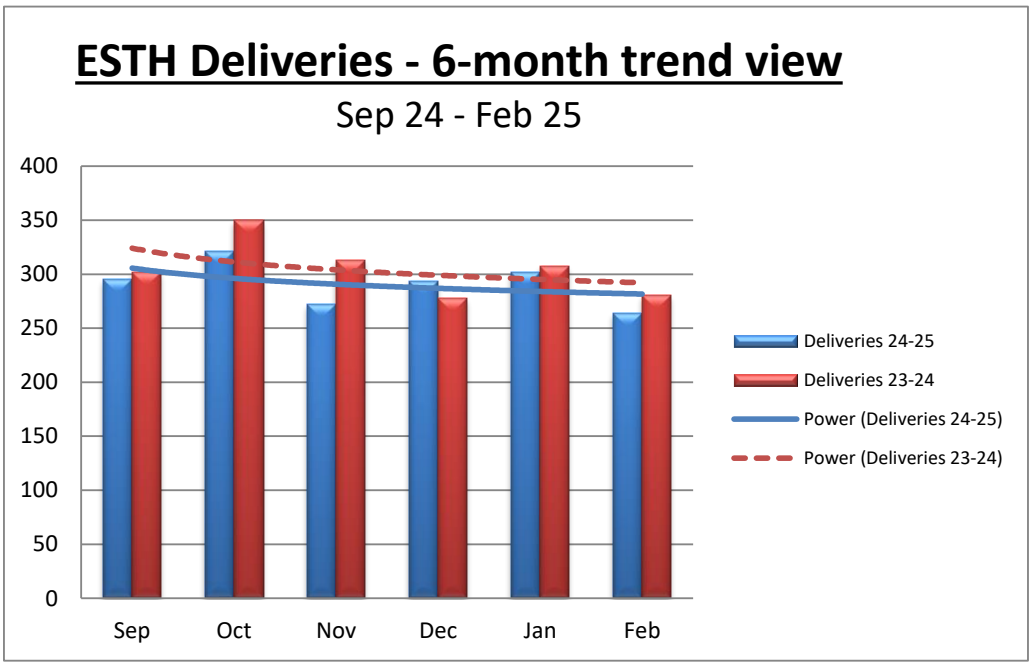
The birth data at Epsom and St Helier is outlined below with the birth rate decreasing generally across the SWL region. There are a number of local building plans which include new homes around Sutton and Epsom which may positively impact our activity in the near future.

Table 3 Women delivered at ESTH

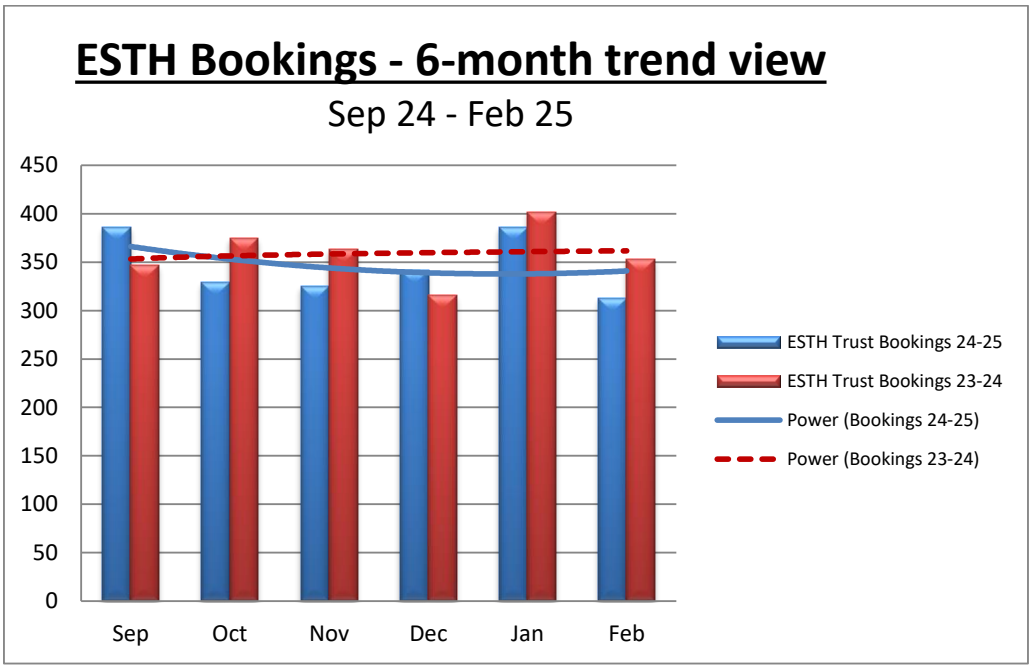
Financial Year	St Helier	Epsom	Total Women Delivered
2020/21	2213	1723	3936
2021/22	2126	1780	3906
2022/23	2105	1686	3791
2023/24	1998	1698	3696
2024/25	1869	1620	3541

However, the service has seen a continued high postnatal workload of around 448 women per year at Epsom and 2,288 at St Helier within the same time period.

For the period Sept 24 to Feb 25, birth rate data shows as slightly lower overall



Within the same time period, bookings and care demands within the service remain fairly consistent, with an overall 3.5% decrease in bookings from 2024.



3.4 Staffing position

As outlined, ESTH use Birth-rate Plus ® (BR+) birth-to-midwife ration as the approved workforce planning tool. The confirmed calculation and methodology used to generate the BR+ 'birth-to-midwife' ratio is patented and is not known or shared with any maternity service. However, using professional judgement, this has been calculated using the rolling annual delivery rate per month and then dividing it by the available clinical band 5 – 7 WTE, excluding 11% non-direct care specialist staff. For the rolling year to February 2025 this was 164.32 WTE.

Using an average of 3541 births with the currently supported staffing in place the birth to midwife ratio for ESTH is **1:23.8 WTE**

Table 4: Birth-to-midwife ratio

Month	Sep 24	Oct 24	Nov 24	Dec 24	Jan 25	Feb 25
Birth to midwife ration	**1:25.4**	**1:24.7**	**1:24.6**	**1:24.1**	**1:24.5**	**1:23.8**

Recruitment of 2.42 WTE B6 RM is underway to join STH community midwifery service and 3 WTE MSW are on-boarding leaving no vacancies at Band 3 in the community setting. A further 7.2 WTE RM recruitment is underway for our in-patient setting (1.9 WTE for EGH and 5.3 WTE for STH); a further review will be undertaken using professional judgement and acuity data to understand the remaining vacancy against any patient safety risks although a number of Red Flag recordings have been noted (see section 11). There have been no incidents related to patient safety during this time period

Status – ongoing assessment

3.5 Triage provision and staffing

Maternity triage is currently based within Delivery Suite on both sites and has 3 spaces for women to be seen at STH and 2 spaces for women to be seen at EGH: both sites deliver care by an experienced midwife before onward referral to an Obstetrician if required. Maternity triage currently utilises NICE Safe midwifery staffing for maternity settings (2015) which clearly outlines the timeframe and escalation process for women within the triage department.

The CQC inspection of August 2023 highlighted that maternity triage required the following immediate and essential action:

1. The service must ensure that medical staffing for triage is reviewed so there are sufficient numbers of staff to review women and birthing people in a timely manner (Epsom and St Helier sites)

2. The service must operate clear triage processes to ensure the safety of women, birthing people and babies (St Helier)

A number of actions have been taken to successfully meet these actions with monthly audits undertaken and presented through governance meetings to review the capacity and demand of triage services across both sites, with immediate learning and intervention where required. ESTH are currently unable to implement BSOTS (Birmingham Symptom-specific Obstetric Triage System) which is the recognised and recommended maternity triage system. BSOTS includes a standardised initial assessment of all women and their babies within 15 minutes of arrival and the use of symptom-specific algorithms to determine the clinical urgency of further investigations and seniority of review. BSOTS recommend:

- That one midwife is responsible for the initial triage assessment and at least one other midwife carries out the subsequent care and investigations. In smaller units, such as those with fewer than 3000 births, one midwife may assume both roles (along with a MSW), but will need to remain responsive to new attendees and interrupt the ongoing care of women to triage each arrival
- Those women who require more urgent clinical assessment (red/orange) should be seen by a ST3–7, specialty doctor or equivalent level of Locally Employed Doctors (LED) obstetrician from labour ward with more senior expertise, to ensure prompt assessment and planned care. Women allocated the red category of urgency should be transferred to the labour ward for assessment. For those women allocated the orange category of urgency, review within 15 minutes is required if there is abnormal MEOWS or MEWS, abnormal cCTG, or urgent maternal/fetal concern (guided by individual algorithms). This is likely to represent 15–20% of women attending triage. Those women prioritised as less urgent (yellow/green) can be seen by a FY2/GP VTS/ST1–2/LED in a timely way. One of the principles in BSOTS is that those assigned red/orange priority are seen and assessed by ST3–7, specialty doctor or equivalent level of LED because they represent the most unwell requiring urgent clinical attention. However, if the ST3–7, specialty doctor or RCOG Good Practice Paper No. 17 10 of 17 © 2023 Royal College of Obstetricians and Gynaecologists LED is not available within the timeframe, that initial assessment can be made by the FY2/GP VTS/ST1–2/LED, with escalation to ST3–7, specialty doctor, equivalent level LED or consultant/specialist to ensure timely review by medical staff.

Known staffing concerns in relation to meeting triage compliance and ensuring patient safety:

- Midwives are continuing to achieve above 99.9% compliance in seeing all women within 15 minutes
- Doctors continuing to see around 40-50% of cases within 15 minutes of referral (RAG system dictates timing for review)

The MSSP team undertook a review of ESTH maternity triage services on 25 April 2025 and the report is expected imminently. This will enable a full review of service provision, both midwifery and medical and will be updated in the next reporting period.

Status – under review. Current midwifery staffing from delivery suite team, obstetric review by on-call team

3.6 Theatre Scrub/recovery nurse update

The CQC inspection of August 2023 reviewed the demands on the maternity workforce and outlined the requirement for the Trust to ensure the role of the recovery practitioner is carried out by staff with the right level of qualification and additional training. Until this point, a midwife with some additional scrub training had been allocated to undertake this role as the need arose leaving the Delivery Suite with a reduced workforce to maintain safe care levels during this time.

The Trust supported the recruitment of a qualified Theatre/Recovery nurse to cover both sites 24/7 with leadership from a Band 7 RN appropriately qualified to do so. The recruitment is now almost completed with 1 WTE vacancy currently out to advert. Each member of the team has received the appropriate training and competency assessment, meeting the RCoA standards. The team are fully integrated in the maternity service with Governance oversight. This addition to the maternity team has been a great step forward in achieving safer staffing standards across ESTH maternity.

Status – On track for completion

3.7 Staffing risks

3.7a Uplift and training backfill

In the last few years CNST and Ockenden requirements have increased the amount of mandatory training hours for each registered midwife. Each midwife is now required to undertake 67 hours of Mandatory training each year. The recommendation is to increase the current uplift from 20% to 22.2% in order to meet the requirements for training hours. This will be reviewed as part of the planned establishment review in Q3/4 on receipt of the Birth-rate Plus® recommendations.

3.7b Maternity leave cover

Maternity leave cover for the midwifery workforce is not currently included in the uplift. As such ESTH maternity rosters utilise bank and agency midwives to cover the shortfall this creates. Over 24/25 financial year, there were between 11-16 WTE staff on maternity leave at any one time, with the current WTE on maternity leave for B5-7 at 7.2 WTE. Once the Birth-rate Plus ® review has completed, we will be able to understand the workforce position to support the gap through either workforce reorganisation or investment request (see section13)

3.7c Establishment review

The planned full maternity establishment review has been delayed until the planned Birth-rate Plus ® review has completed, planned for September 2025. Until this time, we continue to utilise the current templates along with using professional judgement in line with required reduction of agency use and any patient safety incidents.

3.7d Maternity workforce vacancy

The vacancy rate for B5-8 has remained at e% in the time frame outlined using pay budget, establishment and professional judgement. At the time of reporting, there are a total of 10.14 WTE vacancies at bands 5-7, with 7.2 WTE being allocated to recruit B5 preceptorship midwives from our student midwife cohort. As outlined, once the Birth-rate Plus® review in September 2025 has completed, we will be able to finalise further work in relation to our establishment.

Status - ongoing

3.8 Birth Rate Plus review

Birth Rate Plus (BR+) is a framework for workforce planning and strategic decision-making and has been in use in UK maternity units since 1988. As recommended by the National Quality Board (2016), Developing Workforce Safeguards (2018), Royal College of Midwives, and in line with CNST Incentive criteria, a full systematic review of ESTH maternity workforce requirements was undertaken using Birth-rate Plus® (BR+) in July 2022.

There is growing complexity of many births due to rising rates of obesity and diabetes among pregnant women, more women presenting with long-term conditions such as mental health, safeguarding and a substantial increase in the number of births to older mothers. These women need an additional care package over and above the standard maternity pathway, and specialist midwifery roles are required to deliver this. BR+ accounts for complexity in the delivery episode within the staffing ratios.

ESTH will undergo a full Birth-rate Plus® review in September 2025 which will enable a full establishment review to be undertaken to support a safe and thorough workforce plan to be implemented.

Status – planned for review

3.9 Midwifery workforce indicators

Workload in maternity fluctuates due to the unpredictability of admissions, leading to peaks and troughs in activity and acuity. The two labour wards are similar to emergency departments with little control over levels of activity.

Maternity services use the Birth-rate Acuity App® which facilitates daily capture of acuity in real-time at four-hourly intervals and will alert when midwifery staffing is not calibrated to the acuity and dependency of the women receiving intrapartum care. It tracks:

- Staffing vs acuity on delivery suite
- The supernumerary status of the delivery suite co-ordinator.

3.9a Supernumary status of the Delivery Suite Coordinator

The role of the Delivery Suite Coordinator is pivotal to the safe running of this key area within a maternity service. CNST defines this requirement as:

‘The Midwifery Coordinator in charge of labour ward must have supernumerary status; (defined as having a rostered planned supernumerary co-ordinator and an actual supernumerary co-ordinator at the start of every shift) to ensure there is an oversight of all birth activity within the service. An escalation plan should be

available and must include the process for providing a substitute co-ordinator in situations where there is no co-ordinator available at the start of a shift.

Can the labour ward coordinator be considered to be supernumerary if for example they had to relieve staff for breaks on a shift?

A supernumerary coordinator must be allocated for every shift and must start each shift with protected supernumerary status. It is accepted that there may be short periods when the coordinator is temporarily unavailable due to rapidly changing acuity on the labour ward to ensure safety for women, families and staff in the department. The co-ordinator should exercise professional judgement and escalate, if covering for breaks creates a safety risk to other women on labour ward. As long as there is clear evidence that the local escalation policy has been initiated in these circumstances, and this is not a recurrent daily event, Trusts may declare compliance with this standard. If the co-ordinator is regularly required to cover for breaks (more than 2-3 times a week), the Trust should declare non-compliance with the standard and include actions to address this specific requirement going forward in their action plan mentioned in the section above'.

Midwifery coordinator supernumerary status is tracked using the Birth-rate Acuity App® which is completed 4 hourly and via Eroster. There were 0 instances recorded on the acuity tool and datix records between September 2024 and February 2025 where there was no allocated supernumerary midwifery coordinator in charge of labour ward at the beginning of the shift.

Table 5: % Supernumerary status of Band 7 Labour Ward Coordinator

	St Helier	Epsom
September	100%	100%
October	100%	100%
November	100%	100%
December	100%	100%
January	100%	100%
February	100%	100%

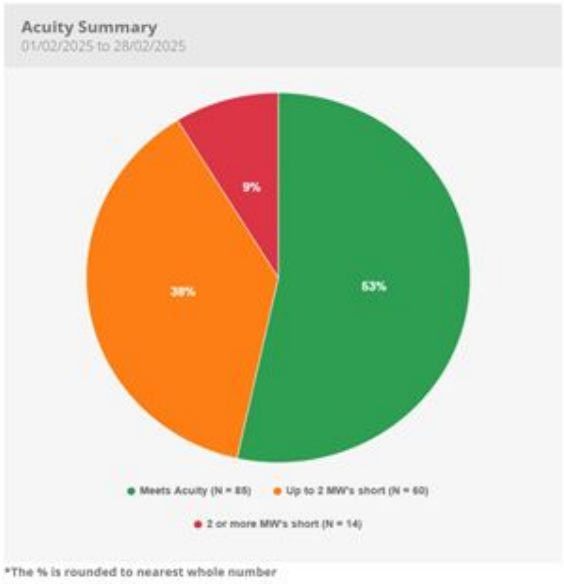
Status - safe

3.9b Staffing vs acuity on delivery suite

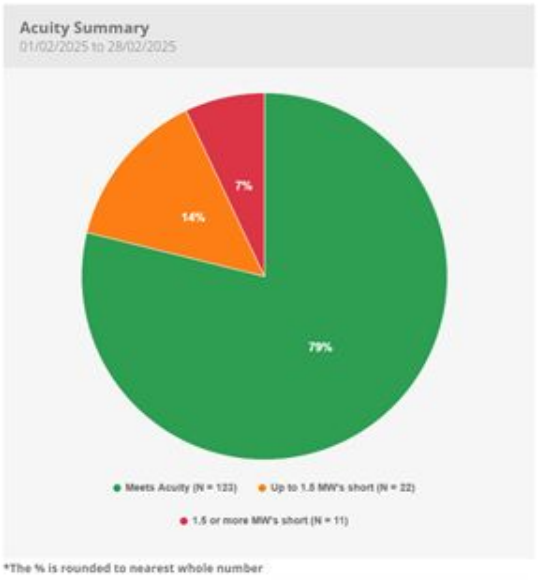
Staffing and acuity data is entered by the Midwifery coordinator into the Birth-rate Acuity App® every 4 hrs and is available to review by the senior midwifery leadership team. It informs the midwife in charge of the acuity status and facilitates the activation of the Maternity Escalation Policy as needed.

Example:

STH Delivery Suite



EGH Delivery Suite



3.10 Actual versus planned midwifery staffing

Monthly fill rates are monitored via safe staffing reporting, and vacancies and turnover at monthly Divisional Management Team meeting. The Matrons have oversight of the operational management of the maternity services in conjunction with the Director of Midwifery/ Head of midwifery. The daily maternity safety huddle is now well established and is attended by the midwifery managers who are responsible for assessing patient flow, bed capacity, staffing, skill mix and the acuity and dependency of women in order to deploy the workforce effectively and safely. There is an escalation process within maternity and to the Trust operational team to ensure that staff and clinical and operational issues are escalated and mitigated. The Escalation policy is currently under review.

The table below shows the planned versus actual fill rate achieved for midwifery staff from September 2024 to February 2025, showing the average fill rate as 92%. However, and of note, this includes bank and agency covered shifts. This means patient safety is being maintained to just below accepted standards utilising locum cover to bolster the cover by substantively employed staff. On-going recruitment is underway to move to an established position that improves the fill rate excluding locum colleagues.

Table 6: Previous 6 month fill rate includes bank/agency (against previous recommended staffing levels) with target >94%:

	St Helier %	Epsom %
September	91%	92%
October	94%	92%
November	94%	94%
December	92%	92%
January	91%	92%
February	92%	92%

Status – on-going

3.11 Midwifery red flags

NICE red flag events relating to midwifery staffing are captured. There were a total of 66 red flag events recorded the reporting period. 52% (n=31) of the Red Flags were delay between admission for induction and beginning of process. This was related to patient flow due to insufficient staffing, including medical cover, and unavailable capacity on the delivery suite. 26% (n-8) were delay between presentation and triage. One occasion was recorded as missed medication. 23% (n-7) incidents of delay or cancelled time critical activity which indicates that safety may have been compromised during this period.

Over the same period there have been 28 Datix relating to delayed care for one or more patients, when staffing levels are not sufficient to meet acuity.

Table 7: St Helier Red Flag Incidents 01/09/24 to 28/02/25

Red Flag	No of Incidents
Delayed or cancelled time critical activity	3
Missed or delayed care	0
Missed Medication	0
Delay in providing pain relief	0
Delay between presentation and triage	4
Full clinical examination not carried out when presenting in labour	0
Delay between admission for induction and beginning of process	7
Delayed recognition and action on abnormal vital signs	0

Table 8: Epsom Red Flag Incidents 01/09/24 to 28/02/25

Red Flag	**No of Incidents**
Delayed or cancelled time critical activity	4
Missed or delayed care	0
Missed Medication	0
Delay in providing pain relief	0
Delay between presentation and triage	4
Full clinical examination not carried out when presenting in labour	0
Delay between admission for induction and beginning of process	9
Delayed recognition and action on abnormal vital signs	0

3.12 One to one care in labour

One to One midwifery care in labour is a key safety metric; the twice daily internal SitRep monitors, among other things, the provision of 1:1 care in labour. There is a clear escalation process within maternity to ensure women receive one to one care in established labour. The 100% target was achieved within this period. The table below shows the performance against the 1:1 care in labour target Sept 24 – Feb 25.

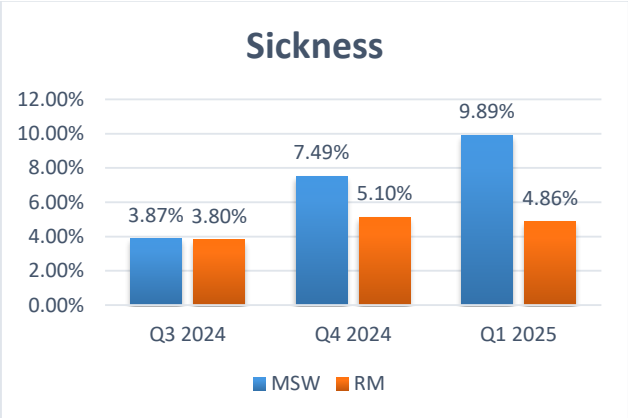
Table 9: One to one care in labour (Data source Badgernet)

Sept 24	Oct 24	Nov 24	Dec 24	Jan 25	Feb 25
100%	100%	100%	100%	100%	100%

Status - safe

3.13 Maternity workforce sickness and maternity leave

Maternity workforce sickness remains above the Trust KPI of 3.8%. During the timeframe of this report Sept 24 – Feb 25 the average midwifery sickness was 5.77%. This led to an increase of bank and agency usage to cover the required shifts



Status – on-going review of robust sickness management locally to reduce sickness rates

Maternity leave remains high across the groups and is not included within the uplift. This means maternity leave must be covered by bank and agency colleagues to ensure the service is safe.



Status – request to recruit to maternity leave will be undertaken on receipt of the Birth Rate Plus (BR+) review in Q3 2025

3.14 Neonatal Transitional Care

Neonatal transitional care (NTC) is located within the maternity setting, with 6 beds/ cots, including one side room at St Helier and 4 beds/cots at Epsom. The British Association of Perinatal Medicine (BAPM 2017) sets out clear guidance on the provision of transitional care, including staffing.
In 2023, our CQC report asked for immediate action to ensure this was in place and that all staff had the appropriate level of training.

Postnatal care of mothers within NTC is provided by midwives, as the total numbers sit within the existing postnatal footprint, this is provided by the existing postnatal ward staff and ratios calculated by BR+.

Neonatal care within NTC is a joint responsibility between the residing parent (usually mother) and both nursing and ancillary staff. Implementation of NTC to meet BAPM standards was split into two phases. Phase one and two are now complete on the St Helier site, with 5.4 wte band 4 neonatal support workers providing 24/7 care under the oversight of the 'floating' RN/ANNP from NNU. Epsom have completed phase one with 1wte band 7 NTC /SCBU lead in post. Phase two has commenced, 2.92 wte band 4 NTC support workers are in post, progression is ongoing for upskilling a further 2.4wte band 3 MSW's into the remaining posts.

4.0 Sources of assurance

4.1 Delivering Midwifery Continuity of Carer at full scale: Guidance on planning, implementation and monitoring 2021/22 Version 1, October 2021

4.2 Ockenden D (2020 &2022) Emerging Findings and Recommendations from the Independent Review of Maternity Services at the Shrewsbury and Telford Hospital NHS Trust

4.3 Francis R (2013) Final report of the independent inquiry into care provided by Mid Staffordshire NHS Foundation Trust. www.midstaffspublicinquiry.com/report

4.4 Kirkup B (2015) the Report of the Morecambe Bay Investigation. https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/408480/47487_MBI_Accessible_v0.1.pdf

4.5 RCM guidance on implementing the NICE safe staffing guideline on midwifery staffing in maternity settings.

4.6 NICE Safe midwifery staffing for maternity settings. NICE guideline Published: 27 February 2015 nice.org.uk/guidance/ng4 Safe Staffing Guideline NG4 2015

4.7 Implementing Better Births: Five Year Forward View. NHS: December 2017

4.8 Quality and Safety Programme. Maternity services London quality standards November 2015

4.9 Three Year Delivery Plan for Maternity and Neonatal Services, NHSE, March 2023

4.10 Birth-rate Plus® acuity tool

5.0 Recommendations

5.1 The Group is asked to:

a. Note the ongoing work to ensure compliance with the national guidance for midwifery staffing levels and the implementation of a robust methodology in determining the correct levels and skill mix of staff.

b. Note that the staffing review is achieved in consideration of the following recommended documents:

- NICE safe staffing guideline for midwives in maternity settings
- Better Births: Improving outcomes of maternity services in England, the report of the National Maternity Review in England 2016
- RCM State of Maternity Services Report 2015
- How to ensure the right people, with the right skills, are in the right place at the right time: a guide to nursing, midwifery and care staffing capacity and capability, National Quality Board 2013
- Supporting NHS providers to deliver the right staff, with the right skills, in the right place at the right time, National Quality Board 2016
- Developing Workforce Safeguards: Supporting providers to deliver high quality care through safe and effective staffing 2018
- Clinical Negligence Scheme for Trusts (CNST) year 5
- Three Year Delivery Plan for Maternity and Neonatal Services, NHSE, March 2023

c. Note the ongoing work to review the implementation of BSOTS within the maternity triage setting

Group Board

Meeting on Friday, 05 September 2025

Agenda Item	4.1
Report Title	**SGUH bi-annual midwifery and maternity safer staffing report**
Executive Lead(s)	Arlene Wellman, Group Chief Nursing Officer
Report Author(s)	Fiona Walkinshaw, Deputy Director of Midwifery and Gynaecology Nursing Natilla Henry, Group Chief Midwifery Officer
Previously considered by	Choose an item.
Purpose	**For Assurance**

Executive Summary

It is a requirement for NHS providers to have systems in place to ensure they continue to have the right people, with the right skills, in the right place, at the right time, to achieve safer nursing and midwifery staffing in line with the National Quality Board (2016) guidance on safe staffing requirements.

The purpose of this report is to provide assurance to the Trust Board that there is an effective system of midwifery workforce planning and monitoring of safe staffing levels in place to achieve this aim

Providing assurance on safe staffing is also a requirement of the Maternity Incentive Scheme Year 7 - Safety Action 5: **Can you demonstrate an effective system of midwifery workforce planning to the required standard?**

The required standard includes:

a) A systematic, evidence-based process to calculate midwifery staffing establishment is completed.
b) The Trust Board evidencing midwifery staffing budget reflects establishment as calculated in a) above.
c) The midwifery coordinator in charge of labour ward must have supernumerary status; (defined as having a rostered planned supernumerary coordinator at the start of every shift) to ensure there is an oversight of all birth activity within the service. An escalation plan should be available and must include the process for providing a substitute co-ordinator in situations where there is no co-ordinator available at the start of the shift
d) All women in active labour receive one-to-one midwifery care.
e) Submitting a midwifery staffing oversight report that covers staffing/safety issues to the Board every 6 months, during the maternity incentive scheme year seven reporting period.

Key areas to note

Workforce Planning

1. A **Birthrate Plus assessment** was completed in April 2025.

- Annual birth rates have **declined by 990 over 5years,** but **case complexity has increased**, especially in Category V (most complex).
- Staffing needs are adjusted based on complexity:
  - Cat IV: 1.3 midwives/woman
  - Cat V: 1.4 midwives/woman

2. Staffing Establishment

- **Positive variance** of 7.54 WTE midwives identified through Birth Rate Plus, April 2025.
- Natural attrition (4.61 WTE leaving) may help balance this.
- **Specialist roles** (e.g., bereavement, mental health) are essential but underfunded.
- The unit is rated **Inadequate by CQC** and under a Section 29a Safety Warning and this should be considered when considering staffing reductions.

3. Specialist Midwives

- 34.08 WTE specialist midwives; 50% contribute to clinical care.
- Roles cover areas like diabetes, safeguarding, fetal monitoring, and public health.

4. Health Inequalities

- 50.1% of babies born are of non-White ethnicity (vs. 28% UK average).
- Black and Asian women face significantly higher maternal mortality risks.
- Language barriers and social deprivation are key challenges.
- SGUH provide services to address health inequalities e.g., Language line on wheels in all areas, disability leads and champions, service around teenage pregnancy and research into the experiences of LGBTQ+ who have maternity care at SGUH. However, its recognised that more needs to be done to address health inequalities and reduce morbidity and mortality

Performance Metrics

5. Birth to Midwife Ratio

- March–May 2025: 1:23 to 1:24, which is above the 1:22 recommended for tertiary level units

6. Planned vs. Actual Staffing

- Fill rates vary by ward and shift; Carmen ward shows lower fill rates due to redeployment.
- Measures include redeployment and levelling of staff across clinical areas

7. Supernumerary Labour Ward Coordinator

- 100% compliance Jan–Apr; 98.4% in May (1 exception mitigated).

8. One-to-One Labour Care

- 100% compliance across all wards from March to May.

9. Red Flag Incidents (May 2025)

- 3 incidents: 1 delayed induction, 2 delayed medications.
- All addressed with appropriate clinical actions and learning.

Medical Staffing

10. Obstetricians

- Consultant presence extended to 08:00–22:00 daily.
- Positive feedback from staff; further SHO recruitment is subject to a business case, this would help release senior doctors to support areas such as triage.
-

11. Anaesthetists

- 100% compliance with 24/7 availability and supervision standards.

12. Neonatal Staffing

- **Medical**: Fully compliant with BAPM standards.

- **Nursing**: QIS-trained staff at 64% due to new hires.
  - Action plan in place to improve compliance to meet BAPM standard (BAPM standard 70% QIS).

Action required by Group Board

The Board is asked to:

a. Note the recent Birthrate plus recommendations
b. Note the content of this report for assurance that SGUH has an effective system of midwifery workforce planning to meet CNST safety action 5 compliance
c. Note the key points highlighted

Committee Assurance

Committee	Quality Committees-in-Common
Level of Assurance	Choose an item.

Appendices

Appendix No.	Appendix Name
Appendix 1	[…]

Implications

Group Strategic Objectives

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

Risks

[…]

CQC Theme

☒ Safe	☐ Effective	☐ Caring	☐ Responsive	☒ Well Led

NHS system oversight framework

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

Financial implications
Legal and / or Regulatory implications
NICE Safe Staffing Guidance 2014 **NICE Safe midwifery staffing for maternity settings 2015** **National Quality Board 2016, 2018** **Developing Workforce Safeguards 2018**
Equality, diversity and inclusion implications
50.1% of babies born are of non-White ethnicity (vs. 28% UK average). Black and Asian women face significantly higher maternal mortality risks. Language barriers and social deprivation are key challenges
Environmental sustainability implications
N/A

SGUH bi-annual midwifery and maternity Safer Staffing Report
Quality Committees-in-Common, 31 July 2025

1.0 Purpose of paper

1.1 The purpose of this report is to provide assurance to the Trust Board that there is an effective system of midwifery workforce planning and monitoring of safe staffing levels in place to provide safe care to women and babies.
The paper also provides a summary of all measures in place to ensure safe midwifery and neonatal staffing; including workforce planning, planned versus actual midwifery staffing levels, the midwife to birth ratio, specialist hours, compliance with supernumerary labour ward coordinator, one to one care in labour and red flag incidents as well as neonatal nurse staffing and QIS numbers against target. It also gives a summary of key workforce measures for obstetricians and anaesthetics to provide evidence for the maternity incentive scheme (MIS) year 7.

2.0 Background

2.1 It is a requirement that as NHS providers we continue to have the right people with the right skills in the right place at the right time to achieve safer nursing and midwifery staffing in line with the National Quality Board (NQB) requirements.

Organisational requirements for safe midwifery staffing for maternity settings (NICE 2017) states that midwifery staffing establishments develop procedures to ensure that a systematic process is used to set the midwifery staffing establishment to maintain continuity of maternity services and to always provide safe care to women and babies in all settings.

To provide evidence of meeting Safety Action 5: **Can you demonstrate an effective system of midwifery workforce planning to the required standard** of NHS Resolutions Maternity Clinical Negligence Scheme for Trusts Incentive Scheme. This paper also includes staffing data on other key groups, obstetricians, and anaesthetics.

3.0 Key issues for consideration

3.1 **Birthrate Plus Workforce Planning**

A formal Birth Rate Plus workforce assessment was completed for SGUH and reported on in April 2025. The RCM recommends using Birthrate Plus® (BR+) to undertake a systematic assessment of workforce requirements, since BR+ is the only recognised national tool for calculating midwifery staffing levels.

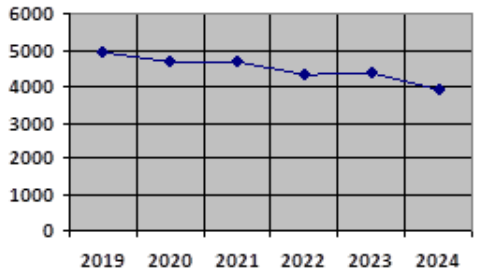
NICE (2017) recommend that an assessment is carried out every three years and it was recognised that this review was overdue. As part of the Birth rate plus review the maternity workforce, annual birth rate and case mix of the women attending St George's was analysed along with the midwifery staffing budget to assess whether this accurately reflected the establishment as calculated by Birth rate plus.

It was noted that the annual birth rate had steadily decreased over the past 5 years.

Annual births	2024/5	2019/20	Variance
Delivery Suite	3632	4155	-523
Birth Centre	223	695	-472
Home	54	49	5
Total	**3909**	**4899**	**-990**

Table 1: Annual Activity

Fall in Delivery Numbers by Year



However, the delivery suite case mix was also noted to have changed from that of 2019/20.

Case mix changes (2025 vs 2020)

- Increase in Category V (most complex): 51.4% (↑ 3.8%)
- Decrease in Category IV: 25.7% (↓ 6.7%)
- Reflects rising complexity, more inductions, and caesarean sections.

The Birthrate Plus Report 2025 for St George's does not specify a single numerical birth-to-midwife ratio. Instead, it emphasizes a standard of care based on one-to-one midwifery support during established labour, which is the core principle of the Birthrate Plus methodology.

This is addressed as:

- One-to-one care is the minimum standard for women in established labour.
- For more complex cases (Categories III, IV, and V), additional midwife time is allocated:
  - Category IV: 1.3 midwives per woman
  - Category V: 1.4 midwives per woman

This means that the effective ratio varies depending on the casemix (i.e., the complexity of the births). For example, a higher proportion of Category V cases increases the staffing requirement significantly beyond a 1:1 ratio.

Based on the standard of one midwife to one woman, women in Cat V are allocated 1.4 midwives, so a 40% increase for the intrapartum care. A Cat IV woman has a 1.3 ratio.

	% Cat I	% Cat II	% Cat III	% Cat IV	% Cat V
DS casemix 2025	3.4	8.3	11.2	25.7	51.4
	22.9%			77.1%	
DS casemix 2020	*0.9*	*5.2*	*13.9*	*32.4*	*47.6*
	20.0%			*80.0%*	

Table 2: Delivery Suite Case Mix

Summary of workforce as reported through Birth rate plus calculations

Current Funded Clinical, Specialist, Management wte	Birthrate Plus wte	WTE Variance
256.05	248.51	7.54

Table 3: Total Clinical, Specialist and Management WTE

Note: the current and Birthrate Plus establishments do include the RNs and Band 3 contribution in delivery suite and postnatal services.

The Birthrate Plus report has identified an over establishment variance of 7.54WTE midwives. There is the potential to manage this through natural reduction of staffing and resignations (non-specialist posts) as 4.61WTE band 5 & 6 are leaving the service by the early July. However, it is also important that the key points below are considered when deciding where the staffing establishment should settle.

Key Considerations:

- Community care is expanding due to shorter hospital stays.
- Safeguarding cases (571 annually) impact workload.
- Specialist roles (e.g. bereavement, mental health, fetal monitoring) are essential but underfunded.
- Support staff needs are determined by professional judgment, not casemix.
- The Maternity Unit is currently rated as Inadequate by the CQC and has been issued a Section 29a Safety warning. It is important to have the correct staffing to meet the service needs whilst also supporting and embedding key quality improvements across the service.

3.2 Specialist Midwives

Within our Birth Rate Plus calculations 14% of the total establishment is not included in the clinical numbers. This includes management positions and specialist midwives.

Currently there are 34.08wte Specialist Midwives in substantive funded posts of which 17.10wte (50.2%) is allocated to the clinical total. The remaining 16.98wte (49.8%) are included in the additional WTE plus the 8.00wte senior midwifery managers.

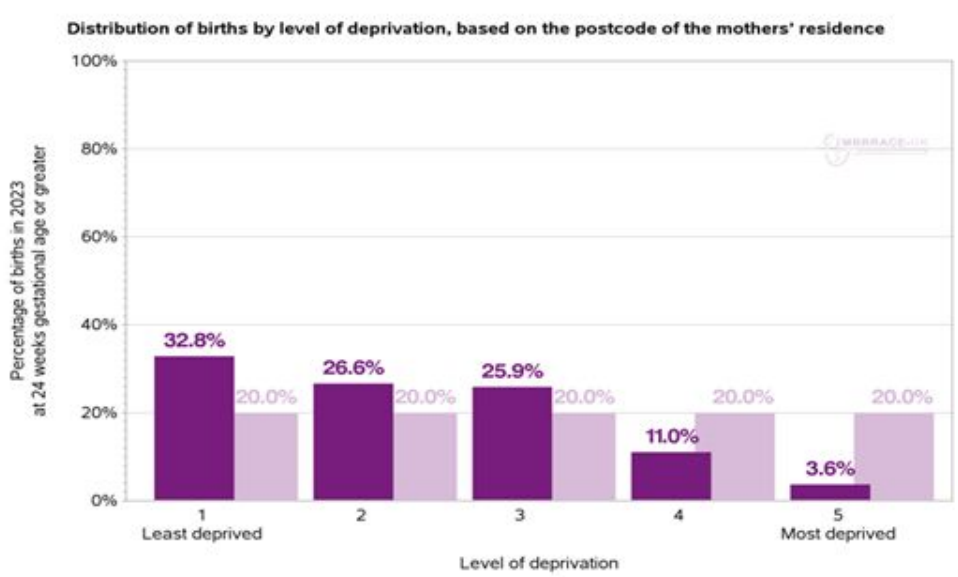
RMs Bands 5 – 7	Specialist Midwives contribution	RNs	PN MSWs	Current Total Clinical wte
191.04	17.10	5.17	17.76	231.07

Current funded establishment

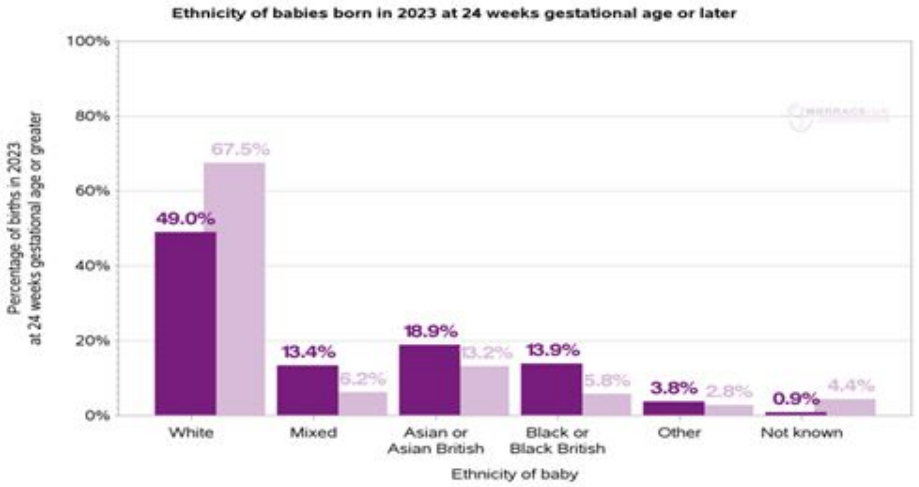
Specialist Midwives with responsibility for:

- Consultant Midwives (Public Health, Intrapartum, Maternal Medicine)
- Antenatal and Newborn Screening/Failsafe
- Diabetes
- Bereavement
- Public Health
- Infant Feeding
- Mental Health
- Birth Options
- Preterm Births
- Perineal Health
- FGM
- Safeguarding
- Digital
- Fetal Monitoring
- Practice Development
- Recruitment and Retention
- Audit and Guidelines
- Quality Improvement
- Risk
- Practice Development

3.3 Health inequalities and Patient Demographics



The above graph demonstrates the distribution of births by level of deprivation based on the postcode of the mother's residence and using the Children in Low-Income Families Local Measure, MBRRACE-UK 2023. Mother's giving birth at St George's are less likely to live in an area of social deprivation than those giving birth elsewhere across the UK. (Dark purple shows SGUH).



However, the proportion of babies of non-White ethnicity is considerably higher than that of the UK as a whole: 50.1% versus 28.0%. In the UK, Black and non-White women continue to face significantly higher risks during pregnancy and childbirth compared to White women. MBRRACE-UK (Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries) latest report demonstrated that Black women are 2.8 to 3.7 times more likely to die during pregnancy or up to six weeks after childbirth compared to White women. Asian women are 1.7 times more likely to die in the same period. In addition, English is not always a first language which brings significant challenges to the maternity team with the regular use of interpreters and Language Line services. The daily staffing is reviewed to ensure safe equitable care is provided for all women and that it reflects the care needs on each individual day.

Top 5 languages spoken in Tooting and Wandsworth borough after English –

1. Polish
2. Urdu
3. Somali
4. Gujarati
5. French

Specialist midwife services listed above are available to provide support to our specific patient care needs.

4.0 Sources of assurance

4.1 Planned Versus Actual Midwifery Staffing Levels

Birth to Midwife Ratio

	Jan 25	Feb 25	March 25	April 25	May 25
Birth to midwife ratio	1:23	1:23	1: 23	1: 24	1: 24

The following table outlines percentage fill rates for the inpatient areas by month.

	Carmen		Delivery Suite		Gwillim	
	Day %	Night %	Day %	Night %	Day %	Night %
Jan 2025	96%	99%	88%	89.5%	91.5%	91%
Feb 2025	90%	72%	89%	92%	82%	93%
March 2025	87%	86%	89%	93.5%	88%	95%
April 2025	73%	64%	86%	90%	95%	98%
May 2025	86%	82%	94%	92%	95%	95%

Fill rates have dropped in Carmen as these staffing numbers include Carmen Antenatal Ward and Carmen Birth Suite. Staffing is monitored three times over the 24hour shift during staffing escalation meetings in relation to activity and acuity across the unit, and each individual area. Staff from the Carmen Birth Suite have been redeployed to support Gwillim and Delivery Suite (if the Birth Suite has no patients), and this decision is based on the acuity and activity within these areas. On delivery Suite and Gwillim the fill rates are affected by maternity leave, short and long-term sickness.

When staffing is less than optimum, the following measures are taken in line with the escalation policy:

- Relocate staffing to ensure one to one care in labour and dedicated supernumerary labour ward co-ordinator and bleep holder roles are maintained.
- Elective workload prioritised to maximise available staffing.
- Management or Study days reviewed to identify if any staff can be moved.
- Request midwifery staff undertaking specialist roles to work clinically.
- Request additional support from the on-call midwifery manager.

All the above actions are designed to maximise staffing into critical functions to maintain safe care for the women and their babies.

A significant number of bank and agency hours have been used across the service to cover maternity leave and long and short-term sickness. Work has been taking place over Q4 2024 and Q1 2025 to manage all sickness. Managers have directed all staff to the Sickness Policy

and all required Stage 1 & Stage 2 sickness meetings have taken place. A positive reduction in sickness has been noted since the beginning of this year.

	Jan 25	Feb 25	Mar 25	Apr 25	May 25
Long term sick %	5.03%	4.98%	4.69%	2.63%	3.19%
Short term sick %	4.40%	3.42%	2.66%	2.33%	2.35%

There is also work taking place to reduce bank and agency usage. Trust SOP on the management of RN/RM sickness reporting was updated in April to support decision making on when shifts should / or shouldn't be sent to the Staff Bank. The overall aim for 2025 is the significantly reduce agency use across the unit.

4.2 Supernumerary Labour Ward Co-ordinator

Availability of a supernumerary labour ward co-ordinator is recommended as best practice to oversee safety on the labour ward. This is an experienced midwife available to provide advice, support, and guidance to clinical staff and able to manage activity and workload through the labour ward.

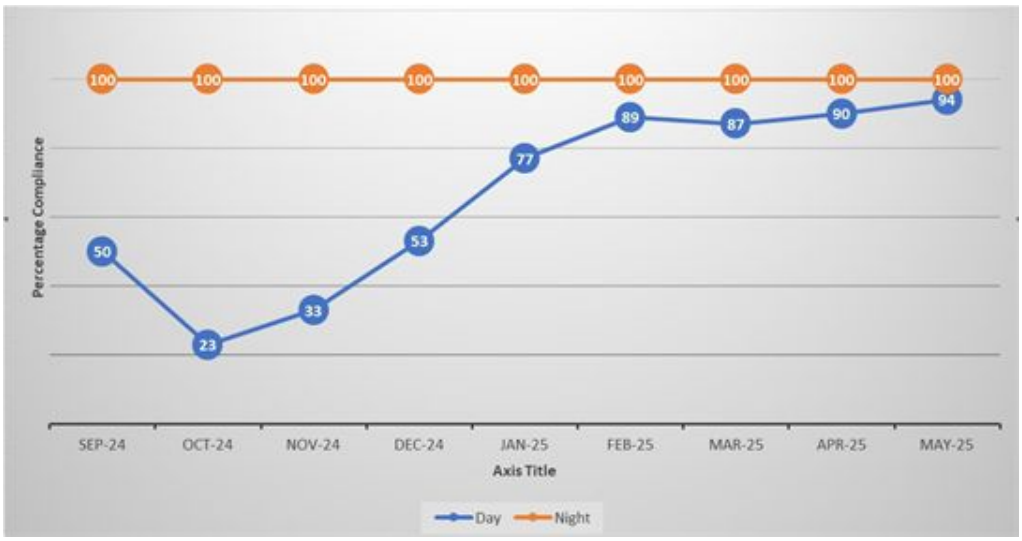
The following table outlines the compliance by month:

	Number of days per month	Number of shifts per month	Compliance
January	31	62	100%
February	28	56	100%
March	31	62	100%
April	30	60	100%
May	31	62	98.4%

There was one occasion in May when the ward coordinator was not supernumerary at the start of her shift. This was mitigated by bringing a midwife from the Birth Centre to delivery Suite to take a patient and therefore enabling the co-ordinator to be supernumerary.

4.3 Triage Staffing

Triage is budgeted to have 2 midwives and one MSW on a day shift, and 1 midwife and one MSW on a night shift. As the helpline is diverted to triage overnight, the coordinators allocate 2 midwives to Triage during the night shift (taken from delivery suite staffing) to maintain safety by ensuring all women are seen within 15-30minutes (NHS Framework KPI). Staffing in Triage has continued to improve from February to May as the team have worked to ensure appropriate day time staffing. The aim going forward would be for this area to be budgeted to support 2 midwives day and night as this is the standard the team are working to achieve.



4.4 One to One in Established Labour

Women in established labour are required to have one to one care and support from an assigned midwife. One to one care will increase the likelihood of the woman having a 'normal' vaginal birth without interventions and will contribute to reducing both the length of labour and the number of operative deliveries. Care will not necessarily be given by the same midwife for the whole labour.

If there is an occasion where one to one care cannot be achieved, then this will prompt the labour ward co-ordinator to follow the course of actions within the acuity tool. These may be clinical, or management actions taken.

The following table outlines compliance by Month.

	Jan	Feb	March	April	May
Birth Centre	100%	100%	100%	100%	100%
Labour Ward	100%	100%	100%	100%	100%

4.5 Red Flag Incidents

A midwifery red flag event is a warning sign that something may be wrong with midwifery staffing (NICE 2015). If a midwifery red flag event occurs, the midwife in charge of the service is notified. The midwife in charge will then determine whether midwifery staffing is the cause and the action that is needed. Red flags are collected through the live Birth Rate Plus acuity tool and Datix.

The following tables demonstrate red flag events:

Red Flag Category May 2024	SGUH (data on Datix)
Coordinator not supernumerary	0
Delay in time critical activity	0
Delayed Induction of Labour	1
Delayed Pain Relief	2

Delayed or cancelled care	0
Total Number of clinical incidents related to red flags	**3**

90 datix's reported in May

Datix	Red Flag	Description	Action Taken
DW227693	IOL delay for 2 hours	Delay due to doctor busy with a patient in DAU	CTG carried out to reassure and apology given. IOL commenced when doctor attended.
DW227128	Delayed medication for 12hours	Missed dose due to misinterpretation of drug chart. Delay in managing tissued cannula.	Doctor informed, prescription updated and cannula re-sited.
DW227127	Delayed medication for 12hours	Mismanagement of antibiotics by midwife	Doctor review and antibiotics given. Education to midwifery staff regarding the importance of correct management of newborn antibiotics.

4.6 Obstetric staffing

The obstetric consultant team and maternity senior management team acknowledge and commit to incorporating the principles outlined in the RCOG workforce document: 'Roles and responsibilities of the consultant providing acute care in obstetrics and gynaecology' into the service. This includes obstetric staffing on the labour ward and any rota gaps.

Trusts should monitor their compliance of consultant attendance for the clinical situations listed in the RCOG document when a consultant is required to attend in person. Episodes where attendance has not been possible should be reviewed at unit level as an opportunity for departmental learning with agreed strategies and action plans implemented to prevent further non-attendance. Trusts' positions with the requirement should be shared with the Trust board, the board-level safety champions as well as LMS.

From January 2025, the Obstetric Consultant resident hours were updated. This changed to 08:00 to 22:00every day including weekends. With no resident consultants overnight.

This major shift was put in place to provide a consistent consultant presence. It also means that a second consultant ward round now takes place with the night team after handover. This has been positively received by the midwifery and obstetric team.

Areas that still require attention is the assurance of adequate medical cover for Triage (day/night/weekends). A case has been presented to SLT regarding the need for additional funding to support a Tier 3 level of residents.

4.7 Anaesthetic staffing

For safety action 4 of the maternity incentive scheme evidence must be provided to demonstrate that a duty anaesthetist is immediately available for the obstetric unit 24 hours a day and should

always have a clear line of communication to the supervising anaesthetic consultant. Where the duty anaesthetist has other responsibilities, they should be able to delegate care of their non-obstetric patients to be able to attend immediately to obstetric patients. (ACSA standard 1.7.2.1). The following demonstrates compliance with this standard by month.

Month	Jan 25	Feb 25	March 25	April 25	May 25
% compliance	100%	100%	100%	100%	100%

4.8 Neonatal medical staffing

To meet safety action 4 of the maternity incentive scheme the neonatal unit needs to demonstrate that it meets the British Association of Perinatal Medicine (BAPM) national standards of junior medical staffing. This requirement has been met in Year 6 of MIS and as we progress into Year 7 this remains fully complaint.

This is shared with the LMNS and the Neonatal Operational Delivery Network (ODN).

4.9 Neonatal nursing staffing

To meet safety action 4 of the maternity incentive scheme the neonatal unit needs to demonstrate that it meets the service specification for neonatal nursing standards.

The Trust is required to formally record to the Trust Board minutes compliance to BAPM Nurse staffing standards annually using the Neonatal Nursing Workforce Calculator (2020). Currently the QIS (Qualified in Speciality) trajectory has dropped slightly to 64% going into June. This is due to a number of new starters at band 5 (7 since April 25) which has diluted the overall total. There are 9 staff who have completed the QIS course, and the unit has maximised the number of staff on current QIS modules.

As the neonatal staffing currently does not fully meet the standard for QIS trained nurses, an action plan has been developed to address deficiencies and evidence of progress monitored. A copy of the action plan, outlining progress against each of the actions, has been shared with the LMNS and Neonatal Operational Delivery Network (ODN) and is attached below. In addition, the quarterly workforce tool is also shared to the ODN.

5.0 Recommendations

5.1 The Committee is asked to:

a. Note the recent Birthrate plus recommendations
b. Note the content of this report for assurance that SGUH has an effective system of midwifery workforce planning to meet CNST safety action 5 compliance
c. Note the key points highlighted

Group Board

Meeting on Friday, 05 September 2025

Agenda Item	2.3.5	
Report Title	Maternity and Neonatal Safety Champions' Report – July 2025	
Executive Lead(s)	Arlene Wellman, Group Chief Nursing Officer	
Report Author(s)	Sarah Hodgson, Business Manager – Group Chief Nursing Officer	
Previously considered by	N/A	
Purpose	**For Noting**	

Executive Summary

This report provides Board-level assurance on the activities, insights, and actions arising from recent Maternity and Neonatal Board Safety Champion engagement across the GESH Group. It captures both strategic oversight and on-the-ground feedback from executive and non-executive visits, engagement meetings, and triangulation forums.

Key Highlights:

- **Board Safety Engagement:** The Executive and Non-Executive Safety Champions continue to lead a structured programme of formal and informal engagement across maternity and neonatal services. This includes bi-monthly Triangulation and SLT meetings (to be merged into a new Clinical Strategy and Standards Group from July 2025) and quarterly in-person/virtual staff engagement sessions across all sites.
- **Positive Site Feedback (Epsom – June 2025):**
  Visits identified motivated, cohesive teams and visible, effective leadership. Cleanliness and organisation were noted strengths. However, estates-related issues require renewed executive scrutiny to ensure resolution plans are prioritised appropriately.
- **Continued Concerns (St George's – March to May 2025):**
  Persistent cultural and leadership challenges remain, with executive concern about resistance to change and limited progress on previously identified issues. The appointment of a new interim Director of Midwifery and upcoming changes to the Obstetric Clinical Director role present an opportunity—but also a risk—requiring close oversight to ensure leadership capability and cultural change are embedded.
- **Staff Engagement and Transformation (June 2025):**
  The Maternity Transformation Project has resumed post-CQC inspection, with strong staff engagement on themes such as patient experience, staff wellbeing, and quality of care. A co-designed action plan is being developed to translate staff feedback into meaningful change.

Key Risks & Actions:

- **Cultural resistance** and **leadership instability** at St George's remain critical risks to improvement delivery.
- **Estates issues** at Epsom require executive review for appropriate prioritisation.

- **Progress tracking** for transformation initiatives must remain visible and driven by Board-level oversight.

Meetings held this financial year:

Number of meetings – current financial year (YTD)	
Bi-monthly Maternity & Neonatal Triangulation Meetings	1
Bi-monthly Maternity & Neonatal SLT Meetings	1
Monthly CSSG Meetings	1
Quarterly Staff Engagement Meetings	1
Safety Champion Site Visits; Semi-Formal, Pre-Board and Ad-Hoc Visits	2

Appendix 1 provides a summary of:

- feedback (positive observations and concerns raised) and updates on actions from the Safety Champions' visits to the group sites since the last report

Appendix 2 provides a summary of:

- issues raised and new actions agreed at the quarterly staff engagement meetings (attended by staff across all three units)

Next Steps:

- Establishment of the new Clinical Strategy and Standards Group to streamline governance and assurance.
- Continued monitoring of leadership appointments and embedding of safety culture.
- Timely update and delivery of action plans aligned to CNST and transformation priorities

Action required by Group Executive

The Group is asked to:

a. Note the contents of the report for assurance of Safety Champion activity, engagement and action.
b. Make any recommendation for further action.

Committee Assurance

Committee	Quality Committees
Level of Assurance	Choose an item.

Appendices

Appendix No.	Appendix Name
Appendix 1	Maternity and Neonatal Board-Level Safety Champions' Update July 2025

Implications

Group Strategic Objectives

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

Risks

No issues to consider

CQC Theme

☒ Safe	☒ Effective	☒ Caring	☒ Responsive	☒ Well Led

NHS system oversight framework

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

Financial implications

No issues to consider

Legal and / or Regulatory implications

Enforcement undertakings applicable to SGUH and ESTH.
Compliance with the Health & Social Care Act 2008 (Regulations 2014) and CQC Registration Regulations.

Equality, diversity and inclusion implications

Staff Experience and Psychological Safety

- Positive engagement at Epsom suggests a culture where staff feel safe and supported to speak up, reflecting inclusivity in practice.
- In contrast, the St George's visit highlights resistance to change and cultural barriers, which may signal issues around:
  - Psychological safety for staff from diverse backgrounds.
  - Limited inclusivity in leadership approaches.
  - Potential inequities in how staff voices are heard or acted upon, particularly in underperforming areas.

Patient Voice and Experience

This report creates a mechanism to capture and act on the voices of diverse women and birthing people—especially vital in maternity services where outcomes for Black, Asian, and minority ethnic women are statistically worse.

Environmental sustainability implications

The report highlights ongoing concerns about the maternity estate, especially at ESTH

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Quality Committees-in-Common: gesh Maternity Safety Champions' Report – July 2025

Appendix 1 – Feedback and updates on actions from the Safety Champions' visits to the group sites (since the last report)

Presented by:
Arlene Wellman
Group Chief Nurse & DIPC
31 July 2025

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Maternity & Neonatal Assurance and Engagement Meetings

In addition to the formal walkabouts, the Executive ("EBSC") and Non-Executive Board Safety Champions also undertake informal and semi-formal visits around the units to observe and engage with staff. The EBSC also chairs a regular series of assurance and formal engagement meetings for Maternity and Neonatal teams:

- ***Bi-monthly Maternity & Neonatal Triangulation meeting**** – chaired by the EBSC. This meeting discusses emerging issues in relation to legal claims, coroners' cases, Freedom To Speak Up feedback and CQC enquiries, and also offers the opportunity to provide feedback to staff from the Executive and Non-Executive Board Safety Champions' visits.
- ***Bi-monthly Maternity & Neonatal SLT meeting**** – co-chaired by the EBSC and Group Chief Midwifery Officer ("GCMidO"). This is a forum to discuss more specific governance-related issues and challenges, e.g. PMRT, risk registers, ATAIN and satisfy the requirement for CNST.
- ***Quarterly Staff Engagement Sessions**** – chaired by the EBSC, with the Non-Executive Safety Champion and GCMidO. These meetings are held in-person and alternate between sites (with the option for all sites to also attend virtually). These offer maternity and neonatal staff another opportunity to discuss any challenges with the Board Safety Champions and the GCMidO and also feedback on any concerns that they wish to raise with the Trust Board.

**Formal minutes and action logs are recorded*
*** A rolling action log is maintained*

NOTE: From July 2025, the Triangulation and SLT meetings will be replaced by a new Clinical Strategy and Standards Group ("CSSG") meeting and will continue to include key updates from both meetings, e.g. CNST Safety Action updates, triangulation feedback.

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Recent visits *(since last QCiC report)*

Safety Champion Visit – 4 June 2025 – Epsom

Area / Theme	Positive Observations	Concerns Raised	Actions	Action Owner/Deadline
Antenatal Clinic	• The second theatre is nearly ready, which is positive progress.	A lack of waiting space: • Women undergoing glucose tolerance tests having to wait in the waiting room as they are unable to wait at the haematology department after they have been seen. • Women who have suffered a miscarriage have to check in at the same reception. A self check-in in the small waiting area for those who have miscarried would make a big difference. This has been requested previously.	Service is looking to install check-in kiosks in the EPU to prevent women waiting in the clinic area.	Anu Sharma, General Manager **Deadline: November 2025**
SCBU	• The nursery is a spacious room offering a number of side rooms for the use of parents and staff members. The unit is well run and felt calm and ordered. The sister in charge was happy to speak to the NEDs.			

Area / Theme	Positive Observations	Concerns Raised	Actions	Action Owner/Deadline
Delivery Suite	• Well organised with both the private and non-private rooms of a high standard. • The bereavement room was thoughtfully furnished with sensitive touches, such as a screen shielding the baby montage outside the delivery room. • The safety of patients and babies is of paramount importance, with regular safety drills involving actors simulating incidents to reinforce patient safety. • The second theatre is nearly ready for use.	1. A lack of front desk cover on Tuesdays and Thursdays, potentially impeding the monitoring of individuals leaving the unit. 2. Lack of triage waiting space meaning some women have to sit on chairs in the corridor or be sent elsewhere. An estates plan has been agreed but not yet prioritised.	1. MSW vacancy is out to advert which will cover the remaining gaps. 2. It was noted that as the Matron's office is located very close to the Delivery Suite, she and other senior midwives assume this monitoring role when there is no cover.	1. Mary Willocks, Matron 2. Works for the triage commences 21/09 and the waiting area will be included in this. Katherine Hughes, DDO **Deadline: 31 March 2026**

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Overall reflections of the visit:

NED Safety Champion:

"Everywhere we went was clean, tidy and seemed well organised. All staff members responded warmly to us and we felt very welcome. Mary, the Maternity Matron, showed us round and she was excellent. We got an impression of strong leadership and motivated and happy teams".

Accompanying NED – Yin Jones:

"I thought we received a warm welcome from Annabelle, Mary and Natilla, who were all open, approachable and insightful. All the members of staff we spoke to were also happy to speak to us about their units/their roles, etc. which was good. From what I saw, there appeared to be a good team spirit amongst the members of staff who we spoke to, and Annabelle appeared to have a good grip of the key priorities/issues particularly as she has only been in post since November *last year".*

The issue of estates featured strongly in conversations with the team. Whilst it was noted that plans have been put in to resolve all the issues, the NEDS have recommended Executive review of the Estates plan is needed, in order to give a view on whether the issues are being appropriately prioritised.

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

Safety Champion Visit – 21 May 2025 – St George's

Area / Theme	Positive Observations	Concerns Raised	Actions	Action Owner/Deadline

IT		• iClip implementation:
		  • Having to still have two systems open and transfer data between the two
		  • Not having mandatory fields in iClip and issues with usability
			• A Task & Finish Group has been convened to address the IT issues since iClip go-live.	**Jacqueline Gabriel-King *(DoM)***
				
				IN PROGRESS
				Meeting scheduled for 23.07.25 by COO

Antenatal		• Midwives report ongoing difficulty securing timely obstetric reviews, especially out of hours, with some reluctance from resident doctors to review patients and from the critical care outreach team to attend unless the patient has had an obstetric review first. The CD felt improvement work would require increased obstetric resident doctor cover (~£200k), alongside clearer guidance for midwives on appropriate escalation.	• Escalation protocols need to be clarified for both midwives and doctors with clear monitoring and oversight of such.	**Hugh Byrne, Clinical Director** Business case to increase SHO tier of Doctors which would release senior Doctors to attend other arears **IN PROGRESS**
Day Assessment Unit		• The Midwife in Charge felt very negative about the service and reported high staff turnover and sickness levels.	• Responsible Matron to meet with member of staff to understand concerns.	Sandra Linton End of Sep 2025 **IN PROGRESS**

Area / Theme	Positive Observations	Concerns Raised	Actions	Action Owner/Deadline
Birth Centre		• Discussions were held around the intended closure of the Birth Centre due to a lack of activity.	• A strategic discussion is needed to ensure the space is used to meet the group's highest priorities, rather than being filled with non-essential features that may not serve core needs. • 17/07 – email advising that an options appraisal is being developed to consider the future of the birth centre at St George's. Considering this further discussion and engagement sessions are delayed until Sep.	Kate Slemeck, ESTH Managing Director **IN PROGRESS**
Transitional Care	• Positive feedback and praise for the Paediatric Nurse on the unit	• It was noted by the Paediatric Nurse that they often get inappropriate referrals from midwives with babies who do not meet the threshold for transitional care. More training required?	• Transition care pathway to be shared with midwives for eligibility for TC.	Laura James, Neonatal Matron **IN PROGRESS** **Deadline: End of August 2025**

Area / Theme	Positive Observations	Concerns Raised	Actions	Action Owner/Deadline
Triage	• Midwives reported that the new system was working well and an improvement over what was done pre-CQC. • Staffing levels not currently a problem.	• None noted	• **No actions**	
Fetal Medicine Unit	• New CTGs on order; a working laser stack following repair and a new laser machine awaiting configuration.	• None noted	• **No actions**	
Delivery Suite	• The Matron has started managing sickness more proactively which has led to a significant improvement on sickness rates. • Equipment checklists more consistently completed. • Drug cupboards in theatre now all have code locks in place and were locked.	• None noted	• **No actions**	
Postnatal		• Seven women waiting to go home postnatally who were medically fit for discharge but were awaiting social care input.		Resolved on the day. **COMPLETE**

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Quality Committees-in-Common: gesh Maternity Safety Champions' Report – July 2025

Appendix 2 – Issues raised and new actions agreed at the quarterly staff engagement meetings

Presented by:
Arlene Wellman
Group Chief Nurse & DIPC
31 July 2025

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Recent meetings *(since last QCiC report)*

Staff Engagement Session – 30 June 2025 – MS Teams

Issues/Concern	Actions	Lead	UPDATE
SGUH: iClip - smoking cessation audits – Saving Babies' Lives Care Bundle compliance 36wk CO2 monitor reading – we have failed for Feb & March. Since the Cerner go-live, manual audits are now needed. We are unable to evidence that we have consistently done this or evidence where all the manual data is being recorded. The impact off this will be that we do not meet the CNST standard for SBLCB #6 for Q4 or Q1.	1. We need a clear plan detailing how we will capture the audit from 1 July until we have fully transitioned to iClip (end of Sept?). 2. In parallel (i) JGK will continue to drive the Task & Finish group to ensure IT prioritises and addresses the actions related to the iClip go-live issues; (ii) Safety Champions for each area will be identified to be trained by the Digital Midwife to be able to support their areas; (iii) staff will be held to account for not documenting. This is captured in the Saving Babies' Lives action plan that has been submitted (CLW).	**Chelone Lee Wo** **Jacqueline Gabriel-King**	
SGUH: Maternity Helpline changes Proposal to change the helpline hours of operation from 8am-8pm (7 days a week) to 9am-5pm (Mon-Fri).	**For information – no action required from this group** JGK is working on an action plan looking at various pathways linked to the helpline.	**Jacqueline Gabriel-King**	Engagement with staff continues, last session with staff was 22/07/25. Aim is for changes to take effect from Sept.

Issues/Concern	Actions	Lead	UPDATE
SGUH: Birth Centre closure communications A lack of clear communication to all stakeholders about plans for the SGUH Birth Centre following the announcement of its planned closure.	A series of meetings will be scheduled, which all stakeholders will be invited to. At these meetings, future plans for the birth centre and comms to the wider teams, will be shared and discussed. Once scheduled, details will be shared with the Executive and Non-Executive Safety Champions to provide Board assurance.	**Cheryl Stewart** **Jacqueline Gabriel-King** **Hugh Byrne**	**17/07/25** – email advising that an options appraisal is being developed to consider the future of the birth centre at St George's. Considering this further discussion and engagement sessions are delayed until Sep.
ESTH: iClip challenges (1) Overcalculation of VTE risks leading to more patients than necessary being put on medication *(SGUH also had this issue and now use the paper format to enter the information)* (2) Difficulties with PODs picking up referrals and therefore patients not receiving expected referrals (3) Issues with prescriptions, particularly within Outpatient Pharmacy.	All iClip risks need to be captured with a clear plan of action to mitigate the risks and interim workarounds to be agreed whilst these issues with Cerner are being resolved. SGUH has drafted a comprehensive action plan which IT is working through. A manual workaround has been implemented for VTE calculation at SGUH and for ESTH, the VTE calculator on BadgerNet will be used instead. All delivery rooms in SGUH have visual reminders displayed of processes pre-Cerner for calculating scores, for staff to refer back to.	Director of Midwifery for both sites	**ONGOING** SGUH have identified one particular issue relating to an iClip update from April affecting MEWS scores. A meeting with IT is scheduled for 1 July to explore next steps and workarounds if necessary, until the issue is sorted. Meeting scheduled for 23/07/25 by COO

Issues/Concern	Actions	Lead	UPDATE
ESTH: Saving Babies' Lives: Diabetes and HbA1c measurements Audit undertaken for the Diabetes element – 50% of cases didn't meet the criteria so were rejected for diabetes – 50% of the cases that didn't meet the criteria had samples rejected as the lab wouldn't do HbA1c measurements if it was within two months of the last test. This is at odds with CNST's prescriptive requirements. The six-week window to get the bloods test done is being reduced to one week.	The labs have been told of the importance of these tests being completed to comply with CNST requirements. Requests will now be made as part of the 28wk blood tests to ensure none are missed.	Laura Rowe, Lead Midwife for Governance	

SGUH – Maternity Transformation Project update

Fiona Walkinshaw also gave an update on the maternity transformation project which has been restarted following a brief hiatus due to other priority events, e.g. the CQC visits. Five topics were identified, e.g. patient experience, staff experience, excellent care, etc. and a lot of work has been undertaken to collect feedback from staff. This has been displayed for staff to add to. Engagement has been excellent. The next step is for the TRI to work through all the feedback and agree a clear action plan. Further progress updates to follow.

Appendix 6

Maternity Improvement Advisor Bimonthly Progress Report

Name of Trust: St Georges, Epsom & St Helier
Date report Covers: March – April 2025
Phase: Improvement

Maternity Improvement Advisors:
Amanda Pearson – National Maternity Improvement Advisor
Susie Al Samarrai – Obstetric National Maternity Improvement Advisor

Dates of Site Visits/Meetings/Forums/1:1s

1:1 Meetings
DoM /HoM
Matrons
Regional Lead Obstetrician
Clinical Director

Meetings and Forums
Evidence Assurance Panel
Senior Leadership meeting
Consultant meeting E&SH
Triangulation meeting

Site visits
ESTH
SGH

Summary of Findings

Midwifery leadership
the midwifery leadership remains challenged due to interim DoM posts and the upcoming vacancy of the Group DoM

Governance
Governance boards have been implemented and demonstrate clear oversight of up-to-date information, learning, themes and number of incidents. Trust unsuccessful in appointing to the Group governance role and therefore site specific 8b governance leads posts are in place, this could lead The Trust should consider some overarching oversight to ensure there is a group approach to learning from incidents and sharing experiences

Obstetrics
Medical staffing remains a significant concern with a bid for a tier of SHO level doctors to be incorporated into the overnight on call rota being turned don unless the division can fund it from within their baseline. This has therefore not moved forwards.

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Appendix 6

There has been a change in leadership roles with a new Clinical Director having started early in March with a handover period and taking over fully from early April. He is very engaged with ensuring appropriate responses to the CQC actions but is also having to deal with challenges within gynaecology that are significant.

The Care Group lead for Obstetrics has only recently returned to work following a period of sickness and has not fully returned to all of his roles. Similarly, the divisional director has also been off sick, so challenges have been found within the leadership structure presently.

The fetal medicine review is ongoing with terms of reference having been agreed with the external reviewer and work underway.

Plans to appoint new obstetric governance lead as previous CD was also lead for governance and has now stepped away from both roles. No immediate interest from obstetric team but discussions underway with potential candidates.

Birthrate plus SGH
Has highlighted a positive variance of 7.54 of the total establishment when combining all roles, this is based on an uplift of 21% due to challenges with mandatory training there is consideration for Trusts to apply a 24% uplift to representative of maintaining compliance without impacting clinical activity. The report should be reviewed for the opportunities that this could provide in stretched specialist services.

Telephone triage
A QIA assessment has been undertaken to reduce the hours of the current telephone triage. Current hours are 8-8 Monday to Friday and the proposed hours are 9-5, There are communications planned for women with a go live date potentially July 2025. This change could have a significant impact on calls then coming through to the Triage area and should be closely monitored along with and delays or adverse outcomes.

CQC actions
The Trust has made considerable progress against the must do's and should do's, sustainability of changes should be tested for further assurance.
SGH – daily checks improving
ESTH – good compliance
Appraisals remains red and a drive to complete by end of July
Mandatory training remains amber for compliance with immediate adult life support red
medicines management remains amber
The DoM at SGH is reviewing all compliance parameters

Diabetic service
A review of the diabetic services has been undertaken due to capacity not currently meeting demand, an establishment review is taking place to ensure staff are in the right place to ensure the service can run effectively and that women are seen within the national KPI. Recruitment is ongoing for a band 7 lead. Currently the Trust do not use the perinatal diabetic notes and consideration could be given to adopting these to reduce duplication.

Perinatal mental health

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Appendix 6

Demand not meeting capacity and an ongoing review is taking place as to who to increase midwifery hours to support women who will need individualised care pathways.

IT – Cerner
There are ongoing challenges around the migration of data with approximately 2677 cases to be reviewed and migrated.

MNVP
Challenges to compliance for year 7,conversations ongoing with ICB to increase hours currently 2 days a month

Maternity & Neonatal improvement plan

Has now been developed for SGH, the governance framework around this still needs to be developed as to accountable SROs and action leads and where this will be monitored and updated. This should be a live document and inclusive of neonates

Next steps to review the exit criteria for both sites and benchmark against compliance

Review and Reset meeting date to be confirmed meeting to take place before the end of July

Progress against exit criteria

This will be underpinned by a Trust developed overarching quality improvement plan (Maternity & Neonatal Improvement Plan (MNIP), with realistic milestones developed as part of the improvement phase.

To review with DoMs

Newly emerging findings or additional recommendations not included in the MNIP or exit criteria and as observed/identified
[These should be included in the Trust MNIP if not an action that can be quickly resolved]

Recommendation	Trust Lead	Completion date	Progress	RAG Rating
Leadership roles JD to be reviewed and advertised	NH	31/12	Proposed structure taken to quality committee in common May 29 following discussion at Group Executive Committee	
Governance team meetings to be forwarded	NH	31/12	Not all meetings received	

Appendix 6

Guidelines to be forwarded	NH	31/12	All requested guidelines have been received	
Quad meeting invites to be forwarded	NH	31/1		
Baby abduction drill and policy to be implemented and updated	Safeguarding Lead MW	31/3	January 25 baby abduction policy awaiting ratification	
Audit of compliance for sonography KPI's	Lead sonographer	31/3	To be confirmed	
Review implementation of BSOTS	GCMidO DOMs Clinical Directors	31/3	Triage review undertaken 2/4 SGUH 24/4 ESTH Report from MIA pending	
Diabetic service capacity and demand exercise	Consultant midwife maternal Medicine	31/3	Work underway to address staffing and clinic capacity to enable the service to return to a fully functioning service	
Review concerns raised about cleanliness	Directors of Midwifery	31/3	A review occurred and monthly review meetings in place which has resulted in improvements	
Workforce review of staff with OH restrictions	Directors of Midwifery	31/3	Ongoing	
Next Planned Visits				
Further visits TBA				
MIA Support/Focus				
Workforce Reporting				

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Report distribution:

- Trust executive and maternity clinical leadership team
- Regional Chief Midwife/Regional Chief Obstetrician
- Intensive Support Director
- ICB Chief Nurse
- LMNS SRO
- LMNS Senior Midwife
- System and/or regional service user voice lead

Group Board Meeting (Public)

Meeting on Friday, 05 September 2025

Agenda Item	2.4	
Report Title	Responsible Officer Annual Report on Medical Appraisal and Revalidation	
Executive Lead(s)	Richard Jennings, Group Chief Medical Officer	
Report Author(s)	Steve Hyer - Responsible Officer ESTH Nino Geliashvili - Revalidation Officer ESTH Jenifer Loudon, Responsible Officer, ESTH Elizabeth Rhodes, Responsible Officer, SGUH	
Previously considered by	People Committees	21 August 2025
Purpose	**For Approval / Decision**	

Executive Summary

The Responsible Officer (RO) has a statutory role in medical regulation and is accountable to the Board for the local governance processes focusing on the conduct and performance of doctors. Each RO is accountable for the performance of doctors connected to the designated body for which they act. St George's currently has 1062 connected doctors (this excludes doctors in training who are connected to HEE or agency / locum doctors connected to other designated bodies.)

This paper contains the two annual reports from Epsom and St Helier, and St George's, University Hospitals. This paper was previously considered by the People Committees on 21st August 2025.

Every licensed doctor who practices medicine must revalidate through the regulator, the GMC, every 5 years to maintain a license to practice medicine. Revalidation is based on a system of annual appraisal of the whole scope of practice, based on a Good Medical Practice framework. A core responsibility of the RO is to ensure that all connected doctors have access to high quality appraisal and are supported to revalidate. As designated bodies, the Trusts are required to provide NHS England with an Annual Report on the revalidation of medical staff and the activities undertaken by the Responsible Officer (RO) over the previous year. This report should be presented to the Board and submitted to NHS England with a statement of compliance signed on behalf of the Board. The content and format of the report is largely prescribed by NHS England.

The Trust Responsible Officer's Annual report outlines progress in medical revalidation and key developments during the year 1 April 2024 to 31 March 2025. It serves as a required assurance document, approved by or on behalf of the Board.

The General Medical Council (GMC) sets the framework for medical appraisal and revalidation to:

- Ensure licensed doctors regularly demonstrate they are up to date and fit to practice.
- Support doctors' professional development, enhance patient safety and care quality, and maintain public confidence in the profession.

- Identify and remove doctors who cannot address significant professional shortfalls.
- To meet these goals, the GMC mandates that all doctors designate a body to monitor and assure their practice. Epsom and St Helier University Hospitals NHS Trust is the Designated Body for 798 doctors, whose revalidation is the focus of this report.

Following review, the Board is recommended to endorse this report, and the GCEO sign the reports for submission to NHS England.

Action required by Group Board

The Board is asked to:

a. Note the report.
b. Endorse that the GCEO signs the report for submission to NHS England.

Committee Assurance

Committee	People Committees
Level of Assurance	Reasonable Assurance: The report and discussions assured the Committee that the system of internal control is generally adequate and operating effectively but some improvements are required, and the Committee identified and understood the gaps in assurance

Implications

Group Strategic Objectives

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

Risks

The RO programme is designed to support patient safety and high quality services. A well-run RO programme will support risk mitigation in our services by supporting and maintaining high professional standards.

Key components include:

- Enhanced annual appraisal of doctors' fitness to practise
- GMC revalidation every five years confirming fitness to practise
- Pre-employment checks to ensure doctors' competence
- Raising, investigating, sharing, and addressing concerns about practice
- Supporting doctors to maintain their fitness to practise

CQC Theme

☒ Safe	☒ Effective	☐ Caring	☐ Responsive	☒ Well Led

NHS system oversight framework

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

Financial implications

The RO programme is run by a small number of designated officials at each Trust. Safe medical practices will reduce financial risks to the organisation.

Legal and / or Regulatory implications
The Responsible Officer (RO) has a statutory role in medical regulation and is accountable to the Board for the local governance processes focusing on the conduct and performance of doctors.
Equality, diversity and inclusion implications
The RO programme is focused on recruiting appraisal officers from diverse backgrounds, to adequately represent the medical professional population and support EDI principles in the profession. The Annual Reports include data on ethnicity of appraisal officers for transparency.
Environmental sustainability implications
There are none identified.

Responsible Officer Report on Medical Appraisal and Revalidation

Group Board, 05 September 2025

1.0 Purpose of paper

The purpose of this report is to provide the Group Board with timely information on the compliance of the organisation with the Medical Profession (Responsible Officer) Regulations 2010. This supplements the Annual Organisational Audit and Statement of Compliance which is submitted annually to NHSE.

2.0 Background

2.1 Prior to the Covid-19 Pandemic each Trust would make a self-assessment return to NHSE for the Annual Organisation Audit (AOA) but since the temporary pause of appraisals and associated activities in March 2020 formal returns of the AOA were also paused but at St George's the RO continued to report to assure the board on activities related to the revalidation of doctors. The AOA is now reinstated but quarterly reporting is not.

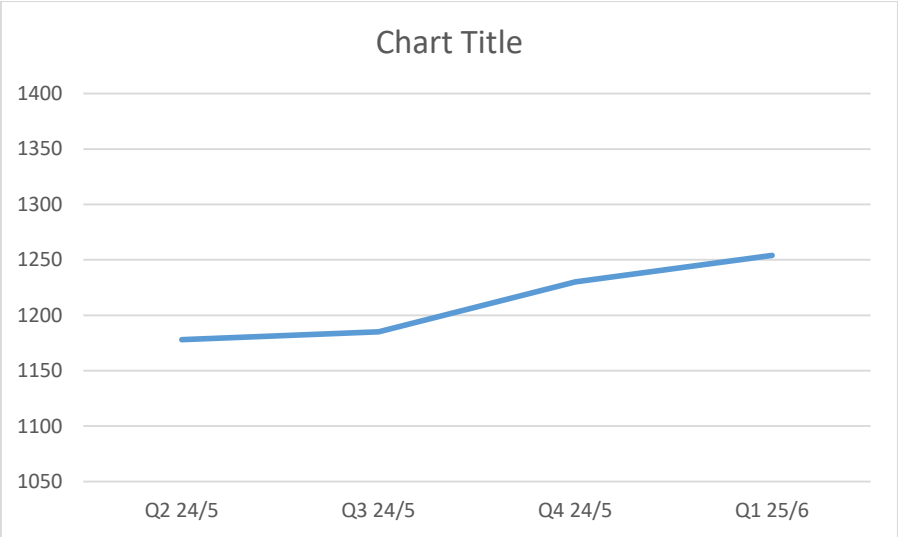
2.2 Attached is the designated body annual board report for each Trust within the gesh Group, which summarises the key requirements for compliance with regulations and key national guidance enabling us to demonstrate not only basic compliance but areas of improvement and identify actions required.

3.0 St George's University Hospital Annual Report

Q4 Update SGUH

3.1 Number of doctors connected and compliance with appraisal

There were 1254 doctors connected to St George's on the 30th June 2025. This number has remained relatively stable over the last year.



The compliance rate for appraisals has dropped to just below 90% in all divisions (compared to all being >90% at the end of 2024/5. The number of doctors now more than 6 months overdue has remained rather stable in Q1 compared to Q4 (numbers in brackets). 29 doctors are now 6 months overdue compared to 25 last quarter. For one doctor we have updated the GMC regarding their non engagement with the process which has now improved. 3 doctors have been given warnings of concern and have engaged and completed their appraisal. The three large clinical divisions continue to have similar compliance rates overall and in general there has been an improvement over the last 6 months.

Q1 01-04-2025 to 30-06-2025								
Divisions	Due	Held	Not held	Reason Accepted	Reason Not Accepted	>6 months	Total	Appraisal Compliance Rate
CWTD	95	52	43	4	39	6 (5)	351	88.89%
Community Services	0	0	0	0	0	0	1	100.00%
Corporate	2	2	0	0	0	0	4	100.00%
MedCard	109	55	54	3	51	10 (11)	453	88.74%
SNCT	93	45	48	4	44	12 (8)	417	89.45%
SWLP	9	5	4	0	4	1 (1)	28	85.71%
Total	308	159	149	11	138	29	1254	89.00%

Compliance rates per clinical division over the last year {Q3 data disrupted}

	Q1 2024/5	Q2 2024/5	Q3 2024/5	Q4 2024/5	Q1 2025/6
CWTD	92	95		93	89
Med Card	84	83		93	89
SNCT	90	88		92	89

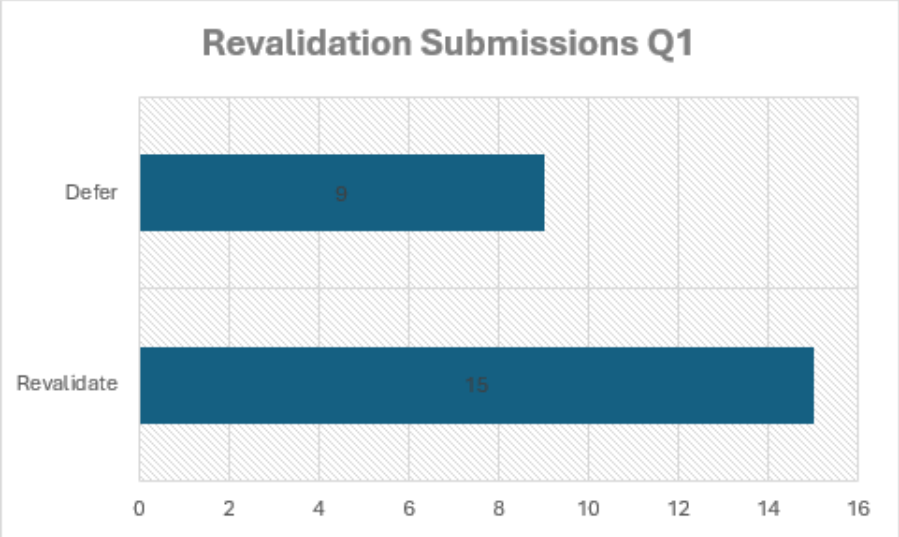
Looking at compliance data by employment status (see table below) at SGUH we see, not unexpectedly, that completing appraisal continues to be more challenging for doctors on our bank system. We are aware of the challenge in overseeing bank doctors and are working with medical staffing and departments with large numbers of bank doctors to improve this and are hoping that recent appraisal training will also help with this metric. We will monitor the SAS rates and look seek to support further if no improvement in the next quarter. Our appraisal rate for locally employed doctors has now dipped below 90% so we will need to monitor that as we know this is a particularly vulnerable group of doctors and work continues with care group leads, resident doctor leads and our tutor for locally employed doctors and SAS doctors.

Grades	**Due**	**Held**	**Not held**	**Reason Accepted**	**Reason Not Accepted/Not Known**	**>6 months**	**Total**	**Appraisal Compliance Rate**
Academic Consultant	8	5	3	0	3	0	41	92.68%
Bank Doctor	20	11	9	0	9	3	57	84.21%
Consultant	124	58	66	5	61	14	639	90.45%
Honorary	9	6	3	0	3	0	37	91.89%
Locum Consultant	29	15	14	2	12	1	85	85.88%
SAS	10	5	5	1	4	2	41	90.24%
Locally Employed Doctors	108	59	49	3	46	9	354	87.01%
Total	308	159	149	11	138	29	1254	89.00%

3.2 GMC Recommendations at time of revalidation decision

In Q1 we recommended 15 doctors for revalidation and deferred 9 doctors: a revalidation rate of 63% which is a significant drop from the 91% last quarter. This is all for insufficient evidence.

We have one doctor at risk of non-revalidation in the next 6 months due to difficulties with engagement. They are being supported by a wide range of people.

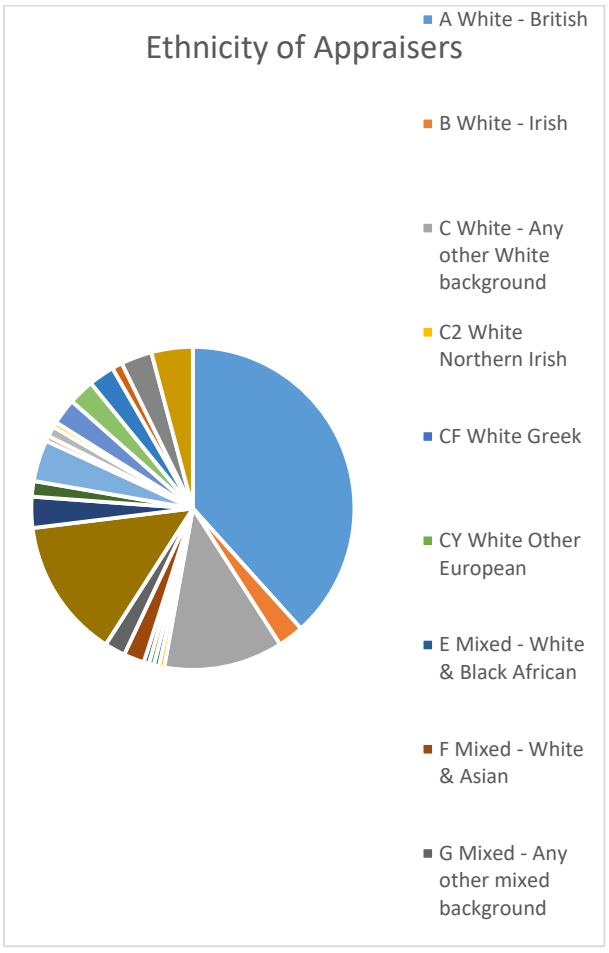


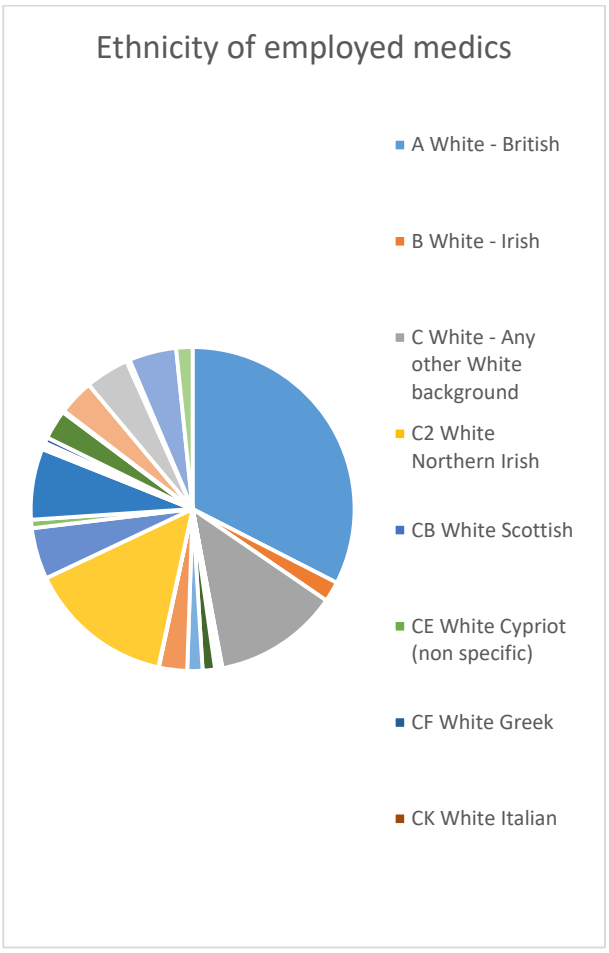
3.3 Governance of Appraisal process

- Number of appraisers

At SGUH we now have 193 trained appraisers - an increase since last quarter as new appraiser training was run in internally in July (Q2) and a session for ED Consultants. This includes 24 appraisers who do LED only appraisals. In addition to 1254 connections, we also appraise dentists (12 - don't revalidate), Military doctors (2 - don't connect but have appraisal through us) and appraise doctors at RHN (7) who we have an arrangement to appraise. This gives us an approximate 1:7 ratio and we plan to run further appraisal training.

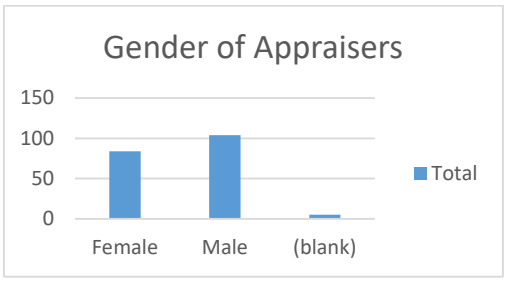
- Quality process
    - ASPAT (Audit assessment) : data awaited
- Demographic breakdown of appraisers –

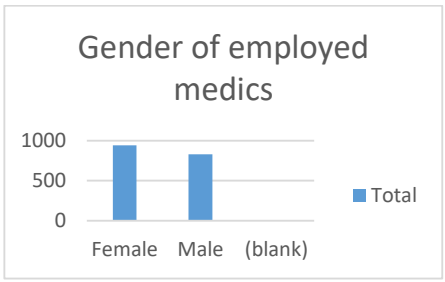




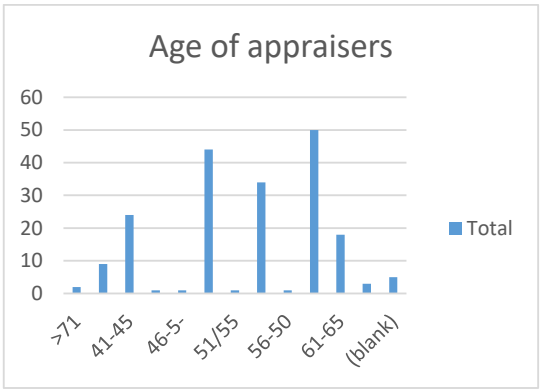
	No – appraisers	% - appraisers	No – employed medics	%- employed medics
A White - British	74	38	578	33
B White - Irish	5	3	36	2
C White - Any other White background	23	12	222	12
C2 White Northern Irish	1	0.5	1	0.05
CB White Scottish	0	0	1	0.05
CE White Cypriot	0	0	1	0.05
CF White Greek	1	0.5	1	0.05
CK White Italian	0	0	3	0.2
CP White Police	0	0	2	0.1
CY White Other European	1	0.5	1	0.05
D Mixed – White & Black Caribbean	0	0	2	0.1
E Mixed - White & Black African	1	0.5	22	1.2
F Mixed - White & Asian	4	2	27	1.5
G Mixed - Any other mixed background	4	2	50	3
GC Mixed – Black and White	0	0	1	0.05
H Asian or Asian British - Indian	27	14	259	15
J Asian or Asian British - Pakistani	6	3	91	5
K Asian or Asian British - Bangladeshi	3	1.5	15	0.8
L Asian or Asian British - Any other Asian background	8	4	126	7
LE Asian Sri Lankan	1	0.5	4	0.2
LH Asian British	0	0	3	0.2
LK Asian Unspecified	2	1	5	0.28
M Black or Black British - Caribbean	1	0.5	10	0.6
N Black or Black British - African	5	2.5	52	3
P Black or Black British – Any other Black background	0	0	3	0.2
R Chinese	5	2.5	63	3.5
S Any Other Ethnic Group	5	2.5	78	4.4
SE Other Specified	2	1	6	0.3
Z Not Stated	6	3	84	4.7
(blank)	8	4	29	1.6
	193		1777	

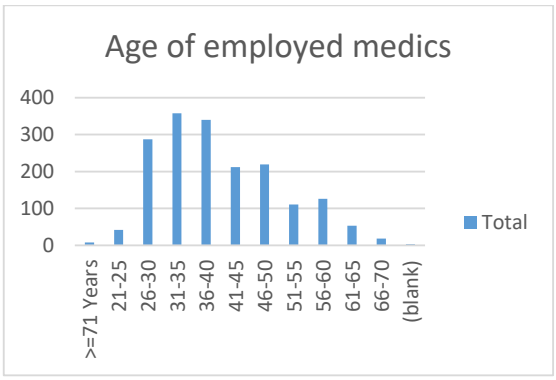
In the 7 ethnic groups where we have 50 or more doctors employed identified we are slightly overrepresented in white British doctors and mildly underrepresented in the other 6 groups





We have more male appraisers trained considering we employ more female doctors





We have an older group of appraisers compared with the age shape of our employed medics which fits with the practice that appraising is from our senior medical body.

- Engagement with appraisers

We continue to hold quarterly appraiser fora for discussion and ongoing learning and updates. The last two were held on 22nd May and 30th June. Topics covered have included the role of AI in appraisal process, quality assessment of appraisal and the Paterson Inquiry with relation to appraisals.

- Engagement with divisions / operational teams

Our engagement with divisional and operational teams are key to reduce the number of overdue appraisals due to logistical and operational teams. Our Appraisal and Revalidation Advisor emails each clinical lead monthly with a breakdown of their departments appraisal status.

Action Plan for SGUH

- Improve attendance at appraiser forum - continue to monitor attendance and review if no/low attendance means lower ASPAT scores and vice versa. To reach out to appraisers who do not attend to ask how they will demonstrate their CPD for their role as a medical appraiser.
- Embed Appraisal Team / RO attendance regularly if infrequently to divisional meetings
- Ensure we are working towards availability of data on doctor demographics (protected characteristics) for doctors who are overdue appraisal or being deferred for revalidation. Also to ensure we have the same data available with respect to our appraiser team to ensure our appraiser body reflects the appraisee demographics.
- Work with medical staffing on best way to support and oversee appraisals for bank doctors.

1.0 Epsom and St Helier University Hospital Annual Report 01 April 2024- 31 March 2025

1.1 This tenth annual report from the Responsible Officer to the Board provides an overview of the Trust's recruitment, performance, revalidation and appraisal processes in relation to medical staff working at the Trust as required by NHS England.

1.2 The report comments on the Trusts compliance during 2024/25, current challenges and actions required during the next 12 months.

2 Governance

2.1 Dr. Steve Hyer was appointed Responsible Officer by the Trust Board on 1 September 2019, supported by a Revalidation Officer managing 798 doctors through appraisal and revalidation.

2.2 Progress and compliance are overseen by:

- A well-established Appraiser Group
- Weekly compliance meetings addressing overdue appraisals
- NHS England's review of the AOA format; a new self-assessment tool for Designated Bodies will be introduced for 2024/25
- Comprehensive appraisal data dashboards within SARD for review and improvement
- Formal appraisal quality audits via the ASPAT tool on SARD

3 Context

3.1 The number of doctors connected to ESTH rose to 798 in 2024/25, with increasing numbers of Locally Employed and overseas doctors.

3.2 The Trust continued providing external Responsible Officer services for a local hospice, overseeing their medical appraisal and revalidation governance.

4 Revalidation and Medical Appraisal Update Appraisal 2022 Format

4.1 Appraisals continued throughout this reporting period, with appraisers and appraisees embracing the 'Appraisal 2020' format. The introduction of the updated Medical Appraisal 2022 format, which builds upon the previous version, meets revalidation requirements and places greater emphasis on wellbeing while reducing pre-appraisal paperwork.

4.2 Doctors were advised to focus on reflecting and discussing relevant information during their appraisals, avoiding unnecessary administrative tasks to gather additional documentation. The aim has been to make appraisals as supportive and developmental as possible, encouraging doctors to engage in a constructive and challenging dialogue during their appraisal meetings.

4.3 The Revalidation team has successfully collaborated with the SARD team to implement SARD version 7, which fully integrates the Medical Appraisal 2022 format alongside the MAG 4.2 form.

4.4 Appraisal meetings are encouraged to be held virtually via MS Teams or Zoom, as well as through traditional in-person sessions where feasible. This flexibility has enabled appraisals to proceed within socially distanced settings and increased participation among doctors who work across multiple sites or have schedules that make in-person meetings challenging to arrange.

5 GMC Connect

5.1 GMC Connect is the General Medical Council's database used by Designated Bodies to manage doctors with a prescribed connection to their organisation.

5.2 At the Trust, Connect is maintained by the Revalidation Officer on behalf of the Responsible Officer. It is primarily updated using real-time data from the Electronic Staff Record (ESR), which tracks starters and leavers.

5.3 Doctors can also add themselves directly to Connect. Doctors are advised not to establish a connection until their first working day at the Trust.

6 Policy and Guidance

6.1 The Medical Appraisal and Revalidation Policy is reviewed regularly in line with the Good Medical Practice 2024 guidelines.

7 Revalidation

7.1 The GMC recognises the ongoing pressures on the profession and health services due to the cost-of- living crisis, recent doctor strike actions, and work pressures.

7.2 To better support doctors in preparing for revalidation, the GMC has extended the routine notice period from four to twelve months. This allows Responsible Officers greater flexibility to submit revalidation recommendations up to 12 months in advance, helping doctors to revalidate when ready.

7.3 The Trust has maintained strong revalidation submission rates during this period. Of 177 scheduled revalidations, 165 were submitted, with 12 deferred - mainly due to doctors practicing abroad, maternity leave, work pressures, or needing more time to gather evidence.

8 Appraisal Lead

8.1 The Trust currently has no Appraisal Lead role, having adopted a new model to ensure timely appraisals and maximize completion rates. Responsibility is shared between the Responsible Officer's (RO), Revalidation Officer and divisional Clinical Directors. The RO manages appraisers, reviews appraisal summaries, and oversees appraiser training with the Revalidation Officer. Clinical Directors ensure doctors under their supervision complete appraisals and have adequate time and resources.

8.2 Plans are in place to evaluate this in the future through the introduction of dedicated Appraisal Lead roles, assessing how these would work alongside Clinical Directors.

8.3 Appraisers

8.4 The Trust acknowledges the importance of recruiting and retaining skilled appraisers, with recruitment ongoing. The quarterly Appraiser and Revalidation Forum supports knowledge and experience sharing.

8.5 Appraiser training through MIAD has continued over the past year, delivered via webinars for new appraisers and mandatory online refresher training for existing appraisers. Currently, there are 124 trained cross-speciality appraisers.

9 Risks and Issues

9.1 The appraisal due date was extended to support doctors affected by increased work pressures during last year's strike actions.

9.2 Each doctor should have at least 1 SPA to gather evidence for appraisal, covering activities such as CPD, audit, PDP, and grand rounds. Appraisers also use 1 SPA per appraisal. Appraisers conduct between 5 and 15 appraisals

9.3 Appraiser capacity remains the biggest risk to the appraisal process, with recruitment and retention challenges as many appraisers approach retirement. Efforts are underway to recruit more appraisers, focusing on increasing diversity.

10 Performance

10.1 Feedback from appraisals completed between April 1, 2023, and March 31, 2024, indicates overall success in providing supportive, timely appraisals, supported by an enthusiastic team of appraisers.

10.2 Following GMC guidance, we have remained flexible with appraisal extensions, allowing doctors necessary time to re-engage amid ongoing work pressures.

10.3 Quality assurance audits were conducted using the national Appraisal Summary and PDP Audit Tool (ASPAT).

10.4 Collecting patient feedback remains challenging in some areas, but doctors receive advice and support as needed. Communication with the GMC regarding concerns has continued, with ongoing efforts to strengthen processes for reflecting on complaints and serious incidents, including identifying themes for further analysis.

10.5 The Trust monitors doctors' fitness to practise through existing routine systems, including:

- Mortality and morbidity reviews
- Clinical governance forums and specialty meetings
- Participation in national and local audits
- Quality improvement activities

Clinical Directors are responsible for identifying and managing performance concerns, escalating serious issues as necessary.

11 Supporting our doctors

11.1 The Responsible Officer (RO) and Revalidation Officer are available to address doctors' concerns. Regular SARD training sessions encourage engagement with appraisal and revalidation. Additional support strategies include:

11.2 Virtual appraisal meetings to accommodate doctors working across sites

11.3 A responsive revalidation officer providing short-notice support

11.4 A mentoring scheme available to all doctors, regardless of grade or specialty Junior Doctor Strike:

11.5 Due to strike-related work pressures, appraisal deadlines were extended to allow appraisers sufficient time to prepare for disrupted appraisal meetings.

12 BAME

12.1 The Trust has an active ethnic minority group that includes doctors. The group provides a safe space for staff to raise concerns about issues or discriminatory practices and facilitates signposting to the appropriate departments.

13 Appraisal toolkit

13.1 The web-based appraisal toolkit, SARD, has been in use across the Trust for 54 months and is well received by users. Communication with the SARD team remains strong, leading to several agreed system improvements, including the addition of the Appraisal Summary and PDP Audit Tool (ASPAT) and guidance notes to support appraisers in writing appraisal summaries.

14 Quality Assurance Measures

14.1 Current and planned quality assurance measures include:

- Appraisee feedback on the appraisal process and appraiser
- Use of the ASPAT quality assurance tool
- Formal appraiser recruitment process
- Quarterly appraiser meetings
- Weekly revalidation meetings between the Revalidation Officer and Responsible Officer
- Online refresher training for medical appraisers
- RO participation in NHS England appraisal networking events

15 Raising and Investigating Concerns about Doctors

15.1 Concerns about a doctor's fitness to practise should be addressed promptly and not arise through appraisal or revalidation.

15.2 Common sources of concerns include colleague queries, critical incidents (e.g., Never Events), patient complaints, and coroner's inquests. These concerns are reviewed by Medical Workforce, which includes Joint Medical Directors, the Responsible Officer, Head of Medical Workforce, and Director of People.

15.3 When clinical practice restrictions are necessary for patient safety, Responsible Officers communicate directly with their counterparts at other clinical sites where the doctor works.

15.4 The GMC is notified of concerns meeting their investigation thresholds. The Responsible Officer meets quarterly with the GMC Employer Liaison Officer to discuss such matters.

15.5 The table below highlights significant progress in addressing complaints, reflected by a steady reduction in numbers since 2021, with Trust averages provided for comparison.

FTP Summary *(Based on incident location by complaint received year)*
Showing data for your selected organisation

	2021	2022	2023	2024	2025
Enquiries	**10**	**18**	**17**	**22**	**9**
Complaints	**9**	**16**	**16**	**19**	**8**
Investigations	**0**	**2**	**3**	**0**	**0**
Still Open	0	0	1	0	0
Closed without a Hearing	**0**	**1**	**2**	**0**	**0**
No Action	0	0	2	0	0
Advice	0	1	0	0	0
Warning	0	0	0	0	0
Undertakings	0	0	0	0	0
Closed at Hearing	**0**	**1**	**0**	**0**	**0**
No Action	0	0	0	0	0
Warning	0	0	0	0	0
Undertakings	0	0	0	0	0
Conditions	0	0	0	0	0
Suspension	0	1	0	0	0
Erased	0	0	0	0	0

16 Risk and Mitigations in Raising and Investigating Concerns

16.1 The Maintaining High Professional Standards (MHPS) guidance is often seen as cumbersome and legalistic, leading to prolonged investigations that can take over a year to resolve, delaying rapid problem resolution.

17 Remediation

17.1 Most doctors who make errors can be supported to return to good practice through retraining or behavioural coaching. As Responsible Officer, Dr. Hyer works closely with the Senior Advisor at NHS Resolution for appropriate guidance.

18 Recruitment and Engagement Background Checks

18.1 All doctors employed by the Trust, including locums, undergo mandatory NHS pre-employment checks. Since April 2014, the GMC requires Trusts to ensure doctors have sufficient English language proficiency for safe practice, which is verified during recruitment.

19 Forward Look

19.1 Future priorities include maintaining and enhancing wellbeing support for doctors by ensuring they:

- Are informed of their GMC connection and appraisal/revalidation requirements
- Work in environments with adequate support and facilities to safely deliver care, including time and resources for training, education, and CPD reflection
- Have access to mentoring, especially for new consultants, ethnic minority doctors, locally employed doctors, and those facing difficulties

20 Conclusion

20.1 Despite pressures from austerity and doctors' strikes, good progress has been made in peer networking, appraiser recruitment and retention, ongoing quality improvement, up-to-date appraiser training, and improved appraisal engagement.

21 Recommendations

21.1 Board members are asked to:

- Note the report
- Endorse that the GCEO signs the report for submission to NHS England.

Group Board

Meeting on Friday, 05 September 2025

Agenda Item	3.1	
Report Title	**Report from Finance and Performance Committee**	
Executive Lead(s)	Andrew Grimshaw, Group Chief Finance Officer	
Report Author(s)	Ann Beasley, Committee Chair	
Previously considered by	n/a	-
Purpose	**For Assurance**	

Executive Summary

This report sets out the key issues considered by the Finance and Performance Committee at its meetings in August 2025 and sets out the matters the Committee wishes to bring to the attention of the Board.

This Assurance rating of Limited reflects the current financial risk at the Trusts.

Action required by Group Board

The Board is asked to:

a) Note the paper

Committee Assurance	
Committee	Finance and Performance Committees
Level of Assurance	Limited Assurance: The report and discussions did not provide sufficient assurance that whilst the system of internal control is adequate and operating effectively, significant improvements are required to deliver the current financial deficit plan.

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

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

Finance and Performance Committee Report
Group Board, 05 September 2025

1.0 Purpose of paper

1.1 This report sets out the key issues considered by the Finance and Performance Committee at its meetings in August and sets out the matters the Committee wishes to bring to the attention of the Board.

2.0 Background

2.1 At its meetings on 1st August and 29th August 2025, the Committee considered the following items of business:

1st August 2025	29th August 2025
PUBLIC MEETING • GCFO briefing • FRB update • Finance Performance M3 • Forecast, Risks and Mitigations • CIP update M3 • Cash update • Costing update • Productivity update • SWL Procurement partnership update	**PUBLIC MEETING** • GCFO briefing • Integrated Finance report M4* • FRB update and forecast* • Productivity update • NHSE Strengthening Financial Management • IQPR • Policies update

**items marked with an asterisk are on the Group Board agenda as stand alone items in September 2025*

2.2 The Committee was quorate for both meetings.

4.0 Sources of Assurance

4.1

a) Financial Performance M4

Both trusts have reported being on plan at month 4. As in previous months, additional non-recurrent benefit has been added to help support that position. At ESTH this is £1.5m and SGH YTD £8.2m. This brings forward other planned benefits and means the challenge for later in the year increases. Committee members noted the particular challenge at SGH, and executive colleagues noted the importance of good communication in key changes of service provision.

b) FRB discussion

Committee members focussed on the rapid action that needs to be taken to deliver the financial plan, and that all efforts need to go into this. It was noted the DCEO has the role of internal turnaround director, who would provide challenge but also have the long term future of the Group as part of decision making.

c) Productivity update

The Committee noted the update and how productivity would come under more scrutiny in the new financial management environment.

d) Costing

The committee noted the latest costing update.

e) IQPR

Operational colleagues updated on some of the key challenges and successes in operational performance. They noted the trajectory of elective performance and some of the key tenets that would be part of the winter plan discussion next month.

f) Group Policy update

The Committee noted the update and **approved the extensions to the following policies:**

- **SGH Petty Cash**
- **SGH Business Expenses**
- **SGH Treasury Management**
- **SGH Asset Valuation**

4.2 During this period, the Committee also received the following reports:

a) SWL Procurement Partnership report

The Committee noted the update from SWLPP

b) SWL Pathology report

The Committee noted the update from SWLP

5.0 Implications

5.1 The Committee has suggested no changes to the BAF operational-related risk SR 8 – Reducing Waiting Times and recommended no changes to the score of ‘20’ and limited assurance. The target for the year end remains ‘15’ and Reasonable assurance.

5.2 The Committee has suggested no changes to the BAF finance risk SR4 - Achieving financial sustainability and recommended no changes to the score of ‘25’ and limited assurance. The target for the year end remains ‘20’ and Reasonable assurance.

6.0 Recommendations

6.1 The Group Board is asked make decisions as requested above and to note the issues escalated to the Board and the wider issues on which the Committee received assurance in August 2025.

Group Board

Meeting on Friday, 05 September 2025

Agenda Item	3.2	
Report Title	**Integrated Finance Report M4**	
Executive Lead(s)	Andrew Grimshaw, GCFO	
Report Author(s)	GCFO, SCFOs	
Previously considered by	n/a	-
Purpose	**For Review**	

Executive Summary

- Both organisations remain on plan at M4
- While the trusts remain on plan at month 4 there is material pressure on the year end forecast. The Group executive remains committed to work to deliver the financial plan as agreed but recognises there are material challenges in achieving that. The Finance Committee reinforced the need to work towards that and asked for assurance on plans at its next meeting

Action required by Group Board

The Board is asked to:

a) Note the paper

Appendices

Appendix No.	Appendix Name
Appendix 1	M4 Full Report

Implications

Group Strategic Objectives

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

Risks

[Set out summary of risk and state link to Board Assurance Framework]

CQC Theme

☐ Safe	☒ Effective	☐ Caring	☐ Responsive	☒ Well Led

NHS system oversight framework

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

Financial implications
[Provide summary of financial implications of the paper]
Legal and / or Regulatory implications
[Provide summary of the legal and regulatory implications of the paper]
Equality, diversity and inclusion implications
[Provide summary of the EDI implications of the paper]
Environmental sustainability implications
[Provide summary of the environmental sustainability implications of the paper]

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

Group Board-in-Common - Public
05th September 2025

Integrated Finance Report M4

GCFO



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

ESH – Executive Summary

gesh

Performance	YTD Plan £'000s	Actual £'000s	Variance £'000s	Annual Plan £'000s	Forecast £'000s	Variance £'000s
Income	241,366	241,439	-73 F	733,034	733,034	0
Total Pay	**-168,246**	**-168,103**	**-143 F**	**-493,469**	**-493,469**	**0**
Non-Pay	-84,242	-84,451	209 A	-238,237	-238,157	80 A
Non Operating Items	-1,845	-1,853	7 A	-7,028	-7,108	-80 F
Performance Target	**-12,968**	**-12,968**	**0 A**	**-5,700**	**-5,700**	**0**

Pay	YTD Plan £'000s	Actual £'000s	Variance £'000s	Annual Plan £'000s	Forecast £'000s	Variance £'000s
Substantive	-146,772	-144,847	-1,925 F	-437,575	-437,575	0
Bank	-17,667	-20,371	2,704 A	-47,298	-47,298	0
Agency	-3,093	-2,389	-704 F	-6,449	-6,449	0
All Other Pay	-715	-496	-219 F	-2,147	-2,147	0
Total	**-168,247**	**-168,103**	**-144 F**	**-493,469**	**-493,469**	**0**

Workforce	YTD Plan WTE	Actual WTE	Variance WTE	Closing Plan WTE
Substantive	6,370	6,404	-34 A	6,377
Bank	709	919	-210 A	897
Agency	64	82	-18 A	76
Total	**7,143**	**7,405**	**-262 A**	**7,349**

Key Metrics		Plan	Actual	Variance
Bed Number	**No**	**568**	**614**	**-46 A**

Summary financial position

- While the trust remain on plan at month 4 there is material pressure on the year end forecast. The Group executive remains committed to work to deliver the financial plan as agreed but recognises there are material challenges in achieving that. The Finance Committee reinforced the need to work towards that and asked for assurance on plans at its next meeting

Income

- Income overall is in line with plan M4 YTD and forecast. EPR 'go live' has impacted productivity in excess of plan resulting in ERF activity below plan by £3.1m. The position assumes this financial risk will be mitigated by recovery of activity, ERF being blocked and paid in line with plan, or ERF being paid in line with RTT performance.

Non pay

- Non pay overall is £209k adverse to plan YTD but with an overspend of £1.5m in non pay relating to EPR offset by underspend in clinical supplies. More work is required to understand the nature of the clinical supplies underspend and if this is related to activity, price or lower inflation than plan.

Pay and workforce

- Trust is 262 WTE adverse to plan, 18 adverse M3. This is driven by plan movement of 182 bank WTE CIP reduction not delivered (ESTH CIP WTE reduction targeted bank and agency and very little substantive reduction) and actual of 31 WTE adverse relating to cover for Industrial action and 40 WTE increase across all staff groups.
- Pay overall £ is reported £144k favourable to plan which does not triangulate to the adverse position on WTE due to use of above plan £1.5m of non recurrent pay balance sheet above plan reported in substantive pay.
- £2.7m adverse position on bank £ largely triangulates with the WTE variance but c. £0.5m is a plan error between substantive and bank planned £. This is being reviewed.

Other key metrics

- G&A beds M4 are 614 compared to 568 plan. The plan included a reduction in 48 G&A beds for M4 based on closing one ward on each site. Site reconfiguration plans are in progress but there are changes to plans and slippage following QIA. Bed reductions are now planned to start in M6. The adverse position is expected to continue in M5.

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

SGH – Executive Summary

gesh

Jul-25

Performance	Plan £'000s	Actual £'000s	Variance £'000s	Plan £'000s	Forecast £'000s	Variance £'000s
Income	425,741	425,456	-285	1,282,094	1,282,094	0
Total Pay	-271,400	-275,201	-3,801	-793,756	-793,756	0
Non-Pay	-161,417	-157,434	3,983	-467,624	-467,624	0
Non Operating Items	-6,954	-6,851	103	-20,714	-20,714	0
Performance Target	**-14,030**	**-14,030**	**0**	**0**	**0**	**0**

Workforce YTD	Plan £'000s	Actual £'000s	Variance £'000s	Plan £'000s	Forecast £'000s	Variance £'000s
Substantive	-247,200	-253,760	-6,560	-722,693	-725,693	-3,000
Bank	-18,952	-18,140	812	-55,566	-55,566	0
Agency	-4,180	-2,234	1,946	-12,297	-9,297	3,000
Other Pay	-1,068	-1,067	1	-3,200	-3,200	0
Total	**-271,400**	**-275,201**	**-3,801**	**-793,756**	**-793,756**	**0**

Workforce	Plan WTE	Actual WTE	Variance WTE	Closing plan WTE
Substantive	9,622	9,984	-362	9,691
Bank	645	755	-110	739
Agency	58	82	-24	58
Total	**10,325**	**10,822**	**-497**	**10,488**

Key Metrics	Plan	Actual	Variance
Bed Numbers	**797**	**797**	**0**

Summary financial position

- While the trust remain on plan at month 4 there is material pressure on the year end forecast. The Group executive remains committed to work to deliver the financial plan as agreed but recognises there are material challenges in achieving that. The Finance Committee reinforced the need to work towards that and asked for assurance on plans at its next meeting

Income

- Income overall is in line with plan M4 YTD and forecast. ERF activity is ahead of plan by £1.1m year to date went looked at on a cost and volume basis. This over-performance is inclusive of an estimated impact of lost activity due to strike action. The position assumes this ERF being blocked and paid in line with plan limiting the opportunity.

Non pay

- Non pay overall is £3.9m favourable to plan YTD due to use of above plan non recurrent non-pay balance sheet reported in non-pay.
- Underlying pressure in consumables linked to specialities such as cardiology and neurosciences offset this with work underway to understand the nature of and how much is related to a change in clinical activity.

Pay and workforce

- Trust is 497 WTE adverse to plan, 55 adverse M3. This is driven by plan movement of 425 WTE CIP reduction not delivered.
- Pay overall £ is reported £3.8m adverse to plan which triangulate to the adverse position on WTE.
- Bank and Agency reductions have been positive with c30% reduction in usage from the start of the year, the key issues remains on the substantive workforce with the majority of the variance linked to how CIP is being delivered.

Other key metrics

- G&A beds M4 are on plan at 797. The planned reduction of 83 G&A beds has been actioned and is in delivery. Focus now on winter planning and making sure there are plans to keep this capacity closed over the more pressured period.

Group Board Meeting (Public)

Meeting on Friday, 05 September 2025

Agenda Item	3.3	
Report Title	**Group Integrated Quality & Performance Report (IQPR)**	
Executive Lead(s)	Michael Pantlin, Group Deputy Chief Executive Officer	
Report Author(s)	Michael Pantlin, Ed Nkrumah	
Previously considered by	Finance and Performance Committee	29 August 2025
Purpose	**For Review**	

Executive Summary

This report provides an overview of the key operational and quality performance information, and improvement actions across St George's Hospitals (SGUH), Epsom and St Helier Hospitals (ESTH), and Integrated Care (IC) sites, based on the latest available data.

The executive summaries in the report highlight successes achieved throughout the month and challenges affecting quality, safety, and operation performance for each Trust.

The overall picture provided illustrates the challenge to improve access to safe care for patients while achieving substantial cost reductions. Whilst emergency department attendance trends have remained broadly stable, the key challenge lies in directing patients to appropriate care settings and managing capacity effectively.

Given the financial recovery challenge, the Trusts initially proposed maintaining RTT performance at 2024/25 levels to reduce Waiting List Initiative spend and meet the requirements of a balanced plan. In response to NHSE's request to reconsider its position and explore improvement options, the Group Executive approved revised RTT trajectories—submitted on 15 July—to align with national ask of 5% improvement against referral to treatment waiting times and also reviewed and endorsed the high-level actions (relating largely to outpatients transformation) required to deliver the plan and noted the associated risks. The IQPR has been updated to reflect the revised trajectories – 68% for SGUH and 70% for ESTH by March 2026.

In elective care, validation of the waiting list is helping improve data quality and enabling more accurate service planning. RTT Performance at both Trusts was maintained through June 2025 with long waits seeing early stabilisation reflecting a deceleration in growth compared to previous months. SGUH continuing to exceed planned levels for first outpatient waits, with an ongoing increase in the number of patients converted to Patient Initiated Follow Ups (PIFU). At ESTH, there are a number of data quality issues impacting the size of the PTL and a plan to validate the waiting list is being worked through along with a focus on increasing activity and productivity as teams get used to the new system. Patient satisfaction with outpatient services remains high at over 95% with further work needed to realise the further productivity benefits – including reducing follow-up rates and missed appointments (or Did Not Attend rates).

Performance against urgent and emergency care (UEC) measures remains variable, with SGUH maintaining a compliant position against the 4-hour target (78%) and ESTH tracking below trajectory at 74.2%. UEC transformation remains a key priority for gesh, with several initiatives underway to improve flow, reduce 12-hour waits—which remain high at both Trusts—and enhance patient experience towards the 90% positive response target. SGH has delivered the ask of 83 beds being closed whilst maintaining average length of stay reduction including the number of super stranded patients (those with a length of stay exceeding 21 days). emergency department waiting times at ESTH improved in the month of July 2025, reporting 74.2% versus 65.4% in June 2025, linked to improvements to the emergency department workflows, improvements in flow, and rectifying data quality issues. Urgent community response teams and virtual wards are key enablers of the improvement programme. Sustained progress depends on continued collaboration with local partners.

A key success in this reporting period, in relation to quality and effectiveness of care, is improved mortality performance as measured by the Summary Hospital-level Mortality Indicator (SHMI). SGUH improved to a ratio of 0.86, placing the Trust in the 'better than expected' range. ESTH moved from the 'higher than expected' range to 'as expected' after a prolonged period of elevated rates which was partly attributable to a change in reporting. Mortality performance will continue to be closely monitored. In addition, both sites achieved 100% complaints acknowledging all complaints received within 3 working days of receipt.

Technology is also worth highlighting, ESTH's EPR stabilisation, following its May 2025 rollout, marks a major digital shift across the Group. While long-term benefits include improved care delivery and the example of improving VTE risk assessments post-stabilisation is provided in the report as a priority. Staff have adapted to the changes admirably and the leadership and responsiveness of the programme team are also worthy of recognition. In the short term, however, the implementation of the new EPR continues to adversely impact data quality, reporting, and performance. Actions underway to resolve these issues are referenced in the report.

Keeping with our people, we continue to see high retention of staff but challenges with sickness absence. A focus on sickness prevention is underway as part of a wide range of measures to improve attendance and the benefits this has for care and team morale.

The format and content of this report will continue to evolve throughout 2025/26 to reflect both national and local priorities. This includes alignment with the recently published NHS Oversight Framework, which sets out NHS England's approach to assessing provider performance. Under this framework, providers are segmented from Segment 1 (high performing) to Segment 4 (low performing), based on delivery against a defined set of national priorities. A financial override is applied, meaning that organisations in deficit or receiving deficit support cannot be rated better than Segment 3. A fifth category, Segment 5, is reserved for the most challenged organisations requiring intensive support through the *Provider Improvement Programme*. NHS England will also introduce a *Provider Capability Assessment*, which will be conducted alongside segmentation to inform the national oversight response. The IQPR has been updated to incorporate the focus metrics outlined in the framework. Further detail on the assessment process and indicative segmentation scores will be provided in next month's report.
The data in the IQPR is presented using statistical process control with benchmarking information where available. The data quality status of metrics is also noted in the reported.

Action required by Group Board

The Board is asked to note this paper.

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

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

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

gesh

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

Group Integrated Quality & Performance Report

July 2025

Outstanding Care, Together: Our strategy 2023 to 2028

Publication Date: 29th August 2025| Contact: gesh.performance@stgeorges.nhs.uk

gesh CARE Board: Board Level Improvement Priorities for 2025/26

C **Collaboration & Partnership:** Work with other teams to reduce delays in patient journeys through our services

A **Affordable healthcare, fit for the future:** Live within our means: innovating, working more efficiently and cutting costs

R **Right care, right place, right time:** Keep our patients safe – including those waiting for our care

E **Empowered, engaged staff:** Make our team a great and inclusive one to work in

Reduce average Non-Elective LOS: Jul 25

	Actual	Plan	Trend
SGUH	10 days	9 days	normal variation
ESTH	11.3 days	tbc	normal variation

Deliver Financial Plan (month 4)

	Variance to plan	Assurance on deliverability
SGUH	£0.0m (on plan)	Very challenging
ESTH	£0.0m (on plan)	Very challenging

Improve VTE Risk Assessment Rates: July 25 (ESTH Jun 25)

	Actual	Plan	Trend
SGUH	68.3%	95%	normal variation
ESTH	70.0%	95%	downward trend

Staff recommending gesh as an employer 2024 v 2023

	Actual 2023	Actual 2024	Trend
SGUH	59.50%	63.20%	Improved
ESTH	59.30%	61.46%	Improved

Reduce delays between planned and actual discharge: June 25

	Actual	Plan	Trend
SGUH	4.4 days	5.6 days	normal variation
ESTH (May)	10 days	10 days	normal variation

Improve (Implied) Productivity Mar 25

	YoY Change	Assurance on deliverability
SGUH	5.20%	positive
ESTH	0.20%	positive

Reduce RTT 52-week waiters: June 25

	Actual	Mar 2026 Plan	Trend
SGUH	2.39%	1.0%	increasing trend
ESTH	1.8%	1.0%	increasing trend

Reduce staff sickness absence rates

	Actual	Plan	Trend
SGUH	4.40%	3.20%	normal variation
ESTH	5.30%	3.80%	normal variation
Sutton	5.40%	3.80%	normal variation
Surrey Downs	5.00%	3.80%	decreasing trend

Increase Referrals to Urgent Community Response Teams: Jul 25

	Actual	Trend
Sutton	560	increasing trend
Surrey Downs	541	normal variance

Deliver CIP Target (month 4)

	YTD Delivery	Note
SGUH	£17.7m to date	In line with plan. Includes £5.6m of NR B/f and £1.6m of NR additional to support
ESTH	£11.8m to date	Includes £0.8m of non-recurrent balance sheet to support the non-delivery of planned CIP

Maintain 12-Hour waits in ED at or below 24/25 level: Jul 25

	Actual	Plan	Trend
SGUH	10.3%	13.5%	normal variation
ESTH	12.4%	13.5%	normal variation

Improve Cash Position (month 4)

	Current Balance	Cash stress expected based on current cash flow
SGUH	£79.7m (£9.3m favourable)	Late Q3
ESTH	£41.3m (£25.3m favourable)	Early Q3

Executive Summary
Safe, High-Quality Care

St George's Hospital

Key Messages

- **Patient Safety Incident Investigations (PSII) and Never Events:** One Never Event was declared at SGUH in July 2025, a mis-selection of high strength midazolam during conscious sedation in Cardiology. No new Patient Safety Incident Investigations (PSIIs) were declared at SGUH in July 2025.
- **VTE Risk Assessments:** In July 2025, VTE risk assessment compliance within 14 hours of admission was 68.3% against the national ambition of 95%. Site Chief Medical Officer's are leading targeted programs to improve assessment rates.
- **Falls Prevention and Management:** In July 2025, there was one high harm and no moderate harm falls. The fall occurred on Trevor Howell ward , where the patient had a fractured Neck of Femur (NOF). The patient subsequently went to the theatre on the 2/8/25. Unfortunately has a poor cancer prognosis so plans for discharge are happening. All incidents have been or will be investigated using the SWARM (safety incident huddle that takes place as close as possible in time and place to the incident), approach with themes shared across divisions. A Trust-wide action plan is in place.
- **Pressure Ulcers:** There were zero category 4 pressure ulcers and four category 3 pressure ulcers in July 2025, of which zero were medical device related. This is the same as June and down from April and May 2025 (7). All incidents have been investigated and discussed via divisional governance management. Trust level actions are in place.
- **Infection Prevention and Control:** No MRSA bacteraemia reported in July, total YTD is one on Trevor Howell; source IV line associated . Five cases of C. difficile have been reported in July, YTD 21 against an annual threshold of 43. Continuous reviews are underway, with specific training needs being identified and addressed. CPE (Carbapenemase-producing Enterobacteriaceae) Outbreak on Gray ward involving two NDM (New Delhi metallo-beta-lactamase) cases resulting in extensive contact tracing and patient screening. Screening to end week beginning 11th Aug, no further cases identified to date. 1x bay closed initially, since reopened.
- **Complaints:** SGUH consistently achieves its goal of providing full responses to complaints within 35 working days with performance in July at 100%, exceeding the target of 85%.
- **Mortality:** Current mortality rate, as measured by the Summary Hospital-level Mortality Indicator (SHMI), is 0.86—better than expected. However, the upcoming change to Same Day Emergency Care (SDEC) data reporting may have a negative impact on future SHMI results.

Epsom & St Helier

Key Messages

- **VTE Risk Assessments:** The Trust's VTE performance declined during the iClip Pro go live. The reasons behind this are multifaceted including: inconsistent use of decision to admit (D2A) documentation which is used as the 'clock start time', incorrect coding of low-risk cohorts and human factors. Meetings are planned with relevant colleagues across gesh to work through these issues and performance improved through June 2025 to 70% compared to 66% in May 2025.
- **Falls Prevention and Management**: In July 2025, two falls resulted in severe harm and one moderate The severe harm falls occurred on Britten and SDEC (STH), both hip fractures and the moderate harm fall occurred on Urgent Care Centre (STH.) All have been reviewed with a SWARM (safety incident huddle that takes place as close as possible in time and place to the incident), response and discussed at DIRG (Divisional Incident Response Group) meetings.
- **Infection Prevention and Control:** New MRSA bacteraemia in a renal patient reported in July 2025, YTD 3. Post-infection review undertaken and suggests likely line-related. Eleven (11) cases of C. Difficile have been reported YTD 29, against an annual threshold of 63. An overarching C. difficile action plan is being drafted. Continuous reviews are underway, with specific training needs being identified and addressed. South West London Integrated Care Board Infection Prevention and Control Lead have shared a report from their findings following a site visit in June. The report has not revealed any concerns/new actions required. Another peer visit took place on 7th August by Guys and St Thomas's IPC team and no immediate concerns were raised. Report expected this week.
- **Infection Prevention and Control:** A Ventilation working group has also been formulated with key stakeholders to review key areas for fund allocation and to prioritise for remedial works.
- **Patient Safety Incident Investigations (PSII) and Never Events (NE):** No new PSIIs or Never Events were declared at ESTH in July 2025.
- **Complaints:** In July 2025, 100% of complaints were acknowledged within three working days which represents good practice. There remains a drive to maintain this level of performance aiming for 100% through continued improvement.
- **Mortality:** The latest SHMI for April 2024-Mar 2025 is now as expected level at 1.14 rather than above expected. This continues to be closely monitored and reviewed but is on the background of an improving trend for SHMI.
- **Pressure Ulcers:** There were no hospital-acquired category 3 or above pressure ulcers in July 2025.

Executive Summary

Operational Performance & Productivity

St George's Hospital

Successes

- The Trust has sustained 18-week performance in June at 62.2%, and continuing to exceed planned levels for first outpatient waits, with an ongoing increase in the number of patients converted to Patient Initiated Follow Ups (PIFU)
- Diagnostic waiting times continue to remain within the national recovery target, which will be supported by the review of the Directory of Services (DOS – for Primary care) so appropriate referrals are made to include diagnostic results, with the aim to reduce the number of tests being undertaken and releasing capacity.
- The 4-hour emergency department standard continues to be maintained and the average wait for ambulance handover continues to perform well.
- The Trust has delivered the ask of 83 beds being closed whilst maintaining our average length of stay reduction including the number of super stranded patients (those with a length of stay exceeding 21 days).
- The Trust have launched a site operations incident management system and continue to embed the use of live data in the control room, which has seen a 28% reduction in the time taken to allocated beds, reduced delays for patients waiting repatriation, provided clearer escalation for mental health patients, and reduced Emergency Department corridor care by 13% and ward boarding by 15%. This also supports the 4 hour performance delivery and flow across the site.

Challenges

- Cancer 28 day Faster Diagnosis Standard performance was 75.4% in June 2025, below the 77% national target, due in part to a higher seasonal fluctuation.
- Cancer 62-day referral-to-treatment performance improved to 77% in June 2025 but remains below plan. A proposal for a short-term, high-volume solution to reduce the skin backlog is underway and if approved this will support an improvement in the FDS performance.
- The proportion of patients waiting over 52 weeks on an RTT pathway, although reflecting a deceleration in growth compared to previous months remains high at 2.39%. The Trust Elective access group are undertaking focused sessions to go through the patients line by line to bring forward appointments and validate waiting lists to try to bring this back in line with the trajectory set.
- Theatre capped utilisation continues to show a step change of improvement. July performance was impacted by high-temperature-related estates issues and two breakdowns in the hybrid theatre. Planning of the reallocation of activity from QMH to other facilities is underway to minimise the impact on performance and to redeploy staff to suitable alternative employment within the Group.

Epsom & St Helier

Successes

- National cancer performance standards were achieved in June 2025: 28-day Faster Diagnosis standard (78.0%), 31-day standard (99.1%), and 62-day standard (85.7%). A significant achievement following a dip in May linked to the implementation of IClip.
- A number of metrics that have deteriorated, linked to the implementation of IClip in May, have improved as operational and clinical teams work to rectify the data and process issues and to improve activity and productivity.
- The outpatient DNA rate has reduced from its peak in May 2025 of 9.3%, to 7.52% in July 2025.
- Emergency department waiting times improved in the month of July 2025, reporting 74.2% versus 65.4% in June 2025, linked to improvements to the ED workflows, improvements in flow, and rectifying DQ issues.

Challenges

- Implementing iClip Pro has been resource intensive, requiring teams to adapt to new processes. To ensure a safe transition, a six-week activity reduction plan was introduced. This has impacted across elective and non-elective performance metrics, and teams are still working through a combination of getting used to workflow changes, Data quality and reporting issues, and administrative and booking challenges. Performance is expected to continue to improve, however some of the issues are taking time to work through. Vacancy control processes particularly on A&C vacancies is also impacting the ability for some services to provide appropriate administrative and booking support.
- Dermatology and Gynaecology services are experiencing capacity challenges across cancer and RTT pathways. Recovery plans are being worked through for both services and a SWL/gesh plan is being pursued for dermatology utilising AI.
- Diagnostic performance remains challenged post IClip. Delays in endoscopy bookings and clinical workflows are affecting cancer and diagnostic pathways. A recovery plan is in place supporting increasing activity and working through the on-going workflow issues. Echo capacity has also been impacted, and other modalities are working through DQ issues along with plans to increase activity. The main imaging modalities have managed to maintain performance well through the last few months.
- For RTT the patient tracking list increased to 56,144, and long waits over 52 week waits have increased. The focus for activity through the IClip implementation was to prioritise urgent and cancer work and therefore the largest performance impact was expected to be on long waiters and to the overall waiting list. There are a number of DQ issues impacting the size of the PTL and a plan to validate the waiting list is being worked through along with a focus on increasing activity and productivity as teams get used to the new system. Financial savings plans limiting the number of additional sessions are impacting the ability to recover activity quickly and the focus is on increasing productivity in core sessions.
- Despite the improvements in July ED waiting times remain below trajectory, work is being undertaken to improve the DQ issues and the new UEC governance is now in place and progressing the workstreams at pace.

Executive Summary

Integrated Care

Safe, High-Quality Care Key Messages

Sutton Health & Care (SHC)

- **Palliative**- Thematic review being undertaken- communication between teams increasing the amount of "Hand offs"
- **Blocked catheters**: A deep dive report to be taken to Integrated Leadership Team at the end of August 2025.
- **Coroners**: A patients case where learning and process amendments around our management of missed insulins was heard . Outcome expected in September.

Surrey Downs Health & Care(SDHC)

- Meatal Tears - a laceration or injury to the urethral meatus-Review of catheter pathway and use of catheter passport being undertaken.
- Heart Failure- caseload management -(long length on caseload) currently being reviewed.
- IPC have reviewed and signed off the remedial works for the new physiotherapy suite/gym at Leatherhead Hospital.

Community Wide Issue:

- Nutricia Feeds- The lack of products and delays.

Operational Performance Key Messages

Sutton Health & Care (SHC)

- Children's Speech and Language Therapy (SALT) Service is experiencing pressure, in both waiting list volumes and 52-week breaches. However good progress has been made on 52week waiters. At the end of July 20 children were waiting more than 52 weeks within SALT services.
- Virtual Ward occupancy rate exceeded target of 85% achieving 94.1% with reduced length of stay.
- Technical data issues have caused the 2 Hour UCR performance to drop significantly. This has now been resolved by EMIS.
- Appraisal Rate for non-medical staff remains below target at 72.6%.

Surrey Downs Health & Care(SDHC)

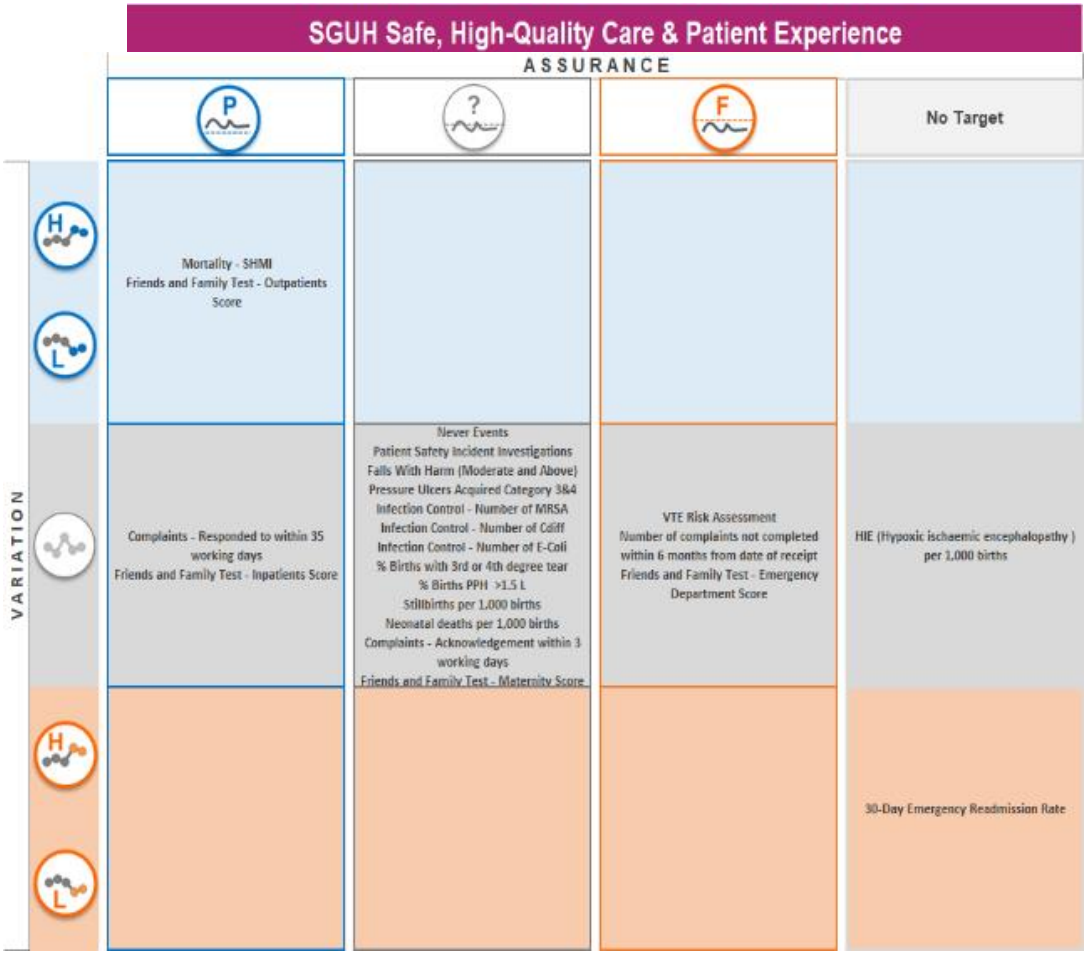
- Service consistently achieves the 2 –hour Urgent Community Response (UCR) target with a performance of 87.8% in July 2025 against a national target of 70%, while managing high levels of referrals.
- Virtual ward admissions remains above average with occupancy targets being met.
- Reduction in waiting list size across the month and no patients waiting over 52 weeks for specialist services.

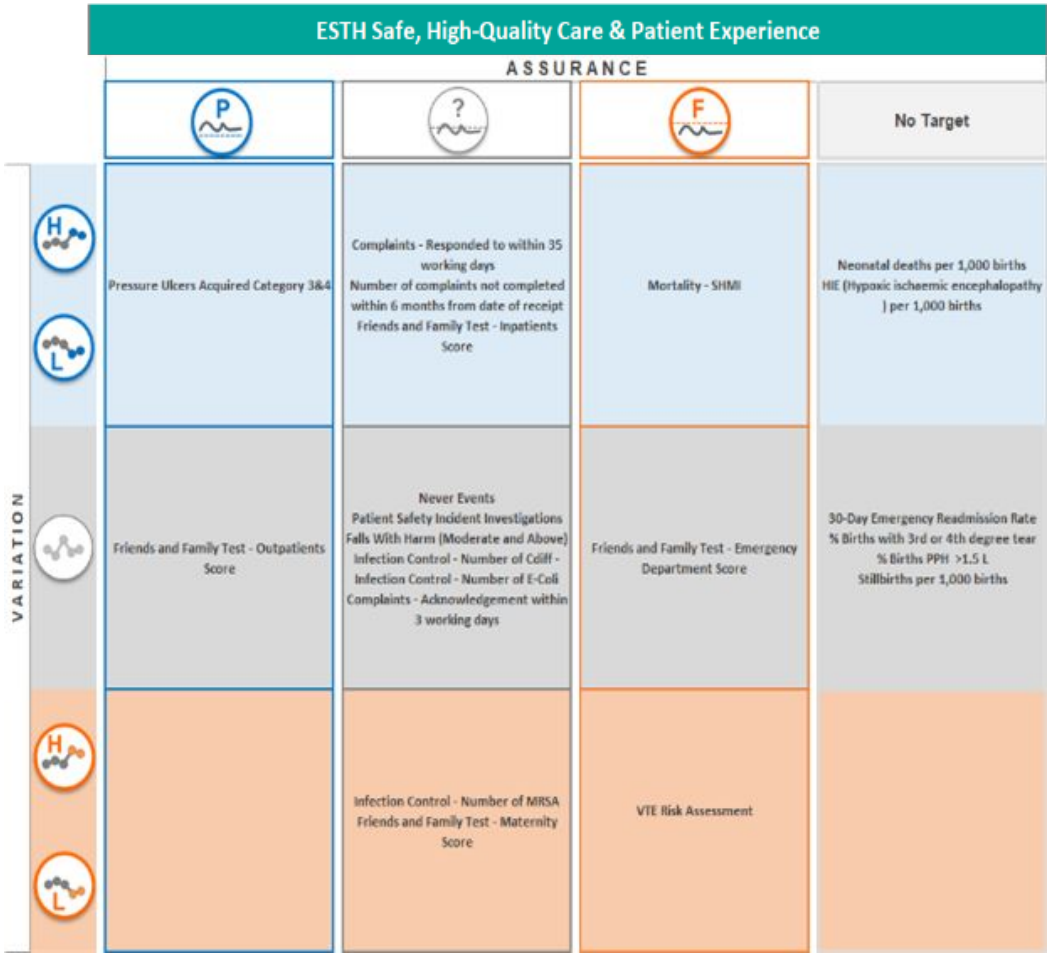


Quality & Safety

Safe, High-Quality Care & Patient Experience

Matrix Summary





Safe, High-Quality Care

Overview Dashboard

KPI	St George's Latest month	St George's Previous Month Measure	St George's Latest Month Measure	St George's Target	St George's Variation	St George's Assurance	St George's Benchmark	Epsom & St Helier Latest month	Epsom & St Helier Previous Month Measure	Epsom & St Helier Latest Month Measure	Epsom & St Helier Target	Epsom & St Helier Variation	Epsom & St Helier Assurance	Epsom & St Helier Benchmark
Never Events	Jul 25	1	1	0			N/A	Jul 25	0	0	0			N/A
Patient Safety Incident Investigations	Jul 25	0	0	0			N/A	Jul 25	0	0	0			N/A
Number of Falls With Harm (Moderate and Above) per 1,000 bed days	Jul 25	0.04	0.04	0.12			N/A	Jul 25	0.07	0.18	0.03			N/A
Pressure Ulcers - Acquired Category 3&4	Jul 25	4	4	7			N/A	Jul 25	0	0	7			N/A
Infection Control - Number of MRSA	Jul 25	1	0	0			3rd Quartile	Jul 25	0	1	0			3rd Quartile
Infection Control - Number of Cdiff - Hospital & Community	Jul 25	9	5	5			2nd Quartile	Jul 25	7	11	6			2nd Quartile
Infection Control - Number of E-Coli	Jul 25	10	11	9			Lowest Quartile	Jul 25	7	7	5			2nd Quartile
30-Day Emergency Readmission Rate	Jun 25	14.4%	12.4%	-			TBC	Mar 25	6.0%	5.9%	-			TBC
VTE Risk Assessment	Jul 25	66.3%	68.3%	95.0%			N/A	Jun 25	66.0%	70.0%	95.0%			N/A
Mortality - SHMI	Mar 25	0.86	0.86	1.00			Better than Expected	Mar 25	1.13	1.14	1.00			As expected
% Births with 3rd or 4th degree tear	Jul 25	2.7%	1.2%	5.0%			3.0%	Jul 25	3.36%	0.66%	-			2.7%
% Births Post Partum Haemorrhage >1.5 L	Jul 25	0.9%	3.7%	4.0%			3.2%	Jul 25	2.6%	2.2%	-			3.1%
Stillbirths per 1,000 births	Jul 25	0.0	0.0	2.0			3.50	Jul 25	7.2	10.8	-			3.50
Neonatal deaths per 1,000 births	Jul 25	0.0	0.0	2.0			1.60	Jul 25	0.0	0.0	-			1.60
HIE (Hypoxic ischaemic encephalopathy) per 1,000 births	Jul 25	0.0	3.1	-			1.00	Jul 25	0.0	0.0	-			1.00

New VTE guidance implemented from Q1 2024 to monitor VTE assessment completed within 14 hours.

- Mortality: SDEC reporting will be introduced at SGUH over the next few months and likely to have an adverse impact on SHMI performance

* Never Events are a subset of PSIIs

Safe, High-Quality Care

Overview Dashboard

St George's

KPI	Latest month	Previous Month Measure	Latest Month Measure	Target	Variation	Assurance	Benchmark
Complaints - Responded to within 35 working days	Jul 25	100.0%	100.0%	85.0%			N/A
Complaints - Acknowledgement within 3 working days	Jul 25	100.0%	100.0%	100.0%			N/A
Number of complaints not completed within 6 months from date of receipt	Jul 25	1	1	0			N/A
Friends and Family Test - Inpatients Score	Jul 25	97.8%	98.4%	90.0%			Top Quartile
Friends and Family Test - Emergency Department Score	Jul 25	78.3%	78.4%	90.0%			2nd Quartile
Friends and Family Test - Outpatients Score	Jul 25	95.3%	95.0%	90.0%			3rd Quartile
Friends and Family Test - Maternity Score	Jul 25	92.1%	90.0%	90.0%			2nd Quartile

Epsom & St Helier

Latest month	Previous Month Measure	Latest Month Measure	Target	Variation	Assurance	Benchmark
Jul 25	86.0%	87.0%	85.0%			N/A
Jul 25	99.5%	100.0%	100.0%			N/A
Jul 25	9	9	0			N/A
Jul 25	98.8%	100.0%	90.0%			3rd Quartile
Jul 25	35.7%	50.0%	90.0%			3rd Quartile
Jul 25	93.0%	96.9%	90.0%			2nd Quartile
Jul 25	100.0%	75.0%	90.0%			2nd Quartile

Sutton Healthcare

KPI	Latest month	Previous Month Measure	Latest Month Measure	Target	Variation	Assurance
Patient Safety Incidents Investigated	Jul 25	0	0	0		
Number of Falls	Jul 25	3	11	-		
Pressure Ulcers Category 3&4	Jul 25	4	4	-		
Infection Control - Number of MRSA	Jul 25	0	0	0		
Infection Control - Number of Cdiff	Jul 25	0	1	-		
Infection Control - Number of Ecoli	Jul 25	0	0	-		
Complaints	Jul 25	1	1	-		
Community FFT	Jul 25	-	97%	90%		

Surrey Downs

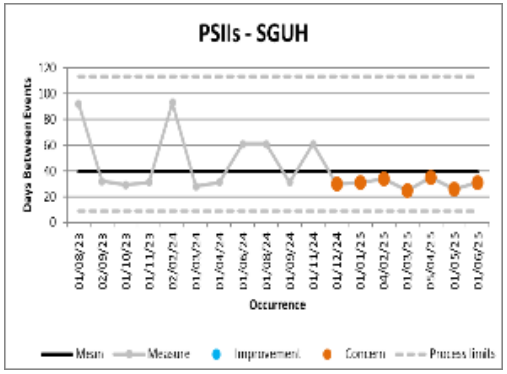
Latest month	Previous Month Measure	Latest Month Measure	Target	Variation	Assurance
Jul 25	0	0	0		
Jul 25	12	13	-		
Jul 25	7	5	-		
Jul 25	0	0	0		
Jul 25	0	0	-		
Jul 25	0	1	-		
Jul 25	0	1	-		
Oct 24	97.8%	96.3%	90.0%		

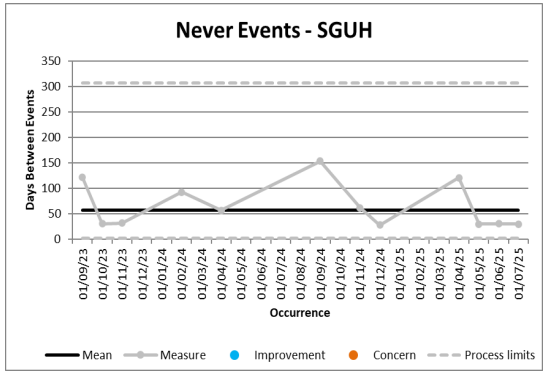
- Community FFT is a subset of Epsom and St Heliers FFT data. Analysis following migration to a new system is under review..
- IC (Dorking and Molesey Hospitals – community do not have set national trajectories for HCAIs although all cases are reviewed and investigated)

Safe, High-Quality Care

Incident Reporting- *[T-Charts used to measure Time(days) between incidents]*

St George's





Summary & Actions

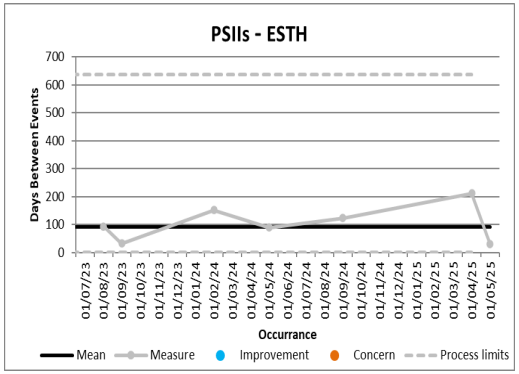
No new Patient Safety Incident Investigations (PSIIs) were declared at SGUH in July 2025.

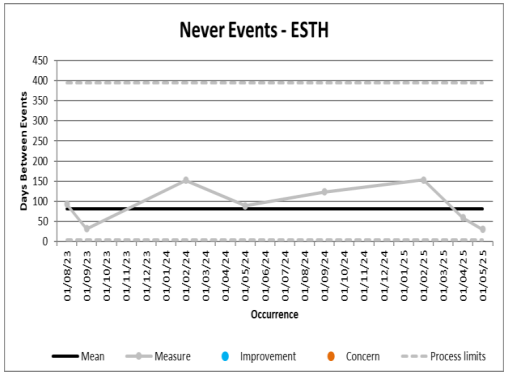
Summary & Actions

One Never Event was declared at SGUH in July 2025.

A mis-selection of high strength midazolam during conscious sedation in Cardiology.
A SWARM was undertaken to identify the relevant learning which is now being taken forward.

Epsom & St Helier





Summary & Actions

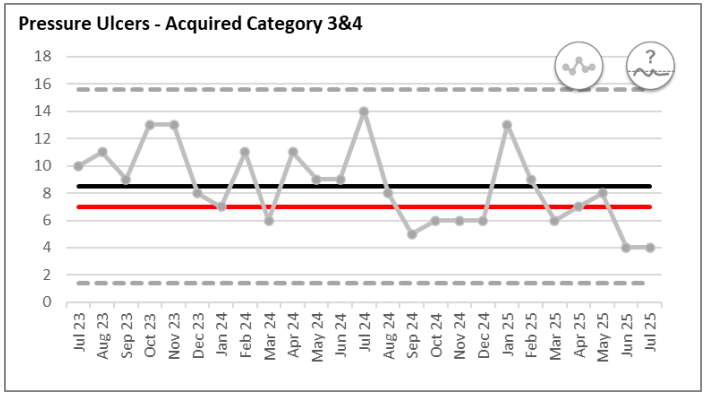
No new Patient Safety Incident Investigations (PSIIs) were declared at ESTH in July 2025.

Summary & Actions

No new Never Events (NE) were reported at ESTH in July 2025.

Safe, High-Quality Care

Exception Report | SGUH Pressure Ulcers - Category 3 & 4



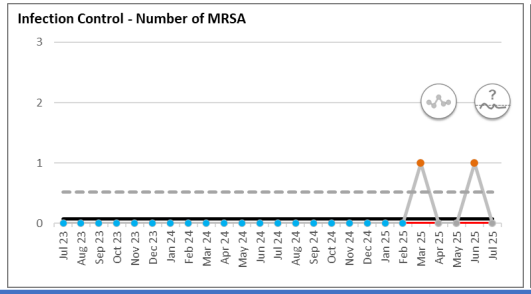
Indicator	Apr-25	May-25	Jun-25	Jul-25
Pressure Ulcers - Acquired Category 3	7	7	4	4
Pressure Ulcers - Acquired Category 4	0	1	0	0

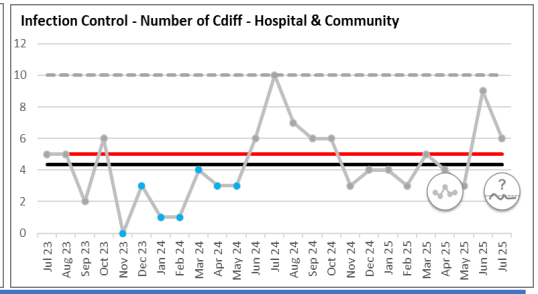
Site & Metric	Cause of variance/ non-compliance	Actions: Completed since last update, New, and Ongoing	Recovery Date	Data Quality
SGUH Pressure Ulcers Category 3 A total of 4 in July 2025 Pressure Ulcers Category 4 0 incidents occurred in July 2025 Shows common cause variation with no significant change	• There were four category 3 pressure ulcers acquired in July 2025, this is the same as June and down from April and May 2025 (7). There were zero category 4 pressure ulcers in July 2025. • Zero of the four Category 3 PUs were medical device-related • All pressure ulcers in July 2025 were around the sacral/ coccyx area and all patients were acutely unwell • There is currently only one full-time Tissue Viability Nurse in the SGUH team due to a vacancy. This has meant there is not enough capacity to review category 2 (lower harm) pressure ulcers. Increased emphasis has been placed on Ward Managers and Matrons to manage these incidents without support over the last couple of months, this may have contributed to the small decrease seen over last 2 months	• New band 7 to start in SGUH team 1st September 2025 • Pressure relieving mattresses – after reviewing engineering changes to the current brand of hybrid pressure relieving mattresses used in general inpatient areas at SGUH, the medical physics team have decided to explore options from other providers and stop replacement of the current mattresses. Viable options will be reviewed by teams across gesh in September 2025. A stable funding source to replace pressure relieving mattresses is still required. • A new continence product formulary and training programme has now been agreed. Meetings are underway with subject matter experts across gesh to review the continence documents on iCLIP Pro along with relevant policies and guidelines. • The new nationally recommended pressure ulcer risk assessment Purpose –T (Pressure Ulcer Risk Primary or Secondary Evaluation Tool) is awaiting build in iCLIP Pro	As part of 2025/26 Quality Priorities this is being reviewed regularly	Sufficient for assurance

Safe, High-Quality Care

Exception Report | SGUH & ESTH - Infection Prevention and Control

St George's





SGUH - Summary & Actions

Healthcare Associated MRSA Bacteraemia:

Trust	MRSA Cases YTD (M4)	Annual Threshold
SGUH	1	0

MRSA: No MRSA bacteraemia reported in July, YTD 1, source line related.
Actions in place include:

- Train staff on documentation and Infection Prevention and Control; Daily spot checks by senior nursing team: Cannulation skills must include documentation; Sign-off by senior/practice educator and recording all vascular access details in iClip, including pre-admission devices.

Healthcare Associated CDIs:

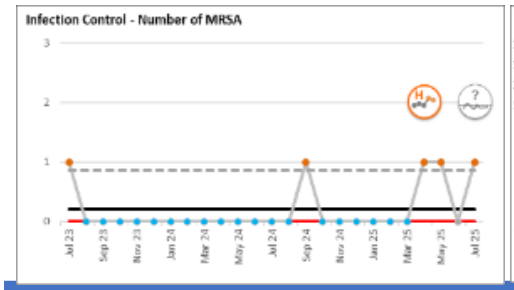
Trust	CDI Cases YTD (M4)	Annual Threshold
SGUH	21	43

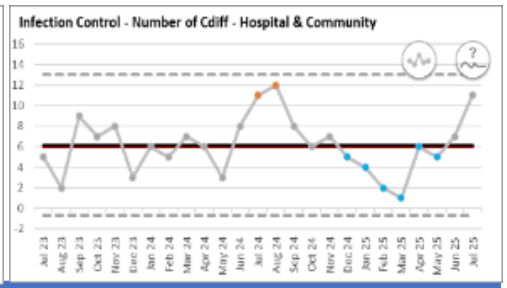
C difficile: An overarching group C diff action plan has been drafted, continuous reviews are underway, with specific training needs being identified and addressed.
Actions in place include:

- Case reviews to identify outbreak themes/learning; Extra C. difficile education delivered across key forums and training groups; Enhanced chlorine cleaning ongoing until PISA lifted; Bay decanting for deep clean & HPV disinfection in progress.

Outbreaks: CPE Outbreak on Gray ward involving two cases resulting in extensive contact tracing and patient screening. Initial bay closure since reopened.

Epsom & St Helier





ESTH - Summary & Actions

Healthcare Associated MRSA Bacteraemia:

Trust	MRSA Cases YTD (M4)	Annual Threshold
ESTH	3	0

MRSA: New case reported in a renal patient, likely source is line related. Vascular access team have drafted an action plan/training package for vascular access management.

Healthcare Associated CDIs:

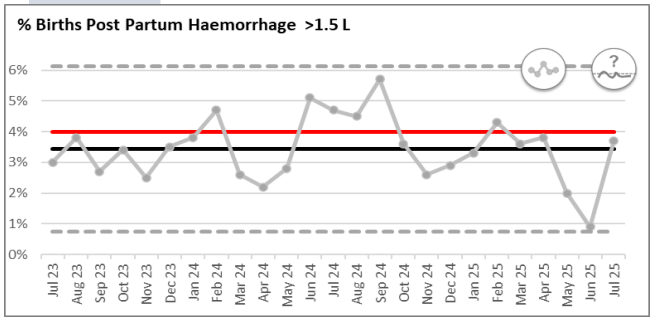
Trust	CDI Cases YTD (M4)	Annual Threshold
ESTH	29	63
Integrated Care	0	0

C difficile: An overarching group C diff action plan has been drafted, continuous reviews are underway, with specific training needs being identified and addressed.
Water Safety - E Block: SWL ICB IPC Lead have shared a report from their findings following a site visit in June. The report has not revealed any concerns/new actions required. Another peer visit will be undertaken on the 7th of August by Guys and St Thomas IPC team.
Ventilation: Ventilation working group has been formulated with key stakeholders to review key areas for fund allocation and to prioritise for remedial works

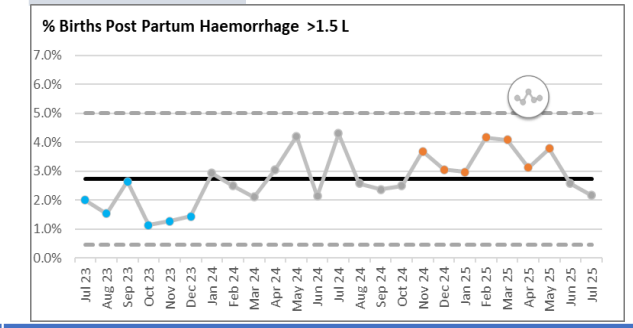
Safe, High-Quality Care

Exception Report | SGUH & ESTH | % of Births with Post Partum Haemorrhage >1.5L

St George's



Epsom & St Helier

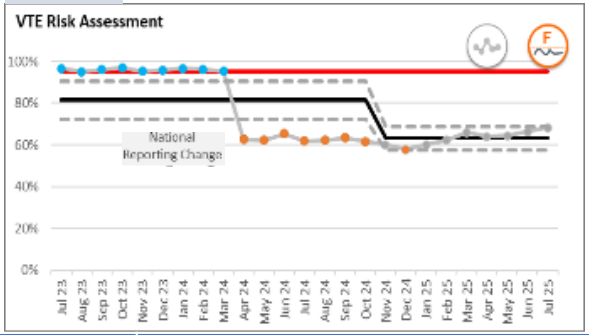


Site & Metric	Cause of variance/ non-compliance	Actions: Completed since last update, New, and Ongoing	Recovery Date	Data Quality
SGUH The percentage of births with Post Partum Haemorrhage >1.5L and shows common cause variation.	In February 2025, the National Maternity and Perinatal Audit (NMPA) notified SGUH that it was being flagged as a potential alarm-level outlier for postpartum haemorrhage (PPH) exceeding 1.5L. As of July 2025, the percentage of births with PPH >1.5L at SGUH was 3.7% — below the local target of 4%, but still above the peer average of 3.2%.	The Trust has conducted a detailed analysis of potential clinical factors contributing to postpartum haemorrhage (PPH), using 2024 data. While known risk factors such as SGUH's role as a placenta accreta spectrum referral centre and the performance of caesarean sections in patients with a high BMI (≥50) are present, the deep dive revealed that most PPH cases were linked to spontaneous vaginal births following induction of labour. PPH was also commonly associated with forceps deliveries, particularly where significant perineal trauma occurred. The service continues its improvement work to reduce PPH rates to meet or fall below the peer average of 3.2%. On 12 June, SGUH received correspondence from the National Maternity and Perinatal Audit (NMPA) confirming that, following a review of the evidence submitted in response to the alarm-level alert, the hospital will remain at alarm-level status in the NMPA report scheduled for publication in July 2025. The Trust is actively addressing the actions arising from this outcome. Further correspondence from NMPA was received on 3 July, advising that the publication of the 'State of the Nation' report has been delayed. The revised release date is now expected to be 14 August 2025	NMPA has advised SGUH the report is delayed - now expected 14 August 2025	Sufficient for assurance
ESTH Special cause variation of a concerning nature.	There has been a recent increase in postpartum haemorrhage (PPH) cases, with rates surpassing the target set at 3%. A comprehensive retrospective audit spanning five years was conducted, which revealed no significant issues apart from the need to ensure that PPH proformas are consistently completed.	• The increase was discussed in the maternity risk meeting, with ongoing efforts to reduce and keep below 3%. • Focus is always on prevention, starting from the antenatal period. • Staff are reminded to risk assess at booking, improve Haemoglobin (Hb) with oral iron, and offer parenteral iron if Hb remains low at 34 weeks—an approach we have implemented promptly. • Aim is active management of 3rd stage and to offer tranexamic acid and carbetocin for operative births if no contraindications. Measures and reminders given to our anaesthetists, Obstetrics and Gynaecology team.	September 2025	Sufficient for assurance

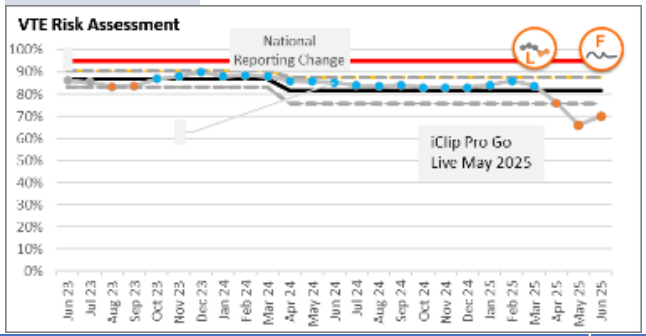
Safe, High-Quality Care

Exception Report | SGUH & ESTH VTE Risk Assessment

St George's



Epsom & St Helier

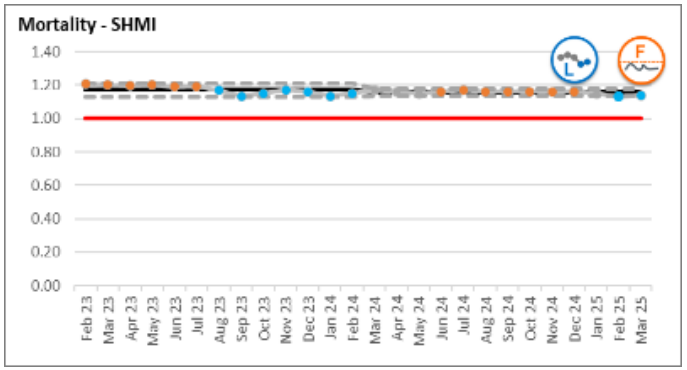


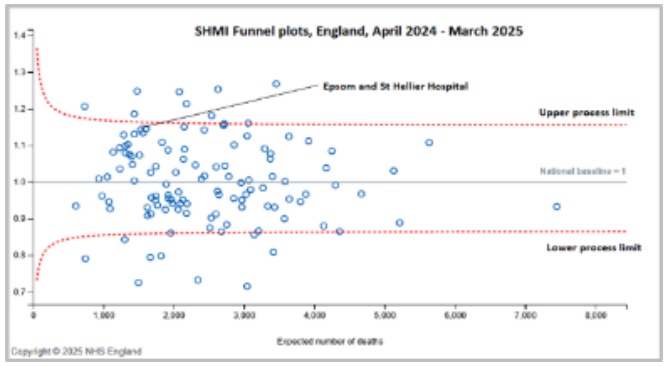
Site & Metric	Cause of variance/ non-compliance	Group Actions: Completed since last update, New, and Ongoing	Recovery Date	Data Quality
SGUH: VTE 68.3%. Not meeting target of 95%- improving trend	• The national definition of this metric revised in April 2024 to reflect guidance recommending VTE assessment to be completed within 14 hours of admission or decision to admit, resulted in the significant decrease in performance. • VTE assessment alerts are not triggered in ED, causing delays in completion, Additionally, the alert system for other locations can be inappropriately bypassed. • The mandatory online training requirement (MAST) compliance target, applicable only to doctors and dentists, is currently not being met. Training is not currently mandated for the rest of the multidisciplinary team.	• The Site CMOs have programs of work at both acute trusts to improve VTE performance. • VTE champions form a multiprofessional group to boost assessment compliance, aiming for a 5% increase by October 2025, with further gains by December. • A joint workshop with thrombosis leads and VTE champions from both trusts will be held within 3 months to assess challenges and align assessments before iClip updates. • Shared digital VTE risk assessment tool, rules and controls to be developed to improve compliance but current change freeze. • Improve MAT (Medication Administration Tool) compliance and targeted support for underperforming areas • gesh VTE policy to be developed • At ESTH, iClip Pro now includes VTE reminders, and a similar engagement model will be introduced under the CMO's guidance, with a later timeline due to iClip implementation. A new consultant thrombosis lead will join ESTH in September 2025 to drive these actions. • From 1st April ESTH using DTA as the clock start time for admissions from ED. All planned admissions, the date of admission is being used.	Trajectories under review for 2025/26	Sufficient for assurance

ESTH: VTE Not meeting target of 95%	• The ESTH risk assessment data for ESTH has been significantly impacted by iClip Pro go-live:
	  ○ Inconsistent use of decision to admit (D2A) documentation which is used as the 'clock start time' impacting compliance figures for emergency admissions. If D2A is missing the patient's ED presentation time is used which can significantly change the time by which the VTE risk assessment needs to be completed by
	  ○ Maternity risk assessments do not match national guidance, Badgernet being used for post pregnant and birthing people – working group in place
	  ○ Issues with incorrect coding of low-risk cohorts – meeting with BI team
	  ○ Patient tracker boards including VTE risk assessment completion not easily found on iClip Pro; VTE nurses working with services to support with re-imbedding this
	  ○ Staff have taken some time to adjust to the system and navigate their way
			Trajectories under review for 2025/26	Not sufficient for assurance

Safe, High-Quality Care

Exception Report | ESTH Summary Hospital- Level Mortality Index (SHMI)



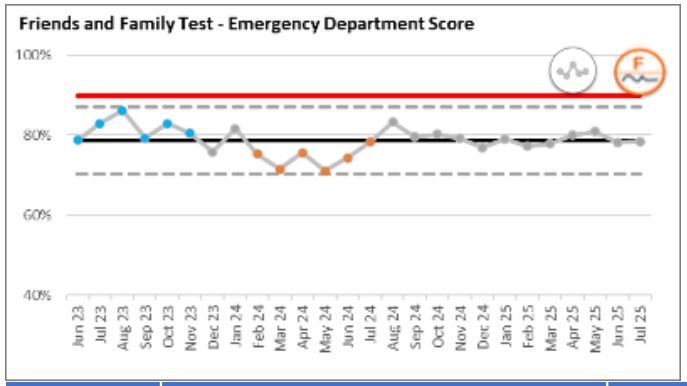


SHMI Source NHS Digital data based on rolling 12 months-April 2024 to Mar25 reported in July 2025. There were 215 more deaths than expected

Site & Metric	Cause of variance/ non-compliance	Actions: Completed since last update, New, and Ongoing	Recovery Date	Data Quality
ESTH SHMI: Special cause improving variation and consistently above expected rate. However, ESTH is now within expected range.	The latest SHMI for April 2024 to March 2025 is now within the expected range at 1.14, rather than above expected, based on the 95% confidence interval shown in the funnel plot. In 2020, ESTH reclassified Same Day Emergency Care (SDEC) activity as non-inpatient. This reduced the total spell count used in the SHMI model, leading to a decrease in the expected number of deaths—a trend observed since the change. Other Trusts with SDEC services were initially expected to adopt the same reporting approach by July 2024. However, the latest national data indicates that around half have yet to do so. NHSE extended the implementation deadline to July 2025.	Comprehensive deep dives and thematic analyses of outlying areas have been conducted, covering electrolyte imbalances, UTIs, COPD, and pneumonia. The findings did not indicate any quality concerns. An in-depth review of themes from Structured Judgement Reviews (SJRs) has highlighted areas for improvement. Any identified care concerns are reported and thoroughly investigated Clinical leads in Sepsis and the Deteriorating patient have been appointed to support improvement work. Plans are underway for the recruitment of additional staff to ensure 24/7 Critical Care Outreach on both sites. Collaboration between clinicians and coders will be highly beneficial in improving record accuracy. The implementation of iClip Pro is expected to lead to improvement in coding as experienced in other Trusts. Several enhanced monitoring workstreams are in place, including mortality reviews and medical examiner scrutiny.	Now within expected range, and closely monitored	sufficient for assurance

Safe, High-Quality Care

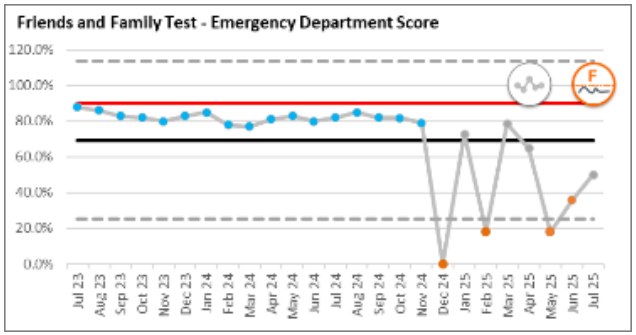
Exception Report | SGUH Emergency Department Patient Experience

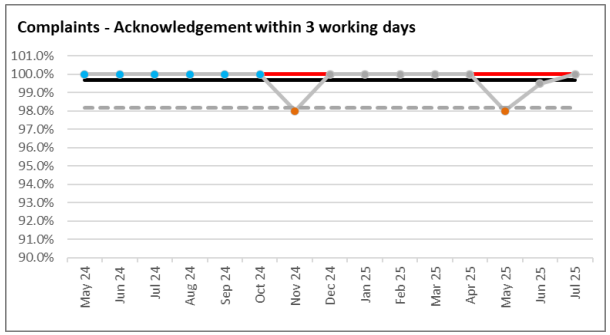


Site & Metric	Cause of variance/ non-compliance	Actions: Completed since last update, New, and Ongoing	Recovery Date	Data Quality
SGUH FFT ED Score	The ED FFT survey response rate continues to be well above the national average with 1,315 patients responding to the survey in July 2025. The number of patients that would recommend the department to friends and family was 78% for July 2025 – the same, compared on the previous month, and July 2024. It is just below the latest national data, when comparing with the national average of 80%. During July 2025 , the number of ED attendances and patients waiting for a bed in the department remained high with the most consistent theme for negative responses being waiting times.	Actions for improving patient experience whilst waiting in ED include: 1. Review of patient feedback by each area with the relevant leads to identify areas where improvement is required - ongoing 2. Corridor care checklist and intentional rounding – ongoing 3. Standardised documentation template for use by RNs when looking after patients in the corridor – includes all elements of documentation to ensure all patients receive the same level of documentation and risk assessments. We are also offering all patients a comfort pack, consisting of eye masks and ear plugs - ongoing 4. Nurse In Charge (NIC) checklist on RATE – quality checklist to be completed by NIC at the start of each shift to identify safety checks completed within the department - ongoing 5. ED matron assurance checklist on RATE – completion for each area during Matron of the day rounds with focus on red crosses, enhanced care, safety checks, fire warden and quality/safety huddles - ongoing 6. Consultant Referral and Triage (RAT) rota ongoing. Rota amended so RAT shift is covered Mon-Fri 11:00-19:00 to give patients a more senior review sooner and redirect if necessary - ongoing 7. Patient Check-In (a digital check in tool) launched in January 2025 to make the checking in process more efficient 8. Same Day Emergency Care (SDEC) ongoing - 10 new clinical pathways for medical SDEC launched to redirect patients to medical service if more appropriate. Surgical SDEC launched beginning of June, to stream patients directly to Nye Bevan Unit clinic - ongoing 9. Frailty SDEC launched July 2025	Ongoing	sufficient for assurance

Safe, High-Quality Care

Exception Report | ESTH - Patient Experience (Satisfaction & Complaints)





Site & Metric	Cause of variance/ non-compliance	Actions: Completed since last update, New, and Ongoing	Recovery Date	Data Quality
ESTH FFT ED Score Special cause variation of a concerning nature Consistently failing target	The FFT contract at ESTH has concluded and transitioned to Gather, where the survey is accessible via posters, reaching a limited audience. IG approval has now been received to send the survey to patients through text messaging, securing access to a text messaging service via procurement is now in progress. External data reporting continues but is not directly comparable to previous months and shows some variations, particularly in services where surveys are conducted via text.	• Improve Response rates across both hospital sites • DPIA approval now received- progress to seeking suitable text messaging services via procurement now in progress • Analyse the themes and trends of patients who provide negative feedback. • Proposals to involve volunteers in the Emergency Department for feedback collection, including FFT, have been put forward; however, recruitment has not yielded results to date. • The Medical Division is committed to enhancing patient experience during periods of heightened emergency care demand by increasing staffing levels and optimising patient flow to expand inpatient capacity.	Dec 2025	Not sufficient for assurance
ESTH Complaints - Acknowledgement within 3 normal variation. In July the target of 100% was met	Despite some fluctuation in performance, in July the target of 100% was met and there remains a strong commitment to maintain performance. Variance cause has reflected the gap in administrative support, due to a current vacancy highlighting the impact this has had on the complaints team performance.	• Temporary support from the Group Nursing Directorate has been made available to provide administrative support. • Other sources of administrative support are being reviewed, to enable a permanent solution to administrative vacancies.	Sept- 2025	Sufficient for assurance



Section 2.1:
Operational Performance

Section 2.1 Operational Performance

Matrix Summary

SGUH Operational Performance

VARIATION \ ASSURANCE	P	?	F	No Target
H	RTT- Waiting List – total children under 18	Cancer - 28 Day Faster Diagnosis Standard	Cancer 31 Day Decision To Treat to Treatment Standard	
L				
H		RTT - Percentage of waits within 18 weeks for first appointment Cancer 62 Day Referral to Treatment Standard 4 Hour Operating Standard Ambulance average Handover Time (min)		
L				
H		RTT - Waits over 52 weeks RTT - Percentage of waits over 52 weeks Diagnostics - 6 Week Waits Ambulance average Handover Time (min) RTT - Proportion Waits over 52 weeks	RTT - Waits over 65 weeks RTT - Percentage of waits within 18 weeks	
L				

ESTH Operational Performance

VARIATION \ ASSURANCE	P	?	F	No Target
H				
L				
H		RTT - Percentage of patients waiting for first attendance who have been waiting less than 18 weeks Cancer - 28 Day Faster Diagnosis Standard Cancer 62 Day Referral to Treatment Standard 4 Hour Operating Standard Over 12 Hours in ED from Arrival(%) Type 1	RTT - Percentage within 18 weeks	
L				
H		RTT- Waiting List – total children under 18 Ambulance average Handover Time (min) Cancer 62 Day Referral to Treatment Standard	RTT - Percentage of waits over 52 weeks Diagnostics - 6 Week Waits	
L				

Operational Performance

Overview Dashboard

KPI	St George's Latest month	St George's Previous Month Measure	St George's Latest Month Measure	St George's Target	St George's Variation	St George's Assurance	St George's Benchmark	Epsom & St Helier Latest month	Epsom & St Helier Previous Month Measure	Epsom & St Helier Latest Month Measure	Epsom & St Helier Target	Epsom & St Helier Variation	Epsom & St Helier Assurance	Epsom & St Helier Benchmark
RTT - Percentage of waits over 52 weeks	Jul 25	2.39%	2.47%	1.00%			3rd Quartile	Jun 25	1.8%	1.8%	1.0%			2nd Quartile
RTT - Percentage of waits within 18 weeks	Jul 25	62.2%	61.2%	68.0%			2nd Quartile	Jun 25	65.8%	65.1%	70.4%			2nd Quartile
RTT - Percentage of waits within 18 weeks for first appointment	Jul 25	66.2%	65.2%	66.6%			2nd Quartile	Jun 25	66.1%	80.4%	81.3%			Top Quartile
RTT- Waiting List – total children under 18	Jul 25	6716	6679	7715			-	Jun 25	6553	6850	6449			-
Cancer - 28 Day Faster Diagnosis Standard	Jun 25	84.8%	75.4%	82.7%			3rd Quartile	Jun 25	79.5%	78.0%	86.8%			2nd Quartile
Cancer 62 Day Referral to Treatment Standard	Jun 25	76.0%	77.0%	85.0%			Top Quartile	Jun 25	74.9%	85.7%	86.6%			Top Quartile
Diagnostics - 6 Week Waits	Jul 25	5.4%	4.3%	5.0%			Top Quartile	Jun 25	10.6%	13.0%	5.0%			2nd Quartile
4 Hour Operating Standard	Jul 25	80.1%	78.6%	78.0%			Top Quartile	Jul 25	65.4%	74.2%	78.0%			2nd Quartile
Over 12 Hours in ED from Arrival (%) Type 1	Jul 25	12.1%	10.3%	13.0%			3rd Quartile	Jul 25	17.0%	12.4%	13.5%			3rd Quartile
Ambulance average Handover Time (min)	Jul 25	00:24:22	00:24:01	00:24:00			3rd Quartile	Jul 25	00:28:28	00:26:00	00:22:00			TBC

Targets based on Operating Plan end of year March 2026 position (trajectories in place)

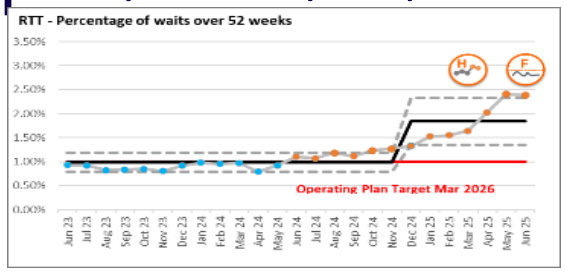
Operational Performance

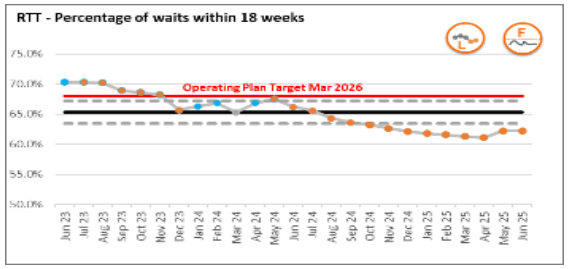
Overview Dashboard

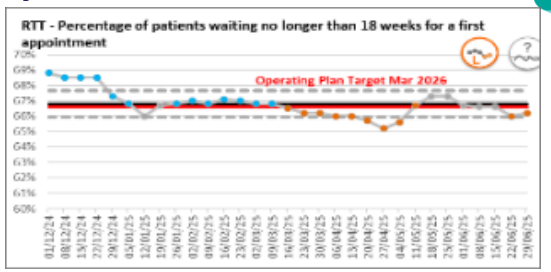
KPI	Sutton Healthcare						Surrey Downs					
	Latest month	Previous month measure	Latest month measure	Target	Variation	Assurance	Latest month	Previous month measure	Latest month measure	Target	Variation	Assurance
Two hour UCR performance	Jul 25	58.8%	61.6%	70.0%			Jul 25	87.1%	87.8%	70.0%		
Virtual ward - Bed Occupancy	Jul 25	83.5%	94.1%	85.0%			Jul 25	91.2%	95.1%	80.0%		
Total Waiting List Size Adult	Jul 25	2091	2019	-			Jul 25	5793	5765	-		
Total Waiting List Size Adult >52wks	Jul 25	0	0	-			Jul 25	0	0	-		
Percentage of waits Adults >52wks	Jul 25	0.0%	0.0%	-			Jul 25	0.0%	0.0%	-		
Total Waiting List Size Children	Jul 25	1064	1064	-								
Total Waiting List Size Children >52wks	Jul 25	59	20	-								
Percentage of waits Children >52wks	Jul 25	5.5%	1.9%	-								

Operational Performance

Exception Report | SGUH Referral to Treatment (RTT)



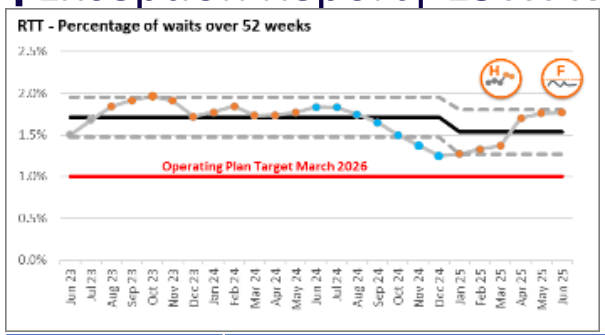


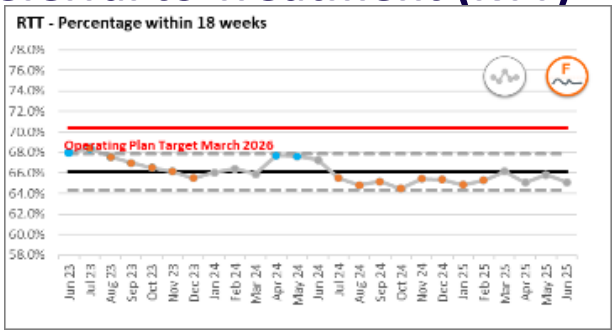


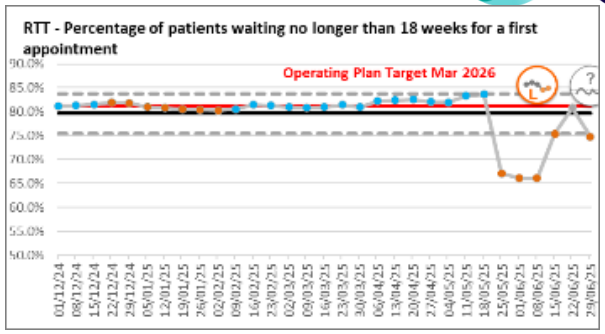
Site & Metric	Cause of variance/ non-compliance	Actions: Completed since last update, New, and Ongoing	Recovery Date	Data Quality
SGUH % waits over 52 weeks – above plan % within 18 weeks – maintained in June below plan % wait for first attendance – decrease through June	At the end of June 2025; Proportion of 52 week waits – Of the total PTL size, 2.4% of patients have been waiting over 52 weeks, reflecting a deceleration in growth compared to previous months. Higher rate driven by a number of specialties particularly Neurosurgery, General Surgery and Gynaecology A high volume of out of area referrals have contributed to the long wait position. Performance against the 18-week standard remained stable throughout June 2025, underpinned by the targeted validation programme, which has played a key role in increasing RTT clock stops and pathway removals from the Patient Tracking List (PTL), improving data quality.	Elective Access has undertaken a review of all patients waiting over 52 weeks ensuring that patients have a TCI or there are validation actions being taken we will see the benefit in the following months with the biggest impact being seen in September. There are still 47 patients in the weight loss category that need resolution by London region .e.g. to be repatriated back to Northwest London and the ICB with agreement that funding will be provided, letters have been sent to the ICB and there are ongoing meetings with the regional teams. Theatre productivity continues to improve, 6-4-2 meeting is ensuring that sessions are reallocated – QMH closure reallocation is on going with Local Anaesthetic lists being stood up for second week in September to support the mitigation of the closure of four theatres. Skin (Dermatology) remains an issue with capacity being outstripped by demand however there is a SWL proposal to implement Skin Analytics (awaiting funding approval in September) which will provide an AI solution. St Georges are looking to run an AI rapid intervention programme to clear our backlog ahead of this (two months task and finish) Divisional lead initiative to hopefully commence in September for 6000 patients – proposal to be presented to site Recovery meeting 9th September (Skin Analytics require 1 week mobilisation). **Ongoing actions**: • Speciality review of the Directory of Services (DOS) this will help to reduce the number of inappropriate referrals and to also ensure that referrals are made with required diagnostic tests • Validation is on going, as is the focus on cashing up of activity in real-time. • Partial booking light – this has been presented to site QIA and GEC – we are asking that we reduce the number of weeks (ahead) that are booked to allow improved management of clinics, reduce hospital cancellations but to also allow for the GIRFT recommendations for clinic slots across the specialities to be aligned which will deliver an additional 3000 clinic slots per annum within the existing budgeted activity. This needs to be approved for Group wide application acknowledging that the sites may implement at different times. NHSE will need to be advised as the number of hospital cancellations will be significant in the month this is enacted. • Improvements in text communications with patients being explored to drive down DNAs – target areas such as Max Fax and Dental that have high DNA rates	March 2026 October 25 November 25 November 25 Ongoing September 25 August 25	sufficient for assurance

Operational Performance

Exception Report | ESTH Referral to Treatment (RTT)





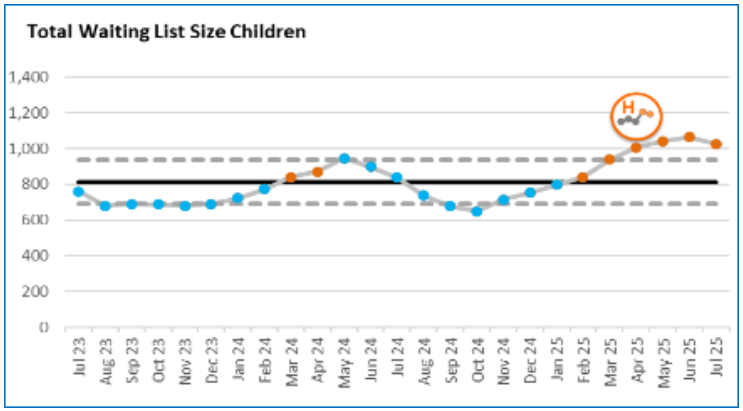


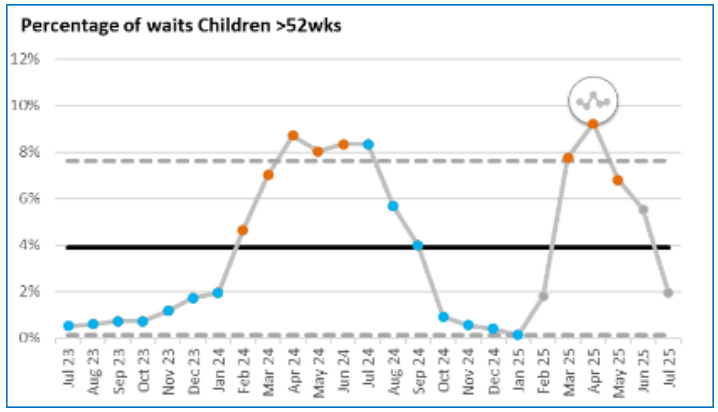
Site & Metric	Cause of variance/ non-compliance	Actions: Completed since last update, New, and Ongoing	Recovery Date	Data Quality
ESTH Proportion waits over 52 weeks – above monthly trajectory (June 2025) of 1.37% Percentage within 18 weeks – above monthly trajectory (June 2025) of 63.00% Percentage waits for first appointment under 18 weeks – above monthly trajectory (June 2025) 78.28%	• 52-week waits did not achieve the ambition of being below 1.37% in June 2025, with a performance of 1.77%. 52 week waits increased again from 950 in May 2025 to 992 in June 2025. The specialties with the highest volumes of patients waiting more than 52 weeks were Dermatology (312), Gynaecology (103) and Trauma & Orthopaedics (100). • 65-week waits also increased again from 98 in May 2025 to 108 in June 2025, with the highest volume being within Dermatology. • The RTT PTL also increased again from 53903 in May 2025 to 56144 in June 2025. • Percentage waits for first appointment under 18 weeks was above plan in June 2025 with a performance across the month of 80.4%.	**Total PTL** • ESTH's PTL grew in May and June 2025 after a sustained decline, mainly due to the EPR implementation. Reduced activity was needed to safely introduce the new system, and as with any major change, task times increased temporarily. Urgent and cancer pathways were prioritised to protect patient safety. Delays in outcome data recording and ongoing training issues, common in EPR rollouts, also contributed. Some patients remain on the PTL despite completed pathways, teams are working to resolve on iCLIP. **Long Waiters -52WW** - Recovery plans remain in place and ongoing for the most challenged specialties. • <u>Dermatology:</u> Long waits in this service stem from reduced activity after EPR implementation, cancer demand pressures, and delayed outcomes from the Virtual Lucy platform. The Virtual Lucy project ended in March 2025, having discharged 620 patients (43% of referrals). However, those still needing first appointments experienced longer waits. The service team are currently working up a recovery plan for RTT and cancer and a bid has gone via SWL to support funding for Skin analytics to help reduce waiting times and reduce the waits for first appointments. • <u>Gynaecology:</u> Long waits are due to limited theatre and clinic capacity for joint cases and Endometriosis patients. Interviews for an additional Endometriosis Consultant were held the week ending 18/07/25, with expanded theatre and clinic capacity expected soon. Plans are also in place to triple joint case lists with Colorectal from July 2025 to January 2026. • <u>T&O</u>**:** Previous delays in patient treatment due to custom implant requirements have been addressed with a new SOP, significantly reducing wait times. This is noticeable in the 52WW reduction from 109 in May 2025 to 100 in June 2025. Outpatient initiatives are also underway to improve performance further.	25/26 trajectories expected to be achieved by March 2026	June 2025 data sufficient for assurance

Operational Performance

Exception Report | Community Services Waiting Times (Children)

Sutton Healthcare

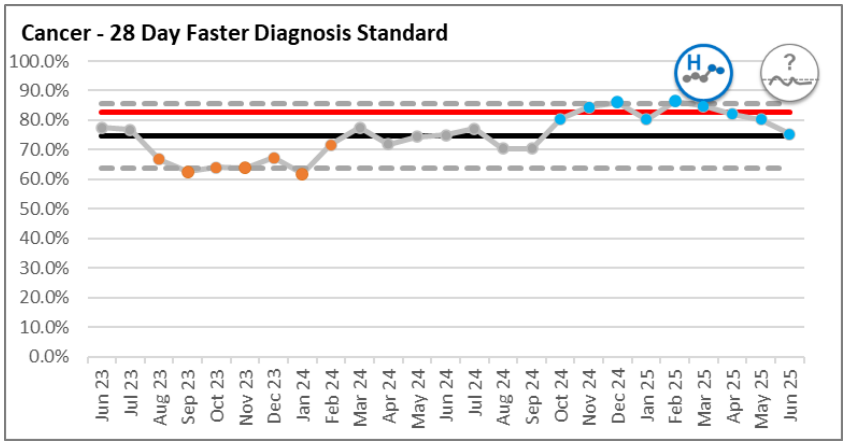


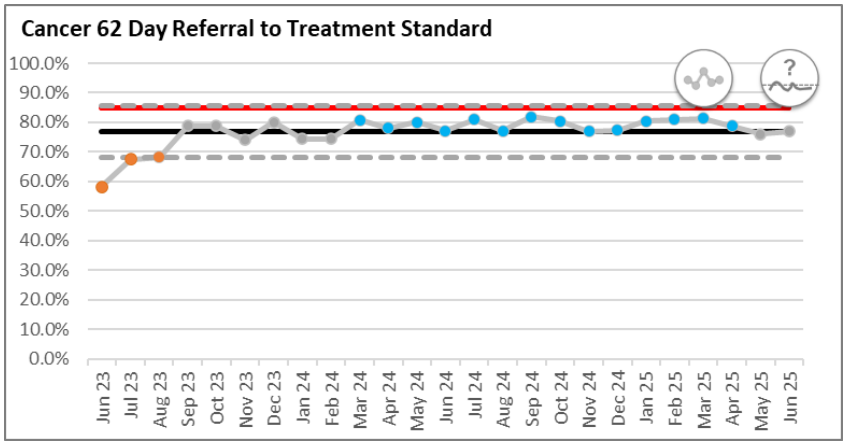


Site & Metric	Cause of variance/ non-compliance	Actions: Completed since last update, New, and Ongoing	Recovery Date	Data Quality
Sutton Health & Care	Children's Speech and Language Therapy (SALT) Service is experiencing pressure, in both waiting list volumes and 52-week breaches. However good progress has been made on 52-week waiters. At the end of July n=20 children were waiting more than 52 weeks within SALT services.	• PLACE via Sutton Alliance in April 2025 agreed actions related to the external scrutiny of children's therapy to provide assurance of maximum efficiency, productivity alongside learning from best practice. SHC have now met with Cognus (LBS children's therapy service) to improve working collaboration and also with other childrens community providers across SWL to share best practice. An action plan will be collated. • SHC undertake continued review of harms with Integrated Care CNO. • Education, Health and Care Plans (EHCP) targets remain on track.	TBC	Sufficient for assurance

Operational Performance

Exception Report | SGUH 28 day and 62 day Cancer Performance

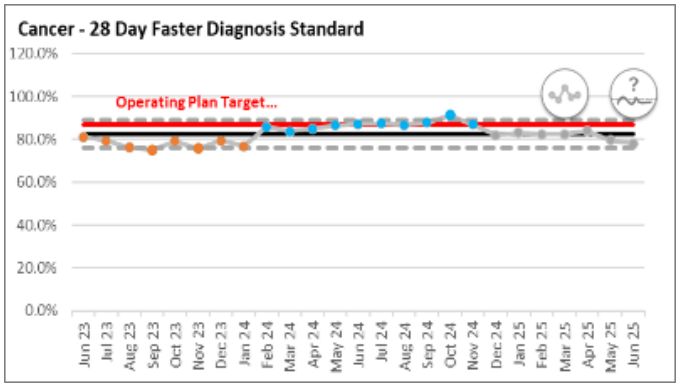


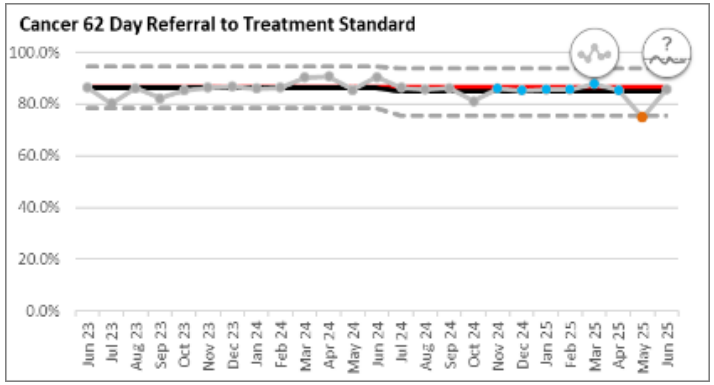


Site & Metric	Cause of variance/ non-compliance	Actions: Completed since last update, New, and Ongoing	Recovery Date	Data25 Quality
SGUH 28 Day – below trajectory of 82.42% 62 Day Normal variation below trajectory of 80%	**28 Day performance 75.4% for June 2025 – below monthly trajectory of 82.42%, driven by:** • Skin (71.7%) has seen an increase in seasonal referrals impacting access to clinic and minor ops. • Gynae (45.2%) saw an improvement from the previous month (72.7%) due to access to one stop Hysto/ Scan. ○ Whilst Breast remained compliant there was a project drop in performance due to workforce gaps and access to one stop **62 Day combined performance for June 2025 77%, improvement from the previous month below monthly plan of 80%.** ○ Theatre Access: Lung (63%), ○ Diagnostics & Complex Pathways: LGI access remains limited (68%). ○ Skin (79.2%): Seasonal referral increase (%) impacting clinic and minor ops capacity. ○ Breast(71%): Worforce Gaps and front end delays	The Trust has received £70K in summer operational resilience funding from RMP to support additional capacity for cancer activity. **Additional initiatives include:** **Dermatology to Plastics:** RMP funded WLIs to manage demand and introduction of triage to redirect referrals to tele dermatology. **Gynae:** Demand and capacity and recovery trajectory being developed to reduce backlog of 57 patients awaiting Hysteroscopy scan. **GI Pathway Group:** Developing a single-entry point for referrals, enhancing straight-to-test access, first-time-right diagnostics, and benign discharge processes. The pathway mapping and 1st clinical Decision Meeting set up in July 25. **Pre-assessment Improvements:** Aiming to deliver a PTL that will take the 7-day median delay from e-TCI to pre-assessment booking. The Tableau dashboard is under testing phase.	Sep 2025	Sufficient for assurance

Operational Performance

Exception Report | ESTH 28 day and 62 day Cancer Performance

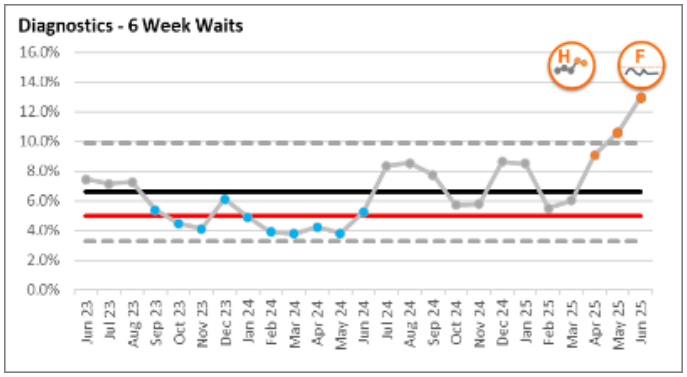




Site & Metric	Cause of variance/ non-compliance	Actions: Completed since last update, New, and Ongoing	Recovery Date	Data Quality
28 Day Faster Diagnosis – Below trajectory of 86.86% 62 Day Standard - Below trajectory of 86.78%	**ESTH met the national standard for Faster Diagnosis standard, achieving 78% but were unable to meet the internal trajectory of 86.86%** FDS performance was affected by two main issues: a high volume of suspected cancer referrals in dermatology alongside consultant shortages, limiting capacity and relying on insufficient ad hoc clinics; and delays in gynaecology, which has struggled to book first appointments within the 14-day target. **ESTH met the national standard for 62-Day Standard, achieving 85.7% but were unable to meet our internal trajectory of 86.78%.** Majority of the 62-day breaches were for lung (8), Gynae (3) and Urology (3) pathways with the remaining 4.5 breaches distributed throughout the remaining tumour sites.	**Dermatology:** is reallocating routine capacity to cancer cases to reduce first appointment waits. **Lower GI:** FDS is also impacted by delays with endoscopy bookings and anaesthetic staffing shortages are causing further delays in deep sedation endoscopy. **Lung:** Breaches reduced from 14 in May to 8 in June. To manage demand and shorten waits, all Navigational Bronchoscopy referrals are now triaged by a multidisciplinary team (MDT) to identify patients suitable for alternative diagnostics such as CT-guided biopsy. RMP is exploring additional services to further reduce delays. PET scan delays at RMH have been resolved following the installation of a new PET scanner and an increase in consultant radiologist capacity, completed in August. **Gynaecology:** Earlier delays due to late booking of first appointments were resolved by July/August. Ongoing challenges remain with hysteroscopy diagnostics and limited surgical capacity, which continue to impact waiting times. **Urology:** Breaches are primarily linked to patient choice and the complexity of care pathways, which can extend diagnostic and treatment timelines.		

Operational Performance

Exception Report | ESTH Diagnostic Performance

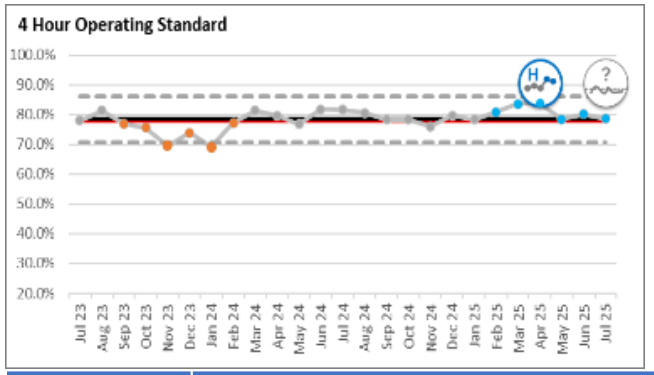


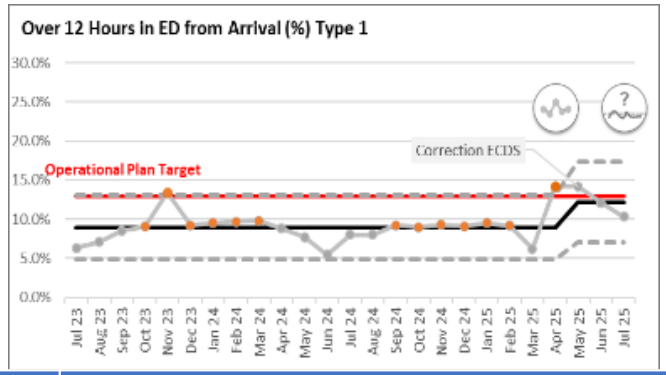
Modality	6Wk Breaches	6Wk Performance
Colonoscopy	428	48.4%
Gastroscopy	404	47.2%
Audiology - Audiology Assessments	351	24.6%
Non-obstetric ultrasound	166	2.5%
Flexi sigmoidoscopy	130	54.6%
Cardiology - echocardiography	99	11.6%
Cystoscopy	58	30.5%
Urodynamics - pressures & flows	23	20.2%
DEXA Scan	18	4.7%
Computed Tomography	7	1.4%
Neurophysiology - peripheral neurophysiology	3	1.5%
Magnetic Resonance Imaging	2	0.3%

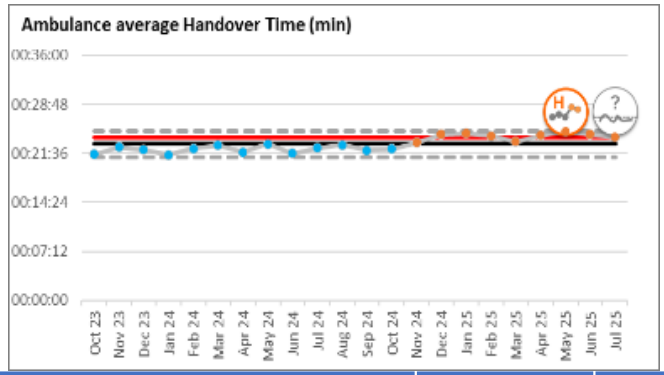
Site & Metric	Cause of variance/ non-compliance	Actions: Completed since last update, New, and Ongoing	Recovery Date	Data Quality
ESTH 6Wk waits 13.0% not meeting national interim target of 5%	At the end of June 2025 there were 1689 patients waiting more than 6 weeks for their diagnostic (DM01). This is the fourth consecutive monthly increase and as a result, the performance deteriorated again from 89.40% in May 2025 to 87.04% in June 2025, still below the national interim target of 95%. The modalities with the highest volumes waiting >6 weeks at the end of June 2025 were Endoscopy (962), Audiology (351) & NOUS (166).	• **ENDOSCOPY:** There continue to be challenges with capacity for patients requiring deep sedation due to limited anaesthetic resources and workforce shortfalls. Saturday Waiting List Initiative (WLI) sessions have been approved for July, August and September. Planned sessions will deliver approximately 300 additional procedures. Due to ongoing challenges presented by iClip (additional admin time for all procedures), we are currently running most lists at reduced capacity (83%), equating to up to 200 fewer procedures monthly. A detailed audit is underway to identify opportunities to increase capacity (subject to clinical workforce discussion and agreement). Additionally, data quality issues, such as duplicate referrals and patients still waiting post-appointment, are being actively investigated. • **AUDIOLOGY:** The audiology service has faced challenges due to the recent inclusion of paediatric audiology in the reporting matrix, along with reduced activity following the iClip implementation. A recovery plan has been worked up but limited due to reviewing options without relying on additional sessions. The department is also experiencing staffing pressures from recent long-term sickness and difficulties in recruiting experienced staff. Following a recent skill mix review, we expect to receive approval to fill vacancies, which should help improve the situation over the next six months. • **NOUS:** NOUS breaches increased to 166 for the June DMO1 submission; however, 77 of these were avoidable. The issue stemmed from a failure in the daily Soliton replication process, which typically generates data automatically. As the report for 1st July was not produced, the team submitted data from 30th June to DMO1. This submission included 77 NOUS patients seen on 30th June who should not have been recorded as breaches.	March 2026	June 2025 data still includes a degree of DQ following EPR implementation that continues to be worked through with BI and operational teams

Operational Performance

Exception Report | SGUH A&E Waits and Ambulance Handovers



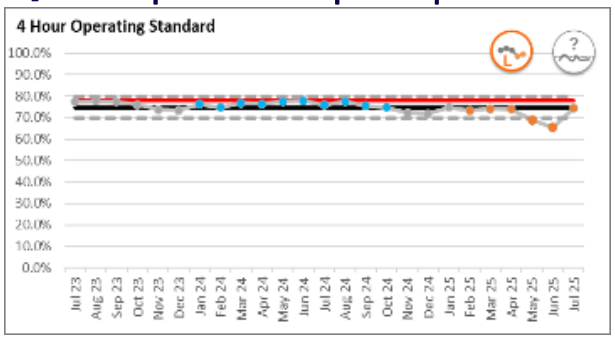


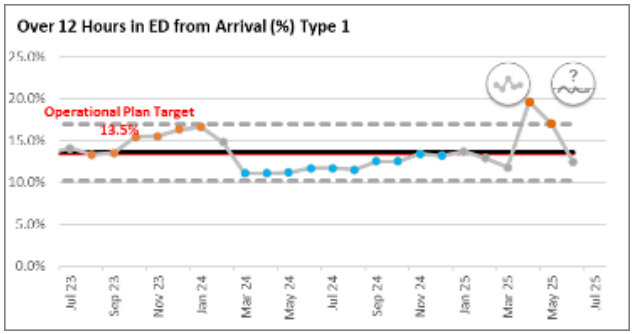


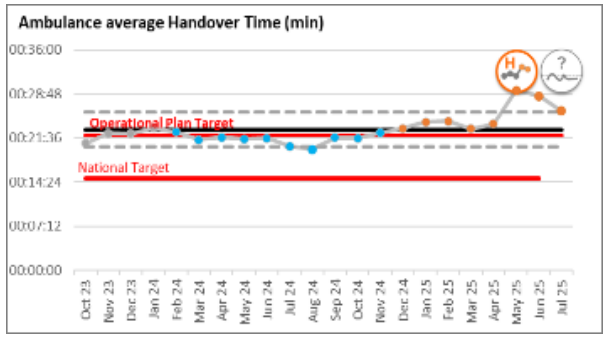
Site & Metric	Cause of variance/ non-compliance	Actions: Completed since last update, New, and Ongoing	Recovery Date	Data Quality
SGUH 4 Hour Target met in July 2025 12 Hour waits Type 1 – normal variance meeting plan Ambulance Handover – in line with plan	Achieved 78.6% 4hr performance in July 2025, meeting 78% national target. High volume of mental health patients attending ED, with long waits for mental health beds .	• Dedicated Treatment pod for faster delivery of IVs and dedicated investigation cubicle. • Maintaining in-and-out spaces to aid flow. • Further development of SDEC inclusion criteria, increase in surgical SDC capacity delivered with more planned. • Direct access to Paediatric clinics for UTC plastic patients. • Monthly meetings with London Ambulance Service (LAS) to resolve issues between both Trust and LAS. • Planned Frailty Same Day Emergency Care (SDEC) launched beginning of July – average 4 patients per day: 79% of patients discharged, 21% patients admitted with average LOS 2.5 days • Launch of Patient Check In has reduced average time in streaming queue from 28 mins to 8. • Long waiting patients in ED are continually monitored through their stay. Tests / diagnostics required for their onward treatment are requested while a ward-based bed is sought • Change of assessment / triage model to allow greater resources at the front door. This will give an additional streamer and have RAT consultant at ambulance triage to support timely handover and redirection – SOP written to go to ED directorate meeting 20th August • Consultation of EP shift patterns / rota to allow additional streamer Mon-Wed completed and will be live from 6th October • Pharmacy first launched 14th July – KPIs being collected to review in Sept • Review EPCH provision to ensure best use of resources • Reviewing medical rota to allow ACPs and PAs to support streaming	4hr Performance currently being delivered 12hr performance meeting plan 15 min LAS handover by April 2026	Sufficient for assurance Sufficient for assurance (data source NHSE ECDS Extract) Sufficient for assurance (NHSE Ambulance data)

Operational Performance

Exception Report| ESTH A&E Waits and Ambulance Handovers



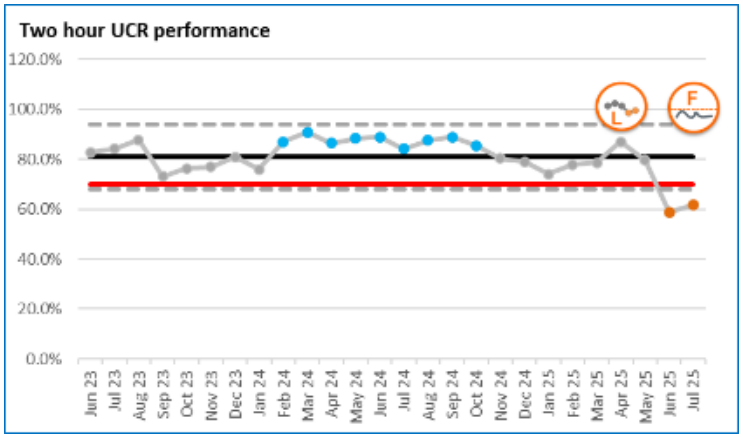




Site & Metric	Cause of variance/ non-compliance	Actions: Completed since last update, New, and Ongoing	Recovery Date	Data Quality
ESTH 4 Hr performance below trajectory of 76.5% ED Type 1 LOS>12 Hours - Meeting plan normal variation LAS Average Handover Time – Increasing Trend	Emergency department waiting times improved in the month of July, reporting 74.2% versus 65.4% in June 2025. ED attendances with greater than 12 hour wait times reduced in the month of July from a reported 17% in June to 12.4% in July exceeding operational plan target. Overall average ambulance handover delays reduced in July 2025 to an average of 26.7 mins from 28.5 mins in June 2025. High numbers of mental health patients requiring admission to an inpatient bed with many of these patients waiting a significant period in the department prior to transfer.	Our UEC transformation programme has undergone a full reset over the last two months and will significantly contribute to operational sustainability over the winter months. The comprehensive programme addresses key actions across the whole patient pathway within our hospitals and is underpinned by a multi-professional leadership structure within each workstream. The programme seeks to balance financial savings, with safety, operational performance, and flow improvements	TBC	4 Hour Sufficient for assurance (validated correct data) 12 Hours in ED – internal validated data (ECDS fix in place to correct) LAS Handover Sufficient for assurance (NHSE Reporting)

Operational Performance

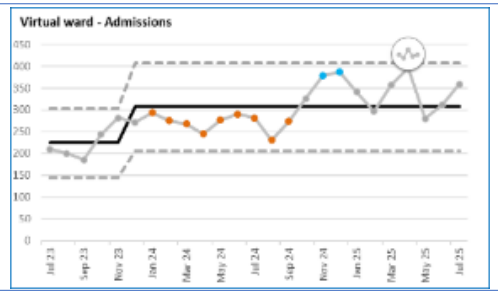
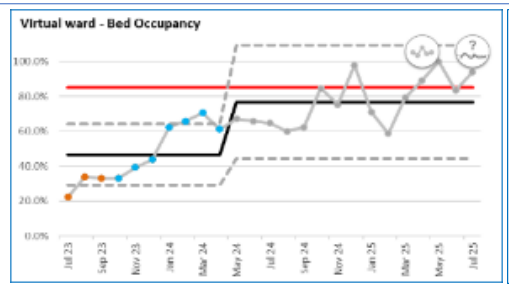
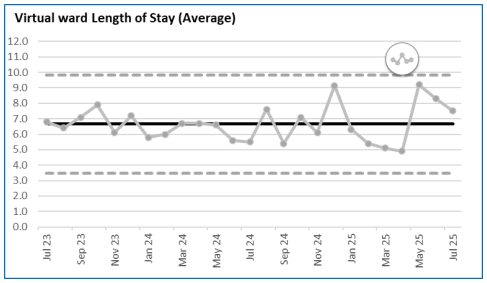
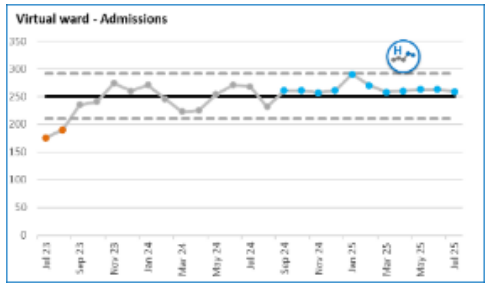
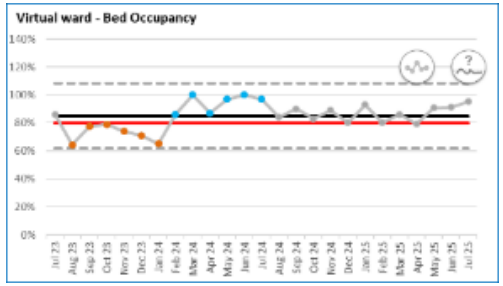
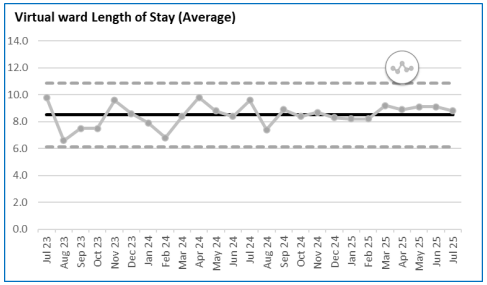
Exception Report | Sutton Health Urgent Community Response Performance



Site & Metric	Cause of variance/ non-compliance	Actions: Completed since last update, New, and Ongoing	Recovery Date	Data Quality
Sutton Health Below target of 70%.	Fix was made in EMIS to resolve an issue where patients where appearing incorrectly as rejected referrals rather than discharged following a contact which has significantly impacted performance reporting.	• This has now been resolved by EMIS. • Immediate actions to support recovery currently being agreed	TBC	Under Review

Operational Performance

Exception Report| **Integrated Care | Virtual Wards**

Sutton Healthcare			
Surrey Downs			

Site & Metric	Cause of variance/ non-compliance	Actions: Completed since last update, New, and Ongoing	Recovery Date	Data Quality
Sutton Health & Care	Admissions to the virtual ward continue to exceed the average, and showing normal variation. Occupancy for July stood at 94.1%, exceeding target of 85% with reduced length of stay.	• LoS reduction programme with ESTH and Sutton Alliance is in progress to include virtual ward redevelopment. • Engagement work with relevant wards and clinicians continues.	N/A	Sufficient for assurance
Surrey Downs Health & Care	Admissions to virtual ward remain above the mean with bed occupancy rate above 80%	• On-going development of enhanced care and new pathways in Virtual Wards.	N/A	Sufficient for assurance



Section 2.2:
Operational Productivity

Operational Productivity

Overview Dashboard

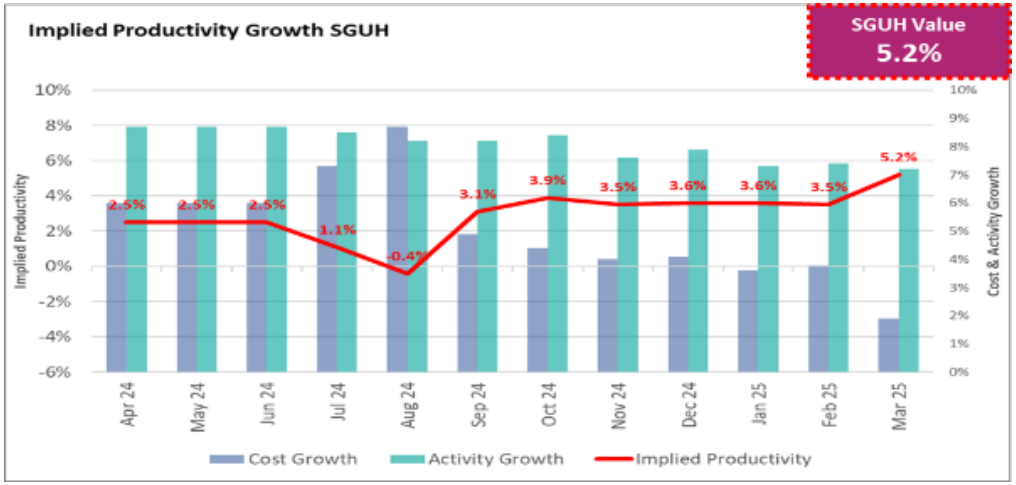
KPI	St George's Latest month	St George's Previous Month Measure	St George's Latest Month Measure	St George's Target	St George's Variation	St George's Assurance	St George's National Benchmark	Epsom & St Helier Latest month	Epsom & St Helier Previous Month Measure	Epsom & St Helier Latest Month Measure	Epsom & St Helier Target	Epsom & St Helier Variation	Epsom & St Helier Assurance	Epsom & St Helier National Benchmark
Implied Productivity Growth	Mar 25	3.1%	5.2%	-	N/A	N/A	N/A	Mar 25	-0.8%	0.2%	-	N/A	N/A	N/A
Non Elective Length of Stay (SWL Methodology exc 0 days and <18)	Jul 25	9.3	10.0	9.7			N/A	Jul 25	10.9	11.3	-		TBC	N/A
Average delay to discharge	Jun 25	5.0	4.4	5.6			2nd Quartile	May 25	10.1	10.0	10.0			TBC
Theatre Utilisation (Capped)	Jul 25	83.0%	82.0%	85.0%			2nd Quartile	Jul 25	70.9%	75.3%	85.0%			Lowest Quartile
BADS All Daycase & Outpatient Procedures % of total procedures	Apr 25	81.9%	82.2%	83.6%			3rd Quartile	Apr 25	81.0%	81.4%	83.6%			Lowest Quartile
Outpatients Patient Initiatied Follow Up Rate (PIFU)	Jul 25	2.4%	2.5%	5.0%			Lowest Quartile	Apr 25	4.6%	5.3%	5.0%			2nd Quartile
Outpatients Missed Appointments (DNA Rate)	Jul 25	9.9%	9.8%	8.0%			Lowest Quartile	Jul 25	8.9%	7.5%	6.0%			Lowest Quartile
First and Procedure Attendances as a proportion of Total Outpatients	Jul 25	52.5%	51.7%	49.0%			2nd Quartile	Jul 25	40.5%	40.9%	49.0%			Lowest Quartile

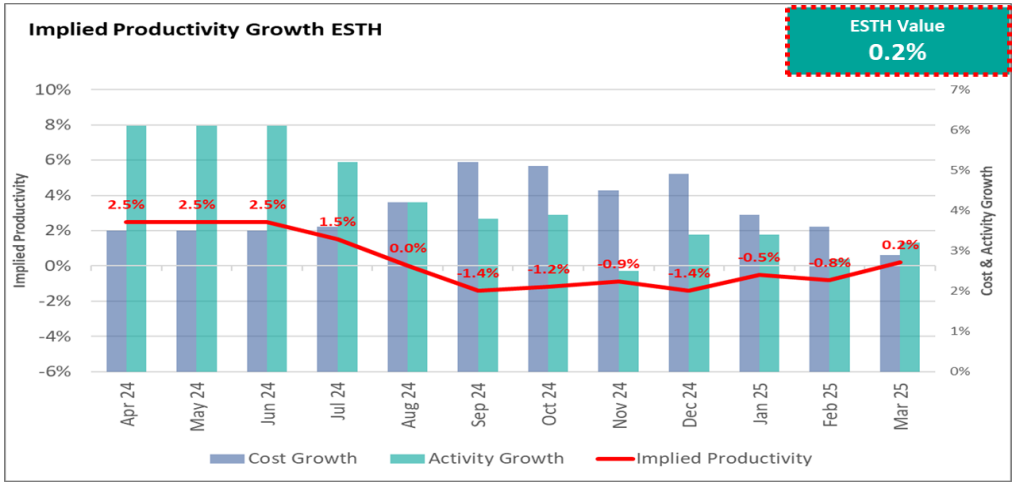
Operational Productivity

Implied Productivity – Headline NHSE Metric

Implied productivity for acute and specialist trusts is assessed by comparing the growth in outputs (cost-weighted activity) to the growth in inputs (operating expenditure), using a baseline period. This measure reflects year-to-date performance against the same period in the previous financial year. Data is drawn from the Model Health System, which reports with a four-month delay. A positive value indicates improved productivity; a negative value suggests a decline.

NHS England is expected to publish further detail on the methodology in September 2025, which will help identify key areas for improvement.





Summary and actions

- The *Implied Productivity* national metric shows a 5.2% improvement in productivity in 2024/25 YTD Month 12 compared to same period the previous year (2023/24). This is driven higher weighted activity growth of 7.2% compared to cost growth of 1.9%.

Summary and actions

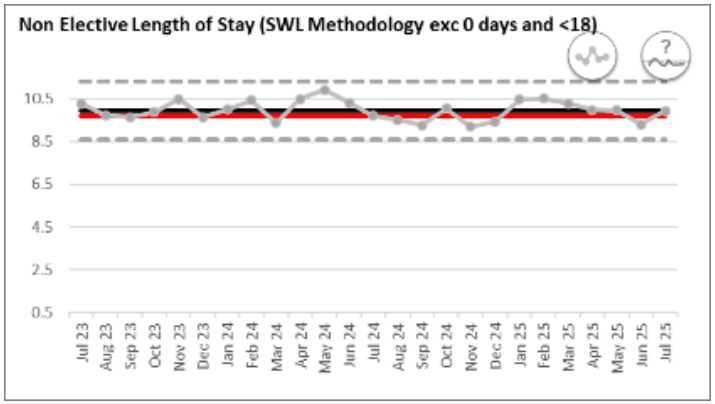
- The *Implied Productivity* national metric shows a 0.2% increase in productivity in 2024/25 YTD Month 12 compared to same period the previous year (2023/24). This is driven by a cost growth of 2.9% compared to growth in weighted activity of 3.2%.
- Activity has increased across all points of delivery except maternity and critical care. However, the scale of growth remains below that of peer trusts. Further analysis of delivery-specific trends is underway, pending detailed data and metric methodology guidance from NHS England.

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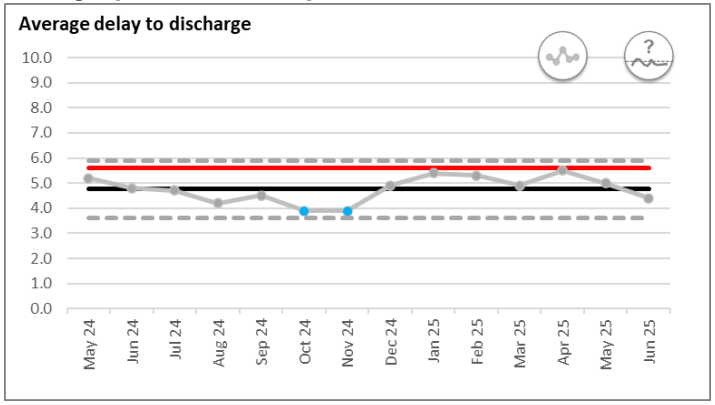
Model Hospital reporting YTD Month 12 2024/25

Operational Productivity

SGUH – Non-Elective Length of Stay (NEL LOS)



Adoption of SWL methodology for calculation of non-elective average LOS (i.e. Adult patients discharged from the hospital in month that had a method of admission of emergency, but excluding patients that did not have an overnight stay in hospital and excluding maternity, paediatric and A&E specialties). The target is predicated on assumptions consistent with plans currently in place to facilitate the effective diversion of a proportion of short-stay admissions at the front door.



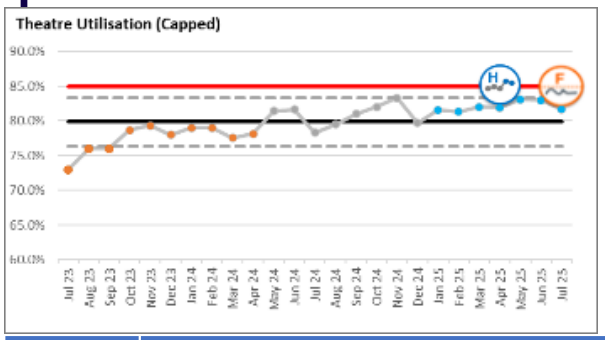
Acute hospital discharges and bed days after the Discharge Ready Date averaged over a complete month.
Numerator: The number of days from discharge ready date to date of discharge
Denominator: The number of patients with a delay of 1 or more days that have been discharged

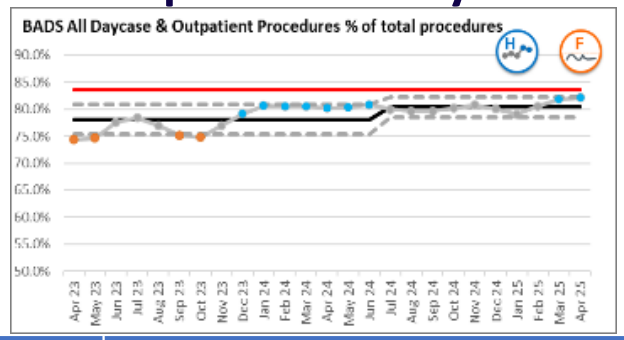
Metric	Reporting Month	Productivity Opportunity vs Target
NEL Length of Stay.	July-25	TBC

Site & Metric	Cause of variance/ non-compliance	Actions: Completed since last update, New, and Ongoing	Recovery Date	Data Quality
SGUH LOS - normal variation Average delay to discharge- normal variation	• Through July 2025, on average in-patients stayed in a hospital bed for 9.9 days, which remains below the mean and close to the target of 9.0 days. • Super Stranded patients >21 days continues to see a sustained reduction and remains on trajectory to decrease further • The number of NCTR patients has also seen a sustained improvement supporting length of stay reductions. • Largest number of NCTR patients are within pathway 0, which is an expected picture, and the site is now achieving the national expectation of 80%, however the length of stay post NCTR for this cohort remains too high with only 37% of pathway 0's being discharged within 24hrs, against a KPI of 80%. • Average delay to discharge remains consistent and below peer and national average	• >7 day LoS meetings embedding lead by all divisions with a 40+day panel established. • Care without corridor workshops being rolled out across all divisions, to nursing, medical and operational staff • IMS system continues to be embedded to ensure delivery of actions to improve flow • Complex case meetings in weekly with each local authority • Project manager allocated to deliver IMPOWER recommendations as a secondment from DHSC due to start by September 2025 and provide 2 months of support • Explore alternative methodologies for capturing NCTR data to improve accuracy and release nursing time		Sufficient for assurance Sufficient for assurance (published NHSE data on month in Arrears)

Operational Productivity

SGUH - Theatre Utilisation & Outpatient & Daycase Procedure Rates





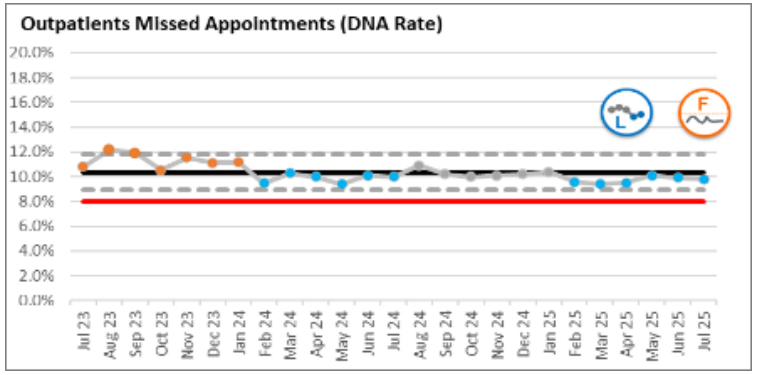
Metric	Reporting Month	Productivity Opportunity vs Top Quartile
Capped Theatre Utilisation	Jul-25	19 cases (based on an average case time of 124 min) to hit top quartile
Day cases and outpatient procedures (BADS)	Apr-25	433 cases opportunity to move to OP (3 month period)

Site & Metric	Cause of variance/ non-compliance	Actions: Completed since last update, New, and Ongoing	Recovery Date	Data Quality
SGUH - Capped Theatre Utilisation increasing trend	**Theatre Utilisation – July 2025 Overview** **Capped Theatre Utilisation:** Maintained at 82% throughout the month. **IP:** Reached 84%, **QMH:** 69%. **DSU :** Increased to 78%. **Key Challenges:** **Same-Day Cancellations:** Rose to 48 cases, representing an increase from the previous month in the main due to technical issues. **Estates Issues:** High temperatures impacted operations, particularly in theatres located in the St James Wing. **Technical Failures:** The hybrid theatre experienced two separate breakdowns during the month.	**1. Theatre Scheduling Enhancements** A structured 6-4-2 escalation framework is being implemented to improve theatre scheduling and utilization, supported by a custom digital tool to boost productivity and align bookings with the overall production plan. **2. OTDC Cancellation Policy** The new OTDC cancellation policy, now in early implementation, aims to standardize cancellation reasons per national frameworks. An IT change request to support this has been approved by CICG **3. ePOA Workstream Progress** Following a successful pilot in Gynaecology, the **ePOA digital pre-operative assessment platform** has now expanded to Breast and ENT specialties. Full Cerner integration will proceed post system change freeze. **4. Anaesthetic QI Project** The Anaesthetic team is leading a QI initiative to reduce avoidable Day Surgery cancellations. This involves closer collaboration with POA to improve early identification and optimisation of at-risk patients	TBC	sufficient for assurance
SGUH: normal variation, below top quartile peer	**Day Case Rate:** Over six months, the average day case rate was 65%, below the 77% peer average. Efforts are ongoing to improve planning and shift eligible procedures to the DSU **Inpatient Procedures:** SGUH sees more inpatient cases than peers due to higher patient complexity, driving demand for beds for procedures typically done as day cases elsewhere	**BADS Compliance:** Surgical teams are engaged via the theatre transformation programme to enhance BADS compliance. This is being promoted through the “Right Procedure, Right Place” initiative within local Theatre User Groups (TUGs). **Training and Job Aids:** Trust-wide training on management code usage has improved data accuracy and reduced LOS. Updated job aids now support accurate coding for both admin and clinical staff. **Operational Process Improvement:** Clinical teams are refining processes to better predict and classify day cases, supported by TUG engagement	TBC	Sufficient for assurance

Operational Productivity

SGUH - Missed Appointments (DNA Rate)

St George's



Metric	Reporting Month	Productivity Opportunity vs Top Quartile
Outpatients: DNA rates	Jul-25	1,215 appointments

The methodology to calculate the opportunity to reduce the number of missed outpatient appointments is based on how your average missed outpatient appointments rate (from the last 6 months) compares to the national missed appointments profile for providers.

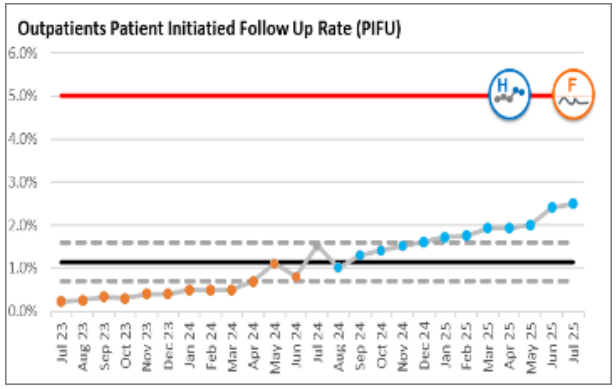
Site & Metric	Cause of variance/ non-compliance	Actions: Completed since last update, New, and Ongoing	Recovery Date	Data Quality

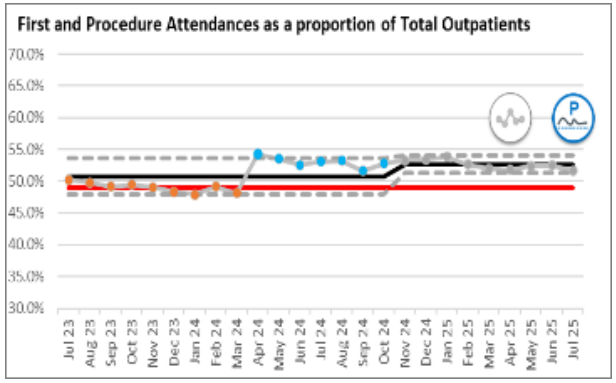
SGUH
Normal variation however not meeting target of 8%
	Current DNA rates of 9.8% against a peer average performance 7.4% through July 2025.
	YTD **two thirds** of the Trusts DNAs have occurred in just 12 specialities.
	• Therapies
	• ENT & Audiology
	• Chest Medicine
	• Dermatology and Lymphoedema
	• Rheumatology
	• Neurology
	• T&O
	• Diabetes & Endocrinology
	• Obstetrics
	• Gastro and Endoscopy
	• Max Fax
	• Paediatric Medicine
		- Speciality-level data reviewed weekly with all operational leads in Elective Access Meetings
		- Reviewing Model Hospital data to view performance against peers and review opportunity to reduce DNAs
		- Site **Outpatient Transformation Board** has a dedicated workstream focused on reducing DNA rates. Priority actions will be agreed and progress will be monitored through the group.
		- Trust sms reminder review underway
		  - Issue identified with Dental and max fax reminders causing them to fail. Issue rectified and 7 and 2 day reminders now switched on, impact will be monitored.
		  - Review of all appt types/clinics with no active sms reminders is taking place with a view to increase the coverage of reminders.
		  - Content and timing of sms under review
		- Updated access policy agreed with stronger/clearer expectations around DNA
		- Proposal submitted around changing approach to rebooking of DNA pts who are not discharged.
		- Partial booking light is being proposed to support letter management of appointments and reduce DNA's.
			Under review at Outpatient Transformation Board	sufficient for assurance

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Operational Productivity

SGUH – Reduction in Outpatient Follow-Ups



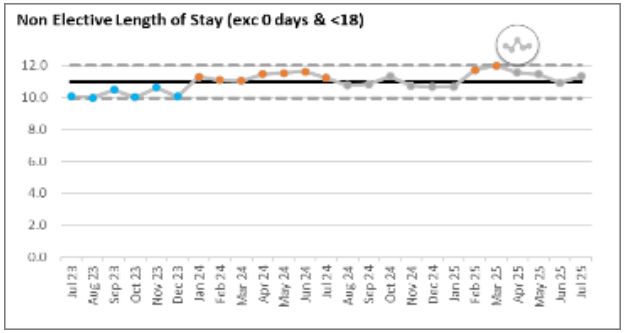


Metric	Reporting Month	Productivity Opportunity vs Top Quartile
1st + Proc as a % of Total OP	July-25	*0 (exceeding target)*
PIFU Rates	July -25	*Not quantified to avoid double-counting with New: FU Ratio opportunity*

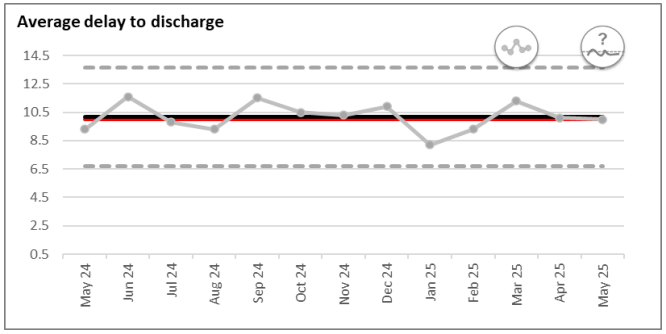
Site & Metric	Cause of variance/ non-compliance	Actions: Completed since last update, New, and Ongoing	Recovery Date	Data Quality
SGUH PIFU Rate: Consistently not meeting target, improving trend at 2.5%	In month performance for July 2025 continues to see a positive upward trend at 2.5%, however a significant increase is required across the year to achieve 5%.	• All GIRFT specialties are now live with PIFU. Plans are in place to ensure more specialties are ready to go live - patient leaflets, clinician understand the process, and local SOP. • New PIFU and Follow up reduction workstream formed within OP Transformation Programme. PID has been agreed. • Work underway to develop PIFU by default pathways for post surgical cohorts. • Work has begun to review and improve access process for PIFU pts requiring appts. To improve patient experience and to provide assurance to clinicians that patients will be well supported, to increase the likelihood of them utilising the PIFU option for their pathways. • Work has begun to develop PIFU type process for post DNA rebooking. • Proposal made for addition of a PIFU Open access option for patient groups who will not be discharged eg, Sickle cell, Lymphoedema etc.	5% target for end of 25/26	sufficient for assurance

Operational Productivity

ESTH – Non Elective Length of Stay



Adoption of SWL methodology for calculation of non-elective average LOS (i.e. Adult patients discharged from the hospital in month that had a method of admission of emergency, but excluding patients that did not have an overnight stay in hospital and excluding maternity, paediatric and A&E specialties).



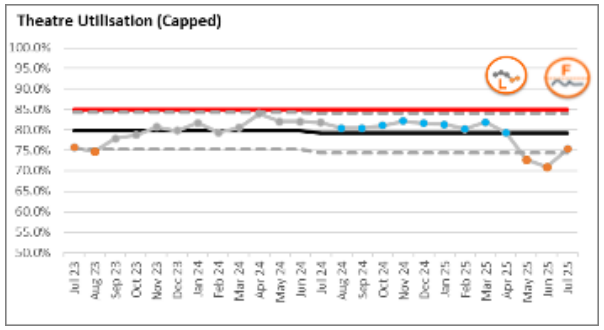
Acute hospital discharges and bed days after the Discharge Ready Date averaged over a complete month.
Numerator: The number of days from discharge ready date to date of discharge
Denominator: The number of patients with a delay of 1 or more days that have been discharged

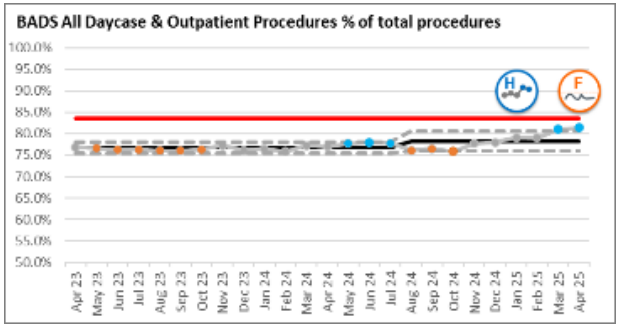
Metric	Reporting Month	Productivity Opportunity vs Target (annualised)
NEL Length of Stay.	July-25	TBC

Site & Metric	Cause of variance/ non-compliance	Actions: Completed since last update, New, and Ongoing	Recovery Date	Data Quality
ESTH LOS Normal Variation Average delay to discharge normal variation (high compared to peer)	• ESTH length of stay increased by 0.4 days in July 2025, from 10.9 days in June 2025. This was contributed by the discharge of a highly complex patient in July with a 326-day LOS. • Average number of patients with no criteria to reside (NCTR) remain static in July. Work continues to ensure compliance and validation in NCTR position post EPR roll out. • Super stranded patients remain static in July 2025 • A high number of patients are still awaiting complex pathway 3 placements or inpatient neuro-therapy providers. Many medically fit patients continue to require acute therapy before discharge.	**The ESTH Urgent Care Transformation programme has defined priorities for 2025/26, including:** 1. Board/Ward Rounds -Standardising ward processes and accelerating discharge pathways via structured board rounds and improvement huddles. 2. Therapies -Enhancing productivity and deployment of the therapy workforce to ensure timely, needs-based care through targeted workforce and process improvements. 3. Bed Reduction Plans - agree and implement a redesign of the internal bed base Trustwide optimising estate footprints and staffing ensuring improved efficiency and a reduction in overall capacity requirements. 4. Acute Medicine Workforce -Reviewing the acute medicine workforce to optimise available resources 5. Operational Flow Management -Strengthening patient flow through improved daily systems, escalation processes, and governance. 6. Data reporting/KPIs –Developing a KPI dashboard to monitor progress across workstreams and the overall programme. • Daily discharge reports now resumed post EPR cutover, aiding internal & external partners with tracking medically fit patients. • Daily CTR status reports and validation continue to support compliance and include alerts by Site, Division, and ward. • Weekly reviews of 0–14 day LOS patients continue under Trust/Site OPEL 3, alongside complex discharge reviews involving external partners. • Revised KPIs to support the 2025/26 UEC Transformation Programme are in draft and progressing with the BI team, aligned to ICLIP reporting.	Target and recovery under review	Sufficient for assurance

Operational Productivity

ESTH - Theatre Utilisation & Outpatient & Daycase Procedure Rates

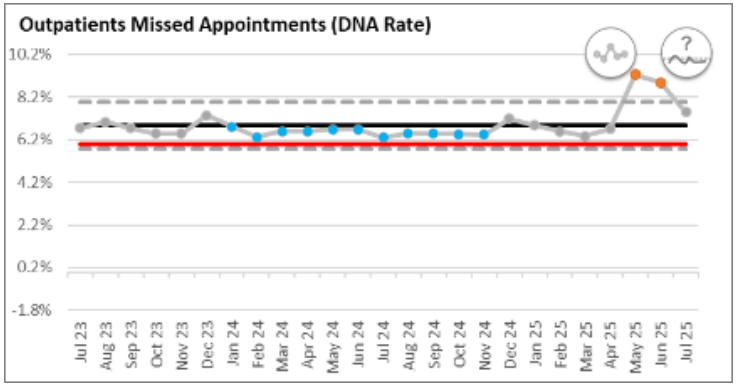




Metric	Reporting Month	Productivity Opportunity vs Top Quartile
Capped Theatre Utilisation	Jun-25	300 cases (based on an average case time of 63 min) to hit top quartile
Day cases and outpatient procedures (BADS)	Jun-25	504 cases opportunity to move to OP (3 month period)

Site & Metric	Cause of variance/ non-compliance	Actions: Completed since last update, New, and Ongoing	Recovery Date	Data Quality
ESTH Theatre Utilisation Special cause variation of a CONCERNING nature. and failing target (85%) BADS performance Not meeting target, Improving trend	**Theatre Utilisation** was 75.34% in July. We are working with SGH to determine whether current scheduling challenges are due to a system training gap in iClip or a genuine reduction in list capacity due to new iClip pathways. We are also exploring digital scheduling solutions e.g. TheatreMan to support accurate case timing. **Late Starts** in July were below target at 24 minutes, and **underruns** were slight above average at 33 minutes. **OTDC July data unavailable**	**Perioperative Care pathway and processes:** In lieu of the patient portal we have identified a possible digital solution to enable us to mass text the Early Health Screening Form to all patients on the admitted waiting list. This is currently pending DPIA approval. We are also planning to move the booking of POA appointments into the POA team from the pods, to ensure POA appointments are booked correctly, and slots are not wasted. **Day Case Rates (BADS):** We have improved Model Hospital day case rates from **77.9% in December 24** to **81% in March 25.** This was mainly driven by coding improvements in **EOC.** Excluding EOC **ESTH** performance was **89%** in quarter ending March 25. We are reviewing High Volume Low Complexity procedures against GIRFT with a view to increasing day case rate for certain procedures. **On The Day Cancellations:** Reporting remains paused due to Theatre Dashboard data quality issues. The OTDC Task & Finish Group will meet on 14 August to confirm resolution and resume reporting **Specialty Deep Dives:** We are continuing to work with specialties who are consistently underperforming against 85% utilisation to understand the challenges and implement changes to support improved utilisation. **Starting on Time:** Following the introduction of additional consenting rooms in Epsom Theatres. Consenting Rooms have been allocated to a specific Theatre resulting in a more streamlined process in the morning.	March 2026	Since the implementation of iClip there have been ongoing issues with accurate reporting for theatres, however, these issues are steadily resolving.

Operational Productivity
ESTH Missed Appointments (DNA Rate)



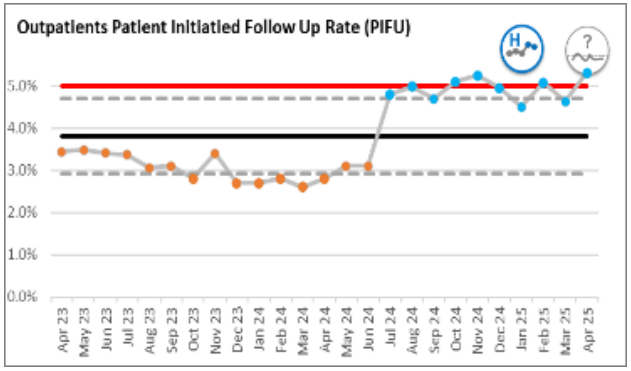
Metric	Reporting Month	Productivity Opportunity vs Top Quartile
Outpatients: DNA rates	Jul-25	720 Appointments

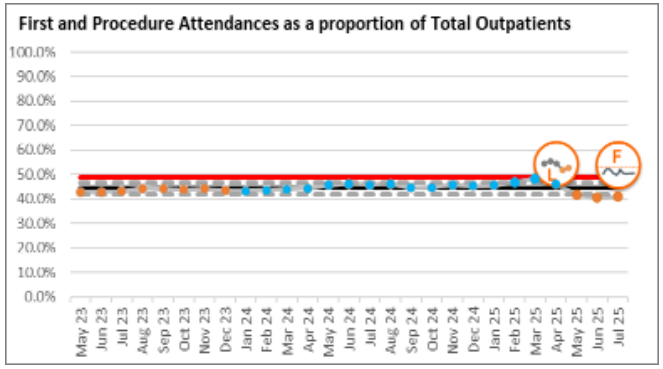
The methodology to calculate the opportunity to reduce the number of missed outpatient appointments is based on how your average missed outpatient appointments rate (from the last 6 months) compares to the national missed appointments profile for providers.

Site & Metric	Cause of variance/ non-compliance	Actions: Completed since last update, New, and Ongoing	Recovery Date	Data Quality
ESTH Failing target of 6%, decrease through July	Following iClip go live it has been identified that some resource appointment types are not successfully running. An issue with appointment letters has been identified and a solution is being developed to resolve the issue.	Work to review and ensure all text reminders are functioning has been successful in further reducing the DNA rate towards the pre iClip baseline, with July at 7.52% (pre iClip baseline April 6.73%) The initial cohort of patient who have DNA'd multiple times highlighted additional queries which are now being worked through. Appointment types and clinic resources with consistently high DNA rates have been identified and are now being discussed with services. While overbooking is being explored as a potential mitigation strategy, progress is currently constrained by the ongoing adjustment of clinicians to the iClip system. However, this is progressing in Gynaecology with 3 consultant clinics and 1 nurse clinic approved for additional bookings with an aim to run the clinics at full capacity to address the underrun that the DNAs create in these clinics. In Gynaecology, proposed changes to appointment letter wording have been requested to better set patient expectations around DNAs, when it could lead to being discharged and to encourage timely rescheduling where needed.	March 2026	May and June 2025 not sufficient for assurance due to large volumes of unoutcomed activity – this is improving

Operational Productivity

ESTH – Reduction in Outpatient Follow-Ups





Metric	Reporting Month	Productivity Opportunity vs Target (annualised)
Outpatients: [1st + Proc] as a % of Total OP	May-25	£600k
Outpatients: PIFU Rates	Apr -25	*Not quantified to avoid double-counting with New: FU Ratio opportunity*

Site & Metric	Cause of variance/ non-compliance	Actions: Completed since last update, New, and Ongoing	Recovery Date	Data Quality
PIFU – increased activity First & Procedure attendances – below target	**Unable to review PIFU rate due to reporting issues. Expected to be resolved by end of August.**	**PIFU –** Work to scale up PIFU continues over the summer. PIFU opportunity is being agreed with specialties in the Outpatient Transformation programmes where opportunity has been found. In Gynaecology and Respiratory, we have identified common use scenarios for PIFU. These will now be reviewed with the teams to create examples for PIFU use to encourage it's use by low users of PIFU and spread best practice. Updates to the PIFU SOP with the new iCLip process are being drafted in August to support lower users of PIFU with clarity on the new process. Low users are also being engaged to explore barriers to uptake, with discharge rates considered alongside to identify further opportunities. In Cardiology, follow-up, discharge, and PIFU protocols are being developed for both PAF and Heart Failure pathways to support consistent and safe implementation. Additionally, in Urogynaecology, a standard 3-6 months PIFU pathway for bladder training is now in use. **Follow Up Reduction:** Strategic opportunity packs have been shared with services to support follow-up reduction initiatives. Opportunity is being quantified with consideration being given to follow up back logs. A funding bid has been submitted to the London Innovation Network for the Gastroenterology Enhanced Triage model for to support implementation at ESTH. and in ENT, the pathway of consultant notes reviews in place of first outpatient appointments for selected adult conditions continues to be developed. In Cardiology and Respiratory, cohorts of stable patient who could be safely managed in primary or community care with clear, robust care plans have been proposed. These will now be discussed with Sutton Place colleagues with an aim for follow up reduction for these patients.	March 2026	Not sufficient for assurance post go live - **Expected to be resolved by end of August 2025**

Section 3 - Our People

Overview Dashboard | People Metrics

St George's

KPI	Latest month	Previous Month Measure	Latest Month Measure	Target	Variation	Assurance	Benchmark
Staff Sickness Absence rate	Jul 25	4.3%	4.4%	3.2%		F	2nd Quartile
Agency rates	Jul 25	1.0%	0.1%	-	L		
MAST	Jul 25	91.8%	91.9%	85.0%	H	P	Top Quartile
Vacancy Rate	Jul 25	4.4%	5.0%	10.0%	L	P	
Appraisal Rate Medical	Jul 25	82.8%	81.9%	90.0%	H	F	
Appraisal Rate Non Medical	Jul 25	81.1%	81.3%	90.0%	H	F	Top Quartile
Turnover	Jul 25	10.0%	9.9%	13.0%	L	P	4th Quartile
Percentage BAME staff band 6 and above	Jun 25	47.0%	47.0%	-	H		
Workforce WTE	Jul 25	10806	10822	10325		?	

Epsom & St Helier

Latest month	Previous Month Measure	Latest Month Measure	Target	Variation	Assurance	Benchmark
Jul 25	5.5%	5.3%	3.8%		F	3rd Quartile
Jun 25	1.2%	1.2%	-	L		
Jul 25	87.5%	85.4%	85.0%		?	Top Quartile
Jul 25	11.3%	11.8%	10.0%		F	
Jul 25	95.4%	99.5%	90.0%		P	
Jul 25	77.1%	79.0%	90.0%		F	Top Quartile
Jul 25	9.7%	9.8%	12.0%	L	?	4th Quartile
Jul 25	41.1%	41.6%	-	H		
Jul 25	7344	7505	7326		?	

Sutton Healthcare

KPI	Latest month	Previous Month Measure	Latest Month Measure	Target	Variation	Assurance
Sickness Rate	Jul 25	5.3%	5.4%	3.8%		?
Agency rates	Jul 25	2.9%	2.0%	-	L	
MAST	Jul 25	91.5%	90.9%	85.0%		P
Vacancy Rate	Jul 25	13.7%	13.7%	10.0%		F
Appraisal Rate Medical	Jul 25	75.0%	100.0%	90.0%		?
Appraisal Rate Non Medical	Jul 25	72.5%	72.6%	90.0%		F
Turnover (12-Month)	Jul 25	10.2%	10.9%	12.0%	L	?
Percentage BAME staff band 6 and above	Jul 25	39.4%	40.3%	-	H	

Surrey Downs

Latest month	Previous Month Measure	Latest Month Measure	Target	Variation	Assurance
Jul 25	4.9%	5.0%	3.8%	L	?
Jul 25	2.6%	2.0%	-	L	
Jul 25	94.2%	92.5%	85.0%		P
Jul 25	10.7%	11.8%	10.0%	L	F
Jul 25	100.0%	100.0%	90.0%		P
Jul 25	90.6%	88.8%	90.0%		?
Jul 25	13.8%	13.8%	12.0%	L	F
Jul 25	22.9%	23.2%	-	H	

gesh

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

Appendices

Appendix 1 - Statistical Process Control (SPC)

Interpreting Charts and Icons

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

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

Appendix 2 - Watch List Metrics

Overview Dashboard

St George's

KPI	Latest month	Previous Month Measure	Latest Month Measure	Target	Variation	Assurance	Benchmark
Mixed Sex Accommodation Breaches	Jul 25	133	155	0			Highest Quartile
Number of Complaints Received	Jul 25	73	75	-			N/A
Number of re-opened complaints in month	Jul 25	0	5	-			N/A
Parliamentary and Health Service Ombudsman (PHSO) Received	Jul 25	0	0	-			N/A
Parliamentary and Health Service Ombudsman (PHSO) Closed	Jul 25	1	1	-			N/A
RTT - Total Size Incomplete Waiting List	Jun 25	70268	71060	74003			3rd Quartile
Cancer 31 Day Decision To Treat to Treatment Standard	Jun 25	96.2%	96.1%	96.0%			2nd Quartile
On the Day Cancellations not re-booked within 28 days	Jul 25	1	1	0			2nd Quartile
Outpatient Advice & Guidance Rate per 100 First OPA	May 25	22.8	23.0	16.0			2nd Quartile
Emergency Department Attendances per day	Jul 25	440	432	-			N/A
Mental health delays 4 Hour Breaches	Jul 25	138	158	-			N/A
Length of stay > 21 days (super stranded)	Jul 25	150	134	-			3rd Quartile
Overnight G&A beds occupancy - Adults	Jul 25	95.9%	93.5%	96.0%			3rd Quartile
Number of patients not meeting criteria to reside (Daily Avg)	Jul 25	106	108	-			2nd Quartile

Epsom & St Helier

Latest month	Previous Month Measure	Latest Month Measure	Target	Variation	Assurance	Benchmark
Jul 25	25	46	0			Highest Quartile
Jul 25	40	62	-			N/A
Jul 25	1	2	-			N/A
Jul 25	1	0	-			N/A
Jul 25	1	2	-			N/A
Jun 25	53903	56144	50386			3rd Quartile
Jun 25	98.0%	99.1%	96.0%			Top Quartile
Jun 25	3	4	0			Top Quartile
May 25	56.8	51.5	16.0			Top Quartile
Jul 25	433	432	-			N/A
Jul 25	159	211	-			N/A
Jul 25	160	167	-			Lowest Quartile
Jul 25	78.9%	78.9%	96.0%			2nd Quartile
Jul 25	138	143	-			3rd Quartile

Sutton Healthcare

KPI	Latest month	Previous Month Measure	Latest Month Measure	Target	Variation	Assurance
Urgent Community Response (UCR) Referrals	Jul 25	537	560	-		
Virtual ward - Admissions	Jul 25	312	359	-		
Virtual ward Length of Stay (Average)	Jul 25	7.5	8.3	-		
Discharge to Assess- Pathway 0-3 Delays (Median Days)	Jul 25	3	4	-		

Surrey Downs

Latest month	Previous month measure	Latest month measure	Target	Variation	Assurance
Jul 25	512	541	-		
Jul 25	263	259	-		
Jul 25	9.1	8.8	-		
Jul 25	2	1	-		

Appendix 3 - Cancer Performance by Tumour Type

Overview Dashboard

St George's

Cancer - 28 Day Faster Diagnosis Standard

KPI	Latest month	Previous Month Measure	Latest Month Measure	Target	Variation	Assurance
Brain/Central Nervous System	Jun 25	N/A	50.0%	90.6%		
Breast	Jun 25	88.3%	86.1%	89.6%		
Breast Symptomatic	Jun 25	88.8%	88.4%	93.0%		
Children's Cancer	Jun 25	100.0%	50.0%	93.8%		
Gynaecological	Jun 25	58.1%	45.6%	62.7%		
Haematological	Jun 25	86.4%	57.1%	61.3%		
Head & Neck	Jun 25	92.2%	91.4%	75.9%		
Lower Gastrointestinal	Jun 25	71.9%	67.7%	63.7%		
Lung	Jun 25	71.1%	73.2%	79.7%		
RDC	Jun 25	51.9%	76.5%	-		
Skin	Jun 25	83.4%	71.5%	90.6%		
Upper Gastrointestinal	Jun 25	65.4%	72.8%	76.3%		
Testicular	Jun 25	N/A	N/A	100.0%		
Urological	Jun 25	77.8%	77.5%	57.5%		

Cancer - 62 Day Referral to Treatment Standard

KPI	Latest month	Previous Month Measure	Latest Month Measure	Target	Variation	Assurance
Brain/Central Nervous System	Jun 25	100.0%	100.0%	-		
Breast	Jun 25	90.5%	71.0%	71.2%		
Gynaecological	Jun 25	72.7%	0.0%	65.2%		
Haematological	Jun 25	100.0%	81.5%	71.4%		
Head & Neck	Jun 25	61.8%	85.2%	58.5%		
Lower Gastrointestinal	Jun 25	51.6%	68.0%	60.0%		
Lung	Jun 25	68.8%	63.0%	63.6%		
Other	Jun 25	100.0%	100.0%	80.0%		
Skin	Jun 25	72.7%	78.3%	91.6%		
Upper Gastrointestinal	Jun 25	71.4%	100.0%	76.2%		
Urological	Jun 25	76.5%	86.9%	62.4%		

Target and Assurance based on national benchmark

Epsom & St Helier

Cancer - 28 Day Faster Diagnosis Standard

KPI	Latest month	Previous Month Measure	Latest Month Measure	Target	Variation	Assurance
Brain/Central Nervous System	Jun 25	100.0%	N/A	90.6%		
Gynaecology	Jun 25	38.1%	44.3%	62.7%		
Haematological	Jun 25	77.8%	93.8%	61.3%		
Head & Neck	Jun 25	89.3%	90.6%	75.9%		
Lower Gastrointestinal	Jun 25	82.0%	80.3%	63.7%		
Lung	Jun 25	84.4%	82.5%	79.7%		
Skin	Jun 25	93.2%	74.4%	90.6%		
Upper Gastrointestinal	Jun 25	81.7%	82.3%	76.3%		
Urological	Jun 25	79.5%	79.5%	57.5%		
RDC	Jun 25	80.0%	80.0%	-		
Prostate	Jun 25	84.3%	93.7%	-		
Testicular	Jun 25	100.0%	100.0%	100.0%		

Cancer - 62 Day Referral to Treatment Standard

KPI	Latest month	Previous Month Measure	Latest Month Measure	Target	Variation	Assurance
Gynaecological	Jun 25	80.0%	62.5%	65.2%		
Haematological	Jun 25	81.8%	88.9%	71.4%		
Head & Neck	Jun 25	0.0%	75.0%	58.5%		
Lower Gastrointestinal	Jun 25	56.8%	93.8%	60.0%		
Lung	Jun 25	45.1%	50.0%	63.6%		
Skin	Jun 25	100.0%	96.6%	91.6%		
Upper Gastrointestinal	Jun 25	66.7%	90.5%	76.2%		
Urological	Jun 25	91.3%	92.9%	62.4%		
Other	Jun 25	0.0%	100.0%	80.0%		

Appendix 4

Metric Technical Definitions and Data Sources

Metric	Definition	Strategy Drivers	Data Source
Cancer 28 Day Faster Diagnosis Standard	The proportion of patients that received a diagnosis (or confirmation of no cancer) within 28 days of referral received date.	NHS Oversight Framework, Constitution, and Priorities & Operational Planning Guidance	NHS England
Cancer 31 Day Decision to Treat Standard	The proportion of patients beginning their treatment within 31 days of deciding to treat their cancer. Applies to anyone who has been diagnosed with cancer, including people who have cancer which has returned.	NHS Oversight Framework, Constitution, and Priorities & Operational Planning Guidance	NHS England
Cancer 62 Day Standard	The proportion of patients beginning cancer treatment that do so within 62 days of referral received date. This applies to by a GP for suspected cancer, following an abnormal cancer screening result, or by a consultant who suspects cancer following other investigations (also known as 'upgrades')	NHS Oversight Framework, Constitution, and Priorities & Operational Planning Guidance	NHS England
Referral to Treatment Waiting Times (RTT)	Monitors the waiting time between when the hospital or service receives your referral letter, or when you book your first appointment through the NHS e-Referral Service for a routine or non-urgent consultant led referral to treatment date.	NHS Oversight Framework, Constitution, and Priorities & Operational Planning Guidance	NHS England
Diagnostic Waits > 6 Weeks	Percentage of patients waiting for more than 6 weeks (42 days) for one of the 15 diagnostic tests from referral / request date.	NHS Oversight Framework, Constitution, and Priorities & Operational Planning Guidance	NHS England
Venous thromboembolism VTE Risk Assessment	Percentage of patients aged 16 and over admitted in the month who have been risk assessed for VTE on admission to hospital using the criteria in a National VTE Risk Assessment Tool.	NHS Standard Contract & Constitutional Standard	Local Data
Capped Theatre Utilisation Rate	The capped utilisation of an individual theatre list is calculated by taking the total needle to skin time of all patients within the planned session time and dividing it by the session planned time	NHS Priorities & Operational Planning Guidance	Model Hospital
Non Elective Length of Stay	Adoption of SWL methodology for calculation of non-elective average LOS (i.e. Adult patients discharged from the hospital in month that had a method of admission of emergency, but excluding patients that did not have an overnight stay in hospital and excluding maternity, paediatric and A&E specialties).	NHS Priorities & Operational Planning Guidance	
Length of Stay>21 Days (Stranded patients)	based on NHSI Sitrep data. The guidance / methodology includes non-elective and elective patients as per operational planning technical guidance. Most of these patients will be non-elective, but to understand the overall impact it is important to include the number of elective patients.	NHS Priorities & Operational Planning Guidance	NHSI
Ambulance Average Handover Times	Data definition numerator: Total time in seconds of patient handover or transfer to a cohort that took place from the time of hospital arrival to handover time at ED and non ED sites. NB: This does not exclude the first 30 mins. Data definition denominator: This is a count of all arrivals at ED and non-ED sites over the period.	NHS Priorities & Operational Planning Guidance	NHSE
PIFU Rate	Numerator: The number of episodes moved or discharged to a Patient Initiated Follow Up (PIFU) pathway. Denominator: Total outpatient activity	NHS Priorities & Operational Planning Guidance	Model Hospital
Never Events	Serious incidents that are entirely preventable because guidance or safety recommendations providing strong systemic protective barriers are available at a national level	National Framework for Reporting and Learning from Serious Incidents	Local Data
Patient Safety Incidents Investigated	Any unintended or unexpected incident which could have, or did, lead to harm for one or more patient's receiving healthcare	National Framework for Reporting and Learning from Serious Incidents	Local Data
Pressure Ulcers	Number of patients with pressure ulcer (Category/Stage 3 & 4) in the Trust over a specific period of time.	gesh Priority - Fundamentals of Care/ National Patient Safety Incidents	Local Data
SHMI	Rolling 12 months ratio between the actual number of patients who die following hospitalisation at a trust and the number that would be expected to die on the basis of average England figures, given the characteristics of the patients treated there.	NHS Oversight Framework	NHS Digital
FFT scores	Proportion of patients surveyed that state that the service they received was 'Very Good' or 'Good'.	NHS – National Priority	NHS Digital
Implied Productivity	Inclusions: Outpatients, outpatient procedures, elective (IP & DC), Non elective, A&E Methodology: Activity weighted by national average costs by HRG and POD so that e.g. overnight elective activity is more highly weighted than A&E attendances Cost: total operating expenditure, excluding impairments, includes PDC dividends, adjusted for inflation Compares YTD position with same YTD from previous year Updated monthly and shown on Model Hospital under Productivity & Efficiency section Published productivity metrics not broken down by POD or specialty	Performance Assessment Framework	SUS & national cost collection (for weighting) Provider Finance Return

Appendix 5
Glossary of Terms

Terms	Description
A&G	Advice & Guidance
ACS	Additional Clinical Services
AfPP	Association for Perioperative Practice
AGU	Acute Gynaecology Unit
AIP	Abnormally Invasive Placenta
ASI	Appointment Slot Issues
CAD	computer-assisted dispatch
CAPMAN	Capacity Management
CAS	Clinical Assessment Service
CATS	Clinical Assessment and Triage Service
CDC	Community Diagnostics Centre
CNS	Clinical Nurse Specialist
CNST	Clinical Negligence Scheme for Trusts
CQC	Care Quality Commission
CT	Computerised tomography
CUPG	Cancer of Unknown Primary Group
CWDT	Children's, Women's, Diagnostics & Therapies
CWT	Cancer Waiting Times
D2A	Discharge to Assess
DDO	Divisional Director of Operations
DM01	Diagnostic wating times
DNA	Did Not Attend
DTA	Decision to Admit
DTT	Decision to Treat
DQ	Data quality

Terms	Description
EBUS	Endobronchial Ultrasound
eCDOF	electronic Clinic Decision Outcome Forms
E. Coli	Escherichia coli
ED	Emergency Department
eHNA	Electronic Health Needs Assessment
EP	Emergency Practitioner
EPR	Electronic Patient Records
ESR	Electronic Staff Records
ESTH	Epsom and St Helier Hospital Trust
EUS	Endoscopic Ultrasound Scan
FDS	Faster Diagnosis Standard
FOC	Fundamentals of Care
GA	General Anaesthetic
H&N	Head and Neck
HAPU	Hospital acquired pressure ulcers
HIE	Hypoxic-ischaemic encephalopathy
HTG	Hospital Thrombosis Group
HSMR	Hospital Standardised Mortality Ratios
ICS	Integrated Care System
ILR	Implantable Loop Recorder
IPC	Infection Prevention and Control
IPS	Internal Professional Standards
IR	Interventional Radiology
KPI	Key Performance Indicator
LA	Local anaesthetics

Terms	Description
LAS	London Ambulance Service
LBS	London Borough of Sutton
LGI	Lower Gastrointestinal
LMNS	Local Maternity & Neonatal Systems
LOS	Length of Stay
N&M	Nursing and Midwifery
MADE	Multi Agency Discharge Event
MAST	Mandatory and Statutory Training
MCA	Mental Capacity Act
MDRPU	Medical Device Related Pressure Ulcers
MDT	Multidisciplinary Team
MHRA	Medicines and Healthcare products Regulatory Agency
MMG	Mortality Monitoring Group
MRSA	Methicillin-resistant Staphylococcus aureus
MSSA	Methicillin-resistant Staphylococcus aureus
MSK	Musculoskeletal
NCTR	Not meeting the Criteria To Reside
NEECH	New Epsom and Ewell Community Hospital
NHSE	NHS England
NMC	Nursing and Midwifery Council
NNU	Neonatal Unit
NOUS	Non-Obstetric Ultrasound
O2S	Orders to Schedule
OBD	Occupied Bed Days
OPEL	Operational Pressures Escalation Levels

Terms	Description
OT	Occupational Therapy
PIFU	Patient Initiated Follow Up
PPE	Personal Protective Equipment
PPH	postpartum haemorrhage
PSIRF	Patient Safety Incident Response Framework
PSFU	Personalised Stratified Follow-Up
PTL	Patient Tracking List
QI	Quality Improvement
QMH	Queen Mary Hospital
QMH STC	QMH- Surgical Treatment Centre
QPOPE	Quick, Procedures, Orders, Problems, Events
RAS	Referral Assessment Service
RADAH	Reducing Avoidable Death and Harm
RCA	Root Cause Analyses
RMH	Royal Marsden Hospital
RMP	Royal Marsden Partners Cancer Alliance
RTT	Referral to Treatment
SACU	Surgical Ambulatory Care Unit
SALT	Speech and Language Therapy
SDEC	Same Day Emergency Care
SDHC	Surrey Downs Health and Care
SGH	St Georges Hospital Trust
SHC	Sutton Health and Care
SHMI	Summary Hospital-level Mortality Indicator
SJR	Structured Judgement Review

Terms	Description
SLT	Senior Leadership Team
STH	St Helier Hospital site
STG	St Georges Hospital site
SNTC	Surgery Neurosciences, Theatres and Cancer
SOP	Standard Operating Procedure
TAC	Telephone Assessment Clinics
TAT	Turnaround Times
TCI	To Come In
ToC	Transfer of Care
TPPB	Transperineal Ultrasound Guided Prostate Biopsy
TVN	Tissue Viability Nurses
TWW	Two-Week Wait
UCR	Urgent Community Response
VTE	Venous Thromboembolism
VW	Virtual Wards
WTE	Whole Time Equivalent

Group Board Meeting (Public)

Meeting on Friday, 05 September 2025

Agenda Item	4.1	
Report Title	**People Committees Report to Group Board**	
Non-Executive Lead	Yin Jones, People Committees Chair, SGUH & ESTH NED	
Report Author(s)	Andrew Murray, SGUH & ESTH NED	
Previously considered by	n/a	
Purpose	**For Assurance**	

Executive Summary

This report sets out the key issues considered by the People Committees at its meeting in August 2025 and the matters the Committees wish to bring to the attention of the Group Board. The key issues the Committees wish to highlight to the Board are:

Group Chief People Officer (GCPO) Report: The Committees received a comprehensive verbal update from the Group Chief People Officer (GCPO) covering topics such as a new Director General for People in the Department of Health and Social Care, the development of a national target operating model for the people function, and the future replacement of the gesh ESR system with a cloud-based system.

WRES / WDES Submission to NHSE
The Committees noted that, while the data showed some progress, the organisation needed to focus on the underlying reasons for disparities rather than just presenting the numbers. There was a discussion about moving from a long, multi-pronged action plan to a more targeted approach, focusing on a few high-impact interventions to create meaningful and sustainable change. The Committees formally endorsed this new, more focused approach to the EDI action plan.

Workforce KPI Performance Report
The Committee reviewed the regular monthly update on vacancy rates, turnover, sickness absence, core skills compliance and appraisal compliance. The Group deployed 18,386 WTE in July 2025, representing a reduction of 18 WTE when compared with June. A reduction in permanent staff (-46), and Agency (-3) offset against an increase in Bank (+32) were the drivers. July 2025 represents a fourth consecutive month of a reduction in total workforce deployment.

2005 NHS Staff Survey Plans
The Committees noted that the 2025 staff survey approach will build on lessons from 2024, aiming to enhance engagement, trust, and impact. Key components - senior leadership advocacy, protected survey time, and tailored communications remain central.

Action required by Group Board

The Group Board is asked to note the issues escalated to the Group Board and the wider issues on which the Committees received assurance in August 2025.

Committee Assurance

Committee	People Committees
Level of Assurance	Reasonable Assurance: The report and discussions assured the Committees that the system of internal control is generally adequate and operating effectively but some improvements are required, and the Committee identified and understood the gaps in assurance

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

Implications				
Group Strategic Objectives				
☐ Collaboration & Partnerships			☐ Right care, right place, right time	
☒ Affordable Services, fit for the future			☒ Empowered, engaged staff	
Risks				
People risks were not reviewed at this meeting.				
CQC Theme				
☐ Safe	☐ Effective	☐ Caring	☐ Responsive	☒ Well Led
NHS system oversight framework				
☐ Quality of care, access and outcomes			☒ People	
☐ Preventing ill health and reducing inequalities			☒ Leadership and capability	
☒ Finance and use of resources			☐ Local strategic priorities	
Financial implications				
As set out in paper.				
Legal and / or Regulatory implications				
N/A				
Equality, diversity and inclusion implications				
As set out in paper.				
Environmental sustainability implications				
N/A				

People Committees Report
Group Board, 05 September 2025

1.0 Purpose of paper

1.1 This report sets out the key issues considered by the People Committees at its meeting in August 2025 and includes the matters the Committees specifically wish to bring to the attention of the Group Board.

1.2 The role of the Committees, as set out in its terms of reference, is to provide assurance on the development and delivery of a sustainable, engaged and empowered workforce that supports the provision of safe, high quality, patient-centred care.

2.0 Items considered by the Committees

2.1 At its meeting in August 2025, the Committees considered the following items of business:

21 August 2025

- Group Chief People Officer Report
- People Strategy
- Medical Revalidation Responsible Officer Report Q1 and Annual Report
- Guardian of Safe Working (GoSW) Reports
- WRES / WDES Submission to NHSE
- NHS Staff Survey Plans 2025
- Workforce KPI Performance Report
- Facility Time Reporting

2.2 As in 2024/25, the Committees, chaired by Yin Jones, is meeting every two months as agreed by the Group Board. An informal meeting between the Chair and GCPO takes place between Committee meetings. This meeting was chaired by Andrew Murray because Yin Jones was on leave.

3.0 Key issues for escalation to the Group Board

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

a) Group Chief People Officer Update:

The Committees received a comprehensive verbal update from the Group Chief People Officer (GCPO) covering national topics such as a new Director General for People in the Department of Health and Social Care, the development of a national target operating model for the people function, and the future replacement of the gesh ESR system with a cloud-based system. The GCPO also reported on local issues within gesh, including the implementation of national pay awards in August 2025 and the uplift of Band 2 healthcare support workers to Band 3 in September 2025. She also reported that all Tier 2 agencies had been removed from use as a cost-saving measure and that the People function was working on delivering a £2million cost-saving plan as well as the High-performing Teams Programme.

b) People Strategy

GCPO provided an overview of the gesh People Strategy 2024-26, including a summary of the key delivery activities underpinning each of the strategic pillars and of the upcoming priorities.

The governance arrangements are now embedded, and delivery of the programme has been fully operational for 10 months. The Committees noted that, due to the complexity of some of the workstreams and the discovery work required from the outset for the associated activities, gesh is not yet in a position to assess the impact on the key People metrics we aim to positively influence. However, as teams make further progress, the impact would be assessed in the upcoming months.

c) WRES / WDES Submission to NHSE

The Committees noted that, while the data showed some progress, the organisation needed to focus on the underlying reasons for disparities rather than just presenting the numbers. There was a discussion about moving from a long, multi-pronged action plan to a more targeted approach, focusing on a few high-impact interventions to create meaningful and sustainable change. The Committees formally endorsed this new, more focused approach to the EDI action plan.

4.0 Key Issues on which the Committees received assurance

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

a) Workforce KPI Performance Report

The Committees noted the updates on vacancy rates, turnover, sickness absence, core skills compliance and appraisal compliance. For July 2025, the Group deployed 18,386 WTE in July, representing a reduction of 18 WTE when compared with June. A reduction in permanent staff (-46), and Agency (-3) offset against an increase in Bank (+32) were the drivers. July 2025 represented a fourth consecutive month of a reduction in total workforce deployment. The report for month 4 2025/26 showed positive trends in key metrics such as a vacancy rate below the KPI threshold and a decrease in turnover compared to the previous year. The total deployed workforce had continued to reduce, although it had been impacted by industrial action.

b) Medical Revalidation & Appraisal Report

The Committees reviewed the Q1 reports for medical revalidation for both Epsom St. Helier and St George's and approved the annual reports to go to the Board. It was noted that there is a need to align the formats of the responsible officer reports from the two trusts for better standardisation and easier review. At ESTH, compliance with annual appraisals is high, between 95% and 100%9. SGUH's has seen a recent dip in appraisal completion rates but hopes to increase them in Q2.

c) Guardian of Safe Working (GOSW)

The Committees noted the Q4 and Annual Report 2024-25 Report for ESTH and Q1 2025-26 Report for SGUH. At ESTH, overall Exception reports (ER) decreased over Q4, 33 in comparison to 106 in the previous quarter. However, the themes were similar the majority of ERs are filled by FY doctors working in general medicine at St Helier.

At SGUH, there was a steep rise in the number of exception reports, mainly in MaxilloFacial Surgery where the rota was found to breach WTD (Working Time Directive). The Committees noted that a new rota had been developed and implemented. Exception reporting was seen as an effective tool for directorates to be responsive to issues and has led to positive changes.

5.0 Other issues considered by the Committees

5.1 During this period, the Committees also received the following reports:

2025 Staff Survey Plans
The 2025 NHS Staff Survey plans were presented and discussed. The Committees found the approach well-set out and appropriate. It was noted that the organisation was doing everything it can to mobilise people and encourage completion of the survey.

Facility Time Reporting
The Committees noted the Facility Time report for the 2024 – 2025 financial year and actions at each Trust to ensure compliance with the Trade Union Facility Time Publication Requirements Regulations 2017.

6.0 Recommendations

6.1 The Group Board is asked to note the issues escalated to the Group Board and the wider issues on which the People Committees received assurance on 21 August 2025.

Group Board Meeting (Public)

Meeting on Friday, 05 September 2025

Agenda Item	4.2	
Report Title	**Group WRES and WDES Report 2025]**	
Executive Lead(s)	Victoria Smith, Group Chief People Officer	
Report Author(s)	Joseph Pavett-Downer, Group Head of EDI (Workforce)	
Previously considered by	People Committees	21 August 2025
Purpose	**For Approval / Decision**	

Executive Summary

All NHS providers are required to complete an annual Workforce Race Equality Standard (WRES) report and a Workforce Disability Equality Standard (WDES). These reports are based on a snapshot of data as of 31st March each year and aim to highlight progress against several key indicators of workforce equality. The reports draw on ESR data from 31/03/2025 and the 2024 Staff Survey results.

STG WRES

- We have seen an improvement in 4 indicators, 4 have remained static, and 1 has declined.
- There have been slight improvements in areas such as recruitment, disciplinary, and perceptions of career progression. However, BME staff remain significantly underrepresented within senior leadership, particularly at VSM level.

ESTH WRES

- We have seen an improvement in 3 indicators, a decline in 5, and 1 remained static.
- There have been slight improvements in experiences of harassment, bullying, and abuse, and reductions in discrimination from managers.
- Declines in areas including recruitment, disciplinary, and perceptions of career progression.

STG WDES

- Out of 13 metrics, we see an improvement (compared to last year) in 9 metrics and a decline in 3.
- Improvements include: the relative likelihood of candidates with a disability being appointed; a reduction in staff with a disability entering the formal capability process; and reported experiences of harassment, bullying, or abuse. Satisfaction with reasonable adjustments for staff has slightly declined.

ESTH WDES

- Out of 13 metrics, we see an improvement (compared to last year) in 5 metrics, a decline in 6, and 1 remained static.
- Improvements include: the relative likelihood of candidates with a disability being appointed; reductions in harassment, bullying, and abuse; and improved perceptions regarding career progression. Declines were noted in satisfaction with how work is valued and with reasonable adjustments being made.

Both reports have been considered and supported at People Committee-in-Common.

Action required by Group Board

The Board is asked to:

a. Review findings of both the WRES and WDES reports
b. Approve the reports for publication

Committee Assurance	
Committee	People Committees
Level of Assurance	Reasonable Assurance: The report and discussions assured the Committee that the system of internal control is generally adequate and operating effectively but some improvements are required, and the Committee identified and understood the gaps in assurance

Appendices	
Appendix No.	**Appendix Name**
Appendix 1	Group WRES Report 2025
Appendix 2	Group WDES Report 2025

Implications

Group Strategic Objectives

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

Risks

Failing to publish our reports each year can lead to governance risks such as non-compliance, reputational damage, and legal exposure, while attracting increased scrutiny from regulatory bodies. Failure to actively engage in these reviews also demonstrates a lack of commitment to improving inclusion and staff experience.

CQC Theme

☐ Safe	☐ Effective	☐ Caring	☐ Responsive	☒ Well Led

NHS system oversight framework

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

Financial implications

Poor staff experience can lead to increased staff sickness, reduced morale and performance and higher staff turnover

Legal and / or Regulatory implications

All NHS providers are required (by NHSE) to complete an annual Workforce Race Equality Standard (WRES) report and a Workforce Disability Equality Standard (WDES).

Equality, diversity and inclusion implications

Completion and publication of our reports demonstrates our on-going commitment to transparency and accountability. It evidences the boards commitment and shows a willingness to review and learn from equality information.

Environmental sustainability implications

n/a

[Group WRES and WDES Reports]
Group Board, 05 September 2025

1.0 Purpose of paper

1.1 The purpose of these papers is to inform the Board of the experiences of staff from BME communities and those with disabilities, providing assurance on progress and transparency on areas requiring improvement. They support the Board's oversight of workforce equality and inclusion, and enable compliance with NHS England's mandatory reporting requirements through publication of the annual WRES and WDES reports.

2.0 Background

2.1 The WRES was introduced in 2015 and mandated through the NHS Standard Contract, WRES measures progress against nine indicators to ensure fair treatment and equal career opportunities for BME staff.

2.2 The WDES was launched in 2019 and uses ten metrics to compare the experiences of staff with a disability and staff that do not have a disability.

2.3 Each trust is required to publish their WRES and WDES reports annually, typically in October each year.

3.0 [Key issues for consideration]

3.1 WRES: BME staff remain underrepresented in senior leadership across the group, with low representation at Band 8d+ and VSM posts, and executive-level gaps of -25% to -35%. Recruitment and disciplinary outcomes highlight ongoing inequalities, with white applicants more likely to be appointed compared to BME applicants. Harassment, bullying, and abuse, and level of discrimination are higher for BME staff and require continued focus. Overall, there are several key areas of focus which will require increased efforts in order to improve staff experience and workplace culture.

3.2 WDES: Staff with disabilities continue to face underrepresentation and inequalities across the group, despite improvements in recruitment and reductions in formal capability cases. Harassment, bullying, and abuse (HBA) remain higher for staff with disabilities from patients, colleagues, and managers, with some year-on-year increases reported. Perceptions of career progression and feeling valued have improved, but gaps persist, and satisfaction with reasonable adjustments and how work is valued has slightly declined (following an improvement last year). Overall, several areas require our ongoing focus to enhance inclusion, support, and workplace culture for staff with disabilities.

4.0 Sources of assurance

4.1 Assured through review and consideration by our internal EDI and Workforce Information Teams.

4.2 Review via internal governance, including Group Executive, Trust Management Group and People Committees.

5.0 Implications

5.1 See individual implications sections above

6.0 Recommendations

6.1 The Board is asked to:

a. Review findings of both the WRES and WDES reports
b. Approve the reports for publication

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Workforce Race Equality Standard (WRES) 2025 Report

Features: 2024 Staff Survey Data and workforce information on 31/03/2025
Published: 00/00/2024

Workforce Race Equality Standard 2025

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Workforce Race Equality Standard 2025
Purpose, background and definitions

Purpose
- This paper provides an overview of the 2025 Workforce Race Equality Standard (WRES) findings.
- This report will be published on the Trust website.
- The Board is asked to receive this report and associated action plan for information and approve for publication.

Background
- In April 2015, NHS England introduced the WRES in response to consistent findings that BME applicants and staff consistently fared worse in employment outcomes and satisfaction surveys. The WRES was designed to enable NHS organisations to demonstrate progress against a number of key indicators of workforce equality, including a specific indicator to address the low levels of BME Board representation.
- Since April 2015, the WRES has been included in the full-length NHS Standard Contract and requires all providers of NHS services to address the issue of workforce race inequality by implementing and using the WRES.
- There are nine WRES indicators. Four of the indicators focus on workforce data, four are based on data from national NHS Staff Survey questions, and one indicator focuses upon BME board representation. The WRES highlights differences between the experience and treatment of White staff and BME staff in the NHS with a view to organisations closing those gaps through the development and implementation of action plans focused upon continuous improvement over time.
- The WRES is produced in line with Technical Guidance issued by NHS England.
- Indicators 1-3 and 9 are produced via the Electronic Staff Record (ESR) from a snapshot of data taken on 31st March 2025. All other indicators are from the 2024 staff survey.

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

Overview of Workforce Numbers

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

ESTH	2021	2022	20223	2024	**2025**
Total number of staff in organisation	6,150	7,092	7,190	7,410	**7,326**
% of BME Staff	38.1%	38.2%	42.0%	44.2%	**47.8%**
% of staff who self-reported ethnicity	95%	91%	92%	94%	**97%**

Workforce Race Equality Standard 2025

Indicator Overview

Note: '*Compared to White Staff*': A green cell indicates BME staff report a more positive experience (compared to white colleagues).
* Changes of +/- 0.5 or less are recorded as Static.

WRES Indicator		STG						ESTH					
		2022	2023	2024	2025	vs. LY	Compared to White Staff	2022	2023	2024	2025	vs. LY	Compared to White Staff
1	% of BME staff in organisation	50.1%	51.9%	53.6%	**54.7%**	**Increased**		38%	41%	44.2%	**47.8%**	**Increased**	
2	Relative likelihood of White applicants being appointed from shortlisting compared BME applicants	1.26	1.50	2.2	**1.77**	**Improved**		1.04	1.30	0.74	**1.56**	**Declined**	
3	Relative likelihood of BME staff entering the formal disciplinary process, compared to that of White staff	1.65	1.67	1.48	**1.17**	**Improved**		1.20	1.45	1.04	**1.36**	**Declined**	
4	Relative likelihood of White staff accessing non-mandatory training and CPD compared to BME staff	0.98	0.95	0.87	**0.93**	**Static***		1.07	0.52	1.01	**1.09**	**Declined**	
5	% of BME staff experiencing harassment, bullying or abuse *from patients, relatives or the public* in the last 12 months.	23.3%	27.0%	25.7%	**25.2%**	**Static***		27.5%	28.3%	25.5%	**24.8%**	**Improved**	
6	% of BME staff experiencing harassment bullying or abuse *from staff* in the last 12 months	25.9%	27.3%	26.9%	**28.0%**	**Declined**		26.2%	25.5%	23.2%	**21.6%**	**Improved**	
7	% of BME staff believing that organisation provides equal opportunities for career progression or promotion	42.1%	43.8%	44.0%	**45.2%**	**Improved**		44.7%	45.9%	51.6%	**51.0%**	**Declined**	
8	% of BME staff personally experiencing discrimination at work from *manager/leader/ or other colleagues*.	16.6%	16.9%	15.9%	**16.4%**	**Static***		15.8%	15.8%	14.7%	**13.4%**	**Improved**	
9	% difference between the board voting membership and its overall BME workforce	-32%	-43%	-35%	**-25%**	**Improved**		-10%	-16%	-26%	**-26%**	**Static***	
	% difference between the board executive membership and its overall BME workforce	-36%	-41%	-41%	**-42%**	**Static***		0	-10	-33%	**-35%**	**Declined**	

Workforce Race Equality Standard (WRES)

Next steps

Our existing Culture and Diversity and Inclusion Action Plans, which were introduced in late 2020, have driven a continued focus and commitment to improving the experience of those from marginalised groups, particularly those from Black, Asian and Minority Ethnic communities and those with disabilities or long term health conditions. Whilst many of the actions and projects set out in these action plans have now been successfully delivered, there are still a number to be implemented.

These open actions or live projects have been mapped across to NHSE's EDI Improvement Plan (appendix b) and aligned to our People Strategy. **This has identified six gesh EDI workstreams for 2025-27**.

Following stakeholder engagement and internal governance, our EDI action plan was approved by our Board in February 2025. This plan has been launched across the group and progress will be monitored and reported quarterly.

Fig 1: Our 2024-2026 People Priority Domains



Leadership Commitment

- High Impact Action 1: Chief executives, chairs and board members must have specific and measurable EDI objectives to which they will be individually and collectively accountable

Inclusive Recruitment and Talent Managment

- High Impact Action 2: Embed fair and inclusive recruitment processes and talent management strategies that target under-representation and lack of diversity

Eliminating pay gaps

- High Impact Action 3: Develop and implement an improvement plan to eliminate pay gaps

Improving Health and Wellbeing

- High Impact Action 4: Develop and implement an improvement plan to address health inequalities within the workforce

Supporting Internationally Recruited Staff

- High Impact Action 5: Implement a comprehensive induction, onboarding and development programme for internationally-recruited staff

Safeguarding our Workforce

- High Impact Action 6: Create an environment that eliminates the conditions in which bullying, discrimination, harassment and physical violence at work occur

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

Workforce Race Equality Standard 2025

Features: 2024 Staff Survey Data and workforce information on 31/03/2025
Published: 00/00/2024

Workforce Race Equality Standard 2025

Trust: STG

Executive summary

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

In line with national requirements, this report and any associated action plans should be reviewed internally and approved at Board before being published on the organisation's website. The deadline for publication is 31st October 2025.

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

Improved indicators

- We have seen an improvement in 4 indicators, 4 have remained static and 1 has declined compared to the last year.
- Overall, the BME staff population at St George's continues to increase year on year (54.7%).
- The relative likelihood of white applicants being appointed from shortlisting compared to BME applicants has improved, reducing from 2.2 to 1.7.
- Relative likelihood of BME staff entering the formal disciplinary processes has reduced for the third consecutive year, from 1.67 in 2023 to 1.17 in 2025
- Continued upward trend in the percentage of BME staff feeling the organisation provides equal opportunities for career progression or promotion. This has increased yearly since 2020 (+4 percentage points).
- Though still significantly underrepresented at senior leadership level, we have seen small improvements in BME representation at bands 8C and above.
- We have seen an improvement in voting board representation, from -35% in 2024 to -25% in 2025.

Reduced / static indicators

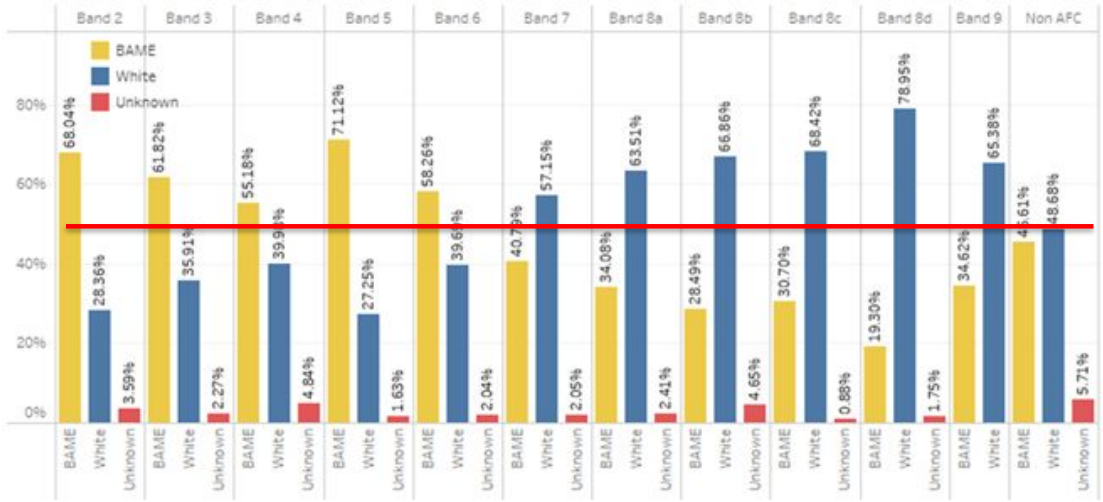
- BME staff are over-represented in lower bands.
- The number of white staff at VSM level has increased from 20 to 25, and BME staff from 3 to 2.
- Of the 42 non-clinical Band 8d and above posts only 19% are held by a BME member of staff, compared to 81% being held by a white member of staff.
- BME staff still make up just 16% of non-clinical VSM posts – compared to 84% white. This is the ratio of 10:1 (up from 8:1 last year).
- Of the Band 8d, only 3 of 15 clinical Band 8d post are held by a BME member of staff. This is a ratio of 5:1.
- Reported experiences of Harassment, Bullying and Abuse have remained static from patient-staff and worsened from staff-staff (for both white and BME staff).
- Reports of experiences of discrimination from managers and colleagues have remained static– but is lower than the London average.

Workforce Race Equality Standard 2025

Trust: STG

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

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



- Our Black, Asian and Minority Ethnic workforce has increased year on year since 2019 and continues to be representative of the local communities we serve.
- For Indicator 1, we see an increase of over 1% which is approximately an increase of 486 Black, Asian and Minority Ethnic members of staff.
- This is not unique to St George's and mirrors what we see across NHS trusts nationally (see table A and B).

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

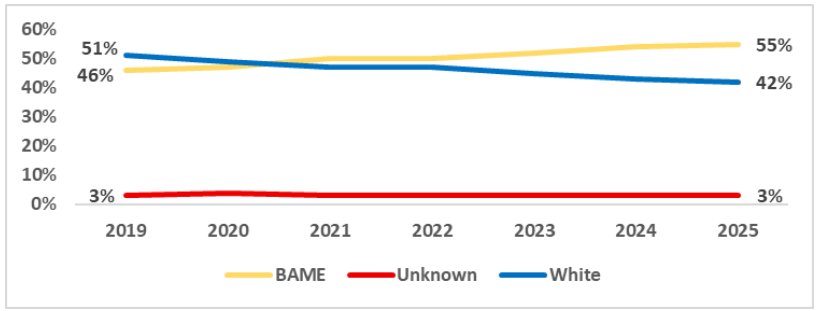
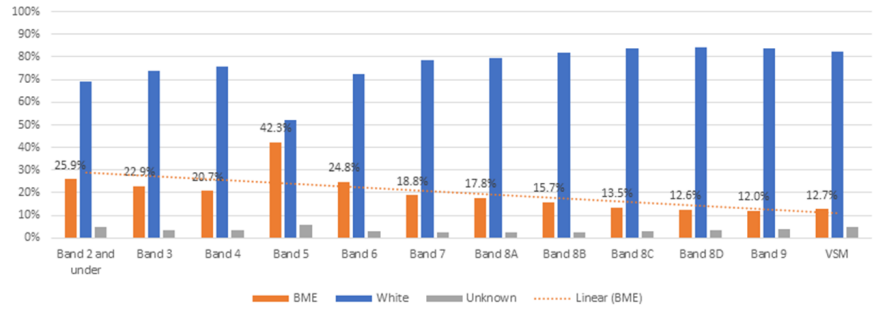


Table B: % of Staff in each AFC Band by Ethnicity (National 2024)



Workforce Race Equality Standard 2025

Trust: STG

Indicator 1

Clinical Staff - *% of staff by AfC pay band and ethnicity*

For Clinical staff (table C), we see an increase in the percentage of Black, Asian and Minority Ethnic staff across 8 of the 11 AFC bands. Compared to last year we have seen an increase of white Staff (6), compared to an increased (+206) BME staff members. This is largely due to an increase at Bands 5 (+117) and 6 (+76).

We have seen a year-on-year increase in diversity with the consultant group, from 43% in 2023 to 46% in 2025. In terms of percentage our 2025 ratio for consultant staff was 48% white to 46% BME – this is one of the closest to representative we have seen within the consultant workforce (to the organisations overall).

The second lowest level of representation remains band 8a-c (31% BME) and 8d+. Our lowest level of representation is Band 8d and above posts. Of the 27 Band 8d+ posts, only 26% (7 posts) are held by a BME member of staff, compared to 70% (35 posts) being held by a white member of staff (table E). This is a ratio of 5:1.

Table C: % of Clinical Staff in each AFC Band at St George's:

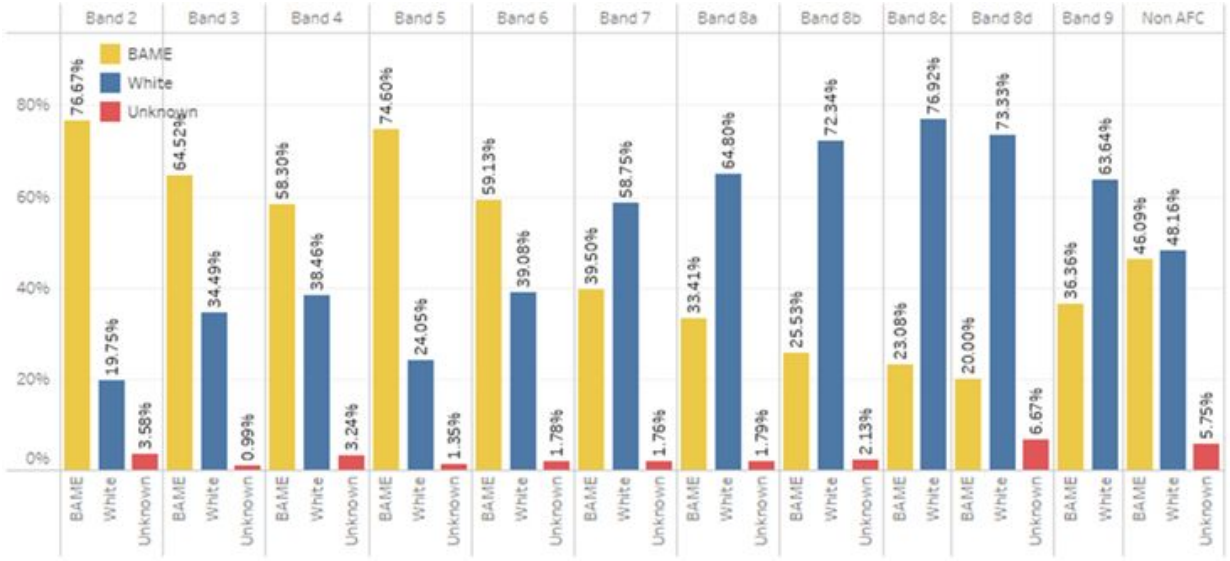


Table E: % of staff by ethnic group (clustered):

Cluster	2022			2023			2024			2025		
	White	BME	Unknown	White	BME	Unknown	White	BME	Unknown	White	BME	Unknown
Band 1 - 5	32.9%	64.4%	2.5%	29.3%	68.4%	2.2%	26.2%	71.6%	2.2%	25.5%	72.5%	2.1%
Band 6 - 7	53.2%	44.8%	1.8%	51.7%	46.5%	1.7%	50.6%	47.5%	2.0%	48.0%	50.2%	1.8%
Band 8a-8c	69.6%	28.5%	1.8%	69.4%	29.3%	1.3%	67.1%	31.1%	1.8%	67.3%	31.1%	1.7%
Band 8d +	85.0%	15.0%	0.0%	79.2%	20.8%	0.0%	80.0%	20.0%	0.0%	70.4%	25.9%	3.7%
Medical	55.1%	37.9%	6.8%	51.1%	43.3%	5.6%	49.4%	45.6%	5.0%	48.1%	46.3%	5.6%

Workforce Race Equality Standard 2025

Trust: STG

Indicator 1

Non-Clinical Staff - *% of staff by AfC pay band and ethnicity*

For Non-Clinical staff we see an increase in the percentage of Black, Asian and Minority Ethnic staff across all 11 AFC bands. This compares to decrease in the number of white staff in all 11 AFC bands.

For the second year BME representation at Band 6 and Band 7 is greater than White representation and close to the organisation overall of 54% – with 51% at Band 6 and 49% at Band 7.

The number of white staff at VSM level has increased from 20 to 21, with the number of BME staff improving from 2 to 4. This means that BME staff make up just 16% of non-clinical VSM posts – compared to 84% White. This is the ratio of 5:1 white staff members to every 1 BME staff member appointed at VSM level. This ratio has remained static when compared to last year.

Of the 82 Band 8d and above posts only 20.7% are held by a BME member of staff, compared to 79.3% being held by a white member of staff (table E).

Table C: % of Non-Clinical Staff in each AFC Band at St George's:

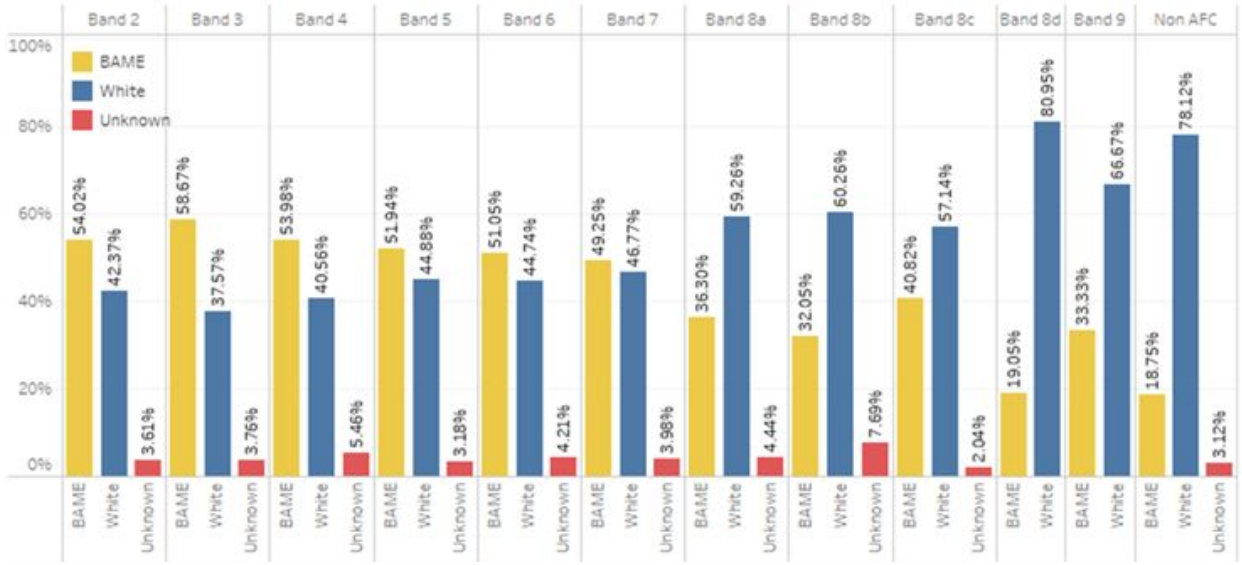


Table E: % of staff by ethnic group (clustered):

Cluster	2022			2023			2024			2025		
	White	BME	Unknown	White	BME	Unknown	White	BME	Unknown	White	BME	Unknown
Band 1 - 5	46.0%	50.0%	3.8%	45.1%	50.7%	4.1%	42.7%	53.2%	4.1%	41.2%	54.6%	4.2%
Band 6 - 7	46.3%	51.7%	1.9%	43.6%	54.6%	1.8%	46.5%	49.6%	3.9%	45.8%	50.1%	4.1%
Band 8a-8c	61.8%	34.0%	4.0%	61.8%	34.2%	4.0%	63.1%	33.1%	3.8%	59.2%	35.9%	5.0%
Band 8d +	81.4%	17.1%	1.4%	82.7%	16.0%	1.2%	83.3%	15.4%	1.3%	79.3%	20.7%	0.0%

Workforce Race Equality Standard 2025

Trust: STG

Indicator 2

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

- Our 2025 figures show that white applicants at St George's are 1.77 times more likely to be appointed from shortlisting compared Black, Asian and Minority Ethnic (BME) applicants. This is an improvement from 2.2 in 2024
- In 2025 the likelihood of Black, Asian and Minority Ethnic applicants being appointed from shortlisting reduced from 27% to 18% - this means that of the 6498 (non-medical) shortlisted BME applicants, 658 were appointed. For medical and dental applicants, of the 207 shortlisted applicants, 147 were appointed. The total number of shortlisted BME applicants decreased from 9825 in 2024 to 7105 in 2025.
- For non-medical white applicants, the likelihood of appointment has increased from 27% in 2024 to 41% in 2025.
- Note: As part of the group formation and to maintain consistency with other SW London trusts serviced by the SWL Recruitment Hub, we have changed the way our data is sourced in 2024 and 2025 this have meant to shift in some of the previously reported figures for 2024.



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

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

Workforce Race Equality Standard 2025

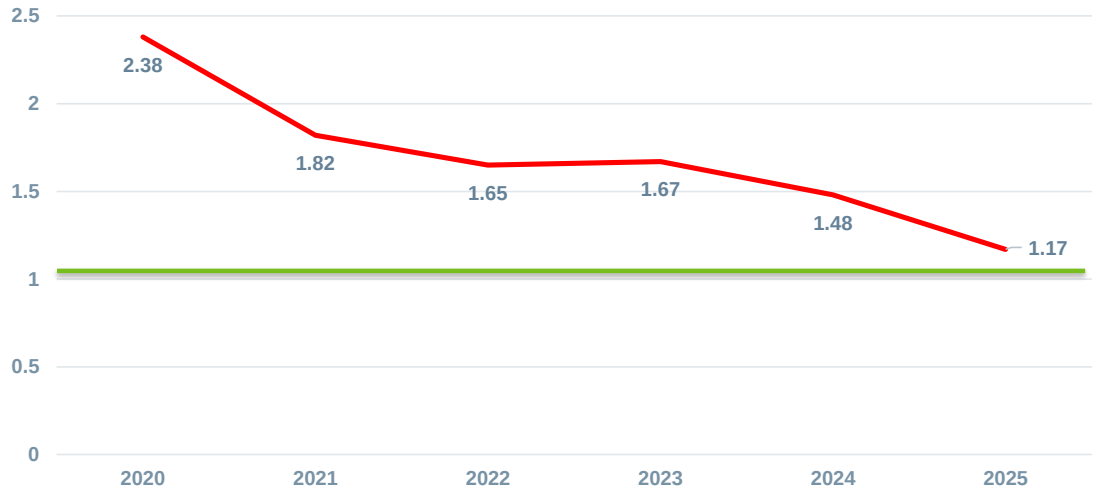
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Indicator 3

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

- Our 2025 figures show that BME staff at St George's are more likely to enter the disciplinary process compared to white staff.
- Over the last five years we have seen a significant reduction in the relative likelihood of BME entering the disciplinary process, from 2.38 times more likely in 2020, to 1.17 in 2025. This is a 50% reduction in this time.
- The number of BME staff entering the disciplinary process has decreased compared to last year - from 33 in 2024 to 26 BME staff members in 2025. This is a 22% reduction on the previous year.
- The number of white staff entering the disciplinary process has also reduced, from 18 in 2024 to 17 in 2025.

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



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

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

Workforce Race Equality Standard 2025

Trust: STG

Indicator 4

Relative likelihood of white staff accessing non–mandatory training and CPD compared to BME staff

For the fifth year we see an increase in the number of Black, Asian and Minority Ethnic staff accessing non-mandatory training and continuing professional development (CPD). The likelihood of BME staff accessing non-mandatory training and CPD has increased to 36%, from 29% in 2023.

In 2025 we saw a 5-percentage point increase in the number of white staff accessing non-mandatory training and continuing professional development, increasing the likelihood from 29% to 34%.

In 2024 we saw the greatest disparity, in terms of likelihood of each ethnic group accessing training, with a 5-percentage point difference – this has now reduced to 1-2 percentage points difference, inline with historic likelihoods.

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

Workforce Race Equality Standard 2025

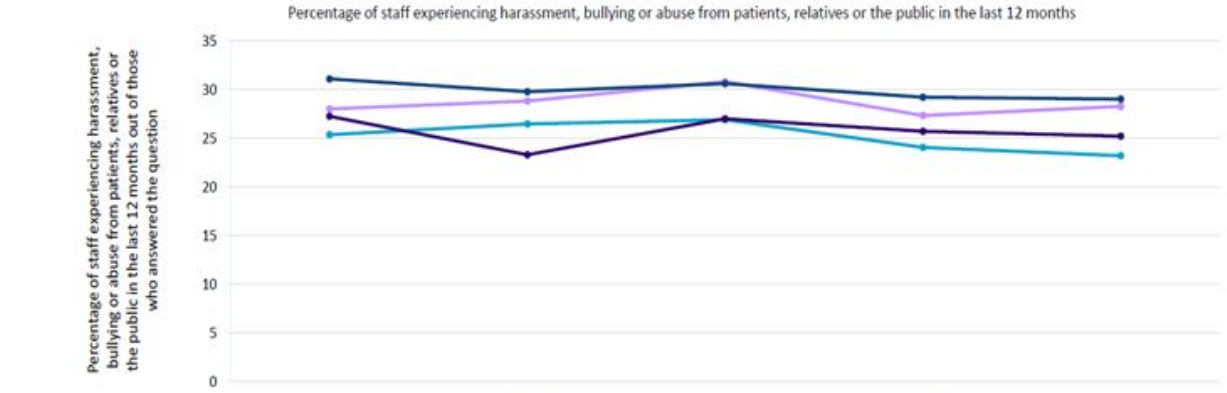
Trust: STG

Indicator 5

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

- For the third year, the percentage of staff who experienced harassment, bullying or abuse from **patients, relatives or the public** in the last 12 months was lower for BME staff (25%) than for white staff (29%).
- When comparing 2024 to 2025, for white staff the figures have remained static at 29%. The gap between white and BME staff is around 3.8 percentage points, over 3 percentage points for the second year.
- Note for internal use only: We are awaiting national WRES insight reports which will provide additional information for this report. This is expected to be received in September/October and will be updated prior to publication.

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



	2020	2021	2022	2023	2024
White staff: Your org	31.10%	29.79%	30.62%	29.22%	29.03%
All other ethnic groups*: Your org	27.26%	23.30%	27.01%	25.72%	25.22%
White staff: Average	25.36%	26.47%	26.91%	24.05%	23.21%
All other ethnic groups*: Average	28.01%	28.84%	30.82%	27.34%	28.27%
White staff: Responses	2524	2484	2296	1832	2329
All other ethnic groups*: Responses	1904	2034	2025	1552	2343

*Staff from all other ethnic groups combined

Workforce Race Equality Standard (WRES)

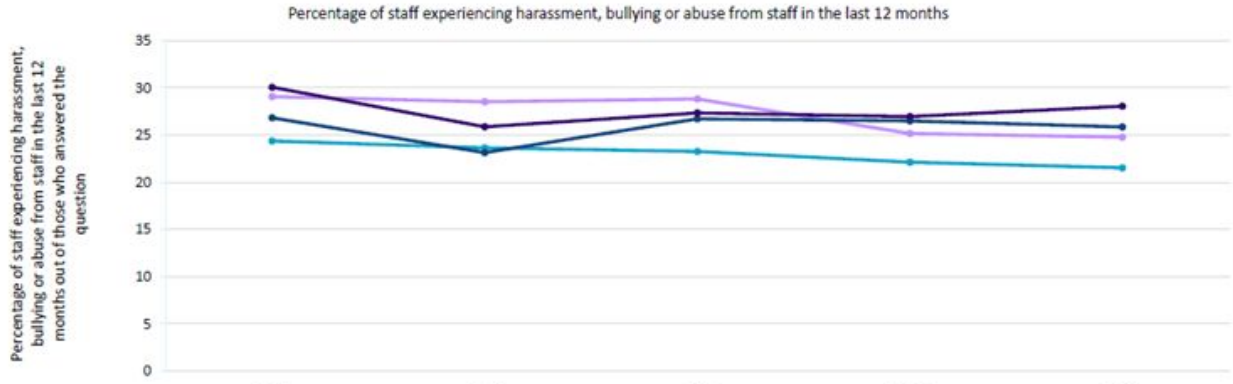
Trust: STG

Indicator 6

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

- Reported rates of staff experiencing harassment, bullying or abuse from other staff have increased by 0.7 percentage points since last year's staff survey. This is a change from the downward trend over the previous two years for this indicator.
- Results show also show a change in trajectory for BME staff at St George's who report higher rates of experiencing harassment, bullying or abuse. This has increased by 1.1 percentage points, from 26.9% in 2023 to 28% in 2024.
- For white staff this has reduced by 0.6 percentage points.
- Note for internal use only: We are awaiting national WRES insight reports which will provide additional information for this report. This is expected to be received in September/October and will be updated prior to publication.

% of staff experiencing harassment, bullying or abuse from staff



	2020	2021	2022	2023	2024
White staff: Your org	26.82%	23.14%	26.71%	26.49%	25.85%
All other ethnic groups*: Your org	30.06%	25.87%	27.34%	26.94%	28.05%
White staff: Average	24.37%	23.65%	23.25%	22.12%	21.53%
All other ethnic groups*: Average	29.07%	28.53%	28.81%	25.16%	24.78%
White staff: Responses	2524	2494	2295	1832	2329
All other ethnic groups*: Responses	1906	2041	2030	1546	2328

*Staff from all other ethnic groups combined

Workforce Race Equality Standard 2025

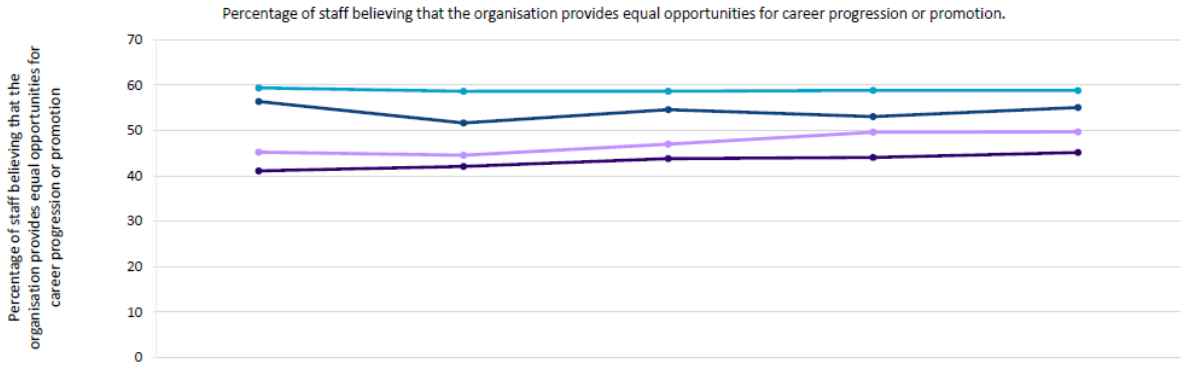
Trust: STG

Indicator 7

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

- 45% of BME staff felt the organisation provides equal opportunities for career progression or promotion. This follows a continued upwards trend since 2020 (+4 percentage points).
- This compares to 55% of white staff, which has increased by 2.02 percentage points compared to last year.
- The gap in perception between white and BME staff has increased from 8 percentage points in 2023 to 9 percentage points in 2024.
- Both white and BME staff at St George's still feel less confident compared to staff nationally.
- Note for internal use only: We are awaiting national WRES insight reports which will provide additional information for this report. This is expected to be received in September/October and will be updated prior to publication

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



	2020	2021	2022	2023	2024
White staff: Your org	56.39%	51.67%	54.59%	53.06%	55.08%
All other ethnic groups*: Your org	41.12%	42.08%	43.82%	44.05%	45.16%
White staff: Average	59.39%	58.64%	58.65%	58.84%	58.82%
All other ethnic groups*: Average	45.24%	44.56%	47.00%	49.64%	49.70%
White staff: Responses	2566	2551	2277	1898	2324
All other ethnic groups*: Responses	1953	2096	2013	1664	2334

*Staff from all other ethnic groups combined

Workforce Race Equality Standard 2025

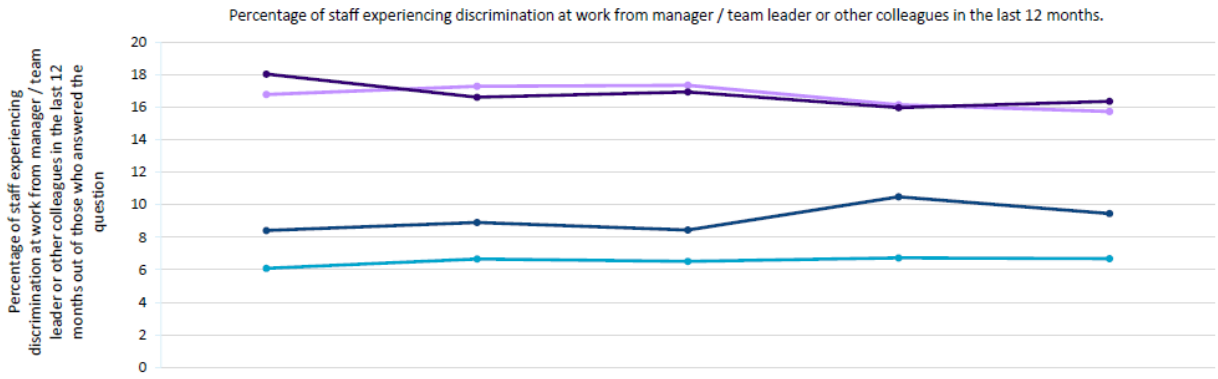
Trust: STG

Indicator 8

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

- In 2024, 16.35% of BME staff completing the staff survey indicated that they had experienced discrimination at work from a manager or colleague. This has increased slightly, by 0.39 percentage points, since last year.
- For white staff, this has reduced compared to last year, from 10.48% in 2023 to 9.45% in 2024.
- Whilst BME staff continue to report experiencing higher rates of discrimination, compared to white colleagues, the gap in experience has widened from a gap of 5.48 percentage points in 2023 to 6.9 percentage points in 2024.
- Note for internal use only: We are awaiting national WRES insight reports which will provide additional information for this report. This is expected to be received in September/October and will be updated prior to publication

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



	2020	2021	2022	2023	2024
White staff: Your org	8.42%	8.91%	8.45%	10.48%	9.45%
All other ethnic groups*: Your org	18.02%	16.60%	16.93%	15.96%	16.35%
White staff: Average	6.09%	6.67%	6.52%	6.73%	6.69%
All other ethnic groups*: Average	16.77%	17.28%	17.33%	16.14%	15.72%
White staff: Responses	2578	2560	2297	1898	2306
All other ethnic groups*: Responses	1964	2102	2020	1654	2330

*Staff from all other ethnic groups combined

Workforce Race Equality Standard 2025

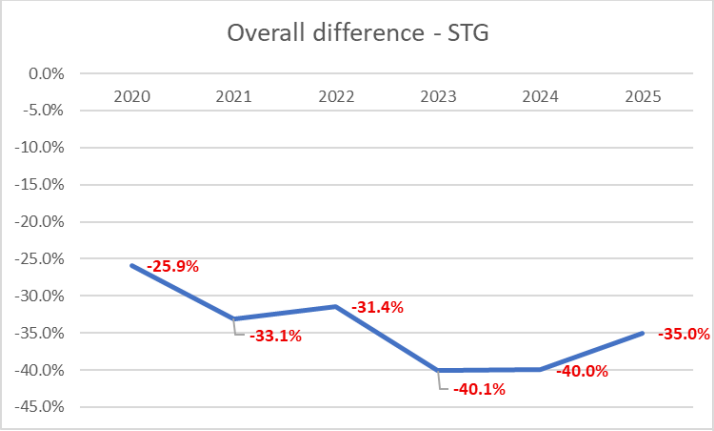
Trust: STG

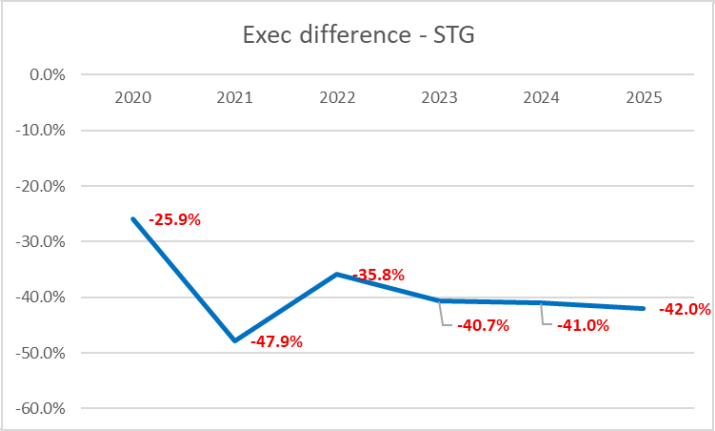
Indicator 9

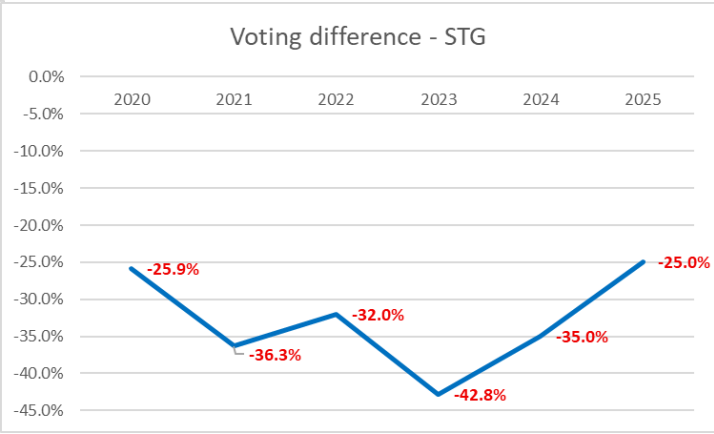
% of board members by ethnicity compared to BME workforce

As of 31 March 2025, the Trust Board of Directors comprised 15 members, three of whom identify as Black, Asian and Minority Ethnic (two non-executive directors, and one executive director). Of this, the Board comprised 10 voting members, seven of whom were non-executive directors and eight were executive directors. Of these 10 voting members of the Board, three voting Board members identify as BME. At St George's this means BME staff are -35% under-represented at Board level overall, and -25% at Voting Board level. At ESTH this means BME staff are -34% underrepresented at Board level overall, and -26% at Voting Board level.

Additional narrative to follow.







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

gesh

Site Report: Epsom and St Helier University Hospitals NHS Trust

Workforce Race Equality Standard 2025

Features: 2024 Staff Survey Data and workforce information on 31/03/2025
Published: 00/00/2024

Workforce Race Equality Standard 2025

Executive summary

Trust: ESTH

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

In line with national requirements, this report and any associated action plans should be reviewed internally and approved at Board before being published on the organisation's website. The deadline for publication is 31st October 2025.

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

Improved indicators

- We have seen an improvement in 3 out of the 10 indicators, the remaining 2 have remained static.
- Overall, the BME staff population at Epsom and St Helier continues to increase year on year (47.8%).
- Reported experiences of Harassment, Bullying and Abuse have reduced, from patient-staff and staff-staff.
- There is a reduction in reports experiences of discrimination from managers and colleagues – this however remains higher than the London average.
- We have seen a year-on-year increase in diversity within the consultant group, from 45% in 2022 to 58% in 2024

Reduced / static indicators

- There has been a decline in 5 out of 10 indicators, with 1 remaining static.
- Relative likelihood of BME staff entering the formal disciplinary processes has declined.
- The number of white staff at VSM level has reduced from 14 to 10, and BME staff remaining static at 1.
- BME staff make up just 7.1% of non-clinical VSM posts – compared to 92% white.
- Of the 37 non-clinical Band 8d and above posts only 13% are held by a BME member of staff, compared to 82% being held by a white member of staff.
- The relative likelihood of white applicants being appointed from shortlisting compared to BME applicants has worsened from 0.74 to 1.56
- BME staff are significantly under-represented at Executive at -35%
- Slight downward trend in the percentage of BME staff feeling the organisation provides equal opportunities for career progression or promotion – from 51.6% to 51.0%
- The % difference between the organisations' board voting membership and its overall workforce has declined from -33% to -35%.

Outstanding care every time

Workforce Race Equality Standard 2025

Indicator Overview

Trust: ESTH

	Indicator	ESTH 2022	ESTH 2023	ESTH 2024	ESTH 2025	Performance vs. previous year	Exp. compared to White Staff	London Av. 2023	London Av. 2024
1	% of BME staff in organisation	38%	41%	44.2%	**47.8%**	**Increased**		52.1%	
2	Relative likelihood of White applicants being appointed from shortlisting compared BME applicants	1.04	1.30	0.74	**1.56**	**Declined**		1.47%	
3	Relative likelihood of BME staff entering the formal disciplinary process, compared to that of White staff	1.20	1.45	1.04	**1.36**	**Declined**		1.41%	
4	Relative likelihood of White staff accessing non-mandatory training and CPD compared to BME staff	1.07	0.52	1.01	**1.09**	**Declined**		0.92%	
5	% of BME staff experiencing harassment, bullying or abuse *from patients, relatives or the public* in the last 12 months.	27.5%	28.3%	25.5%	**24.8%**	**Improved**		32.1%	
6	% of BME staff experiencing harassment bullying or abuse *from staff* in the last 12 months	26.2%	25.5%	23.1%	**21.6%**	**Improved**		28.3%	
7	% of BME staff believing that organisation provides equal opportunities for career progression or promotion	44.7%	45.9%	51.6%	**51.0%**	**Declined**		43.2%	
8	% of BME staff personally experiencing discrimination at work from *manager/leader/ or other colleagues*.	15.8%	15.8%	14.7%	**13.4%**	**Improved**		16.1%	
9	% difference between the organisations' board voting membership and its overall workforce	-10%	-16%	-26%	**-26%**	**Static***		-27%	
	% difference between the organisations' executive membership and its overall workforce	0	-10%	-33%	**-35%**	**Declined**		-33%	

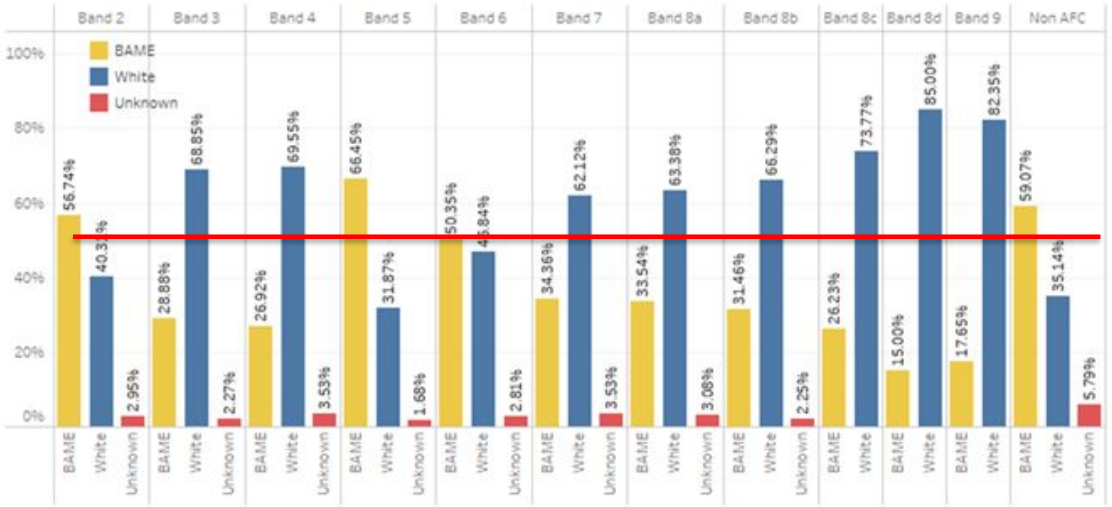
* Changes of +/- 0.5 or less are recorded as Static.

Workforce Race Equality Standard (WRES)

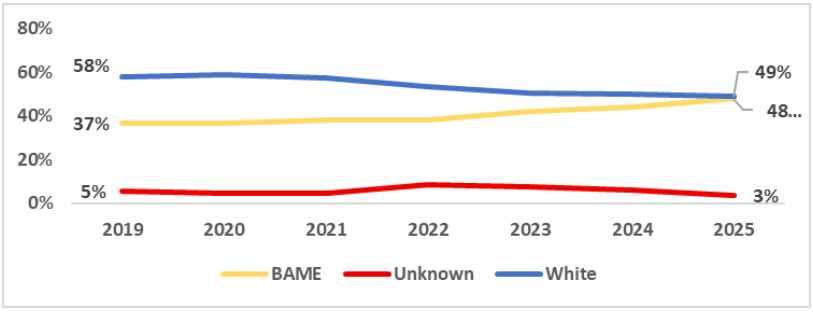
Trust: ESTH

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

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

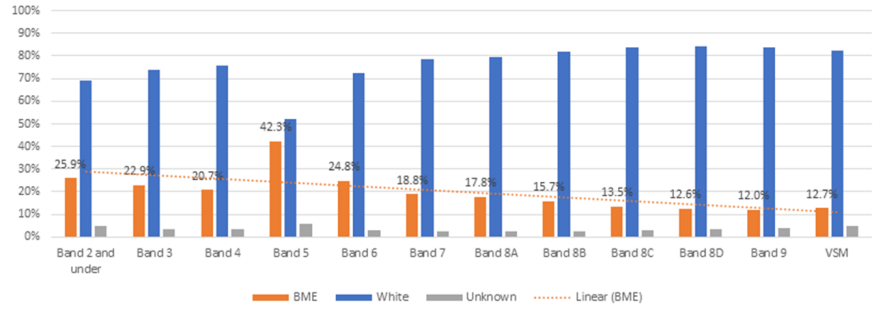


Note: The solid red line indicates the target for St George's to be representative across all AFC pay bands.



- Our Black, Asian and Minority Ethnic workforce has increased year on year since 2020 and continues to be representative of the local communities we serve.
- For this reporting year, we see an increase of +3.6% in indicator 1. This is approximately an increase of 225 Black, Asian and Minority Ethnic members of staff compared to the previous year.
- For the second consecutive year, our Black, Asian and Minority Ethnic workforce remains 4.3% lower than the London average. Whilst we see a continued annual increase across the workforce, our workforce data still highlights that Black, Asian and Minority Ethnic staff are over-represented in lower bands and under-represented in higher bands
- This is not unique to Epsom and St Helier and mirrors what we see across London NHS trusts (see table A and B).

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



Workforce Race Equality Standard 2025

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

Trust: ESTH 23

For Clinical staff (table C), we see an increase in the percentage of Black, Asian and Minority Ethnic staff across 5 of the 11 AFC bands. Compared to last year we have seen a reduction of white Staff (-15), compared to an increased (+67) BME staff members. This is largely due to an increase at Bands 3, 5 and 6.

We have seen a year-on-year increase in diversity with the consultant group, from 45% in 2022 to 58% in 2024. In terms of percentage our 2024 ratio for consultant staff was 35% white to 58% BME.

The lowest level of representation remains band 8a-c (33% BME) and 8d+. Of the 13 Band 8d and above posts only 7% are held by a BME member of staff, compared to 92% being held by a white member of staff (table E).

Table C: % of Clinical Staff in each AFC Band

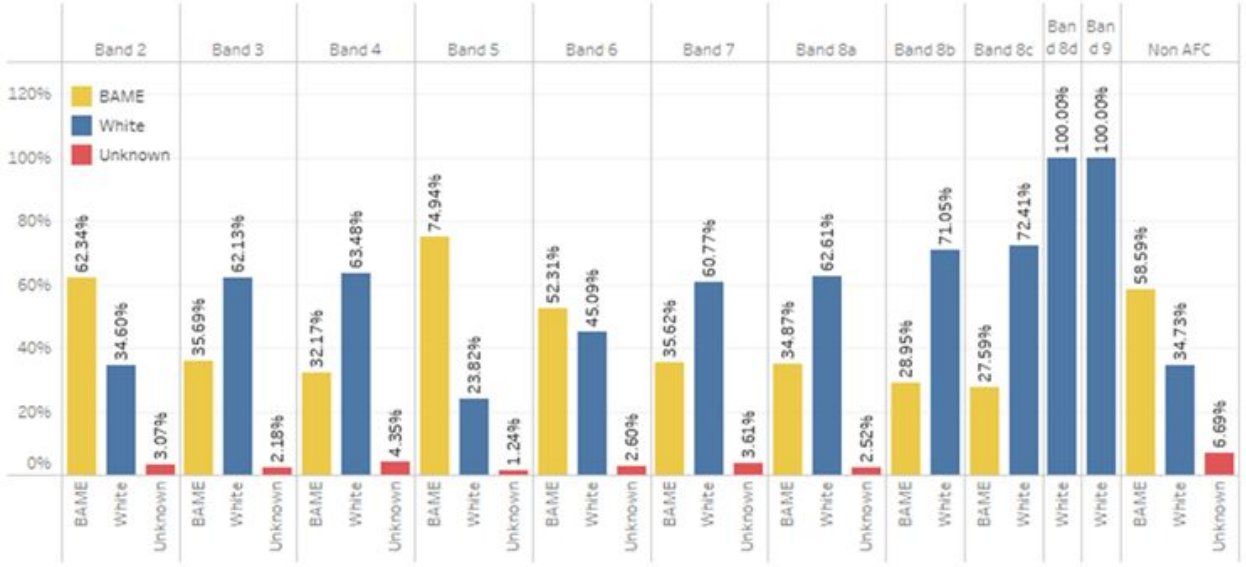


Table E: % of staff by ethnic group (clustered):

Cluster	2022			2023			2024			2025		
	White	BAME	Unknown	White	BAME	Unknown	White	BAME	Unknown	White	BAME	Unknown
Band 1 - 5	45.5%	49.9%	4.6%	41.6%	54.4%	3.9%	38.6%	58.3%	3.1%	37.9%	59.8%	2.3%
Band 6 - 7	56.5%	38.5%	5.0%	54.8%	40.2%	5.0%	53.0%	43.1%	3.9%	51.9%	45.0%	3.0%
Band 8a-8c	65.7%	29.3%	5.1%	67.0%	29.0%	4.0%	64.7%	32.8%	2.5%	64.6%	33.4%	2.0%
Band 8d +	64.3%	35.7%	0.0%	46.7%	53.3%	0.0%	68.8%	31.3%	0.0%	92.3%	7.7%	0.0%
Medical	38.6%	55.7%	5.7%	36.5%	56.2%	7.4%	33.4%	60.6%	6.0%	62.1%	31.2%	6.7%

Workforce Race Equality Standard 2025

Trust: ESTH

Indicator 1

Non-Clinical Staff - *% of staff by AfC pay band and ethnicity*

For Non-Clinical staff we see an increase in the percentage of Black, Asian and Minority Ethnic staff across all of the 11 AFC bands. This conversely compares to decrease in the number of white staff in all of the 11 AFC bands.

For the second year BME representation at Band 6 and Band 7 (25.7%) is significantly lower than White representation (67.8%) and some distance away from the organisation overall of +47% – with 30% at Band 6 and 21% at Band 7.

The number of white staff at VSM level has reduced from 14 to 10, with the number of BME staff remaining static at 1. This means that BME staff make up just 7.1% of non-clinical VSM posts – compared to 92% White.

Of the 37 Band 8d and above posts only 13% are held by a BME member of staff, compared to 82% being held by a white member of staff (table H).

Table C: % of Non-Clinical Staff in each AFC Band

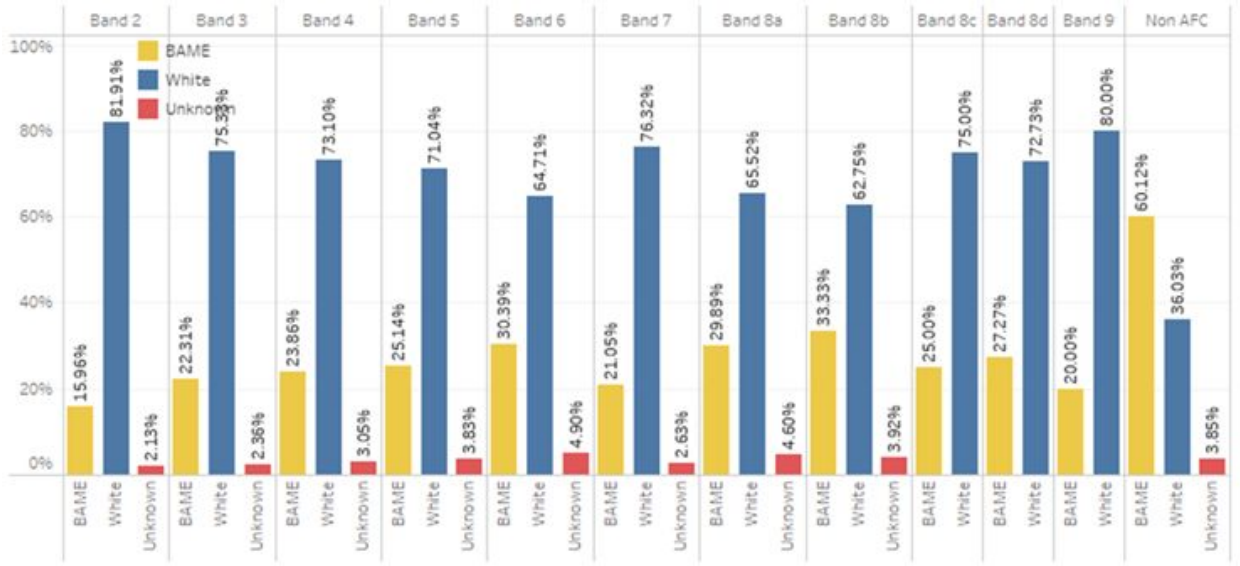


Table E: % of staff by ethnic group (clustered):

Cluster	2022			2023			2024			2025		
	White	BAME	Unknown	White	BAME	Unknown	White	BAME	Unknown	White	BAME	Unknown
Band 1 - 5	76.5%	19.1%	4.4%	75.3%	21.1%	3.6%	75.5%	21.5%	3.0%	74.8%	23.0%	2.2%
Band 6 - 7	72.6%	21.5%	5.9%	69.8%	25.1%	5.0%	70.3%	24.5%	5.2%	67.8%	25.7%	6.6%
Band 8a-8c	64.3%	29.2%	6.5%	66.1%	28.7%	5.3%	66.5%	29.0%	4.5%	65.7%	29.7%	4.7%
Band 8d +	83.6%	12.7%	3.6%	78.3%	19.6%	2.2%	80.0%	17.5%	2.5%	81.1%	18.9%	0.0%

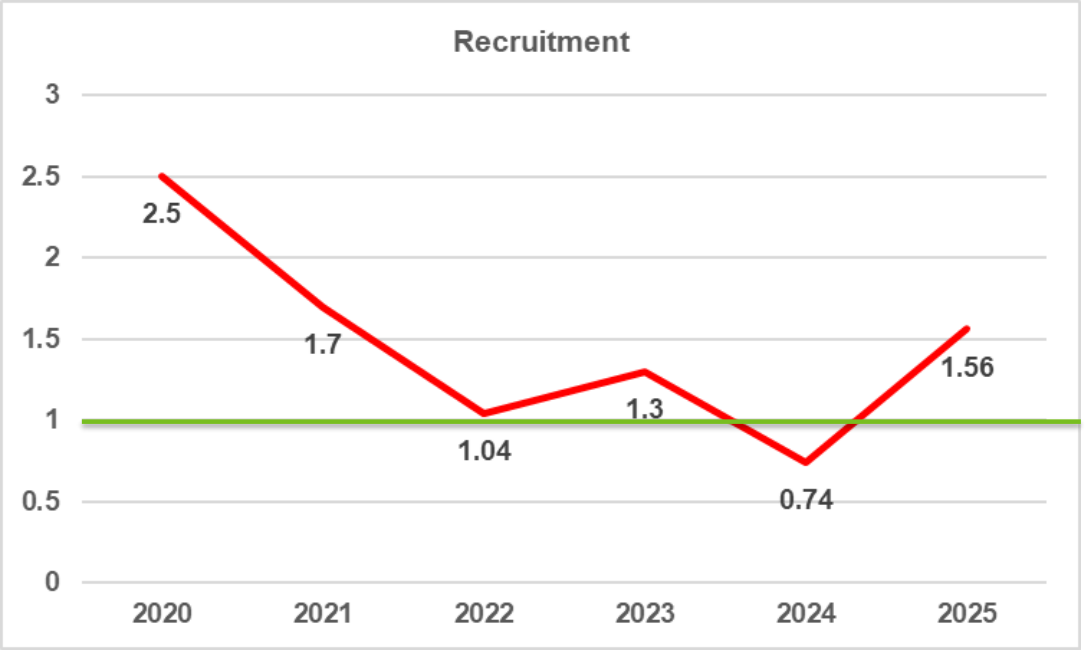
Workforce Race Equality Standard 2025

Trust: ESTH

Indicator 2

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

- Our 2025 figures show that white applicants at Epsom and St Helier are 1.56 times more likely to be appointed from shortlisting compared Black, Asian and Minority Ethnic (BME) applicants. This is a significant increase from 0.74 in 2024.
- In 2025 the likelihood of Black, Asian and Minority Ethnic applicants being appointed from shortlisting reduced from 16% to 9% - this means that of the 3113 shortlisted BME applicants, 311 were appointed. The number of shortlisted BME applicants reduced from 556 in 2024 to 311 in 2025.
- For white applicants, the likelihood of appointment has increased from 12% in 2024 to 16% in 2025.
- For those that did not record an ethnicity the likelihood of appointment is 15% meaning of the 247 candidates who did not record an ethnicity, 38 of them were appointed.



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

2020	2021	2022	2023	2024	2025
2.50	1.70	1.04	1.30	**0.74**	**1.56**

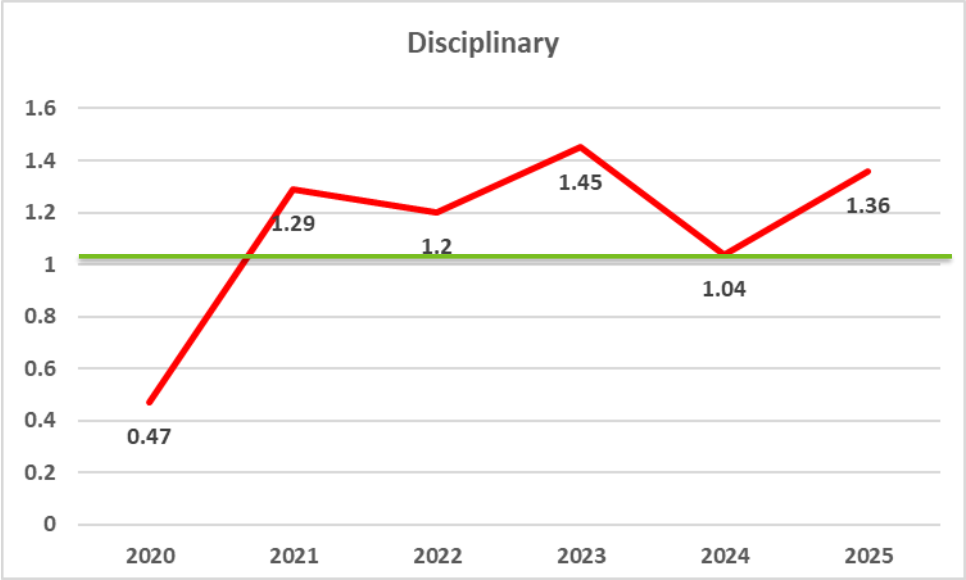
Workforce Race Equality Standard 2025

Indicator 3

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

Trust: ESTH

- Our 2025 figures show that BME staff at Epsom and ST Helier are more likely to enter the disciplinary process compared to white staff.
- There has been an increase from the previous year in the relative likelihood of BME entering the disciplinary process, from 1.04 times more likely in 2024, to 1.36 in 2025.
- The number of BME staff entering the disciplinary process has increase compared to last year - from 13 in 2024 to 16 BME staff members in 2025. This is an increase of 23% on the previous year.
- The number of white staff entering the disciplinary process has reduced, from 14 in 2024 to 12 in 2025. This is an increase of 16% on the previous year.



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

2020	2021	2022	2023	2024	2025
0.47	1.29	1.20	1.45	1.04	**1.36**

Workforce Race Equality Standard 2025

Trust: ESTH

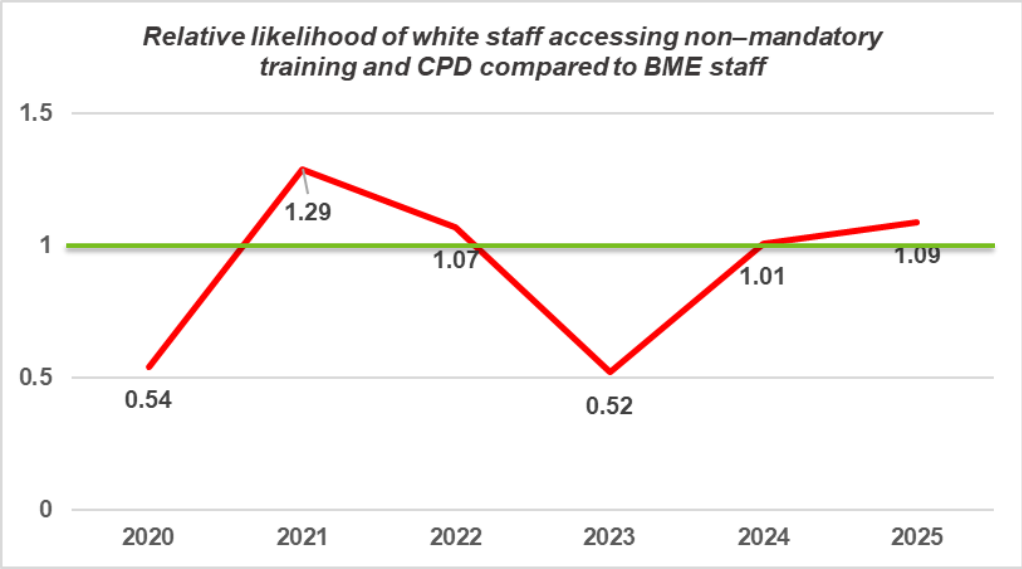
Indicator 4

Relative likelihood of white staff accessing non–mandatory training and CPD compared to BME staff

For the second year we see an increase in the number of Black, Asian and Minority Ethnic staff accessing non-mandatory training and continuing professional development (CPD). The likelihood of BME staff accessing non-mandatory training and CPD has increased from 1.01 in 2024 to 1.09 in 2025.

In 2025 we saw a 3-percentage point increase in the number of white staff (224 white staff out of 3590) accessing non-mandatory training and continuing professional development compared to (113 white staff 3681) the previous year.

In 2025 the disparity, in terms of likelihood of each ethnic group accessing training is not statistically significant, with a 0.5 percentage point difference – in previous years this has been between 1-2 percentage points.



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

2020	2021	2022	2023	2024	2025
0.54	1.29	1.07	0.52	1.01	**1.09**

Workforce Race Equality Standard 2025

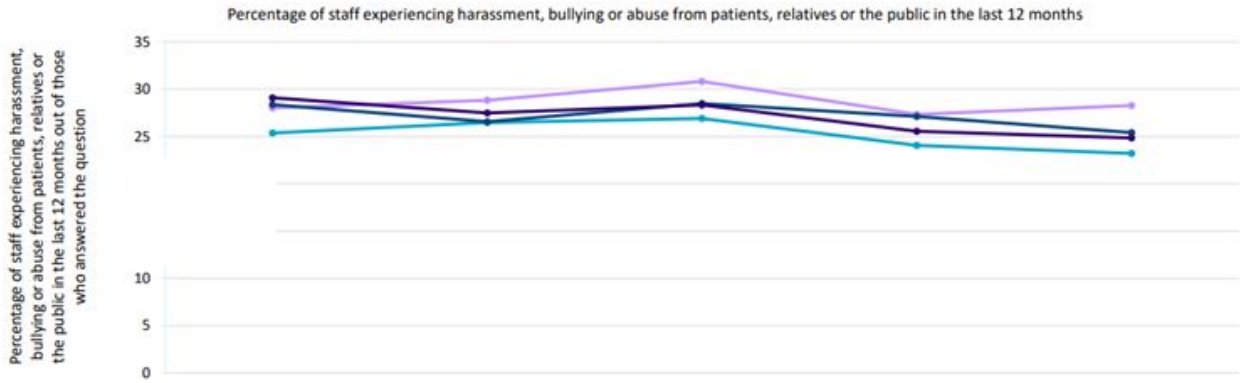
Trust: ESTH

Indicator 5

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

- For the first time in two yeas, the percentage of staff who experienced harassment, bullying or abuse from **patients, relatives or the public** in the last 12 months was lower for BME staff (24%) than for white staff (25%).
- For white staff we see a decrease from 27% to 25%. The gap between white and BME staff has reduced by 1 percentage point from previous year.
- In terms of the percentage of BME staff who experienced harassment, bullying or abuse from patients, relatives or the public in the last 12 months, the Trust performance is 3% lower than the national average.
- Awaiting national benchmarking data for additional insight.

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



	2020	2021	2022	2023	2024
White staff: Your org	28.37%	26.57%	28.48%	27.12%	25.41%
All other ethnic groups*: Your org	29.09%	27.49%	28.33%	25.55%	24.85%
White staff: Average	25.36%	26.47%	26.91%	24.05%	23.21%
All other ethnic groups*: Average	28.01%	28.84%	30.82%	27.34%	28.27%
White staff: Responses	1995	2401	2117	1965	2125
All other ethnic groups*: Responses	959	1197	1253	1237	1638

*Staff from all other ethnic groups combined

Workforce Race Equality Standard 2025

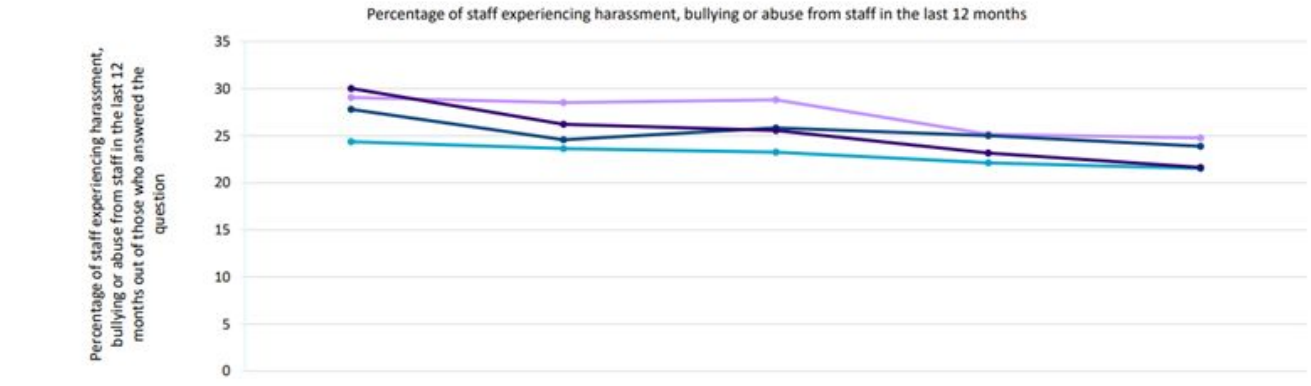
Trust: ESTH

Indicator 6

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

- Reported rates of staff experiencing harassment, bullying or abuse from other staff remains has improved since last year's staff survey. There is a 1% reduction and though a slight reduction, the trend is moving in the right direction. This year's result is also the lowest reported rate since 2020 for both white and BME staff.
- For BME staff at St Epsom and St Helier, this has reduced by 1.52 percentage points, from 23.1% in 2023 to 21.6% in 2024.
- For white staff this has reduced by 1.1 percentage points.
- Awaiting national benchmarking data for additional insight.

% of staff experiencing harassment, bullying or abuse from staff



	2020	2021	2022	2023	2024
White staff: Your org	27.81%	24.58%	25.83%	25.02%	23.89%
All other ethnic groups*: Your org	30.03%	26.22%	25.56%	23.16%	21.64%
White staff: Average	24.37%	23.65%	23.25%	22.12%	21.53%
All other ethnic groups*: Average	29.07%	28.53%	28.81%	25.16%	24.78%
White staff: Responses	1996	2396	2110	1964	2110
All other ethnic groups*: Responses	959	1186	1244	1232	1622

*Staff from all other ethnic groups combined

Workforce Race Equality Standard 2025

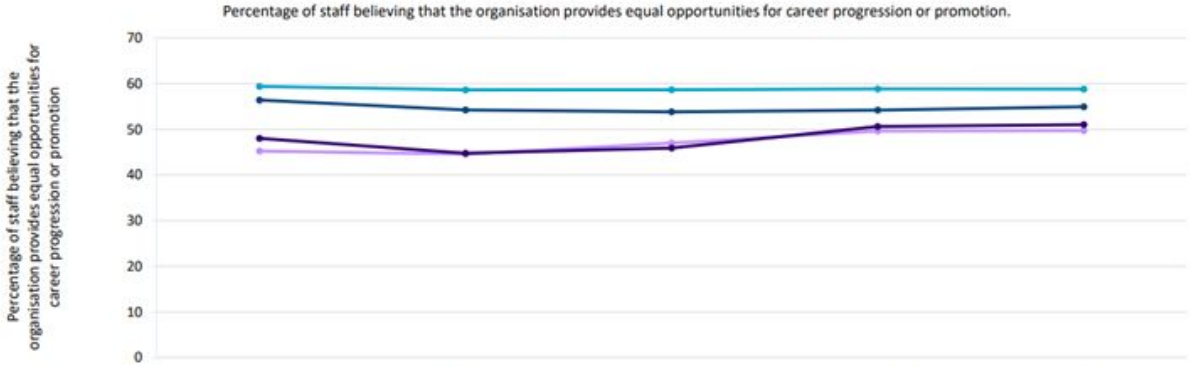
Trust: ESTH

Indicator 7

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

- 51% of BME staff felt the organisation provides equal opportunities for career progression or promotion. This follows a continued upwards trend since 2020 (+2.9 percentage points).
- This compares to 54% of white staff, which has increased by 1.08 percentage points compared to last year.
- The gap in perception between white and BME staff has reduced from 7.9 percentage points in 2022 to 3.9 percentage points in 2024.
- While white staff at Epsom and St Helier still feel less confident compared to staff nationally, BME staff compares above the national average.
- Awaiting national benchmarking data for additional insight.

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



	2020	2021	2022	2023	2024
White staff: Your org	56.40%	54.22%	53.82%	54.19%	54.93%
All other ethnic groups*: Your org	48.02%	44.76%	45.90%	50.63%	51.01%
White staff: Average	59.39%	58.64%	58.65%	58.84%	58.82%
All other ethnic groups*: Average	45.24%	44.56%	47.00%	49.64%	49.70%
White staff: Responses	2030	2466	2096	2063	2108
All other ethnic groups*: Responses	985	1231	1233	1351	1627

*Staff from all other ethnic groups combined

Workforce Race Equality Standard 2025

Trust: ESTH

Indicator 8

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

- In 2024, 13.3% of BME staff completing the staff survey indicated that they had experienced discrimination at work from a manager or colleague. This has increased by 1.35 percentage points, since last year.
- This is the lowest reported rate, for BME staff, since 2020.
- For white staff, this has also reduced compared to last year, from 8.75% in 2023 to 8.25% in 2024.
- Whilst BME staff continue to report experiencing higher rates of discrimination, compared to white colleagues, the gap in experience has remained relatively static over the past four years.
- Awaiting national benchmarking data for additional insight.

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



	2020	2021	2022	2023	2024
White staff: Your org	6.68%	9.04%	9.71%	8.75%	8.25%
All other ethnic groups*: Your org	16.90%	15.79%	15.79%	14.72%	13.37%
White staff: Average	6.09%	6.67%	6.52%	6.73%	6.69%
All other ethnic groups*: Average	16.77%	17.28%	17.33%	16.14%	15.72%
White staff: Responses	2035	2479	2112	2057	2097
All other ethnic groups*: Responses	988	1235	1235	1352	1623

*Staff from all other ethnic groups combined

Workforce Race Equality Standard 2025

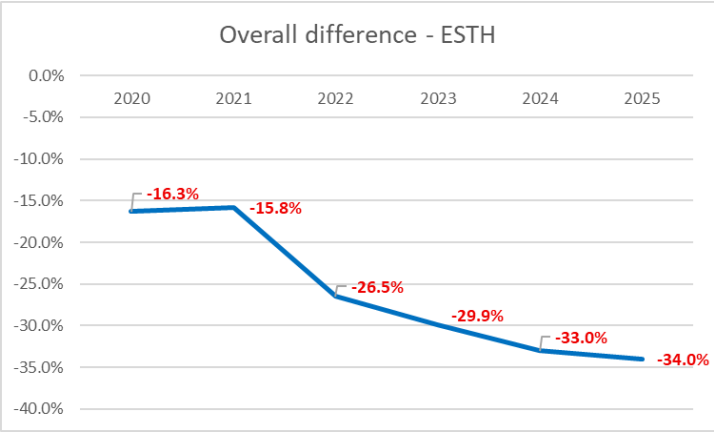
Trust: ESTH

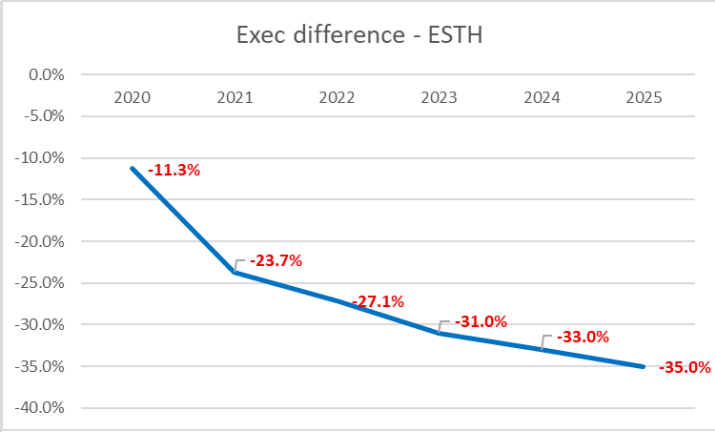
Indicator 9

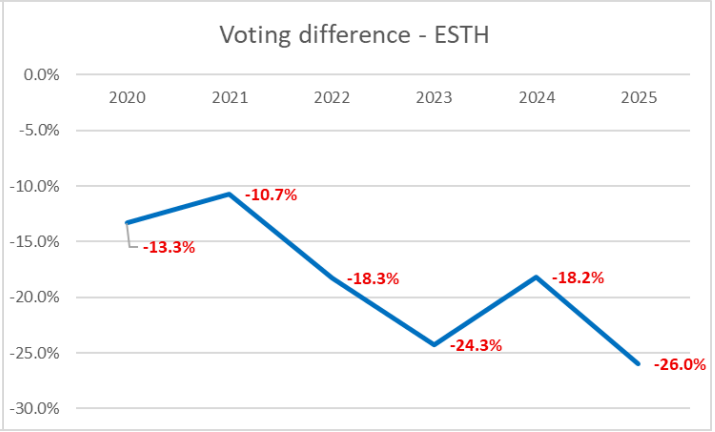
% of board members by ethnicity compared to BME workforce

As of 31 March 2025, the Trust Board of Directors comprised 15 members, three of whom identify as Black, Asian and Minority Ethnic (two non-executive directors, and one executive director). Of this, the Board comprised 10 voting members, seven of whom were non-executive directors and eight were executive directors. Of these 10 voting members of the Board, three voting Board members identify as BME. At St George's this means BME staff are -35% under-represented at Board level overall, and -25% at Voting Board level. At ESTH this means BME staff are -34% underrepresented at Board level overall, and -26% at Voting Board level.

Additional narrative to follow.







Workforce Race Equality Standard (WRES)

Appendix A: Definitions of ethnicity: people covered by the WRES

- **In line with Health Education England's WRES guidance and national WRES reporting metrics, the term 'BME' and 'white' are used to describe the two groups of staff referred to in this report**.
- The definitions of 'black and minority ethnic' and 'white' used in Health Education England's (HEE) WRES guidance 2024 have followed the national reporting requirements of ethnic category in the NHS data model and dictionary and are as used in NHS Digital data. At the time of publication these definitions were based upon the 2001 ONS Census categories for ethnicity. These are presented in Annex B.
- 'White' staff include white British, Irish, Eastern European and any other white i.e. categories 1–4 in the table in.
- The 'black and minority ethnic' staff category includes all others except 'unknown' and 'not stated.'
- To aggregate data for BME staff, organisations should include categories 5-18 from current values and exclude 'not stated' and any 'NULL' values.
- The treatment of staff from ethic categories [2 – white Irish] or [3 – Gypsy or Irish Traveler] or [4 – Any other white background] i.e. eastern European who may, in some organisations, be a significant minority group and experience considerable discrimination, is considered in the WRES FAQs document. Where this is the case, organisations should also explore such discrimination using workforce and staff survey data and take appropriate action.
- Source: WRES Additional Information 2024 for NHS Trusts and Foundation Trusts (30/04/2024)

Ethnicity refers to: ONS definitions found here: Ethnic group, national identity and religion - Office for National Statistics (ons.gov.uk)

Ethnic Categories 2021

WHITE
1 – White –British / Welsh / Scottish / Northern Irish / British
2 – White –Irish
3 - Gypsy or Irish Traveller
4 – Any other white background please describe

MIXED / MULTIPLE ETHNIC GROUPS
5 – White and Black Caribbean
6 – White and Black African
7 – White and Asian
8 – Any other mixed / multiple ethnic background please describe

ASIAN / ASIAN BRITISH
9– Asian or Asian British –Indian
10 – Asian or Asian British –Pakistani
11 – Asian or Asian British – Bangladeshi
12 - Asian or Asian British – Chinese
13 – Any other Asian background please describe

BLACK / AFRICAN / CARIBBEAN / BLACK BRITISH
14 – Black or black British – African
15 – Black or black British – Caribbean
16 – Any other black background please describe

ANY OTHER ETHNIC GROUP
17 – Arab
18 – Any other ethnic group please describe

Workforce Race Equality Standard (WRES)

Appendix B: High impact action plan framework

This plan prioritises the following six high impact actions to address the widely-known intersectional impacts of discrimination and bias.

Measurable objectives on EDI for Chairs Chief Executives and Board members.

Success metric

1a. Annual Chair/CEO appraisals on EDI objectives via Board Assurance Framework (BAF).

Overhaul recruitment processes and embed talent management processes.

Success metric

2a. Relative likelihood of staff being appointed from shortlisting across all posts

2b. NSS Q on access to career progression and training and development opportunities

2c. Improvement in race and disability representation leading to parity

2d. Improvement in representation senior leadership (Band 8C upwards) leading to parity

2e. Diversity in shortlisted candidates

2f. NETS Combined Indicator Score metric on quality of training

Eliminate total pay gaps with respect to race, disability and gender.

Success metric

3a. Improvement in gender, race, and disability pay gap

Address Health Inequalities within their workforce.

Success metric

4a. NSS Q on organisation action on health and wellbeing concerns

4b. National Education & Training Survey (NETS) Combined Indicator Score metric on quality of training

4c. To be developed in Year 2

Comprehensive Induction and onboarding programme for International recruited staff.

Success metric

5a. NSS Q on belonging for IR staff

5b. NSS Q on bullying, harassment from team/line manager for IR staff

5c. NETS Combined Indicator Score metric on quality of training IR staff

Eliminate conditions and environment in which bullying, harassment and physical harassment occurs.

Success metric

6a. Improvement in staff survey results on bullying / harassment from line managers/teams (ALL Staff)

6b. Improvement in staff survey results on discrimination from line managers/teams (ALL Staff)

6c. NETS Bullying & Harassment score metric (NHS professional groups)

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Workforce Disability Equality Standard (WDES) 2025 Report

Features: 2024 Staff Survey Data and workforce information on 31/03/2025
Published: 00/00/2024

Workforce Disability Equality Standard 2025

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Workforce Disability Equality Standard (WDES)

Background

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

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

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

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

Workforce Disability Equality Standard (WDES)

Our ambition

Serving a diverse population of over 1.5 million and with over 17,000 employees, gesh is the largest healthcare provider in south west London. It is crucial that the diversity of our workforce reflects the diversity of the communities we serve, and we are proud that in 2025 the number of Electronic Staff Record (ESR) declarations for people with a disability has increased. We will continue to reinforce the importance of declaring one's disability on ESR to ensure adequate representation, resource allocation and support and importantly, reduce stigma by building inclusion.

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

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

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

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

Workforce Disability Equality Standard 2025
Purpose and Terminology

Purpose

- This paper provides an overview of the 2025 Workforce Disability Equality Standard (WDES) findings.
- This report will be published on the Trust websites.
- The Board is asked to receive this report and associated action plan for information and approve for publication.

Terminology: people covered by the WDES

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

Overview of Workforce Numbers

STG	2021	2022	2023	2024	2025
Total number of staff in organisation	9,154	9,608	9,915	10,345	**10,815**
% of staff with a declared Disability on ESR	2.3%	2.9%	3.5%	3.7%	**4.3%**
% of staff which indicated a disability via Staff Survey	6.3%	7.5%	6.8%	5.9%	**7.5%**

ESTH	2021	2022	2023	2024	2025
Total number of staff in organisation	6,154	7,092	7,190	7,410	**7,326**
% of staff with a declared Disability on ESR	3.5%	4.3%	4.4%	4.3%	**5.0%**
% of staff which indicated a disability via Staff Survey	8.2%	9.1%	8.5%	8.0%	**9.4%**

Gesh	2021	2022	2023	2024	2025
Total number of staff in organisation	15,308	16,700	17,105	17,755	**18,141**
% of staff with a declared Disability on ESR	2.8%	3.4%	3.9%	3.9%	**4.6%**

Workforce Disability Equality Standard 2025

Indicator Overview

Note: '*Compared to Colleagues':* A green cell indicates staff with a disability report a more positive experience than colleagues that do not have a disability. 6

* Changes of +/- 0.5 or less are recorded as Static.

WDES Indicator		STG						ESTH					
		2022	2023	2024	2025	vs. LY	Compared to colleagues	2022	2023	2024	2025	vs. LY	Compared to colleagues
1	% of Disabled staff in organisation	2.9%	3.5%	3.7%	**4.3%**	**Increased**		4.0%	4.4%	4.3%	**5.0%**	**Increased**	
2	Relative likelihood of non-Disabled candidates compared to Disabled candidates being appointed from shortlisting across all posts.	1.21	1.15	1.26	**0.97**	**Improved**		23.2	1.20	1.52	**0.92**	**Improved**	
3	Relative likelihood of Disabled staff compared to non-disabled staff entering the formal capability process, as measured by entry into the formal capability procedure	4.78	4.26	4.08	**0.00**	**Improved**		4.95	7.99	0.00	**0.00**	**Static***	
4a	% of staff experiencing harassment, bullying or abuse from patients/ service users	34.8%	37.1%	35.1%	**30.9%**	**Improved**		32.0%	34.5%	31.7%	**31.2%**	**Improved**	
4b	% of staff experiencing harassment, bullying or abuse from managers	21.1%	20.1%	21.1%	**17.6%**	**Improved**		20.9%	19.5%	18.4%	**19.6%**	**Declined**	
4c	% of staff experiencing harassment, bullying or abuse from other colleagues	31.6%	32.1%	29.3%	**31.2%**	**Declined**		25.7%	26.1%	26.1%	**24.9%**	**Improved**	
4d	% of staff saying that the last time they experienced harassment, bullying or abuse at work, they or a colleague reported it	47.9%	44.3%	50.7%	**52.9%**	**Improved**		49.3%	48.9%	52.8%	**55.2%**	**Improved**	
5	% of staff believing that the Trust provides equal opportunities for career progression or promotion	40.1%	44.1%	41.5%	**45.9%**	**Improved**		46.3%	45.9%	46.4%	**47.6%**	**Improved**	
6	% of staff saying that they have felt pressure from their manager to come to work, despite not feeling well enough to perform their duties	35.2%	32.0%	29.0%	**29.6%**	**Declined**		31.1%	33.5%	30.4%	**31.9%**	**Declined**	
7	% of staff saying that they are satisfied with the extent to which their organisation values their work	31.0%	29.9%	31.3%	**34.1%**	**Improved**		31.5%	32.7%	37.6%	**34.5%**	**Declined**	
8	% of staff saying that their employer has made reasonable adjustment(s) to enable them to carry out their work	-	61.7%	68.9%	**67.2%**	**Declined**		-	66.2%	70.9%	**68.8%**	**Declined**	
9	Staff Engagement score (0-10)	6.25	6.33	6.26	**6.34**	**Improved**		6.47	6.35	6.46	**6.35**	**Declined**	
10	% difference between the organisation's Board voting membership and its organisation's overall workforce	-3.0%	5.6%	14.0%	**16.0%**	**Improved**		12.5%	15.6%	23.0%	**17.0%**	**Declined**	

Workforce Disability Equality Standard (WDES)

Next steps

Our existing Culture and Diversity and Inclusion Action Plans, which were introduced in late 2020, have driven a continued focus and commitment to improving the experience of those from marginalised groups, particularly those from Black, Asian and Minority Ethnic communities and those with disabilities or long term health conditions. Whilst many of the actions and projects set out in these action plans have now been successfully delivered, there are still a number to be implemented.

These open actions or live projects have been mapped across to NHSE's EDI Improvement Plan (appendix b) and aligned to our People Strategy. **This has identified six gesh EDI workstreams for 2025-27**.

Following stakeholder engagement and internal governance, our EDI action plan was approved by our Board in February 2025. This plan has been launched across the group and progress will be monitored and reported quarterly.

Fig 1: Our 2024-2026 People Priority Domains



Leadership Commitment

- High Impact Action 1: Chief executives, chairs and board members must have specific and measurable EDI objectives to which they will be individually and collectively accountable

Inclusive Recruitment and Talent Managment

- High Impact Action 2: Embed fair and inclusive recruitment processes and talent management strategies that target under-representation and lack of diversity

Eliminating pay gaps

- High Impact Action 3: Develop and implement an improvement plan to eliminate pay gaps

Improving Health and Wellbeing

- High Impact Action 4: Develop and implement an improvement plan to address health inequalities within the workforce

Supporting Internationally Recruited Staff

- High Impact Action 5: Implement a comprehensive induction, onboarding and development programme for internationally-recruited staff

Safeguarding our Workforce

- High Impact Action 6: Create an environment that eliminates the conditions in which bullying, discrimination, harassment and physical violence at work occur

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

Workforce Disability Equality Standard 2025

Features: 2024 Staff Survey Data and workforce information on 31/03/2025
Published: 00/00/2024

Workforce Disability Equality Standard 2025

Trust: STG

Executive summary

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

In line with national requirements this report and any associated action plans should be reviewed internally and approved at Board before being published on the organisation's website. The deadline for publication is 31st October 2025. The key findings are outlined below. Unless indicated, each point is compared to the previous reporting period:

Improved indicators

- Out of 13 metrics, we see an improvement (compared to the last year) in 9 metrics.
- There has been a steady increase in staff declaring a disability on ESR.
- There has been a significant improvement in the relatively likelihood of candidates with a disability being appointed.
- Significant reduction in staff with a disability entering the formal capability process.
- Staff report experiencing lower rates of harassment, bullying or abuse (HBA) from patients – lowest report rate in 5 years.
- HBA from managers among staff with a long-term condition dropped notably this year, reversing a slight increase seen in 2023.
- Staff are more likely to report experiences of HBA than in previous years.
- Perceptions regarding career progression have continued to improve for those with disabilities, in 2024 we see the highest rate in the last 5 years. This has reduced the gap in perceptions between the two groups of staff to 4.9 percentage points.
- Staff with long-term conditions feel more valued by our organisation than in previous years.
- Engagement scores have improved for all staff, including those a disability or long-term condition.

Reduced / static indicators

- Out of 13 metrics, we see a decline (compared to the previous year) in 3 metrics.
- Compared to colleagues, staff with disabilities reports high rates or HBA from patients, colleagues and managers.
- Compared to last year, staff with disabilities report experiencing higher rates or HBA from colleagues.
- There has been a slight increase in presenteeism amongst staff with a disability or long term condition.
- Satisfaction with reasonable adjustments for staff with long-term conditions has slightly declined.

Workforce Disability Equality Standard 2025

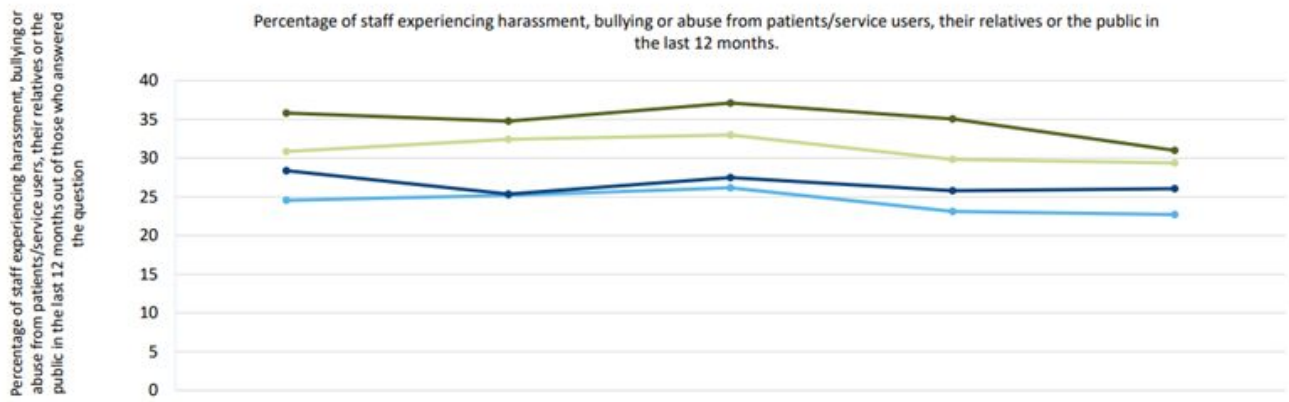
Trust: STG

Indicator 4a

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

- Staff with a long-term condition or illness continue to report higher rates of harassment, with 30.99% reporting it in 2024, compared to 26.04% of staff without a LHC or illness. This is a consistent gap of around 5 percentage points over five years.
- There was a notable drop in harassment reports among staff with a LHC or illness, falling from 35.06% in 2023 to 30.99% in 2024 - the largest decline across the five year reporting period.
- STG figures remain higher than national averages for both groups in 2024, indicating ongoing challenges compared to the wider NHS (LTC: 30.99% vs 29.37%, No LTC: 26.04% vs 22.71%).

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



	2020	2021	2022	2023	2024
Staff with a LTC or illness: Your org	35.81%	34.76%	37.11%	35.06%	30.99%
Staff without a LTC or illness: Your org	28.38%	25.35%	27.47%	25.79%	26.04%
Staff with a LTC or illness: Average	30.86%	32.43%	32.98%	29.83%	29.37%
Staff without a LTC or illness: Average	24.53%	25.19%	26.16%	23.11%	22.71%
Staff with a LTC or illness: Responses	578	722	679	607	810
Staff without a LTC or illness: Responses	4074	3889	3669	2724	3832

Workforce Disability Equality Standard 2025

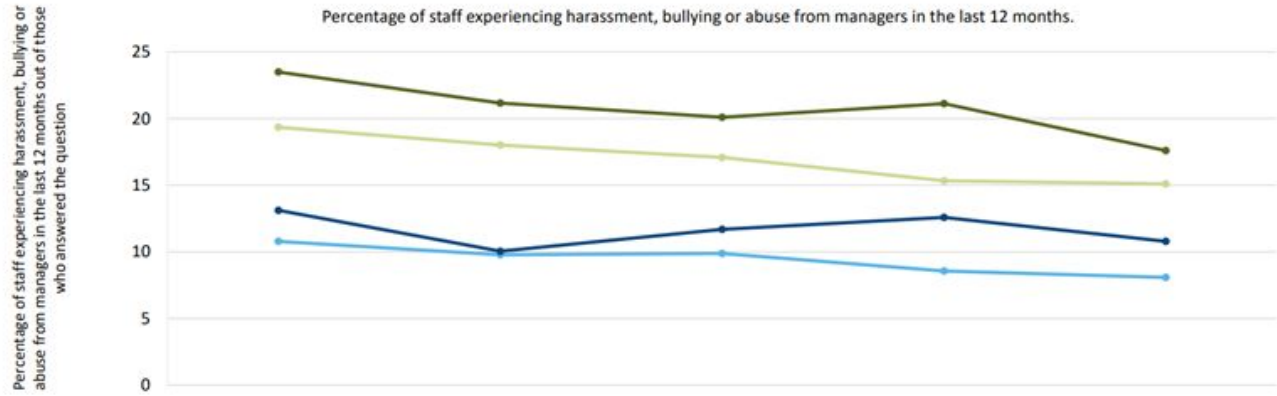
Trust: STG

Indicator 4b

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

- Staff with a long-term condition or illness continue to report higher levels of harassment from managers, with 17.60% affected in 2024 compared to 10.79% of staff without - a 6.81 percentage point gap.
- HBA from managers among staff with a long-term condition dropped notably this year (from 21.12% to 17.60%), reversing a slight increase seen in 2023.
- St George's figures remain above the national average for both groups in 2024 - LTC: 17.60% vs 15.10%; No LTC: 10.79% vs 8.08% - highlighting an ongoing area for improvement.

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



	2020	2021	2022	2023	2024
Staff with a LTC or illness: Your org	23.49%	21.16%	20.09%	21.12%	17.60%
Staff without a LTC or illness: Your org	13.11%	10.05%	11.68%	12.57%	10.79%
Staff with a LTC or illness: Average	19.35%	18.00%	17.09%	15.33%	15.10%
Staff without a LTC or illness: Average	10.78%	9.77%	9.88%	8.56%	8.08%
Staff with a LTC or illness: Responses	579	723	677	602	807
Staff without a LTC or illness: Responses	4065	3872	3646	2692	3790

Workforce Disability Equality Standard 2025

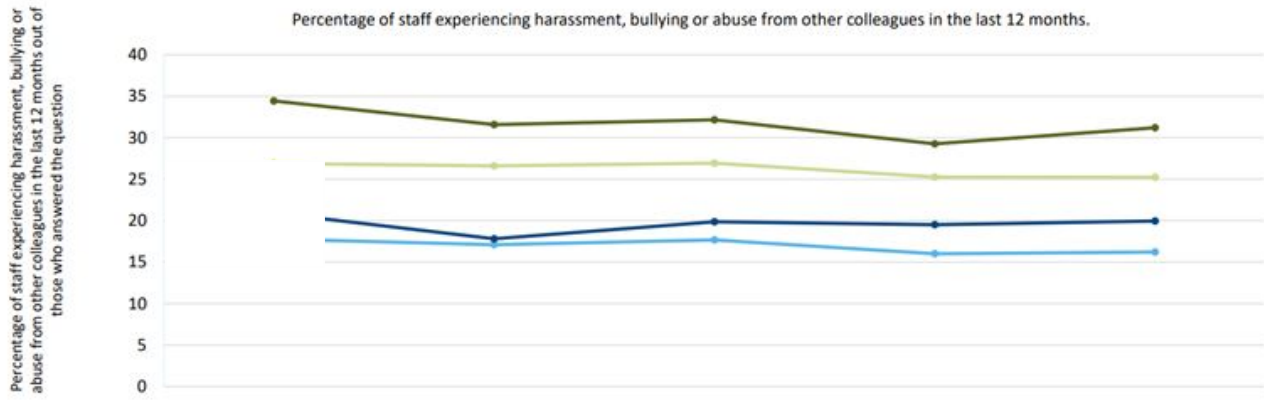
Trust: STG

Indicator 4c

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

- In 2024, 31.21% of staff with a long-term condition or illness reported harassment from colleagues, compared to 19.96% of staff without - an 11.25 percentage point gap, the largest among the three indicators.
- After a drop in 2023, harassment from colleagues toward staff with a long-term condition rose again in 2024, up by nearly 2 percentage points.
- St George's continues to exceed national averages for both groups - LTC: 31.21% vs 25.24%; No LTC: 19.96% vs 16.22% — pointing to a sustained issue with peer-to-peer behaviours.

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



	2020	2021	2022	2023	2024
Staff with a LTC or illness: Your org	34.43%	31.58%	32.15%	29.26%	31.21%
Staff without a LTC or illness: Your org	20.92%	17.82%	19.86%	19.51%	19.96%
Staff with a LTC or illness: Average	26.89%	26.60%	26.93%	25.26%	25.24%
Staff without a LTC or illness: Average	17.79%	17.11%	17.67%	16.01%	16.22%
Staff with a LTC or illness: Responses	575	722	675	596	801
Staff without a LTC or illness: Responses	4064	3873	3630	2678	3762

Workforce Disability Equality Standard 2025

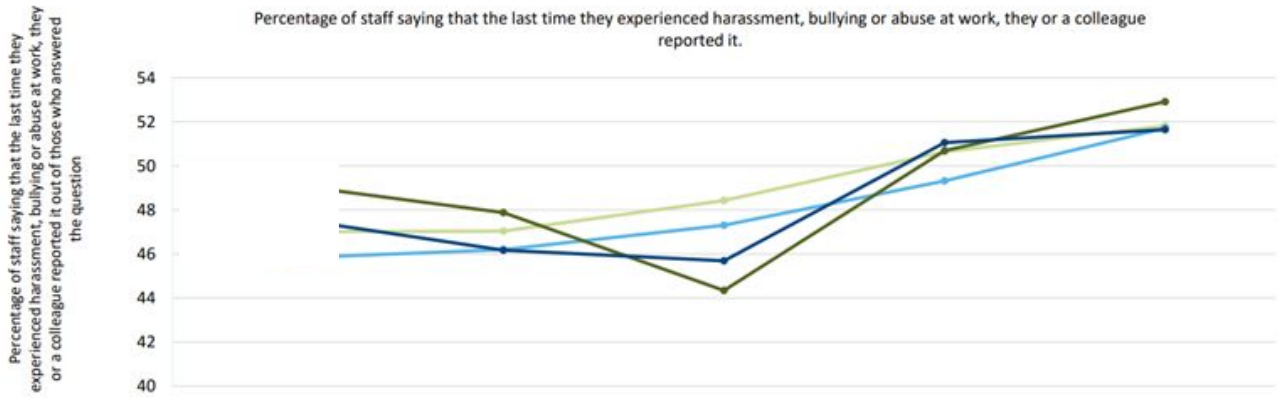
Trust: STG

Indicator 4d

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

- In 2024, 52.91% of staff with a long-term condition or illness reported incidents of harassment, bullying, or abuse, slightly higher than the 51.64% reported by staff without - a positive sign of increased reporting across both groups.
- Reporting among staff with an LTC or illness has steadily increased since 2022, rising by over 8 percentage points in two years (from 44.34% to 52.91%).
- St George's reporting rates now exceed national averages for both groups, indicating progress in encouraging staff to speak up (LTC: 52.91% vs 51.82%; No LTC: 51.64% vs 51.71%).

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



	2020	2021	2022	2023	2024
Staff with a LTC or illness: Your org	49.18%	47.88%	44.34%	50.68%	52.91%
Staff without a LTC or illness: Your org	47.66%	46.17%	45.69%	51.06%	51.64%
Staff with a LTC or illness: Average	47.01%	47.03%	48.43%	50.64%	51.82%
Staff without a LTC or illness: Average	45.80%	46.20%	47.30%	49.31%	51.71%
Staff with a LTC or illness: Responses	305	353	327	302	378
Staff without a LTC or illness: Responses	1496	1280	1287	916	1338

Workforce Disability Equality Standard 2025

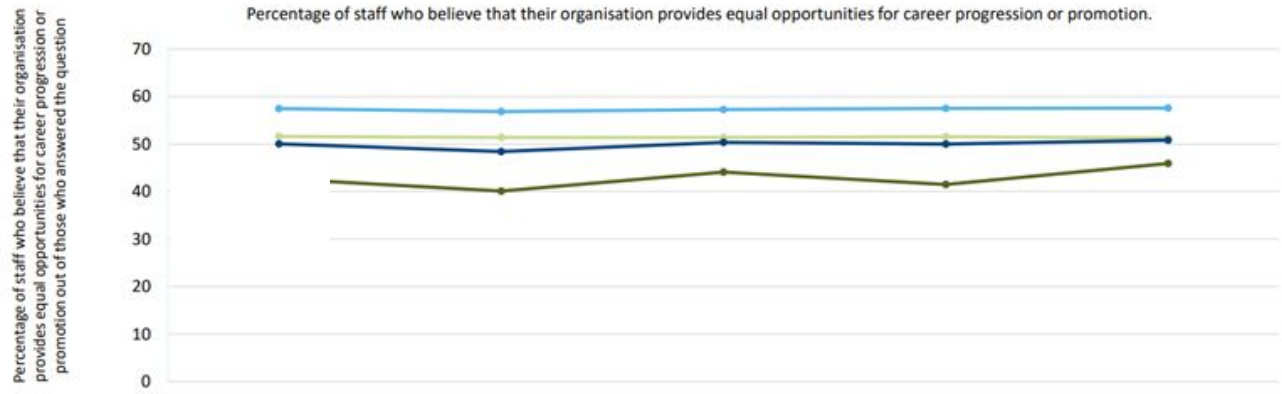
Trust: STG

Indicator 5

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

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

- In 2024, 45.92% of staff with a long-term condition or illness felt St George's provided equal opportunities, compared to 50.82% of those without - a 4.9 percentage point gap.
- Perceptions among staff with an LTC or illness have improved in 2024, rising from 41.51% in 2023 - the highest level seen since 2020.
- St George's remains below the national average for both groups in 2024 (LTC: 45.92% vs 51.30%; No LTC: 50.82% vs 57.57%), suggesting ongoing disparities in perceived fairness of progression opportunities.



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

Workforce Disability Equality Standard 2025

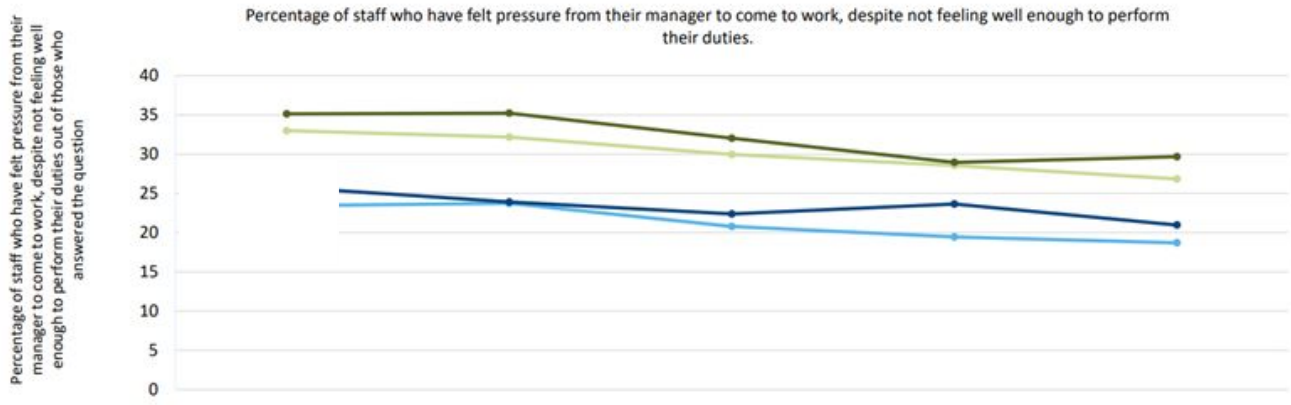
Trust: STG

Indicator 6

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

- In 2024, 29.68% of staff with a long-term condition or illness felt pressure to work while unwell, compared to 20.97% of staff without - a gap of 8.71 percentage points.
- Although pressure levels have declined overall since 2020, the rate among staff with an LTC or illness in your organisation rose slightly in 2024 after three years of improvement.
- St George's continues to report above the national average for both groups (LTC: 29.68% vs 26.85%; No LTC: 20.97% vs 18.71%), indicating an ongoing concern around presenteeism.

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



	2020	2021	2022	2023	2024
Staff with a LTC or illness: Your org	35.14%	35.22%	32.04%	28.95%	29.68%
Staff without a LTC or illness: Your org	25.80%	23.91%	22.40%	23.66%	20.97%
Staff with a LTC or illness: Average	33.00%	32.18%	29.97%	28.55%	26.85%
Staff without a LTC or illness: Average	23.44%	23.74%	20.80%	19.46%	18.71%
Staff with a LTC or illness: Responses	387	565	515	449	566
Staff without a LTC or illness: Responses	1760	2083	1902	1403	1993

Workforce Disability Equality Standard 2025

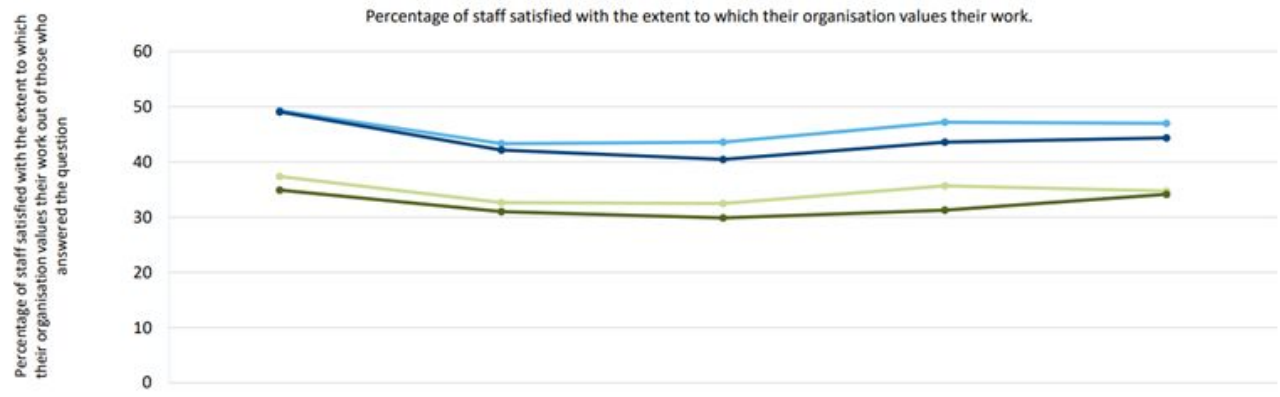
Trust: STG

Indicator 7

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

- In 2024, 34.11% of staff with a long-term condition or illness felt their work was valued, compared to 44.34% of staff without - a 10.2 percentage point gap.
- Satisfaction among staff with an LTC or illness in your organisation increased for the second consecutive year, reaching its highest level since 2020.
- Despite this improvement, St George's remains below the national average for both groups in 2024 (LTC: 34.11% vs 34.73%; No LTC: 44.34% vs 46.98%), indicating further room for improvement in recognition.

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



	2020	2021	2022	2023	2024
Staff with a LTC or illness: Your org	34.89%	30.99%	29.85%	31.27%	34.11%
Staff without a LTC or illness: Your org	49.05%	42.14%	40.45%	43.57%	44.34%
Staff with a LTC or illness: Average	37.36%	32.62%	32.46%	35.66%	34.73%
Staff without a LTC or illness: Average	49.27%	43.30%	43.56%	47.19%	46.98%
Staff with a LTC or illness: Responses	599	755	680	630	815
Staff without a LTC or illness: Responses	4179	4022	3676	2906	3843

Workforce Disability Equality Standard 2025

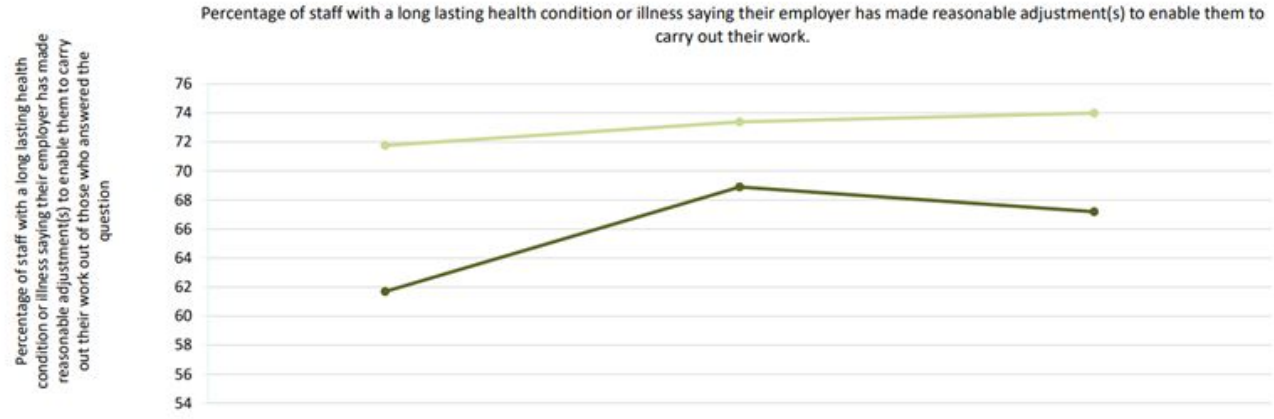
Trust: STG

Indicator 8

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

- 67.19% of staff with a long-term condition or illness in your organisation said reasonable adjustments were made in 2024 - 6.79 percentage points below the national average of 73.98%.
- This represents a modest decline from 2023, where your organisation reached 68.89%, narrowing the gap with the average before widening again.
- St George's has consistently trailed the national benchmark by 6–10 points, suggesting a sustained need to improve the implementation of workplace adjustments for disabled staff.

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



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

Workforce Disability Equality Standard 2025

Trust: STG

Indicator 9

Staff engagement score (0-10)

- Staff with a long-term condition or illness at St George's reported a score of 6.34 in 2024, trailing both the organisational average (6.89) and the national average for disabled staff (6.40).
- Staff without a long-term condition consistently maintain a higher engagement score (7.01 in 2024), while engagement among disabled staff remains over half a point lower annually..
- Whilst we see slight improvement in 2023 and 2024, St George's disabled staff engagement scores are consistently behind the national average.

Staff engagement score (0-10)



	2020	2021	2022	2023	2024
Organisation average	7.01	6.80	6.78	6.80	6.89
Staff with a LTC or illness: Your org	6.58	6.25	6.33	6.26	6.34
Staff without a LTC or illness: Your org	7.09	6.91	6.87	6.92	7.01
Staff with a LTC or illness: Average	6.65	6.42	6.35	6.46	6.40
Staff without a LTC or illness: Average	7.14	6.97	6.92	7.04	7.00
Staff with a LTC or illness: Responses	601	757	685	631	816
Staff without a LTC or illness: Responses	4191	4032	3682	2913	3856

Workforce Disability Equality Standard 2025

Trust: STG / ESTH

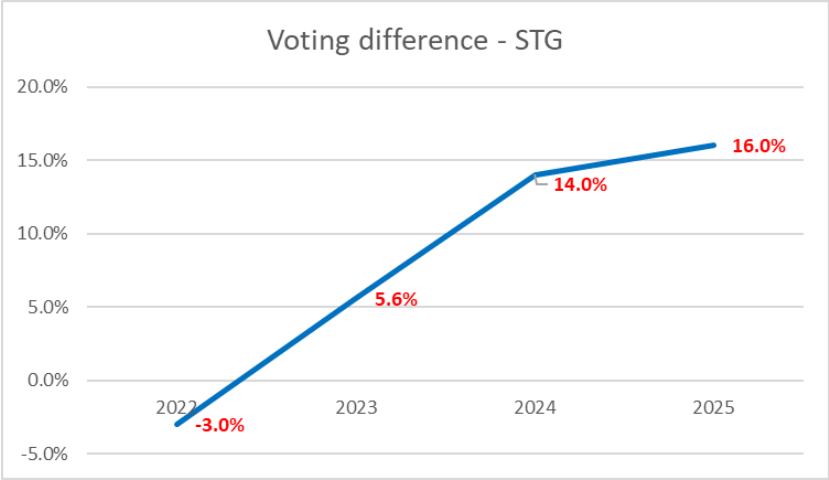
Indicator 10

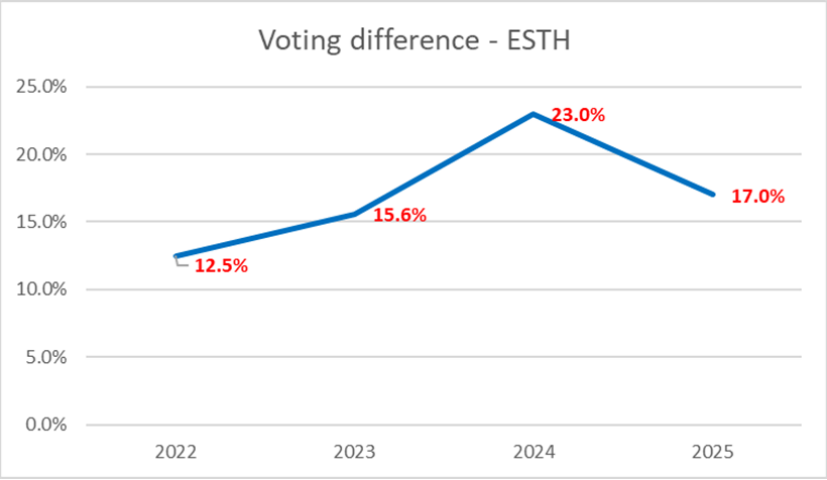
% difference between the organisation's Board voting membership and its organisation's overall workforce

As of 31 March 2025, the Trust Board of Directors comprised 15 members - 10 voting members and 5 non-voting members. Of these 10 voting members of the Board, two voting Board members have a declared disability and one non-voting member has a declared disability.

This means St George's staff are positively represented at Board level, including Board overall (+16%) and Board voting (+16%). ESTH staff are also positively represented, at Board overall (+15%) and Board Voting (+17%).

Following discussions with the Council of Governors, we have agreed that attracting a strong and diverse pool of candidates is a key priority for all future Board appointment processes. Our commitment to improving representation at both Board and wider leadership levels is reflected in our new EDI action plan. This plan includes specific measures to ensure inclusive recruitment practices, such as requiring our recruitment partners to actively seek candidates from across all protected characteristics.





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

gesh

Site Report: Epsom and St Helier University Hospitals NHS Trust

Workforce Disability Equality Standard 2025

Features: 2024 Staff Survey Data and workforce information on 31/03/2025
Published: 00/00/2024

Workforce Disability Equality Standard 2025

Trust: ESTH

Executive summary

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

In line with national requirements this report and any associated action plans should be reviewed internally and approved at Board before being published on the organisation's website. The deadline for publication is 31st October 2025. The key findings are outlined below. Unless indicated, each point is compared to the previous reporting period:

Improved indicators

- Out of 13 metrics, we see an improvement (compared to the previous year) in 5 metrics.
- There has been a steady increase in staff declaring a disability on ESR.
- There has been a significant improvement in the relatively likelihood of candidates with a disability being appointed from shortlisting
- Candidates with a disability are slightly more likely to be appointed from shorting compared to candidates without a disability.
- Staff report experiencing lower rates of harassment, bullying or abuse (HBA) from Patients – lowest report rate in 5 years
- Staff report experiencing lower rates of harassment, bullying or abuse (HBA) from colleagues – lowest report rate in 5 years
- Staff are more likely to report experiences of HBA than in previous years.
- Perceptions regarding career progression have continued to improve for those with disabilities, in 2024 we see the highest rate in the last 5 years.

Reduced / static indicators

- Out of 13 metrics, we see a decline (compared to the previous year) in 6 metrics, and 1 remained static.
- Compared to colleagues, staff with disabilities reports high rates or HBA from patients, colleagues and managers.
- Compared to last year, staff with disabilities report experiencing higher rates or HBA from managers.
- There has been a slight increase in presenteeism amongst staff with a disability or long term condition.
- Satisfaction with how work is valued has declined for staff with a disability.
- Satisfaction with reasonable adjustments being made has declined.
- Engagement scores have shown a slight decrease.
- Whilst staff with disabilities are positively represented at board (voting) compared to colleagues, this has reduced compared to the previous year.

Workforce Disability Equality Standard 2025

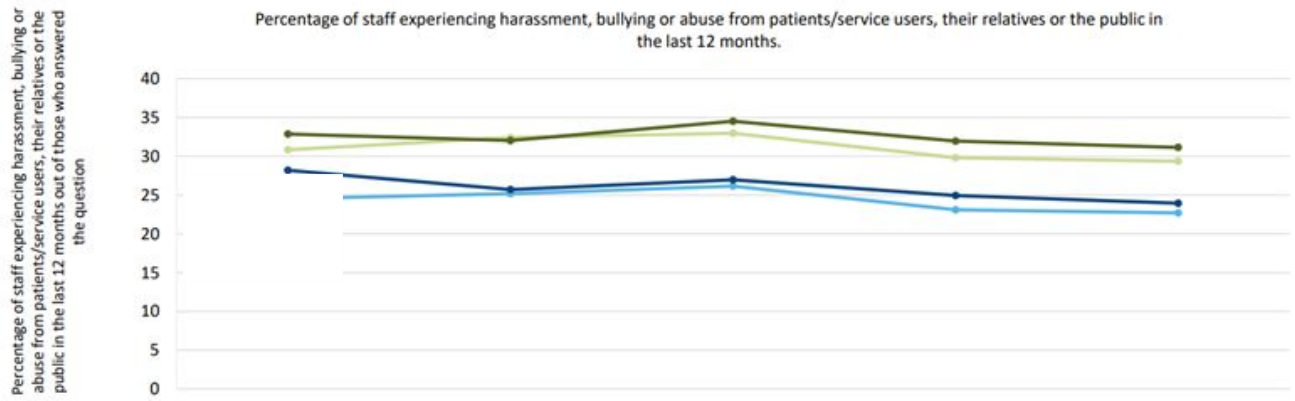
Trust: ESTH

Indicator 4a

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

- Staff with a long-term condition or illness at ESTH report consistently higher levels of harassment, bullying or abuse from patients, relatives or the public compared to those without.
- Both staff groups have seen a small decline in reported incidents in 2024, continuing a downward trend since 2022.
- Despite the decline, reported experiences remain relatively high, higher than the average, especially for staff with a long-term condition or illness..

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



	2020	2021	2022	2023	2024
Staff with a LTC or illness: Your org	32.87%	32.04%	34.53%	31.97%	31.15%
Staff without a LTC or illness: Your org	28.20%	25.71%	26.99%	24.94%	23.96%
Staff with a LTC or illness: Average	30.86%	32.43%	32.98%	29.83%	29.37%
Staff without a LTC or illness: Average	24.53%	25.19%	26.16%	23.11%	22.71%
Staff with a LTC or illness: Responses	508	646	614	594	687
Staff without a LTC or illness: Responses	2560	3030	2779	2577	3089

Workforce Disability Equality Standard 2025

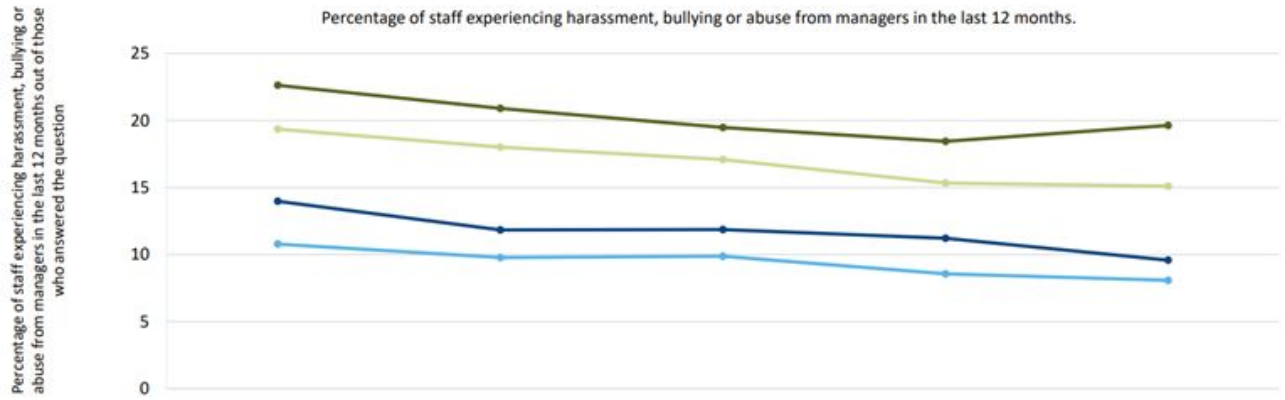
Trust: ESTH

Indicator 4b

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

- In 2024, 19.62% of staff with a long-term condition or illness reported experiencing harassment, bullying or abuse from managers, compared to 9.58% of staff without a condition.
- Reports among staff with a long-term condition declined from 22.62% in 2020 to 18.44% in 2023, before rising slightly in 2024.
- Staff without a condition have seen a consistent improvement, with reported incidents falling from 13.97% in 2020 to 9.58% in 2024.

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



	2020	2021	2022	2023	2024
Staff with a LTC or illness: Your org	22.62%	20.90%	19.48%	18.44%	19.62%
Staff without a LTC or illness: Your org	13.97%	11.84%	11.86%	11.21%	9.58%
Staff with a LTC or illness: Average	19.35%	18.00%	17.09%	15.33%	15.10%
Staff without a LTC or illness: Average	10.78%	9.77%	9.88%	8.56%	8.08%
Staff with a LTC or illness: Responses	504	646	611	589	683
Staff without a LTC or illness: Responses	2548	2981	2748	2547	3038

Workforce Disability Equality Standard 2025

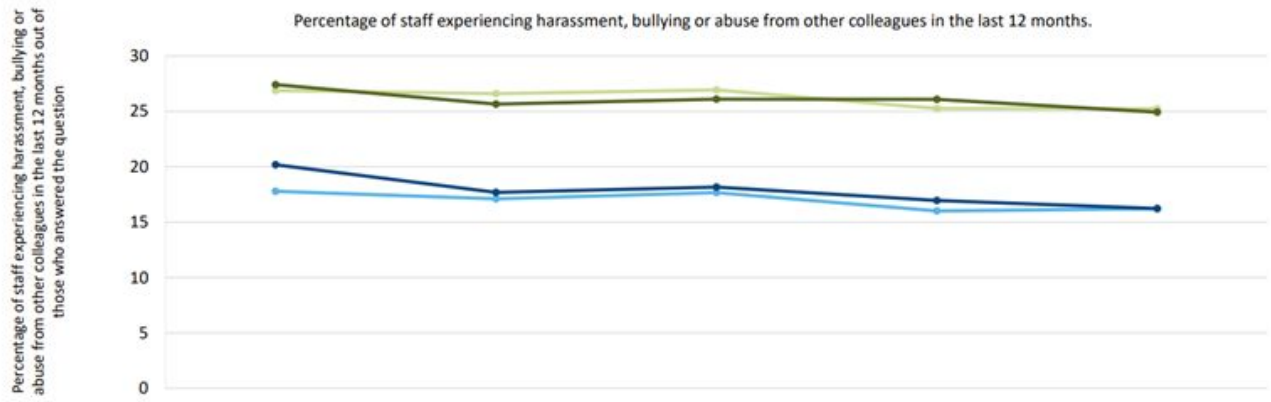
Trust: ESTH

Indicator 4c

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

- The proportion of ESTH staff with a long-term condition or illness reporting harassment or bullying from colleagues declined from 27.42% in 2020 to 24.93% in 2024, showing a modest but consistent reduction over five years.
- Among staff without a condition, reported incidents also dropped, from 20.18% in 2020 to 16.23% in 2024, with year-on-year improvement and the lowest levels seen in the most recent survey.
- Despite these reductions, staff with long-term conditions continue to experience significantly higher levels of colleague-related harassment than their peers, with a persistent 8 to 9 percentage point gap between the two groups.

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



	2020	2021	2022	2023	2024
Staff with a LTC or illness: Your org	27.42%	25.66%	26.11%	26.09%	24.93%
Staff without a LTC or illness: Your org	20.18%	17.68%	18.17%	16.96%	16.23%
Staff with a LTC or illness: Average	26.89%	26.60%	26.93%	25.26%	25.24%
Staff without a LTC or illness: Average	17.79%	17.11%	17.67%	16.01%	16.22%
Staff with a LTC or illness: Responses	507	647	609	586	678
Staff without a LTC or illness: Responses	2552	2986	2736	2542	3032

Workforce Disability Equality Standard 2025

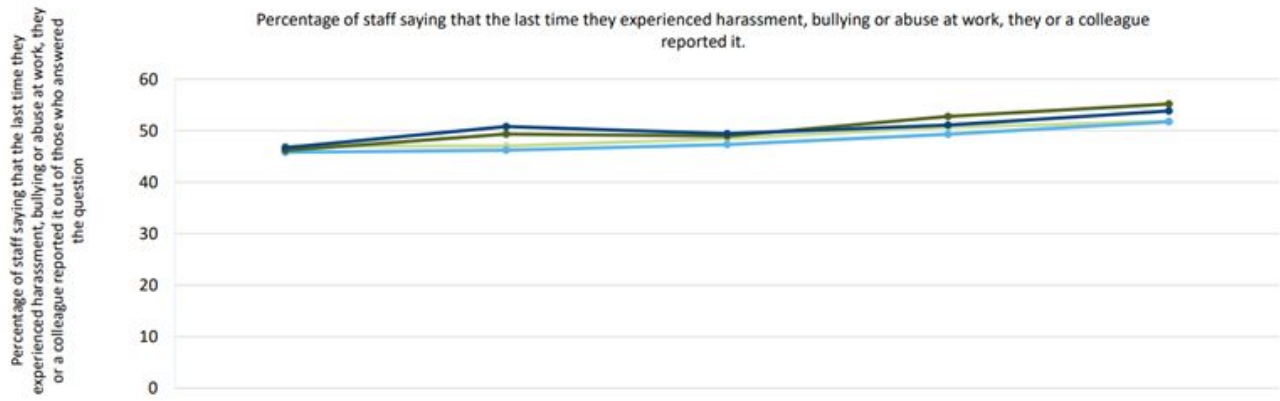
Trust: ESTH

Indicator 4d

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

- The percentage of staff with a long-term condition or illness who reported incidents rose steadily from 46.15% in 2020 to 55.17% in 2024, showing a 9 percentage point improvement over five years.
- Reporting levels among staff without a long-term condition also increased significantly, reaching 53.82% in 2024 compared to 46.68% in 2020 - a positive trend in openness and trust in reporting mechanisms.
- Both groups at ESTH are now reporting above national averages in 2024 (LTC: 55.17% vs 51.82%, No LTC: 53.82% vs 51.71%).

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



	2020	2021	2022	2023	2024
Staff with a LTC or illness: Your org	46.15%	49.32%	48.93%	52.75%	55.17%
Staff without a LTC or illness: Your org	46.68%	50.80%	49.40%	51.08%	53.82%
Staff with a LTC or illness: Average	47.01%	47.03%	48.43%	50.64%	51.82%
Staff without a LTC or illness: Average	45.80%	46.20%	47.30%	49.31%	51.71%
Staff with a LTC or illness: Responses	234	294	280	260	290
Staff without a LTC or illness: Responses	934	996	915	787	929

Workforce Disability Equality Standard 2025

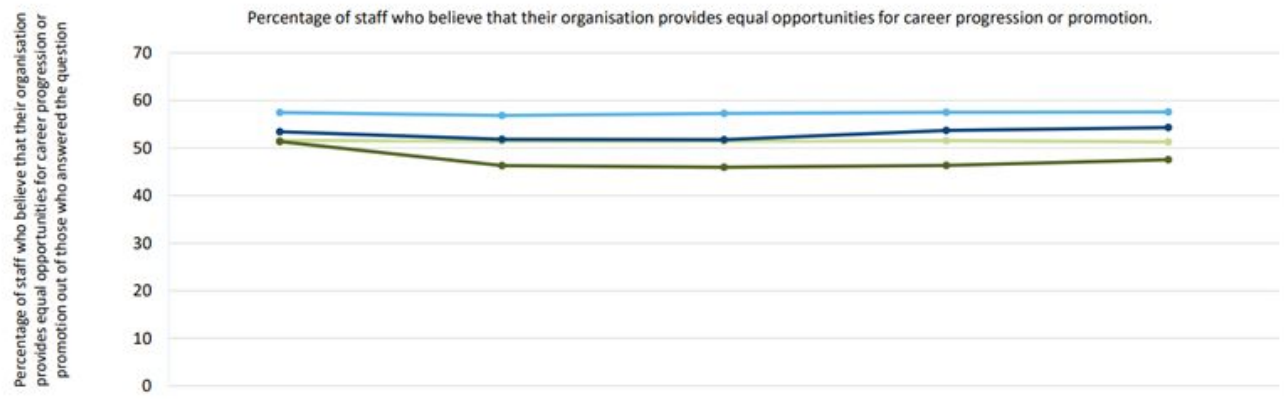
Trust: ESTH

Indicator 5

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

- In 2024, 47.57% of staff with a long-term condition or illness believed ESTH provides equal opportunities for progression, recovering from a low of 45.96% in 2022 but still below the 2020 level of 51.36%.
- Staff without a long-term condition have shown a steadier and more positive trend, increasing from 53.44% in 2020 to 54.30% in 2024, with small, consistent annual gains since 2021.
- While perceptions among both groups have improved slightly in recent years, the belief in equal opportunities remains lower for staff with a long-term condition, with a gap of nearly 7 percentage points in 2024 between the two groups.

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



	2020	2021	2022	2023	2024
Staff with a LTC or illness: Your org	51.36%	46.29%	45.96%	46.35%	47.57%
Staff without a LTC or illness: Your org	53.44%	51.83%	51.75%	53.70%	54.30%
Staff with a LTC or illness: Average	51.61%	51.41%	51.39%	51.54%	51.30%
Staff without a LTC or illness: Average	57.45%	56.84%	57.25%	57.52%	57.57%
Staff with a LTC or illness: Responses	514	661	607	643	679
Staff without a LTC or illness: Responses	2616	3120	2742	2741	3070

Workforce Disability Equality Standard 2025

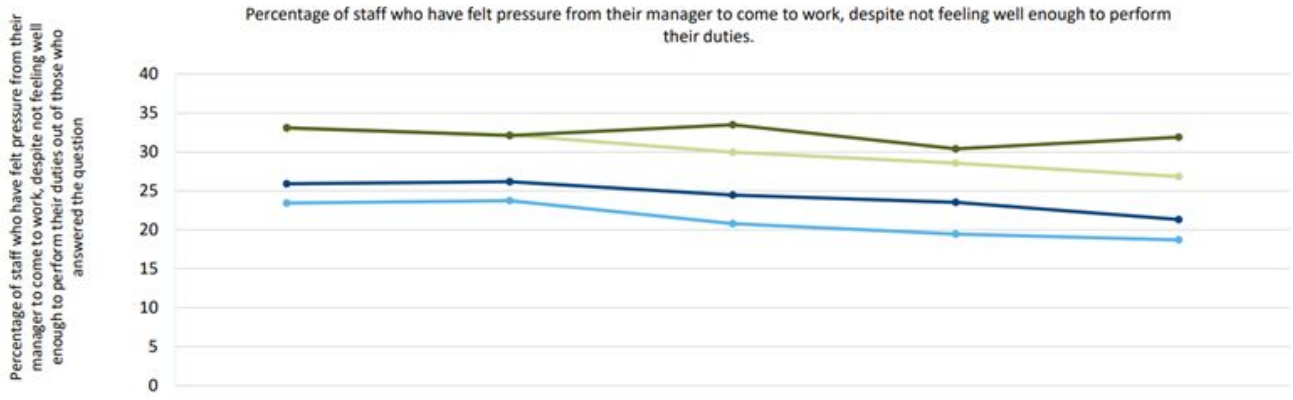
Trust: ESTH

Indicator 6

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

- In 2024, 31.88% of staff with a long-term condition or illness at ESTH reported feeling pressured to attend work while unwell, showing a slight rise from 30.40% in 2023 but remaining below earlier peaks like 33.49% in 2022.
- Staff without a long-term condition have consistently reported lower levels of pressure, with figures declining steadily from 25.91% in 2020 to 21.33% in 2024 - a 4.6 percentage point reduction over five years.

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



	2020	2021	2022	2023	2024
Staff with a LTC or illness: Your org	33.11%	32.10%	33.49%	30.40%	31.88%
Staff without a LTC or illness: Your org	25.91%	26.18%	24.46%	23.52%	21.33%
Staff with a LTC or illness: Average	33.00%	32.18%	29.97%	28.55%	26.85%
Staff without a LTC or illness: Average	23.44%	23.74%	20.80%	19.46%	18.71%
Staff with a LTC or illness: Responses	305	461	433	421	483
Staff without a LTC or illness: Responses	1104	1524	1378	1271	1416

Workforce Disability Equality Standard 2025

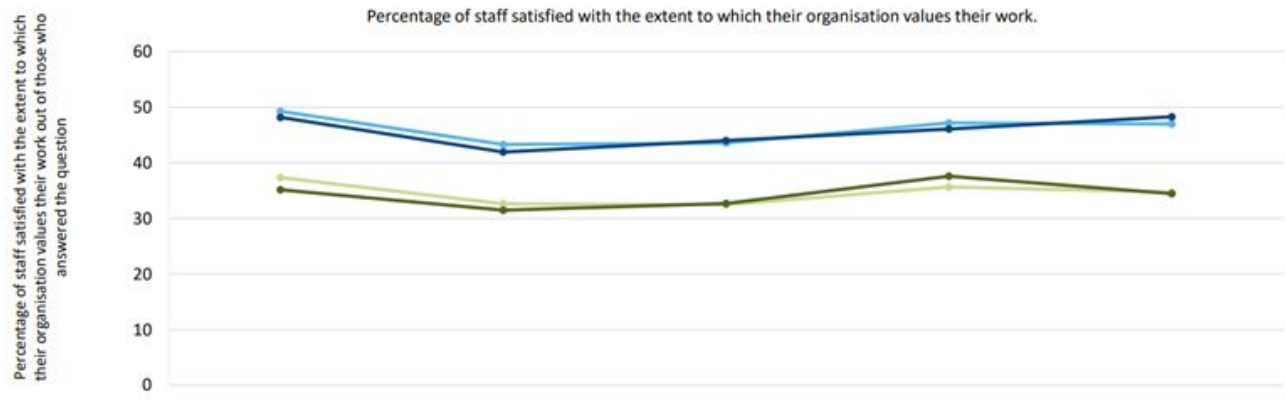
Trust: ESTH

Indicator 7

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

- In 2024, 34.45% of staff with a long-term condition or illness at ESTH felt their work was valued by the organisation - a decrease from 37.60% in 2023, and still below pre-pandemic levels such as 35.15% in 2020.
- Satisfaction among staff without a long-term condition remained considerably higher, with 48.28% feeling valued in 2024 - more than 13 percentage points above staff with a long-term condition, maintaining a consistent disparity over the five-year period.
- Despite some fluctuation, overall satisfaction among staff with a long-term condition has struggled to recover to earlier levels. This highlights a need for more inclusive recognition and engagement strategies.

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



	2020	2021	2022	2023	2024
Staff with a LTC or illness: Your org	35.15%	31.48%	32.68%	37.60%	34.45%
Staff without a LTC or illness: Your org	48.17%	41.94%	44.02%	46.08%	48.28%
Staff with a LTC or illness: Average	37.36%	32.62%	32.46%	35.66%	34.73%
Staff without a LTC or illness: Average	49.27%	43.30%	43.56%	47.19%	46.98%
Staff with a LTC or illness: Responses	515	667	612	641	685
Staff without a LTC or illness: Responses	2620	3138	2783	2754	3088

Workforce Disability Equality Standard 2025

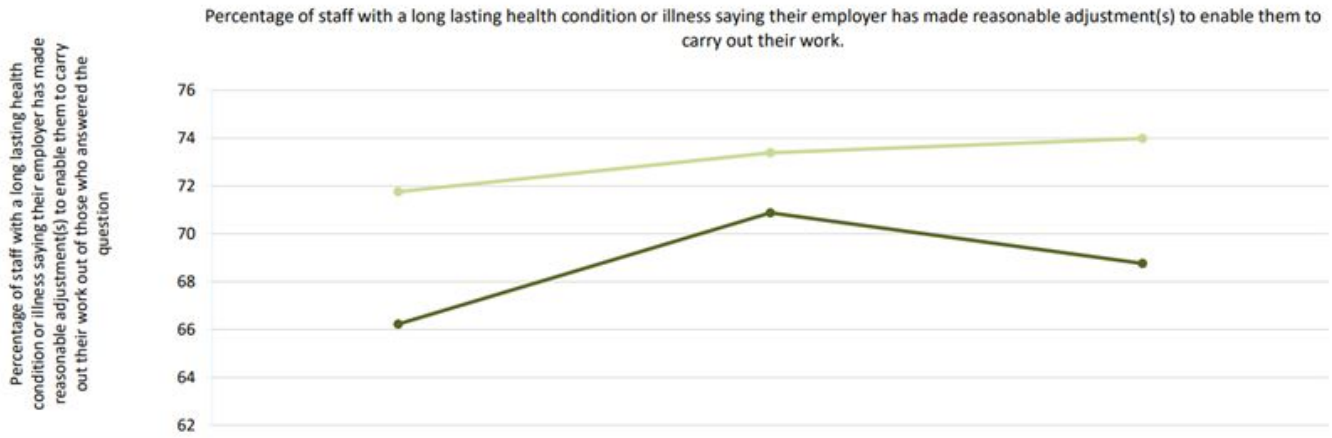
Trust: ESTH

Indicator 8

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

- In 2024, 68.76% of staff with a long-term condition or illness at ESTH reported that their employer had made reasonable adjustments to support them in carrying out their work, a slight decline from 70.88% in 2023.
- While this marks an improvement from 66.23% in 2022, the organisation continues to fall short of the national average, which stood at 73.98% in 2024, highlighting a persistent gap in meeting staff needs.
- The consistent shortfall suggests there is still room for ESTH to enhance its support for employees with long-term health conditions by prioritising reasonable adjustments to improve their work experience and retention.

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



	2022	2023	2024
Staff with a LTC or illness: Your org	66.23%	70.88%	68.76%
Staff with a LTC or illness: Average	71.76%	73.38%	73.98%
Staff with a LTC or illness: Responses	379	388	429

Workforce Disability Equality Standard 2025

Trust: ESTH

Indicator 9

Staff engagement score (0-10)

- In 2024, staff engagement at ESTH was 6.34 for employees with a long-term condition or illness, showing a slight increase from 6.26 in 2023 but remaining below the organisation average of 6.89.
- Engagement scores for staff without a long-term condition or illness were higher, at 7.01 in 2024, consistent with a relatively stable upward trend over five years.
- Both groups at ESTH score slightly below their respective national averages, indicating a need to focus on engagement strategies especially for staff with long-term health conditions to close this gap.

Staff engagement score (0-10)



	2020	2021	2022	2023	2024
Organisation average	7.01	6.80	6.78	6.80	6.89
Staff with a LTC or illness: Your org	6.58	6.25	6.33	6.26	6.34
Staff without a LTC or illness: Your org	7.09	6.91	6.87	6.92	7.01
Staff with a LTC or illness: Average	6.65	6.42	6.35	6.46	6.40
Staff without a LTC or illness: Average	7.14	6.97	6.92	7.04	7.00
Staff with a LTC or illness: Responses	601	757	685	631	816
Staff without a LTC or illness: Responses	4191	4032	3682	2913	3856

Workforce Disability Equality Standard 2025

Trust: STG / ESTH

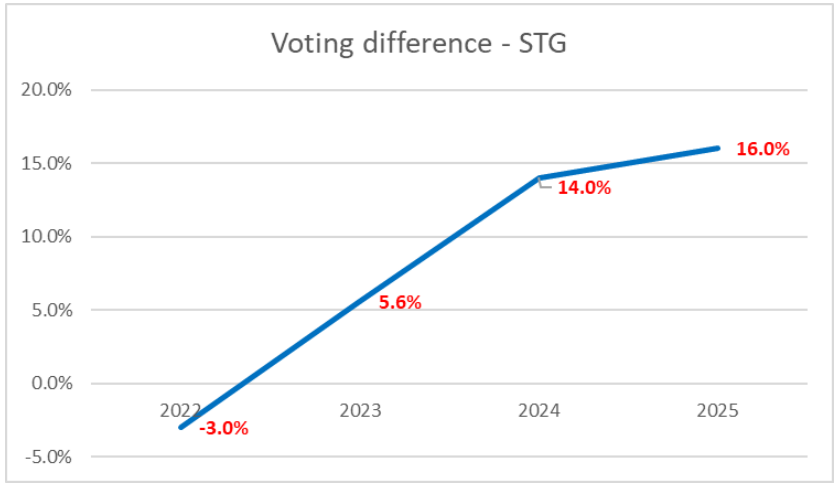
Indicator 10

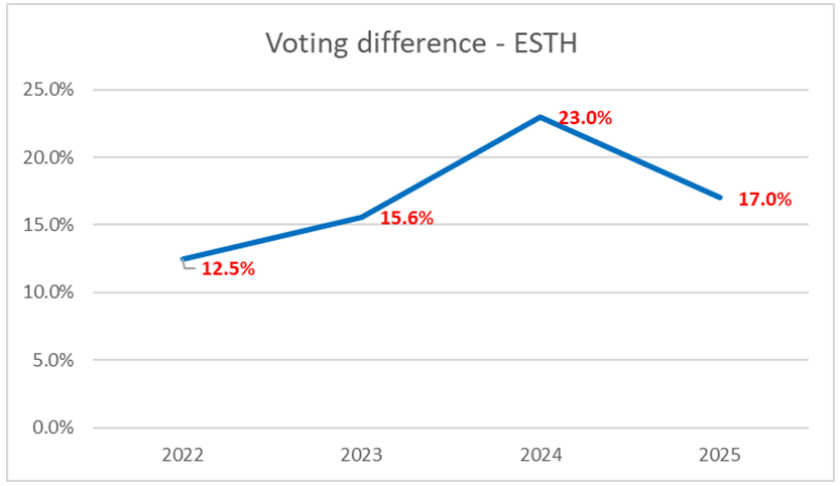
% difference between the organisation's Board voting membership and its organisation's overall workforce

As of 31 March 2025, the Trust Board of Directors comprised 15 members - 10 voting members and 5 non-voting members. Of these 10 voting members of the Board, two voting Board members have a declared disability and one non-voting member has a declared disability.

This means St George's staff are positively represented at Board level, including Board overall (+16%) and Board voting (+16%). ESTH staff are also positively represented, at Board overall (15%) and Board Voting (17%).

Following discussions with the Council of Governors, we have agreed that attracting a strong and diverse pool of candidates is a key priority for all future Board appointment processes. Our commitment to improving representation at both Board and wider leadership levels is reflected in our new EDI action plan. This plan includes specific measures to ensure inclusive recruitment practices, such as requiring our recruitment partners to actively seek candidates from across all protected characteristics.





Workforce Disability Equality Standard (WDES)

Appendix A: Legal Obligations and Disability

Legal Obligations of Employers and Workplace Adjustments (formerly Reasonable Adjustments)

Protection against disability-based discrimination is enshrined in the Equality Act 2010. Due to the additional barriers faced by people with a disability, it is permitted to treat applicants with a disability more favourably than their colleagues without a disability. Understanding this, and the reasons for it, is crucial to removing the barriers that continue to deny people with a disability equality of outcome in work and more broadly.

The Equality Act 2010 protects employees, and covers areas including recruitment, assessment and selection, terms of employment, promotion and training opportunities, dismissal or redundancy, and discipline and grievances. The Equality Act 2010 also requires that reasonable adjustments (now 'workplace adjustments' are made to working conditions, policies and practices that put a staff member with a disability at a disadvantage. A workplace adjustment could include any of the following:

- making adjustments to premises or acquiring/modifying equipment
- providing a reader or interpreter, or employing a support worker
- reallocating an employee with a disability's duties to another person
- providing supervision, training, mentoring or other support
- transferring a person to fill an existing suitable vacancy without competitive interview
- altering working hours or the place of work
- allowing someone to be absent during working hours for rehabilitation, assessment or treatment
- modifying procedures for testing or assessment

Useful checklists and further detail on the legal obligations can be found in the Guidance relating to disability for the NHS document, published by NHS Employers. This guidance document also sets out examples of good practice (when not legally obligated), particularly around the supporting carers and disability related absence from work.

What is 'disability'?

Defining 'disability' is not always straightforward. The Equality Act 2010 defines a person with a disability as:

"someone who has a mental or physical impairment that has a substantial and long-term adverse effect on the person's ability to carry out normal day-to-day activities."

Some of the terms in this definition are open to interpretation, and further guidance is found in Appendix C. However, instead of trying to judge whether a person falls within the statutory definition of disability, we should focus on meeting the needs of the worker (or job applicant). In supporting a staff with a disability, it is almost always more important to understand and support the effects of a disability rather than the cause.

It is important to note that the definition of disability regards the person as they are without aids, support or medication (the exception being visual impairment where it can be addressed by use of wearing prescription spectacles). This is particularly relevant for those with mental health conditions who are able to control their condition with medication, and also for those with conditions such as epilepsy and diabetes that are otherwise controlled by medication.

Additional information on the definition of disability is attached in Appendix C, taken directly from guidance produced and published by NHS Employers. This guidance was published in 2014. We will continue to closely monitor best practice and guidance and communicates updates as necessary.

Workforce Disability Equality Standard (WDES)

Appendix B: High impact action plan framework

This plan prioritises the following six high impact actions to address the widely-known intersectional impacts of discrimination and bias.

Measurable objectives on EDI for Chairs Chief Executives and Board members.

Success metric

1a. Annual Chair/CEO appraisals on EDI objectives via Board Assurance Framework (BAF).

Overhaul recruitment processes and embed talent management processes.

Success metric

2a. Relative likelihood of staff being appointed from shortlisting across all posts

2b. NSS Q on access to career progression and training and development opportunities

2c. Improvement in race and disability representation leading to parity

2d. Improvement in representation senior leadership (Band 8C upwards) leading to parity

2e. Diversity in shortlisted candidates

2f. NETS Combined Indicator Score metric on quality of training

Eliminate total pay gaps with respect to race, disability and gender.

Success metric

3a. Improvement in gender, race, and disability pay gap

Address Health Inequalities within their workforce.

Success metric

4a. NSS Q on organisation action on health and wellbeing concerns

4b. National Education & Training Survey (NETS) Combined Indicator Score metric on quality of training

4c. To be developed in Year 2

Comprehensive Induction and onboarding programme for International recruited staff.

Success metric

5a. NSS Q on belonging for IR staff

5b. NSS Q on bullying, harassment from team/line manager for IR staff

5c. NETS Combined Indicator Score metric on quality of training IR staff

Eliminate conditions and environment in which bullying, harassment and physical harassment occurs.

Success metric

6a. Improvement in staff survey results on bullying / harassment from line managers/teams (ALL Staff)

6b. Improvement in staff survey results on discrimination from line managers/teams (ALL Staff)

6c. NETS Bullying & Harassment score metric (NHS professional groups)

Group Board Meeting (Public)

Meeting on Friday, 05 September 2025

Agenda Item	5.1	
Report Title	**Infrastructure Committees Report to Group Board**	
Non-Executive Lead	Ann Beasley, Infrastructure Committees Chair	
Report Author(s)	Ann Beasley, Chair of Infrastructure Committees & Non-Executive Director ESTH / SGUH	
Previously considered by	n/a	
Purpose	**For Assurance**	

Executive Summary

This report sets out the key issues considered by the Infrastructure Committees at their meetings on 25 July 2025 (Estates & Facilities focus) and 22 August 2025 (IT focus). The key issues the Committees wished to highlight to the Board are:

1. **Group Chief Officer - Facilities, Infrastructure & Environment (GCOFIE) Update**
   The Committees received a written update from the Group Chief Officer - Infrastructure, Facilities and Environment Officer which included updates about the Epsom Hospital multi-storey car park development, a flood that took place on 18th June 2025 in Hunter Wing at SGUH and the integration of the FIE (facilities, infrastructure and environment) directorate.
2. **Digital Strategy Development**
   The Committees received an update on the Digital Strategy development and noted that, following the recent publication of the NHS 10 Year Plan, the Digital Strategy would be presented at the board development session in December 2025, rather than in October, to enable it to be fully aligned to our medium-term plan.
3. **EPR Programme update**
   The Committees noted the formal update on the progress of the Shared EPR Programme post go live. The EPR programme team was scheduled to hand over to the BAU (business as usual) IT team by 1st September 2025. The Committees stressed the importance of actively focusing on benefits realisation to ensure the intended outcomes of the EPR implementation are achieved.

Action required by Infrastructure Committees

The Group Board is asked to note the issues escalated by Infrastructure Committees to the Group Board and the wider issues on which the Committees received assurance in July and August 2025.

Committee Assurance	
Committee	Infrastructure Committees

Level of Assurance	Limited Assurance: The report and discussions did not provide sufficient assurance that the system of internal control is adequate and operating effectively and significant improvements are required and identified and understood the gaps in assurance.

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

Implications				
Group Strategic Objectives				
☐ Collaboration & Partnerships			☐ Right care, right place, right time	
☐ Affordable Services, fit for the future			☒ Empowered, engaged staff	
Risks				
See section 5.1 - Digital Risk Management Update				
CQC Theme				
☐ Safe	☐ Effective	☐ Caring	☐ Responsive	☒ Well Led
NHS system oversight framework				
☐ Quality of care, access and outcomes			☒ People	
☐ Preventing ill health and reducing inequalities			☒ Leadership and capability	
☒ Finance and use of resources			☐ Local strategic priorities	
Financial implications				
Set out in the paper.				
Legal and / or Regulatory implications				
Set out in the paper.				
Equality, diversity and inclusion implications				
N/A				
Environmental sustainability implications				
N/A				

Infrastructure Committees Report
Group Board, 05 September 2025

1.0 Purpose of paper

1.1 This report sets out the key issues considered by the Infrastructure Committees' meetings on 25 July 2025 and 22 August 2025 and includes matters the Committees specifically wish to bring to the attention of the Group Board.

2.0 Items considered by the Committees

2.1 At its meetings on 25 July 2025 and 22 August 2025, the Committees considered the following items of business:

25 July 2025 (Estates & Facilities focus)	22 August 2025 (IT focus)
• Group Chief Officer - Facilities, Infrastructure & Environment Update • Patient-Led Assessments of the Care Environment (PLACE) Report • Premises Assurance Model (PAM) • ESTH Estate and Facilities Update (Fire Safety and Water Safety) • ERIC update (submission) • Deep Dive – Asbestos • Violence & Aggression Update	• Digital Target Operating Model • Digital Strategy Development • Digital Delivery Update • Digital Risk Management Update • EPR Programme update • PACS Project Review

2.2 The Committee was quorate for both meetings.

3.0 Key issues for escalation to the Group Board

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

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

The Committees received a written update from the Group Chief Officer Facilities, Infrastructure and Environment (GCOFIE) on the following key developments:

- A project steering group had been set up for the Epsom Hospital multi-storey car park development. The steering group was clear about the work that needed to be undertaken as well as the work that would be sufficient to demonstrate a meaningful start on the site. Both of these points are important as they are requirements to comply with the planning approval which would otherwise run out on 5th December 2025.
- A serious flood took place on 18 June 2025 in Hunter Wing at SGUH which is leased to the university. The flood caused substantial damage to the university premises to the extent that the Trust's simulation lab (located in Hunter Wing) could not be safely

accessed. At the time of the meeting, this matter had still not been resolved and the university were in discussions with their insurers in order to undertake the works that would be required to make the area safe.

- The FIE (facilities, infrastructure and environment) integration continued to progress. The second phase of the integration was well underway, and the consultation had ended. This phase was about the structure of the senior management team for each of the service delivery streams. At the time of the meeting, no decisions had been made regarding the consultation, but it was anticipated that a small number of staff would be TUPE-d over into SGUH from ESTH. This TUPE transfer should be completed on 1 September 2025 and the new management structure should be completely resolved by 1 October 2025.
- The new ITU building at Atkinson Morley is delayed, now anticipated for completion in December 2025 due to contractor supply chain issues with mechanical ventilation.
- The sale of Doddington House was unsuccessful due to uncertainty in the residential development market and the Building Safety Act, impacting a substantial anticipated capital receipt.

The Committees noted the update and suggested explicitly stating the assumptions underlying the recommended level of assurance.

3.2 **Digital Strategy Development**

Following the update on the development of the gesh Group digital strategy that was last brought to the Infrastructure Committees on 13 June 2025, an away day with the IDT leads took place as well as the publication of the NHS 10 Year Plan. There had been ongoing conversations at gesh about how this should shape a medium-term plan for the group. This has meant that the plan is now to bring Digital Strategy to board development session in December 2025 rather than October, to enable it to be fully aligned to our medium-term plan.

3.3 **EPR Programme update**

The Committees noted the formal update on the progress of the Shared EPR Programme post go live. The EPR programme team was scheduled to hand over to the BAU (business as usual) IT team by 1 September 2025. The Committees noted that there were always some risks from loss of corporate memory as contractors were replaced with permanent staff and also stressed the importance of actively focusing on benefits realisation to ensure the intended outcomes of the EPR implementation are achieved.

4.0 Key Issues on which the Committees received assurance

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

4.2 **Patient-Led Assessments of the Care Environment (PLACE) Report**

The Committees reviewed the summary of the PLACE reports, which included locations inspected, domains, scores, and progress on action plans. The Committees noted the report and agreed with the proposed reasonable assurance level.

4.3 **Premises Assurance Model (PAM)**

All trusts are required to submit self-assessments for the NHS Premises Assurance Model (PAM) annually. The report showed continuous improvement at SGUH, but ESTH continued to fall below expectations, primarily due to staff turnover. The Committees noted the report and requested future reports to clarify whether resource issues are related to headcount or skill levels.

4.4 **ERIC update (submission)**

The Committees noted the ERIC (estates returns information collection) submission for St George's, Epsom, and St Helier hospitals for 2024/25. This information was for noting as the formal submission to NHS England was due in August 2025.

4.5 **Epsom & St Helier Estates and Facilities Assurance Update (Fire Safety and Water Safety)**

The Committees welcomed the news that significant progress had been made on procedural fire safety at ESTH. The trust was also planning capital investments to address the remaining fire safety issues. A formal letter was to be sent to the London Fire Brigade (LFB) to formalise verbal agreements on progress, as the trust had not yet received written updates from LFB.

The Committees also noted a paper setting out progress on water safety issues at St Helier Hospital. An independent expert, Dr. Surman-Lee, was appointed to review the water quality issues at the Maternity Unit (E Block). Her preliminary advice is for the trust to increase monitoring of critical care outlets. The previously considered option to close the building for full renovation was not considered to be viable in current circumstances, and an external project manager will be appointed to assess the expert's plan.

4.6 **Digital Risk Management Update**

This report set out the new risk management processes for reviewing and updating risks relating to Digital across the Group (ESTH & SGUH). It was noted that the digital risk development framework for each area would commence reporting to the Digital Governance Group in August 2025; with changes to the Corporate Risk Register being reviewed at the Risk & Assurance Group from September 2025. Subsequent risk specific reports will be reported to the Board Infrastructure Committees from October 2025. The Committees noted the changes in Digital Risk Management process in alignment with changes to gesh risk management governance.

5.0 Other issues considered by the Committees

5.1 **PACS Project Update**

The Committees noted that the engagement with the supplier was positive and that the revised governance structure for the project was in place with regular meetings. Data migration from the historic SGUH system was a point of concern. The London NHS team are supportive of the actions being taken and progress to date. As previously noted, a bid has been made to the national digital team for £900k of revenue funding to support the cost of the project team across 2025/26.

5.2 **Deep Dive – Asbestos**

The Committees noted the report on Asbestos and discussed the compliance gap that exists at St George's University Hospitals (SGUH) due to the long-term sickness of the appointed asbestos lead. A new surveying company is expected to complete a survey by the end of September 2025, and an Authorising Engineer is providing additional support to mitigate the compliance gap.

5.3 **Digital Delivery Update**

The Committees noted this report that summarised the business of the last Digital Governance Group meeting. To support the development of an integrated IT, Digital and Data function across the gesh group, the following four functional steering groups were being established: Data & Analytics, Clinical Applications, IT Infrastructure and Information Governance. It was noted that alignment of help desks was a priority. Both sites share the same IT Service Management (ITSM) platform provider (Ivanti) and both will be hosted in the cloud as of end of October 2025 which will enable the ability to integrate across the group and support the way towards an integrated service desk capability. The Committee asked the executive team to consider how best to manage cybersecurity through the steering groups.

5.4 **Digital Target Operating Model**

The Committees discussed the proposed digital target operating model. The new model aims to consolidate the two existing IT teams into a single, integrated team with common processes, procedures, and governance. This change is intended to streamline operations and better align with the overall Group strategy, the NHS 10-year plan, and developments across SW London. The Committees suggested that cybersecurity should have its own dedicated focus, as it is a critical concern that goes beyond just technical infrastructure and involves the behaviour of all staff.

5.5 **Violence & Aggression Update**

The Committees reviewed an update on violence and aggression, with key priorities including developing a group-level policy and improving police liaison. The Committees stressed a zero-tolerance policy for assaults on staff.

6.0 Recommendations

6.1 The Group Board is asked to note the issues escalated by the Committees to the Group Board and the wider issues on which the Committees received assurance in July and August 2025.

Group Board

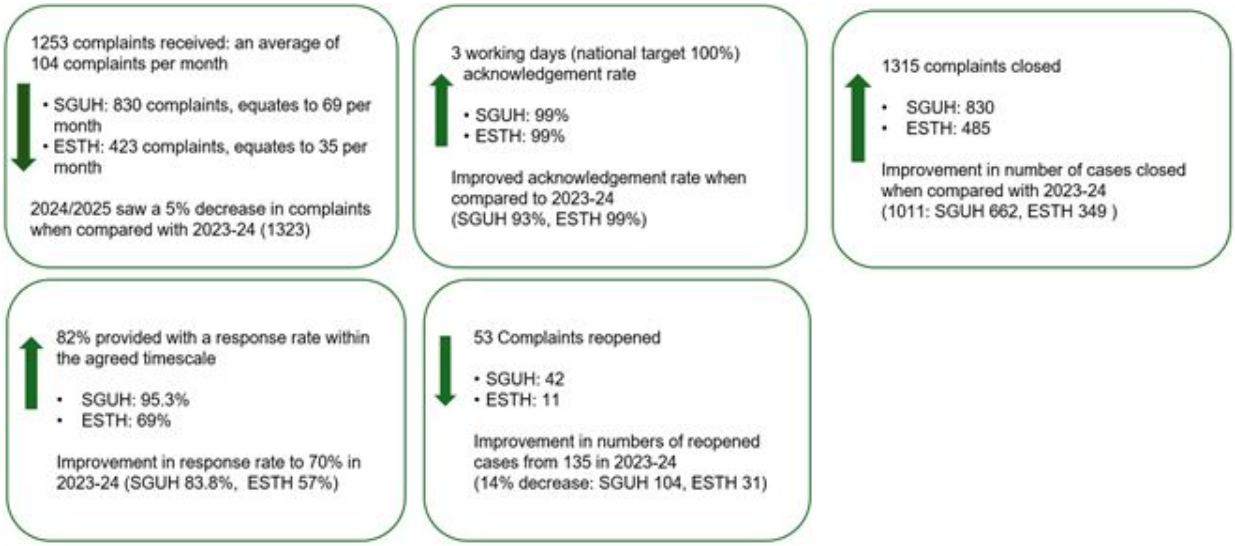
Meeting on Friday, 05 September 2025

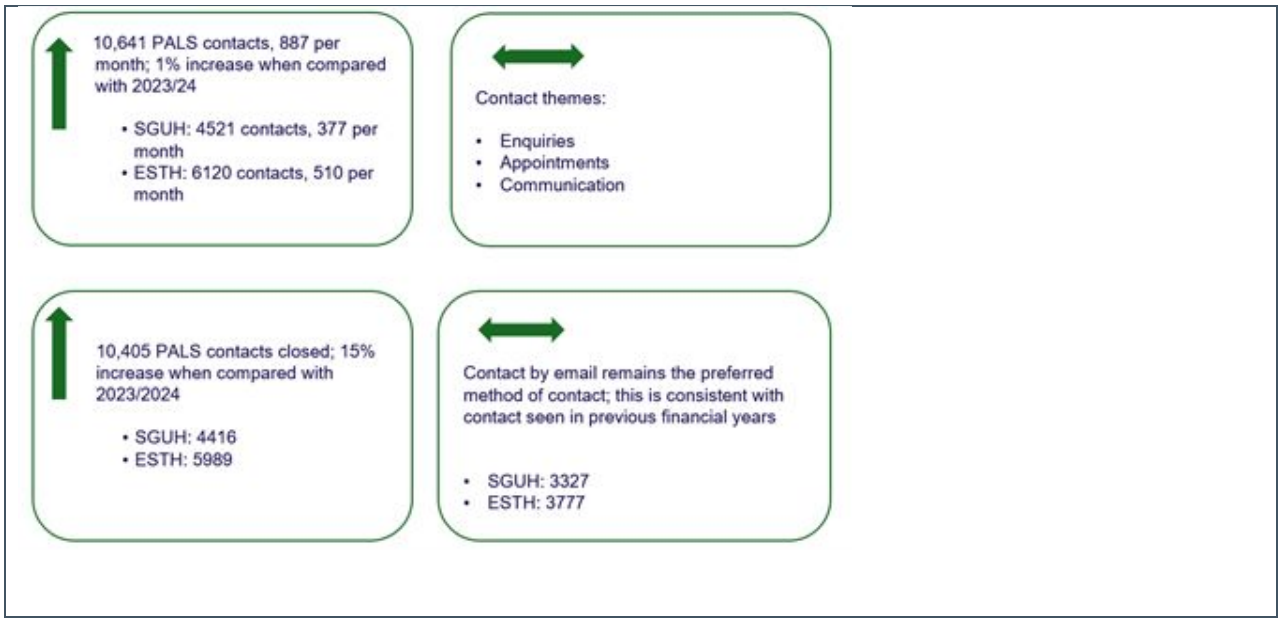
Agenda Item	**6.1**	
Report Title	**gesh Complaints and PALS Annual Report, 2024 - 2025**	
Executive Lead(s)	Arlene Wellman, Group Chief Nursing Officer	
Report Author(s)	Amanda Lavender, Director of Nursing Developments Alison Benincasa, Group Director of Compliance	
Previously considered by	Quality Committees	28 August 2024
Purpose	**For Assurance**	

Executive Summary

This report presents the Complaints and Patient Advice and Liaison Service (PALS) activity and performance for 2024-25.

The 2024-25 reporting year reflects both strong progress in complaint and PALS handling performance and persistent challenges in response timeliness and service consistency across both sites. The progress is demonstrated below and overleaf.





Action required by Group Board

The Board is asked:

- Note the progress made in 2024-25.
- Note the key challenges and areas of risk.
- Review and approve the priorities for 2025-26 and identify any further action required.
- Note the annual report for uploading to the Trust websites.

Committee Assurance

Committee	Quality Committees
Level of Assurance	Choose an item.

Appendices

Appendix No.	Appendix Name
READING ROOM	**gesh Complaints and PALS Report, 2024-25**

Implications

Group Strategic Objectives

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

Risks

Failure to comply with the standards required by the Health and Social Care Act and other regulatory obligations could lead to non-compliance, reduced quality of care, and reputational damage.

CQC Theme

☒ Safe	☒ Effective	☒ Caring	☒ Responsive	☒ Well Led

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

Financial implications
Costs may be incurred from fines, legal claims and complaint resolution.
Legal and / or Regulatory implications
Potential enforcement action if breaches of regulatory duties under the Health and Social Care Act 2008 or CQC standards are identified.
Equality, diversity and inclusion implications
The current system for data collection does not capture the ethnicity of the complainant or the PALS enquiry. The upgrade to Datix web will enable this in future reporting.
Environmental sustainability implications
No issues to consider.

gesh Complaints and PALS Annual Report 2024-25

1.0 Purpose

This report presents the Complaints and Patient Advice and Liaison Service (PALS) activity and performance for 2024-25.

Activity and performance are shown both at Site and Group level.

The 2024-25 reporting year reflects both strong progress in complaint and PALS handling performance and persistent challenges in response timeliness and service consistency across both sites.

2.0 Key areas of progress 2024-25

Progress has been made throughout 2024-25 as highlighted below.

- **Acknowledgement Compliance**: 99% of complaints were acknowledged within the 3-day national target, showing improvement from the previous year.
- **Improved Timeliness**: 82% of complaints were investigated within agreed timescales (up from 70%).
- **Reduced Reopened Complaints**: 53 complaints (4%) were reopened, a significant reduction from 135 in 2023/24, indicating improved quality of initial investigations.
- **PALS Growth and Responsiveness**: PALS managed 10,641 contacts (1% increase in year) with a 15% rise in closures, highlighting its role as a vital early resolution service.
- **Backlog Clearance Effort**: St George's reduced PALS cases backlog from 275 open cases to 77 (January to March 2025).

3.0 Key challenges and areas of risk, 2024-25

Challenges were encountered in 2024-25 as highlighted below.

- **High Volume Management**: 1,253 complaints were received, a 5% decrease from 2023/24
- **Thematic Concerns**: The majority of complaints relate to **clinical care, communication, and staff attitude** mirroring previous years and suggesting systemic issues remain unresolved.
- **PALS Backlog**: Despite progress at SGUH, unresolved contacts at year-end present service risks if cases are not fully resolved, for example missed appointments.
- **Incomplete Data Capture**: Outcomes of complaint investigations (upheld/partially upheld/not upheld) and patient/staff satisfaction data are not yet consistently recorded, limiting learning and assurance.
- **Sustained Operational Pressures**: Divisional capacity constraints, staff absences, and competing clinical priorities risk continued underperformance.
- **Regulatory Compliance**: Failure to meet deadlines or response times could lead to escalation to the Parliamentary and Health Service Ombudsman (PHSO) and regulatory scrutiny.
- **Data System Limitations**: Current Datix configuration hinders consistent monitoring of complaints and PALS performance, creating risks to transparency and improvement.
- **Reputation and Patient Trust**: Persistent concerns about care standards, communication, and delays threaten patient confidence if not addressed systematically.

4.0 Priorities for 2025–2026

The Key priorities for 2025-26 are:

1. **Enhanced reporting and Data Transparency**: Show performance / activity as a % of the number of patients and include benchmarking with similar Trusts.
2. **Consistency and standards**: Introduce a group-wide complaints policy and SOP and a unified Group-wide PALS procedure aligned with national complaints guidance.
3. **System Improvements**: Reconfigure Datix to support consistent monitoring and management.
4. **Accessibility and Transparency**: Update complaints and PALS leaflets and website information.
5. **Feedback and Learning**: Implement experience surveys for complainants and staff; develop stronger monitoring and lesson-sharing.
6. **Translation support:** Review and standardise the role of PALS in providing translation services across the Group.

5.0 Recommendations

The Board is asked to:

- Note the progress, the key challenges and areas of risk.
- Note the annual report in the READING ROOM for uploading to the Trust websites.

gesh

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

Appendix 1

Group Complaints and PALS Annual Report 2024/2025



Executive Summary (1)

This report presents the Complaints and Patient Advice and Liaison Service (PALS) activity and performance for 2024-25.

Activity and performance are shown both at Site and Group level.

The 2024-25 reporting year reflects both strong progress in complaint and PALS handling performance and persistent challenges in response timeliness and service consistency across both sites.

Key Successes

- **Acknowledgement Compliance**: 99% of complaints were acknowledged within the 3-day national target, showing improvement from the previous year.
- **Improved Timeliness**: 82% of complaints were investigated within agreed timescales (up from 70%).
- **Reduced Reopened Complaints**: 53 complaints (4%) were reopened, a significant reduction from 135 in 2023/24, indicating improved quality of initial investigations.
- **PALS Growth and Responsiveness**: PALS managed 10,641 contacts (1% increase in year) with a 15% rise in closures, highlighting its role as a vital early resolution service.
- **Backlog Clearance Effort**: St George’s reduced PALS cases backlog from 275 open cases to 77 (January to March 2025).

Executive Summary (2)

Key Challenges

- **High Volume Management**: 1,253 complaints were received, a 5% decrease from 2023/24
- **Thematic Concerns**: The majority of complaints relate to **clinical care, communication, and staff attitude** mirroring previous years and suggesting systemic issues remain unresolved.
- **PALS Backlog**: Despite progress at SGUH, unresolved contacts at year-end present service risks if cases are not fully resolved, for example missed appointments.
- **Incomplete Data Capture**: Outcomes of complaint investigations (upheld/partially upheld/not upheld) and patient/staff satisfaction data are not yet consistently recorded, limiting learning and assurance.

Key Risks

- **Sustained Operational Pressures**: Divisional capacity constraints, staff absences, and competing clinical priorities risk continued underperformance.
- **Regulatory Compliance**: Failure to meet deadlines or response times could lead to escalation to the Parliamentary and Health Service Ombudsman (PHSO) and regulatory scrutiny.
- **Data System Limitations**: Current Datix configuration hinders consistent monitoring of complaints and PALS performance, creating risks to transparency and improvement.
- **Reputation and Patient Trust**: Persistent concerns about care standards, communication, and delays threaten patient confidence if not addressed systematically.

Accountability for Complaints and PALS

The **GESH CEO** is the statutory *Responsible Person* for ensuring compliance with NHS complaints regulations and standards, delegating operational responsibility to the **Group Chief Nursing Officer**. Complaints and PALS are managed under the Group Corporate Nursing Directorate, led by the **Group Director of Nursing for Quality and Safety Governance** supported by the **Deputy Director of Nursing Development**.

Each site has a **Complaints Manager** overseen by the **Group Head of Complaints & PALS**, ensuring all complaints are fully investigated and responded to within agreed timescales (25, 40, or 60 days), with extensions and progress updates where needed. Responses are issued by the Executive or Site Leadership Teams, and local resolution meetings are encouraged.

The complaints team shares accountability with divisional teams. Complaints are reviewed at multiple levels (monthly, quarterly, annually), including by the **Trust Board**, with prompt responses to Parliamentary and Health Service Ombudsman (PHSO) enquiries.

Complaints: Key Headlines for 2024 - 2025

Highlights of complaint performance against key performance indicators and comparing 2024/2025 performance to 2023/2024 performance.

1253 complaints received: an average of 104 complaints per month

- SGUH: 830 complaints, equates to 69 per month
- ESTH: 423 complaints, equates to 35 per month

2024/2025 saw a 5% decrease in complaints when compared with 2023-24 (1323)

3 working days (national target 100%) acknowledgement rate

- SGUH: 99%
- ESTH: 99%

Improved acknowledgement rate when compared to 2023-24
(SGUH 93%, ESTH 99%)

1315 complaints closed

- SGUH: 830
- ESTH: 485

Improvement in number of cases closed when compared with 2023-24
(1011: SGUH 662, ESTH 349)

82% provided with a response rate within the agreed timescale

- SGUH: 95.3%
- ESTH: 69%

Improvement in response rate to 70% in 2023-24 (SGUH 83.8%, ESTH 57%)

53 Complaints reopened

- SGUH: 42
- ESTH: 11

Improvement in numbers of reopened cases from 135 in 2023-24
(14% decrease: SGUH 104, ESTH 31)

PALS: Key Headlines for 2024 - 2025

Highlights of PALS performance against key performance indicators including comparison with 2023/2024.

10,641 PALS contacts, 887 per month; 1% increase when compared with 2023/24

- SGUH: 4521 contacts, 377 per month
- ESTH: 6120 contacts, 510 per month

Contact themes:

- Enquiries
- Appointments
- Communication

10,405 PALS contacts closed; 15% increase when compared with 2023/2024

- SGUH: 4416
- ESTH: 5989

Contact by email remains the preferred method of contact; this is consistent with contact seen in previous financial years

- SGUH: 3327
- ESTH: 3777

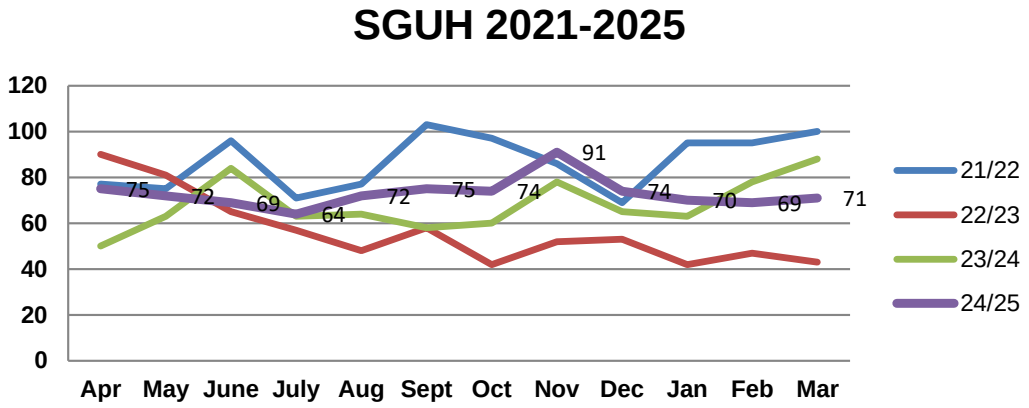
Complaint Performance (1)

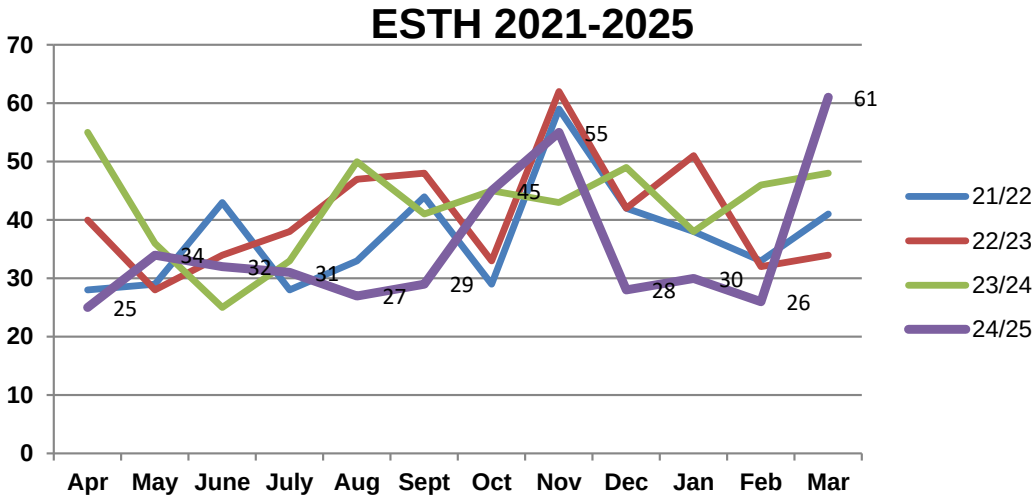
Complaints received

Compared to 2023/2024 (where 1323 GESH complaints were received), the number of GESH complaints received between 1 April 2024 and 31 March 2025, was 1253, an increase of 20%. These complaints spanned various areas, which are broken down into themes and GESH sites in the report. The total number of complaints received during the reporting period equates to an average of approximately 108 complaints received each month, a reduction of one complaint compared to 2023/2024 (an average of 109 each month).

The graph visually represents the trends by breaking down the monthly complaints received over the last four financial years.

The complaints peaks for the 2024/2025 financial year were notably concentrated in April, September and November (SGUH) and November and March (ESTH), indicating the need for targeted interventions in these specific months and locations.





Complaint Performance (2)

Complaints by Site and Divisions

The table below shows the number of complaints received about the Group's divisional areas compared with the previous four financial years. Directional arrows indicate change compared to the last fiscal year.

ESTH Division	2021/2022	2022/2023	2023/2024	2024/2025
Medicine	226	198 ↓	252 ↑	194 ↓
Surgery	84	88 ↑	85 ↓	72 ↓
Women & Children	85	72 ↓	96 ↑	93 ↓
Renal	14	16 ↑	5 ↓	7 ↑
Clinical Services	20	21 ↑	22 ↑	21 ↓
Surrey Downs Health Care Community Service	15	11 ↓	14 ↑	8 ↓
Sutton Health Care Community Services	13	17 ↑	9 ↓	5 ↓
Elective Orthopaedic Centre (EOC)	14	9 ↓	11 ↑	13 ↑
Estates, Facilities and Capital Projects	10	12 -	12	5 ↓
Patient Services	1	1 -	2 ↑	3 ↑
Strategy, Corporate Affairs and ICT, Clinical Operations	2	1 ↓	1 -	2 ↑
Total	**528**	**511**	**509**	423

SGUH Division	2021/2022	2022/2023	2023/2024	2024/2025
Children, Women, Diagnostic, Therapy (CWDT)	254	208 ↓	209 ↑	245↑
Medicine & Cardiology (MedCard)	369	241 ↓	312 ↑	285 ↓
Surgery Neurosciences, cancer & Theatre (SNCT)	345	188 ↓	232 ↑	294 ↑
Estates & Facilities	47	36 ↓	42 ↑	38 ↓
Corporate Department incl. SWL Pathology	26	14 ↓	19 ↑	14↓
Total	**1041**	**687**	**814**	**876**

The data shows that the Medicine and Cardiology (SGUH) and Medicine (ESTH) divisions received the majority of complaints during 2024/2025, which can be attributed to their size as the largest clinical divisions.

However, complaint numbers have increased in CWDT and SNCT divisions within SGUH and four divisions across ESTH, with a noticeable reduction in Estates, Facilities and Capital projects compared to 2023/2024.

The top two staff groups to which the majority of complaints relate across GESH are the medical staff group and the nursing and midwifery staff group. This is linked to the clinical concerns around care standards and communication.

These staff groups represent the number of issues raised relating to the staff group rather than the number of complaints and are consistent with previously available information.

Complaint Performance (3)

Complaints mode of receipt

Anyone who has received care or used services from GESH Group organisations and services can complain. A person may also complain if they are not in direct receipt of our care or services but are affected, or likely to be affected by, any action, inaction, or decision by our organisation and services. If the person affected does not wish to deal with the complaint, they can appoint a representative to raise it. There is no restriction on who may represent the person concerned. There is a consent process to enable the representative to present and discuss the complaint.

Complaints are received via different modes, with emails being the preferred route for complaining.

Complaint Mode of Receipt	SGUH		ESTH	
	2023/24	2024/25	2023/24	2024/25
Complaints via MP	5	5	0	2
Email	653	667	457	384
PALS referral	108	168	29	30
Letter	25	23	22	7
Telephone	20	4	1	0
In person	3	9	0	0
Total	**814**	**876**	**509**	**423**

Complaints acknowledgement

GESH Group considers all accessibility and reasonable requirements for people who wish to make a complaint alternatively. In the future, any reasonable adjustments will be recorded.

All complaints, whether in writing, electronically, or verbally, should be acknowledged within three working days of receipt (national timescale). During 2024/2025, SGUH achieved 99% compliance, and ESTH was also 99% compliant.

Both Sites saw a comparative slight variation in acknowledgement time in 2024/2025 due to staff challenges.

Complaint Performance (4)

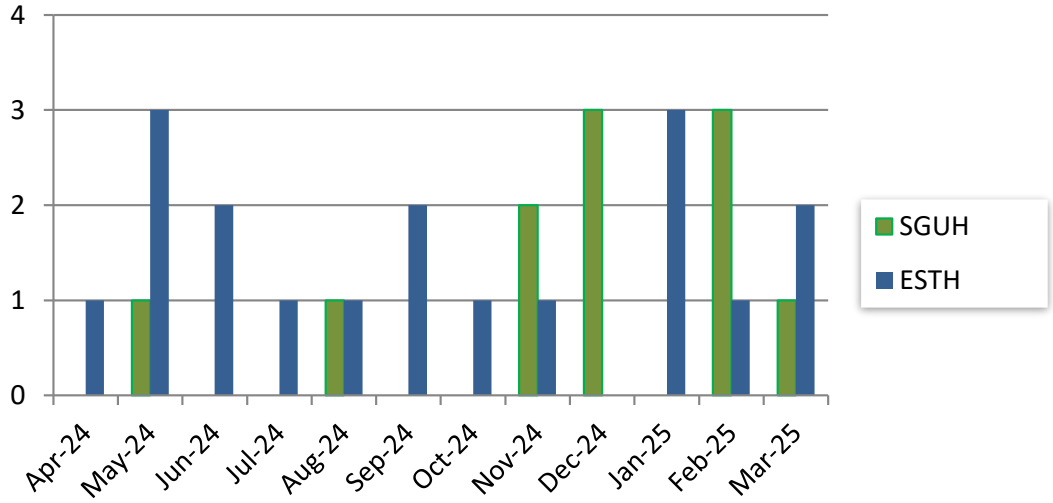
Timescale for making a complaint

A complaint should be made immediately after the action giving rise to it. According to national guidance, the time limit for making a complaint must be within 12 months from the date the matter is being complained about or the date the person investigating the complaint was found out, whichever is later.

During 2024/2025, across GESH, SGUH identified 11 complaints and ESTH 18 complaints that had exceeded the 12-month limits. A decision as to whether to investigate these complaints are based on the following:

- There was good reason for not making the complaint before the deadline,
- It was possible for the Trust to investigate the complaint effectively.

Data indicates that receipt of these type of complaints is variable



Withdrawn or rejected complaints

During 2024/2025, there were a total of 54 (9 SGUH, 45 ESTH) GESH complaints that were withdrawn or rejected.

These were for the following reasons:

- Following receipt of the new appointment, the complainant wanted the complaint withdrawn.
- Complaint was managed through PALS and did not require a full investigation
- Complaints were made about other trusts with nothing for GESH to respond to.
- Consent not received.
- Following the verbal conversation with the clinician, the person raising the complaint withdrew the complaint.
- The person raising the complaints did not want a full investigation; they just wanted GESH to be made aware of the concerns so that they could improve and learn.
- The complaint policy was not the suitable route for managing the complaint: HR procedure
- Complainant decided to put in a legal claim for compensation and withdrew their complaint

Complaint Performance(5)

Complaints response timeframe

National guidance states that Trusts must investigate a complaint within six months and '*in a manner appropriate to resolve it speedily and efficiently and keep the complainant informed*'. Therefore, when a response is not completed in the set timeframe, the trust should explain and agree on a new timetable with the complainant. All complaints received are triaged to determine the level and length of time an investigation will take. The current completion timeframe is set out in the table below. These time frames were reviewed during the reporting period and increased as part of the complaints improvement review to enable the principle of '*investigate once, investigate well*'.

Investigation days	35 working days	55 working days	80 working days
Level of investigation	Early resolution and investigation	Medium level case and investigation	Complex level case and investigation

The table below shows the breakdown of responses within the specified investigation timeframe by Site.

Timeframe	Target	SGUH		ESTH	
		2023/24	2024/25	2023/24	2024/25
35 working days	85%	**95%**	**95%**	**38%**	**68%**
55 working days	90%	**75%**	**96%**	**32%**	**84%**
80 working days	95%	**57%**	**100%**	**21%**	**55%**

SGUH achieved all target timeframes which is testament to the complaints management methodology. Whilst significantly improved from 2023/24, Target timeframes were not achieved at ESTH due to challenges within the complaints and divisional teams from operational pressures resulting in divisional teams having to manage competing clinical priorities alongside their responsibilities within complaints investigation, staff absence, the complaints process not being robust to enable a consistent monitoring approach and frequent changes to the process with a repelling effect on other parts of the complaints service.

Several actions are underway to support improving the response completion timeframe. One such action is Datix, the complaints management and monitoring tool configured for robust tracking of each complaint journey. Weekly complaints team meetings and divisional team meetings are in place for most clinical divisions. This enables the complaints teams and the divisional investigating officers to meet to discuss each complaint. It provides an opportunity to identify challenges and provide support and timely escalation.

Complaint Performance (6)

Closed complaints and Outcomes

During 2024/2025, GESH closed 1315 complaints (830 St Georges, 485 ESTH). The number of complaints closed reflects those that could have been logged the previous year with a completion timeframe in 2024/2025. Complaints logged in 2024/2023 with an investigation timeframe in 2025/2026 are not included.

Across GESH, the final decision (upheld, partially upheld, not upheld) of complaints investigation isn't consistently collected as it is not a compulsory field on Datix. Therefore, this data is currently unavailable but will be available following the reconfiguration of Datix in 2025.

Complaints surveys

It is good practice to understand the experience of the person(s) raising the complaint during and after an investigation, including those staff who either complained about or were involved in the complaints investigations.

GESH does not have a complaints experience survey for persons complaining or staff involved in the complaints. These are being developed to be used consistently from 2025/2026. The complaint experience survey will be sent to the person raising the complaint two weeks after their complaint has been closed and twice a year to staff involved in complaints.

These future surveys promise to enhance our complaints process. The insights they provide will be instrumental in our continuous improvement efforts, fostering a more transparent and effective system.

Complaints reopened

When the person raising a complaint is not satisfied with the final response, they are given the opportunity to ask further questions based on the final response at least once and/or arrange a meeting with the person to discuss the dissatisfaction. This process is in place to ensure that all concerns are thoroughly addressed and that the initial investigation is considered adequate, complete, and satisfactory.

During 2024/2025, GESH Group reopened 53 (4%) complaints (42 (5%) SGUH, 11 (3%) ESTH). This is quite a significant decrease in the number of complaints reopened at St Georges (104) and ESTH (31) in 2023/2024

Through the revised complaint approach, the Site Chief Nursing Officer, in collaboration with the divisional leadership, will decide whether a complaint should be reopened. The improvement in the investigation approach, applying the principle '*investigate once and investigate well*', would contribute to minimising the number of reopened complaints.

Complaint Performance (7)

Stop-the-clock

Stop-the-clock is a formal process for pausing the complaints process and investigation for an agreed period. Therefore, stop-the-clock is usually only applied in exceptional circumstances, for example, when required to do so by:

- The Police
- A Coroner
- A Judge
- In some cases, a resolution meeting has been identified but has not yet occurred.

While stop-the-clock was applied on several occasions during 2024/2025, the complaints team needs a consistent process for monitoring it monthly, quarterly, and annually. The reconfiguration of Datix as part of the complaint improvement project will enable this data to be robustly captured.

Complaint Themes

Complaints are classified into 18 categories by the subject of the complaint. Depending on the nature and complexity of the complaint, each complaint may involve more than one issue or subject.

The complaints are grouped by primary subject, allowing us to identify whether trends are developing. The primary themes for the last two years are clinical treatment, care treatment, care, attitude, and communication. Clinical Care & Treatment accounts for 22% of the complaint themes at SGUH, and ESTH, it is 62%.

More work is still required to unpick the theme and enable a detailed understanding of the areas for improvement. This would allow the Trust to use the Qi methodology to improve and have supporting evidence.

SGUH Divisions	Number of complaints	Top three themes 2023/24	Top three themes 2024/25
Children, Women, Diagnostic, Therapy	245	Care (52), Clinical Treatment (41) Attitude (35)	Clinical Treatment (64), Care (61) Communication (35)
Medicine & Cardiology	285	Care (81), Clinical Treatment (65) Communication (40)	Care (84), Clinical Treatment (70) Communication (36)
Surgery Neurosciences, cancer & Theatre	294	Care (42), Clinical Treatment (42) Communication (37)	Clinical Treatment (61), Care (49), Communication (46)
Estates & Facilities	38	Transport (19), Hotel & Site services (6) Attitude (3)	Transport (20), Hotel Services & Car Parking (6) Attitude (5)
Corporate Department incl. South West London Pathology	14	Communication (3) Attitude (3) Clinical Treatment (3)	Communication (2) Attitude (4) Discharge Arrangement (2)

ESTH Divisions	Number of complaints	Top three themes 2023/24	Top three themes 2024/25
Medicine	194	Clinical Care & Treatment (131) Communication (43) Attitude (36)	Clinical Care & Treatment (118) Communication (26) Attitude (22)
Surgery	72	Clinical Care & Treatment (48) Communication (21) Attitude (8)	Clinical Care & Treatment (44) Attitude (7) Communication (6)
Women & Children	93	Clinical Care & Treatment (53) Communication (14) Attitude (16)	Clinical Care & Treatment (53) Communication (15) Attitude (10)
Renal	7	Clinical Care & Treatment (4) Communication (1) Privacy & Dignity (1)	Clinical Care & Treatment (4) Communication (3)
Clinical Services	21	Clinical Care & Treatment (11) Communication (6) Attitude (10)	Clinical Care & Treatment (10) Attitude (5) Communication (2)
Surrey Downs Health Care Community Service	8	Clinical Care & Treatment (10) Discharge (4) Attitude (6)	Attitude (4) Clinical Care & Treatment (3) Communication (1)
Sutton Health Care Community Services	5	Clinical Care & Treatment (5) Communication (2) Attitude (2)	Communication (2) Attitude (2) Clinical Care & Treatment (1)
Elective Orthopaedic Centre (EOC)	13	Clinical Care & Treatment (6) Communication (3)	Clinical Care & Treatment (11) Communication (1) Attitude (1)
Estates, Facilities and Capital Projects	5	Ambulance Services (8), Car Parking (3), Accommodation, facilities and equipment (3)	Ambulance Services (2) Accommodation, facilities and equipment (2) Patient Safety (1)
Patient Services	3	Clinical Care & Treatment (1) Discharge (1)	Ambulance Services (1) Attitude (1) Medical records (1)
Strategy, Corporate Affairs and ICT, Clinical Operations	2	Communication	Clinical Care & Treatment (2)

PHSO Enquiries & Investigation Summary

A total of 37 PHSO enquiries were made to GESH for the reporting period 2024/2025. From the 37 PHSO enquiries made to GESH between 2024 and 2025, the PHSO decided to carry out detailed investigations of 12 cases. 13 cases were not investigated or are still within the primary investigation stage with the PHSO.

The breakdown of enquiries and investigation are outlined in the table below. Planned care and MedCard saw the highest numbers of enquiries and investigations, followed by medicine in ESTH and CWDT in SGUH

2024/2025	PHSO Primary Investigations (Enquiries)	PHSO Detailed investigations commenced / undertaken
ESTH	8	2
SGUH	17	10
GESH Total	25	12

PHSO Primary & Detailed investigations by Division	2024/2025
ESTH Medicine	3
ESTH Planned Care	4
ESTH SWLEOC	1
ESTH SDHC	1
ESTH W&C	1
SGUH CWDT	6
SGUH MedCard	14
SGUH SNCT	5
SGUH Finance	2
GESH Total	37

The final decisions made by PHSO between the period 2024/2025 are broken down as follows:

The final decision data reflects the final decision received from PHSO that year and are indicative of ongoing PHSO detailed investigations, where the outcome has not yet been completed and shared with the Trust

PHSO Final Decisions	2024/2025		GESH Total
	SGUH	ESTH	
Upheld complaint	0	2	2
Partly upheld complaint	4	0	4
Not upheld complaint	3	0	3
Out of jurisdiction	0	1	1
GESH Total	7	3	10

The top complaint themes reported to PHSO by complainants across GESH continue to be:

- Clinical Care & treatment- which includes pain management, investigations and treatment pathways
- Communication
- Delays in care arrangements

PALS Performance (1)

PALS contacts received

Compared to previous reporting periods (where 8949 in 2022/2023 and 9187 in 2023/2024 GESH PALS contacts were received), the number of GESH PALS contacts received between 1 April 2024 and 31 March 2025, was 10,641, an increase of 14%. These contacts spanned various areas, including concerns and requests for advice. This increase equates to an average of approximately 887 contacts received each month, a 14% increase compared to 2023/2024 (an average of 766 each month).

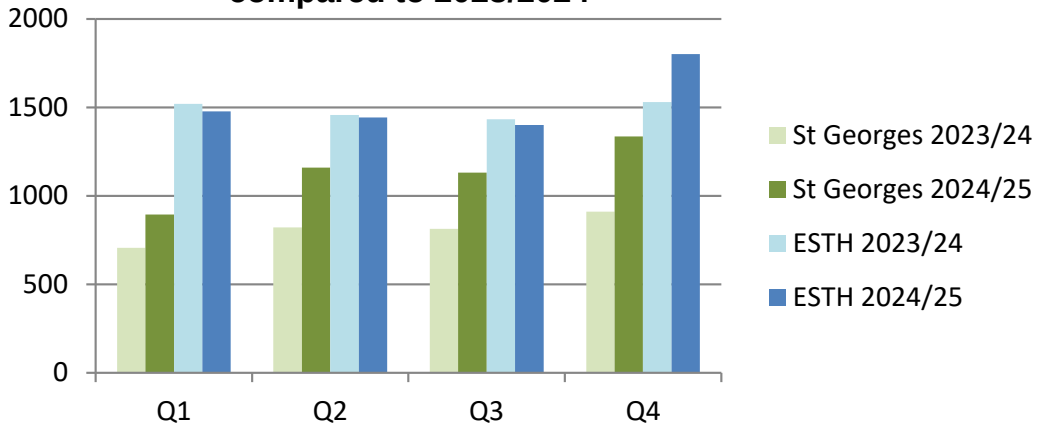
For St George's this represents an increase of 28% when compared to 2023/2024.

For ESTH the number of PALS contacts has seen a more marginal increase of 3% contacts for the reporting period.

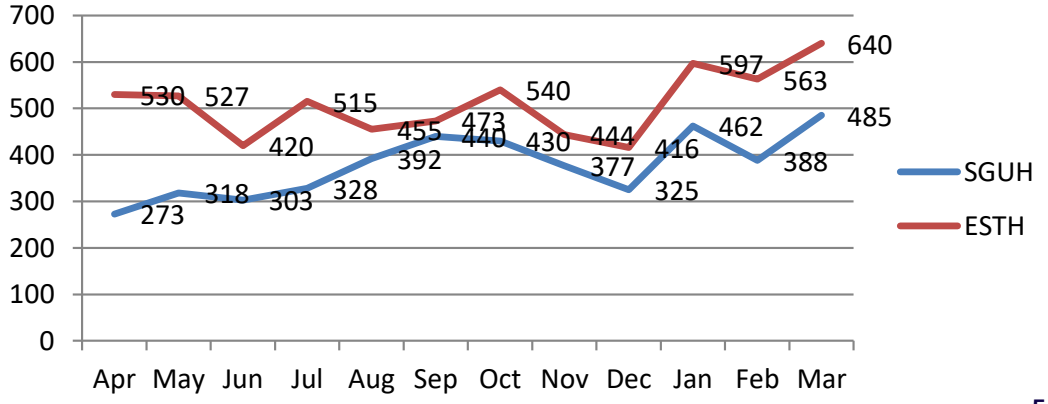
Quarter 4 for the 2024/2025 financial year continues to see the highest number of contacts to each PALS service.

10,405 GESH PALS contacts were closed during the 2024/2025 reporting period, a15% increase from the previous year (8891)

2024/2025 PALS contacts by financial quarter, compared to 2023/2024



2024/2025 PALS contacts by month



PALS Performance (2)

PALS Contacts by Site and Divisions

The table below shows the number of PALS contacts received about the Group's divisional areas for 2024/2025.

ESTH	20223/24	2024/25
Medicine	1940	2178
Planned Care	1094	1330
Women & Children	639	718
Renal	129	149
Clinical Services	434	423
Community Services (SDHC & SHC)	31	106
Elective Orthopaedic Centre (EOC)	204	187
Estates, Facilities and Capital Projects	246	299
Clinical operations and Corporate services	582	430

SGUH	20223/24	2024/25
Surgery Neurosciences, Cancer & Theatre	1399	1866
Medicine & Cardiology	1073	1377
Children, Women, Diagnostic, Therapy	572	965
Corporate Department incl. Southwest London Pathology & external organisations	101	187
Estates & Facilities	34	103

The data shows that Medicine (ESTH) and Surgery, Neurosciences, Cancer and Theatre (St George's) divisions received the majority of PALS contacts during 2024/2025. which can be attributed to their overall size in terms of the collation of specialist services managed by each division. 310 contacts for ESTH and 23 contacts for SGUH did not provide a name or contact number or did not respond to return calls to enable further service allocation or concerned external organisations.

PALS Performance (3)

PALS acknowledgement

GESH Group considers all accessibility and reasonable requirements for people who wish to contact PALS. In the future, any reasonable adjustments will be recorded.

All PALS contacts, whether in writing, electronically, or verbally, should be acknowledged within three working days of receipt. As there is no National timeframe for the acknowledgement of PALS contacts, this has been set locally as a GESH Group, which is in line with Complaints and also other Trust's PALS and complaints teams. This is now being monitored on a weekly basis in the Complaints & PALS flash report.

Management of PALS backlog

In January 2025, a backlog of 275 Open PALS contacts was identified at St George's. The backlog was defined as all PALS contacts that should have been responded to before 31 December 2024.

As of the 31 March 2025, the PALS backlog has significantly reduced with 77 Remaining. This joint effort is a testament to GESH's shared commitment to improving the patient experience.

PALS Contacts mode of receipt

PALS Contacts mode of receipt

Anyone who has received / has planned care or used services from GESH Group organisations and services can contact PALS. This can include a relative or advocate for patients or external organisations. There is no restriction on who may represent the person concerned. With a consent process in place to enable the representative to present and discuss the concern.

PALS Contacts are received via different modes, with emails continuing to be the preferred route of contact.

	SGUH		ESTH	
	2023/24	2024/25	2023/24	2024/25
Email	1904	3327	3200	3777
Telephone	636	448	2444	2103
In person	652	683	234	192
In writing	32	33	58	41
FFT	0	0	1	1

PALS at ESTH have been able to support periodic opening of the Patient facing office at St Helier Hospital, due to staffing challenges during the reporting period. This has enabled continuation of in person contacts.

St George's have an accessible walk-in service open 5 days a week.

Contact Type 2024/2025

A PALS contact refers to any enquiry or request. An example of this is a patient wanting information about specialist treatments for specific conditions and service accessibility i.e. a hospital appointment, or a request regarding information on how to make a subject access request. PALS is also an avenue for patients and relatives to share feedback about their care and treatment received in all hospitals across the group. In cases of contacts, a proportion of these will convert to PALS concerns when enquirers report an expression of concern that requires further follow-up.

A breakdown into the types of contact for 2024/2025 fell into five main categories (the difference in wording remains consistent with the differences in Datix systems used in GESH):

- Enquiry, Advice / Appointments
- Clinical Care & Treatment
- Communication / Request for information
- Delay in care arrangement / Discharge
- Attitude

PALS Themes

Contact Themes

A thematic review of the main contact categories for each Site was completed. It is noted that the wording for these varies across the Group due to the differences in Datix systems

ESTH	2022/23	2023/24	2024/25
1	Enquiry/ Request for information/Advice	Enquiry/ Request for information/Advice	Enquiry/ Request for information/Advice
2	Delay in care Arrangements	Delay in care Arrangements	Clinical Care & Treatment
3	Communication & Information	Clinical Care & Treatment	Delay in care Arrangements
4	Clinical Care & Treatment	Communication & Information	Communication & Information
5	Attitude	Discharge arrangements	Discharge arrangements

SGUH	2022/23	2023/24	2024/25
1	Appointments	Appointments	Appointments
2	Other	Communication	Communication
3	Communication	Care	Care
4	Care	Attitude	Request for information
5	Clinical Treatment	Surgery	Attitude

Further review of the primary subjects identified the variety of sub-themes registered, which determine the wide range of issues / enquiries that are presented to PALS. Appointments and issues around communication remain the top themes PALS support resolution for. Other sub-themes include enquiries about other NHS providers, attitude from a range of clinical and non-clinical staff, loss of patient property and car parking. More work is required to unpick the theme and enable a detailed understanding of the areas for improvement. This would allow the Trust to use the Qi methodology to improve and have supporting evidence.

The PALS teams also receive and manage any direct positive feedback, which are sent to relevant staff individuals and their department and service managers.

Complaints and PALS Priorities for 2025/26

Key Priorities

1. **Enhanced reporting and Data Transparency**: Show performance / activity as a % of the number of patients and include benchmarking with similar Trusts.
2. **Consistency and standards**: Introduce a group-wide complaints policy and SOP and a unified Group-wide PALS procedure aligned with national complaints guidance.
3. **System Improvements**: Reconfigure Datix to support consistent monitoring and management.
4. **Accessibility and Transparency**: Update complaints and PALS leaflets and website information.
5. **Feedback and Learning**: Implement experience surveys for complainants and staff; develop stronger monitoring and lesson-sharing.
6. **Translation support:** Review and standardise the role of PALS in providing translation services across the Group.

Group Board

Meeting on Friday, 05 September 2025

Agenda Item	**6.2**	
Report Title	**gesh Annual Patient Experience Report, 2024 - 2025**	
Executive Lead(s)	Arlene Wellman, Group Chief Nursing Officer	
Report Author(s)	Alison Benincasa, Group Director of Compliance Wendy Doyle, Group Head of Patient Experience and Engagement	
Previously considered by	Quality Committee-in-Common	28 August 2025
Purpose	**For Assurance**	

Executive Summary

The annual Patient Experience and Engagement Report 2024–25 outlines progress, challenges, and risks in patient engagement across St George's, Queen Mary's, Epsom, and St Helier Hospitals.

Key achievements include strategic alignment post-integration, strengthened patient/carer engagement, national recognition for Armed Forces support, expanded Friends and Family Test (FFT) participation, and improved inclusive communication practices.

There are ongoing challenges with data system transitions (GATHER and the impact on FFT data collection), compliance with the Accessible Information Standard, and integration of the Trust specific patient experience and engagement forums. These will be further addressed in the key priorities for 2025-26.

The progress made against the priorities for 2024-25 is summarised in the table below.

Priority Area	Headline Metric / Achievement	RAG
Patient Engagement & Involvement	Expanded partnership groups and co-design approaches; draft Group Patient Experience Strategy	Amber
Friends & Family Test (FFT)	104,812 responses (55% increase at SGH), >90% positive scores; Gather system rollout underway	Amber
Armed Forces Programme	Group Veteran Aware status achieved; iClip flagging; national recognition for ED crisis packs	Green
Carers Programme	Group-wide Carers Forum established; draft Carers Charter co-designed; Carers tab on iClip live	Green
Accessibility & EDI	Patient Communication Triangle launched; **AIS compliance requires improvement**	Red
Training & Workforce	869 staff trained (Carers, Armed Forces, FFT); bite-size virtual sessions increased accessibility	Amber

Corporate Gratitude Reporting	444 positive communications recorded at ESTH; SGH reporting under development	☐ Amber

Action required by Group Board

The Board is asked:

- Note the progress made, the key challenges and areas of risk.
- Note the priorities for the next 2 years, 2025-27.
- Note the annual report for uploading to the Trust website.

Committee Assurance

Committee	Quality Committees-in-Common
Level of Assurance	Choose an item.

Appendices

Appendix No.	Appendix Name
READING ROOM	**gesh Patient Experience and Engagement Report, 2024-25**

Implications

Group Strategic Objectives

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

Risks

Failure to comply with the standards required by the Health and Social Care Act and other regulatory obligations could lead to non-compliance, reduced quality of care, and reputational damage.

Accessible Information Standard: There is a risk that patients are unable to understand health information and/ or instructions.

Mitigation: Implement clear, standardised internal inspection parameters supported by defined reporting mechanisms, enabling timely review and course-correction where needed.

CQC Theme

☒ Safe	☒ Effective	☒ Caring	☒ Responsive	☒ Well Led

NHS system oversight framework

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

Financial implications

Costs may be incurred from fines, legal claims and complaint resolution.

Legal and / or Regulatory implications

Potential enforcement action if breaches of regulatory duties under the Health and Social Care Act 2008 or CQC standards are identified.
Equality, diversity and inclusion implications
Accessible Information Standard: There may be barriers to accessing care for patients with disabilities. **Mitigation:** Embed EDI into all aspects of patient experience and engagement. Carers Charter, Armed Forces support, and accessible communications are key enablers of inclusion.
Environmental sustainability implications
Embedding the Green Plan within all activities will drive environmentally sustainable practices and support NHS Net Zero commitments while enhancing long-term operational resilience. For example, increased virtual engagement (drop-ins, training) will reduce travel emissions, Digital-first feedback collection will reduce paper use; but must be balanced with accessibility for digitally excluded patients.

gesh Patient Experience and Engagement Report

2024-25

1.0 Purpose

The annual Patient Experience and Engagement Report covers the period from April 2024 to March 2025 and presents an integrated view of patient experience across St George's, Queen Mary's (Roehampton), Epsom and St Helier Hospitals.

The report highlights achievements, challenges and risks, and progress across the following programmes of work:

- Patient Engagement and Involvement
- Friends and Family Test (FFT)
- Armed Forces and Veterans Programme
- Carers Programme
- National and local patient surveys
- Accessible Information Standard
- Patient elements of Equality, Diversity and inclusivity (EDI)

2.0 Key areas of progress 2024-25

Progress has been made throughout 2024-25 as described below.

2.1 Integration and Strategic Alignment

- Successfully aligned patient experience functions across the GESH group following integration, enabling shared vision and operational consistency.
- Established the foundation for a Group Patient Experience Strategy, informed by NHS England's 2025 Experience of Care Framework.

2.2 Patient and Carer Engagement

- Co-design of the GESH Carers Charter through extensive engagement with unpaid carers, including nine listening events across boroughs and communities.
- Active Patient Partnership Experience Group (PPEG) and Improving Patient Experience Committee (IPEC) forums provided platforms for real-time feedback and dialogue.
- Implementation of monthly virtual drop-in sessions increased access to Patient Experience support across all sites.

2.3 Armed Forces and Veteran Recognition

- Achieved Group Veteran Aware status from the Veterans Covenant Healthcare Alliance (VCHA).
- Introduced iClip coding for Armed Forces members, enhanced visibility and support mechanisms, and celebrated key community events (e.g., Armed Forces Day, Remembrance).
- Recognised nationally for innovative care packs for veterans in emergency care at ESTH.

2.4 Carers Programme

- New carers tab embedded in iClip with increased recording at St George's.
- Delivered virtual bite-sized training sessions, now open across the group, resulting in 869 staff trained on carers and Armed Forces awareness.
- Strengthened partnership with borough Carers Centres and ran themed awareness weeks (e.g., Young Carers Action Day, Carers Rights Day).

2.5 Friends and Family Test (FFT) Growth

- St George's increased FFT responses by 55% year-over-year by expanding into outpatient areas like radiology and pharmacy.
- Demonstrated over 92% satisfaction rates group-wide in FFT submissions, despite gaps at ESTH.

2.6 Inclusive and Accessible Communication

- Developed the Patient Communication Triangle to guide co-design and production of patient materials.
- Corporate poster review (with 50/50 staff-patient team) led to accessible, inclusive patient information standards.

3.0 Key challenges and areas of risk, 2024-25

Challenges were encountered in 2024-25 as described below.

3.1 Resourcing and Structural Changes

- A prolonged vacancy at St George's reduced operational capacity, impacting on projects on accessibility, user groups, and co-production training.
- Transfer of Voluntary Services out of the Patient Experience team into the Chaplaincy and Voluntary Services Function has led to the development of new ways of working.

3.2 Digital and Data System Transitions

- Delayed implementation of the 'Gather' FFT system at ESTH resulted in a data reporting gap (Nov–Mar).
- Loss of SMS-based feedback mechanisms at ESTH pending Information Governance and procurement decisions.

3.3 Accessibility Standard

- GESH is not fully compliant with the Accessible Information Standard (AIS) which poses a risk to equitable patient access and communication.
- A gap analysis has been completed. An improvement plan will be developed and taken forward in 2025-26.

3.4 Governance

- Requirement to integrate site (PPEG/IPEC) and group-level forums to learn from feedback and promote wider visibility of improvement plans.

- Lack of patient representative on IPEC and no formal route for tracking changes arising from patient feedback.

4.0 Priorities for the next 2 years, 2025–2027

With reference to the key principles and findings of recent national publications (Experience of Care Improvement Framework; Dash Report: Review of patient safety across the health and care landscape; and the 10 Year Health Plan for England: fit for the future), the following priorities will be addressed in 2025-26.

1. **Patient and Engagement and Experience function**
   - Further to the recent integration review the function to establish what works well and to identify any areas for improvement.

2. **Governance and Integration**
   - Establish a Group-level Patient Experience Committee to consolidate governance, align reporting, and bridge gaps between the existing St George's PPEG and ESTH IPEC.
   - Launch and embed the Group Patient Experience Strategy, aligned with NHS England's Experience of Care Framework.

3. **Digital Enablement and Data Quality**
   - Support full rollout and optimisation of Gather FFT platform across ESTH.
   - Resolve text messaging and feedback channels for FFT by securing information governance approvals and suitable service providers.

4. **Accessibility Standard**
   - Work with Equality, Diversity and Inclusion team to plan to develop and implement an improvement plan.
   - Strengthen patient co-design practices, particularly in developing accessible information and inclusive service delivery.

5. **Workforce Development**
   - Continue fortnightly virtual training on carers and Armed Forces awareness, now with performance monitoring templates to track uptake and impact.
   - Expand co-design and patient engagement workshops, reintroducing paused initiatives post-staffing constraints.

6. **Recognition and Feedback Loops**
   - Establish Corporate Gratitude reporting system at St George's, building on ESTH's successful model for tracking and responding to compliments and positive feedback.
   - Increase visibility and celebration of improvement actions derived from FFT and national surveys.

7. **Equity-Focused Programmes**
   - Scale Carers Charter initiatives, including policy creation, audits, passport refresh and discharge support improvements.
     Broaden Armed Forces support, including standardising mental health support packs and co-designed pilot projects.

5.0 Recommendations

The Board is asked to:

- Note the progress made, the key challenges and areas of risk.
- Note the priorities for the next 2 years, 2025-27.

Group Board

Meeting on Friday, 05 September 2025

Agenda Item	6.3	
Report Title	**Safeguarding Annual Report – April 2024 to March 2025**	
Executive Lead(s)	Arlene Wellman, Group Chief Nursing Officer Choose an item.	
Report Author(s)	Sam Page, Group Director of Safeguarding	
Previously considered by	Quality Committees	31 July 2025
Purpose	**For Assurance**	

Executive Summary

This Annual Report provides an overview of safeguarding activity across St George's, Epsom & St Helier University Hospitals and Health Group (gesh) from April 2024 to March 2025.

It demonstrates how the Group continues to meet its statutory responsibilities under the Children Act (2004), Care Act (2014), Mental Capacity Act (2005), and Domestic Abuse Act (2021). The report provides evidence to demonstrate compliance with internal and external assurance processes, including NHS England's Safeguarding Accountability and Assurance Framework (SAAF).

Governance and Leadership

- A new **Group Safeguarding Committee** was established in January 2025 to strengthen oversight, with Site Operational Meetings reporting into it. The Committee is chaired by the Group Chief Nurse with membership including Site Chief Nurses and ICB Directors of Quality.
- Safeguarding risks, policies, training, and audits are reviewed regularly at Group and Site safeguarding meetings.
- gesh Statutory safeguarding roles are in place.
- Recruitment to the Designated Doctor for Looked After Children (Wandsworth) remains a challenge. This is a risk held by the ICB.

Safeguarding Assurance

- A **policy tracker** has been developed and updated policies implemented, including:
  - Managing Allegations
  - Safeguarding Children,
  - Was Not Brought/Unseen Child.
- **Training compliance** remains strong at Levels 1 and 2, with most adult and children safeguarding training targets (85%) met or exceeded. The exception is Safeguarding Adults Level 3 which remains challenging at all sites. A new training programme is in development alongside a review of the Training Needs Analysis.

Safeguarding Adults Training Compliance

Training - Target 85%		Q1	Q2	Q3	Q4
SGH					
Safeguarding Adults	Level 1	90.6	90	89	90.7

	Level 2	90.9	90	89	97.7
MCA	Level 1	92.5	93.5	92.2	94.5
	Level 2	86.8	84.9	84.4	85.7
Prevent	Level 1/2	88.6	88%	89	91.1
	Level 3	91.8	91%	91	93
Oliver McGowan	Level 1	78.9	82.5	85.1	90
ESTH					
Safeguarding Adult	Level 1	84.7	86	86.4	86.1
	Level 2	90.4	90.7	89.1	90.4
	Level 3	55.1	60.4	60	59.2
Prevent	Level 1/2	88.9	89.2	86.4	86.1
	Level 3	80.4	90.2	89.1	90.6
Oliver McGowan	Level 1	74.3	82.5	83.8	85.2

Safeguarding Children Training Compliance

Training - Target 85%		**Q1**	**Q2**	**Q3**	**Q4**
SGH					
Children	Level 1	91.8	91	91	91.1
	Level 2	91.2	92	92	93.6
	Level 3	84.1	85	85	87.5
ESTH					
Children	Level 1	88.7	89.2	89.1	89.1
	Level 2	88.5	88.9	87	87.5
	Level 3	82.8	82.2	80.4	76.9

- **Safeguarding supervision** has been strengthened with a new delivery plan and flexible approaches, though embedding across the Group is ongoing.
- Allegations against staff were investigated with senior oversight from Group and Site Chief Nurses:
- There was **1 mandatory FGM referral** across the Group, no **Prevent referrals**, and **5 modern slavery referrals** (SGH).
- Key **audit activity** included reviews of hospital discharges and Treatment Escalation Plans, identifying both good practice and areas for improvement.

Safeguarding Risks

- Main risks included gaps in Level 3 adult safeguarding training, supervision delivery, and MCA decision-making.
- System challenges were also noted with the new iClip system at ESTH affecting referral quality.

Partnership Working and Reviews

- The safeguarding teams engaged with Local Safeguarding Children and Adults Partnerships across Wandsworth, Sutton, Merton, and Surrey.
- The Trust contributed to **statutory reviews** including Child Safeguarding Practice Reviews (themes: unseen child, neglect, hidden fathers), Safeguarding Adult Reviews (themes: self-neglect, legal literacy), and Domestic Homicide Reviews (themes: professional curiosity, reasonable adjustments).

Safeguarding Activity

- **Children**: High levels of safeguarding concerns in Emergency Departments and inpatients, with themes of neglect, physical abuse, and rising mental health needs (self-harm, suicide attempts). RedThread provided vital youth violence and domestic abuse support at SGH.
- **Community Services (children)**: supervision and support to children's services carried out by a SH&C safeguarding team, with support from the gesh Group Director of Safeguarding. Compliance remains high.
- **Adults**: High numbers of referrals to the SGH and ESTH adult safeguarding teams, with neglect, self-neglect, and domestic abuse as leading concerns. Complexity of cases is increasing with several patients requiring support to engage with services and associated legal processes.
- **Community Services (adults)**: Sutton Health & Care and Surrey Downs services handled 890 adult referrals and maintained strong supervision compliance for children's services.
- **Mental Capacity Act**: The team have worked jointly with the Group legal team, external solicitors, and the clinical care groups when cases require consideration of the courts. It is anticipated that this level of support will continue to increase over time as clinical areas are identifying increasingly complex patients.
- **Maternity**: Significant increase in complex safeguarding referrals, with risks linked to domestic abuse, mental health, trafficking, and unsafe living conditions.
- **Domestic Abuse**: The safeguarding teams work with Independence Domestic Violence Advocates in SGH and St Helier Hospital. Provision at Epsom General Hospital was withdrawn by commissioners.
- **Learning Disability**: The LD service has continued to provide excellent support to extremely vulnerable patients and has supported clinical areas to make reasonable adjustments where required. There is an ongoing focus on TEP/DNACPR audits, reasonable adjustments, and reducing inappropriate hospital stays.

Priorities for 2025/26

Priority	Activity
Training	• Deliver flexible and accessible level 3 training offer standardised across the Group • Agree training passport with MAST team to support accurate reporting
Supervision	• Roll our supervision implementation plan across adults and children's services • Agree supervision passport with MAST team
Policy development	• Full suite of up to date safeguarding policies
One risk register	• Create single safeguarding risk register with oversight at safeguarding operational meetings and Group Committee
LD PPEG & Steering Group	• Re-establish the LD Steering Group for the Group • LDPPEG increase the membership of this group and are working in partnership with the Trust patient and public involvement and engagement programme and Merton Mencap
MCA/DoLS audit	• Carry our rolling programme of DoLS audit and update input to ward accreditation programme
DA & MARAC	• Review MARAC attendance and look for opportunities to maximise DA support across the Group
Safe Discharge	• Implement audit action plan and carry out rolling audit programme

Action required by Group Board
a. The Board are asked to receive the report for assurance.

Appendices	
Appendix No.	**Appendix Name**
Appendix 1	GESH Safeguarding Annual Report

Implications				
Group Strategic Objectives				
☒ Collaboration & Partnerships			☒ Right care, right place, right time	
☐ Affordable Services, fit for the future			☐ Empowered, engaged staff	
Risks				
CQC Theme				
☒ Safe	☒ Effective	☒ Caring	☒ Responsive	☒ Well Led
NHS system oversight framework				
☒ Quality of care, access, and outcomes			☐ People	
☐ Preventing ill health and reducing inequalities			☒ Leadership and capability	
☐ Finance and use of resources			☐ Local strategic priorities	
Financial implications				
No issues to consider				
Legal and / or Regulatory implications				
Compliance with the Health and Social Care Act 2008 (Regulations 2014) and CQC Registration Regulations Compliance with the Care Act 2014, the Children's Act 2004 and Working Together 2018				
Equality, diversity, and inclusion implications				
As set out in the papers in the Reading Room				
Environmental sustainability implications				
None identified				

Safeguarding Annual Report
April 2024 – March 2025



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1.0 Introduction

1.1 St George's (SGH), Epsom & St Helier (ESTH) University Hospitals and Health Group (gesh or the Group) are committed to ensuring that all patients, particularly those who are at risk of abuse or neglect, are cared for in a safe, secure and caring environment.

1.2 gesh has a statutory responsibility for ensuring that all services have safe and effective systems in place to safeguard adults and children at risk of abuse, neglect, and exploitation. This includes children of parents who access care. To be effective, this requires; staff members who recognise their individual responsibility to safeguard and promote the welfare of adults and children, and are equipped to fulfil this task, and the organisational commitment to support them. All NHS Trusts must assure that safeguarding is embedded at every level in their organisations.

Vulnerable groups



2.0 Purpose

2.2 This Annual Report Highlights the work undertaken by gesh in respect to its commitment and responsibilities in maintaining the safety and protection of those in at risk of abuse and neglect.

2.3 The purpose of this paper is to provide assurance that gesh is compliant with statutory requirements detailed in legislation, including Section 11 of The Children's Act (2004), Working Together to Safeguard Children (2023), The Care Act (2014), Mental Capacity Act (2005), Domestic Abuse Act (2021).

2.4 The report includes information on safeguarding services across the Group.

gesh Safeguarding Services



2.5 Gesh provides Looked After Children services for the London Boroughs of Wandsworth and Sutton. Each of these services produce a separate annual reports.

3.0 Safeguarding Governance

3.1 Safeguarding Governance Arrangements

3.1.1 Governance and oversight of gesh safeguarding responsibilities has been held in Site Safeguarding Committees, chaired by the Site Chief Nurses or their delegates.

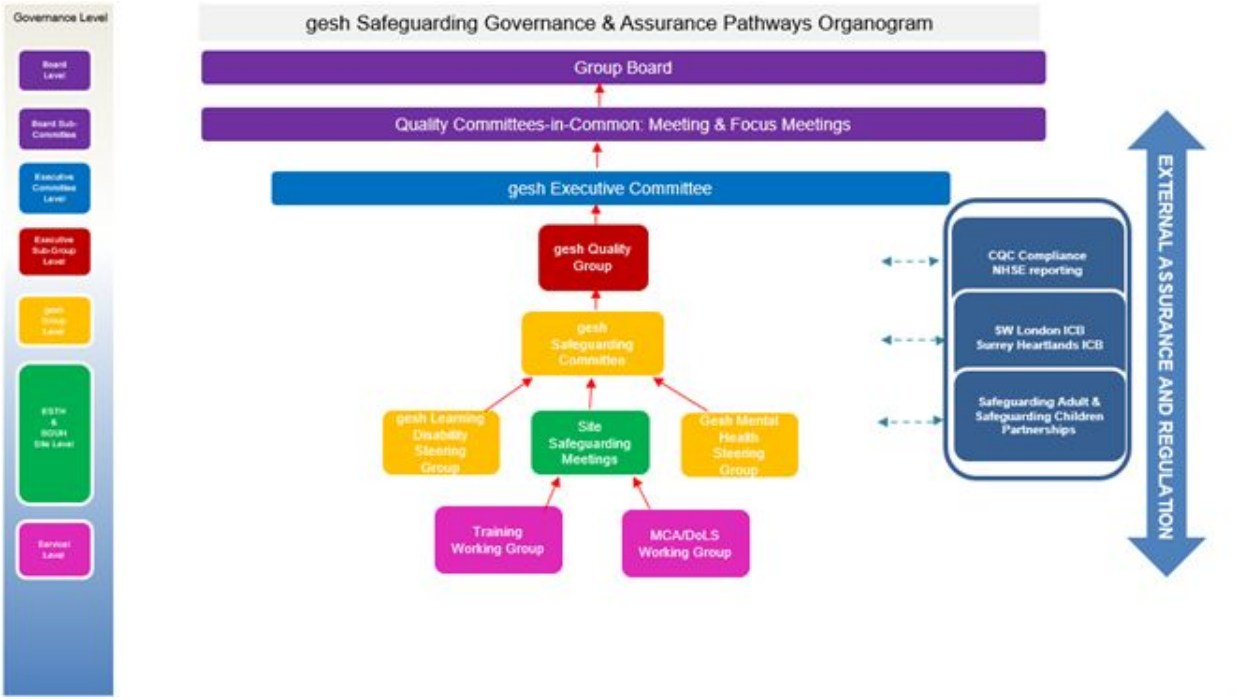
3.1.2 In January 2025 a Group Safeguarding Committee was established, chaired by the Group Chief Nursing Officer (GCNO). The Site meeting terms of reference were updated to become Site Operational Meetings, reporting to the Group Committee.

3.1.3 The Site Operational Meeting and Group Committee meet quarterly to ensure that safeguarding commitments and responsibilities are fulfilled. The Clinical Divisions attend the site meetings and provide information on safeguarding risks in their areas.

3.1.4 The South West London Integrated Care Board (ICB) Designated Safeguarding Professionals Attend the site meetings and the Directors of Quality attend the Safeguarding Strategy Committee, Giving them oversight of the Group's safeguarding activity.

3.1.4 Moving forward, working groups for training and MCA/DoLS will report progress to the Site Safeguarding Meetings, and Learning Disability and Mental Health Steering Groups will report to the Safeguarding Committee.

Safeguarding Governance Organogram



Safeguarding Committee responsibilities

	Responsibilities	Mechanism
1	Assurance:	• Providing assurance to the Group Board on safeguarding standards and improvements. • Advising the Group Executive and the Site Leadership teams on all aspects of safeguarding. • Securing appropriate arrangements for the delivery of high-quality safeguarding practice. • Ensuring commitment from Site Leadership teams, Group Executive, and Group Board. • Monitoring and reviewing compliance with statutory regulations and responsibilities.
2	Monitoring and reporting:	• Regularly reviewing safeguarding performance data and compliance reports. • Strengthening the performance and management of safeguarding concerns across the Group providing assurance to the Site Leadership teams that safeguarding policies and processes are being adhered to.

3	Risk Assessment:	• Identifying and mitigating safeguarding risks. • Developing and reviewing a Group safeguarding risk register with escalation of site and Group safeguarding risks.
4	Policy Oversight:	• Reviewing and approving safeguarding policies and procedures.
5	Training and Awareness:	• Oversight of the delivery of the Safeguarding Training Strategy, including regular review of the Training Needs Analysis and training content against national guidance. • Quality assurance of training delivery. • Ensuring areas of training compliance concern are monitored by respective site leads.
6	Quality Improvement:	• Agreement and oversight of an annual safeguarding audit programme; this will be both site and Group specific.
7	Investigations and Reviews:	• Ensuring thorough responses to safeguarding incidents and learning from them. • Participating in and holding oversight of national and local safeguarding reviews and providing assurance on the implementation of action plans and learning. • Participate in and monitor safeguarding enquiries relating to gesh services and ensure lesson are disseminated and learning embedded.
8	Liaison and Partnership:	• Working with place-based Safeguarding Children and Safeguarding Adult Partnership and with ICB colleagues to ensure coordinated and responsive safeguarding approaches.
9	Making Safeguarding Personal:	• Ensuring that the person is at the centre of safeguarding work through; involvement, choice, and focus on the outcomes the person wants.

3.2 Reporting

3.2.1 The following tables detail internal and external reporting arrangements

gesh reporting arrangements

Reporting to	Frequency	Content	Method
Safeguarding Site Operational Meetings **Safeguarding Committee**	Quarterly	• Mandatory training and supervision performance • Updates on partnership working • Safeguarding activity • Policy development • Audit planning • Risk management	Site-level report
Quality Group **Quality Committee**	6 monthly	Oversight report: • Risks • Policy	Overview report

		• Audit	
Nursing Midwifery & AHP Board (SGH) **NMEC (EStH)**	Quarterly	Oversight report: • Risks • Policy • Learning review feedback	Nurse/AHP focused presentation

External reporting arrangements

Reporting to	Frequency	Content	Method
NHSE **ICB**	Annual	Safeguarding Accountability and Assurance Framework • Quarterly updates where we are not meeting assurance	NHSE Data Collection Framework
Local Safeguarding Children Partnerships • **Wandsworth** • **Merton** • **Sutton** • **Surrey Heartlands**	Quarterly	Hospital and local authority data: • Borough level data on hospital attendance • Safeguarding assurance and activity	Site-level report
Safeguarding Adult Boards • **Wandsworth** • **Merton** • **Sutton** • **Surrey Heartlands**	Quarterly	Hospital and local authority data: • Borough level data on hospital attendance • Safeguarding assurance and activity	Site-level report

3.2.2 Safeguarding Accountability and Assurance Framework

The Safeguarding children, young people and adults at risk in the NHS: safeguarding accountability and assurance framework (SAAF) sets out the safeguarding roles and responsibilities of all individuals working in providers of NHS-funded care settings and NHS commissioning organisations. **Appendix 1**

3.2.3 In October 2024, the National Safeguarding Steering Group (NSSG) changed safeguarding reporting in the following ways:

- The Safeguarding Commissioning Assurance Toolkit (SCAT) data collection was previously submitted by ICBs and is now collected by NHSE directly from providers.
- The quarterly Prevent data collection was simplified following Home Office and DHSC approval with the intention of focusing on staff training needs only.
- The Looked After Children quarterly collection was simplified and submitted to NHS England directly from providers.

3.2.4 Action was taken over the year, and gesh is fully compliant with all elements of the SAAF except for:

1. the requirement to for a Designated Dr for Looked After Children for Wandsworth Looked After Children.
    a. This role has been difficult to recruit to and remains on the Divisional and ICB risk registers.
2. safeguarding supervision for adults and children.

a. A new supervision policy and implementation plan is in development, with a more flexible approach to delivering supervision.

3.3 Statutory Roles

3.3.1 The **Chief Executive** of holds overall responsibility for safeguarding children, young people, and adults at risk

3.3.2 Group Chief Nurse - Executive Lead for safeguarding
Responsibilities include:

- Providing strategic leadership on all aspects of the Group's contributions to safeguarding
- Ensuring the Group is represented at Local Safeguarding Adult and Children's Partnerships
- Ensuring that appropriate safeguarding processes are in place, complying with all legal, statutory, and best practice requirements.

3.3.3 Lead adult and child safeguarding professionals

- Named Doctor for Safeguarding Children
- Named Nurse for Safeguarding Children
- Named Midwife
- Named Nurse for Children Looked After
- Named Doctor for Children Looked After
- Named Lead for Safeguarding Adults, Prevent & MCA

3.4 Safeguarding Service

3.4.1 The gesh safeguarding team has undergone significant change during 2024/25 as part of the reconfiguration of corporate nursing services across the Group. A Director of Safeguarding position has been established, and roles developed to support Group and site leadership.

3.4.2 The team have experienced high staff shortages over the year, and it is hoped that the development of Group-wide leadership, processes and reporting will support team stability. Further work is underway to maximise the opportunities offered by work across the Group. **Appendix 2: Team structure**

3.4.3 Shanique Morgan, Domestic Abuse Clinical Nurse Specialist, and Anne-Marie McEntee, Head of Adult Safeguarding were finalists in the 'Dr Isabel Gal Award for Patient Safety' at the gesh CARE Awards. Anne-Marie was the winner of the award for her work with vulnerable adults at ESTH.

The safeguarding team collaborates to



3.5 Safer Recruitment

The Trust has a legislative requirement to request barring checks to be conducted for employees working in a regulated activity under the Protection of Freedom's Act 2012. There was an increase in DBS numbers at SGH mid-year due to the TUPE of staff within the Corporate integration process.

4.0 Safeguarding Assurance

4.1 Safeguarding Policies

4.1.1 A Group-wide safeguarding policy tracker has been compiled to identify and prioritise policies that need to be updated. Where there are policies in one part of the Group that are in date, they are being reviewed for suitability across all sites.

4.1.2 The following safeguarding policies have been updated and will be implemented Group-wide:

- Managing Allegations Against Staff Policy
- Safeguarding Children Policy
- Was Not Brought/Unseen Child Policy

4.2 Training

4.2.1 Safeguarding training is guided by the Intercollegiate Documents published by the Royal College of Nursing on behalf of multiple stakeholders. These documents outline the roles and responsibilities associated with safeguarding and specify the level of training required for various positions.

4.2.2 Each level of training mandates that staff complete a minimum number of training hours over a three-year period. These training hours can be fulfilled through a variety of different training interventions.

Training requirements – Safeguarding Children

Level	Staff Group	Method
Level 1	All staff	Mandatory e-learning
Level 2	Clinical and non-clinical staff who have contact with children, young people or their parents/carers	e-learning via the national programme
Level 3	All clinical staff who are working with children and young people and who could potentially contribute to assessing planning intervening and evaluating the safeguarding needs of a child and their families.	Blended face to face/virtual and e-learning
Level 4	Named Professionals and safeguarding specialists	This is usually multi-agency
Board	Executive members and Non-Executive Board members	Mandatory e-learning plus Board specific information

Training requirements – Safeguarding Adults & MCA

Level	Staff Group	Method
Level 1	All staff	Mandatory e-learning
Level 2	All staff who have regular contact with patients, their families or carers, or the public	e-learning via the national programme

Level 3	All staff who engage in assessing, planning and intervening and evaluating the needs of adults where there are safeguarding concerns.	Blended face to face/virtual and e-learning
Level 4	Named Professionals and safeguarding specialists	This is usually multi-agency
Board	Executive members and Non-Executive Board members	Mandatory e-learning plus Board specific information

4.2.3 Training Compliance

A Safeguarding Training Working Group has been established with a focus on updating the content and delivery of safeguarding adult and safeguarding children level 3 training. Training materials are being made available on e-learning platforms to support a more flexible offer.

4.2.4 Reporting on Safeguarding Adult Level 3 training at SGH has remained challenging and we are working with the MAST with the aim of providing Divisional level trajectories for improvement.

Safeguarding Adults Training Compliance

Training - Target 85%		Q1	Q2	Q3	Q4
SGH					
Safeguarding Adults	Level 1	90.6	90	89	90.7
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Oliver McGowan	Level 1	78.9	82.5	85.1	90
ESTH					
Safeguarding Adult	Level 1	84.7	86	86.4	86.1
	Level 2	90.4	90.7	89.1	90.4
	Level 3	55.1	60.4	60	59.2
Prevent	Level 1/2	88.9	89.2	86.4	86.1
	Level 3	80.4	90.2	89.1	90.6
Oliver McGowan	Level 1	74.3	82.5	83.8	85.2

Safeguarding Children Training Compliance

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Children	Level 1	88.7	89.2	89.1	89.1
	Level 2	88.5	88.9	87	87.5
	Level 3	82.8	82.2	80.4	76.9

4.2.5 A working group is producing a renewed Level 3 training offer, with a reduced expectation of face to face training and a review of the Training Needs Analysis to create a targeted and flexible offer.

4.2.6 Bespoke training has been developed for groups of staff e.g., training to medical colleagues in the Emergency Department at ESTH, and training for anaesthetists at SGH.

4.3 Supervision

4.3.1 Supervision is a supportive mechanism for staff which promotes staff well-being and is particularly useful when managing challenging cases. gesh recognises that safeguarding supervision is integral to providing an effective person/child centered service and that it has a responsibility to ensure that appropriate staff receive and deliver supervision on a regular basis.

4.3.2 Good quality supervision can help to:

- keep a focus on the child, young person, or adult at risk.
- avoid drift.
- help ensure that practice is soundly based and consistent with the relevant Safeguarding Children Partnership, Safeguarding Adults Board, and organisational procedures.
- ensure that practitioners fully understand their roles, responsibilities and the scope of their professional discretion and authority.
- help identify the training needs of practitioners, so that each has the skills to provide an effective service.
- maintain a degree of objectivity and challenge fixed views.
- evaluate and assess the evidence base for assessment and decisions.
- address the emotional impact of work.

4.3.4 The Safeguarding Supervision Policy is under review and will provide guidance for work with children and adults at risk of abuse or neglect. The new offer will be more flexible and allow clinicians to use existing meetings and processes to evidence supervision.

4.3.5 During 2024/25 the ESTH team established a supervision delivery plan which will be extended across the Group this year. The ability to ‘passport’ multi-agency working and activity to evidence supervision will be developed and will support reporting moving forward. **Appendix 3: Safeguarding Children Supervision Delivery Plan**

4.3.6 A recurring theme that has emerged from supervision sessions is the discomfort some practitioners experience when faced with having difficult or sensitive conversations, particularly in the context of safeguarding concerns. This hesitation can sometimes act as a barrier to effective information gathering, risk assessment, and timely intervention.

4.3.7 In response, some of the supervision sessions have been intentionally structured to create a safe and supportive environment for staff to explore these challenges through practical exercises. Role play and scenario-based discussions have been integrated as valuable tools to help practitioners develop confidence in using professional curiosity and asking difficult, but necessary, questions. These exercises allow clinical staff to rehearse language, consider different approaches, and reflect on real or hypothetical case examples in a guided, non-judgemental setting.

4.4 Manging Allegations Against Staff

4.4.1 The Trust has a statutory duty to investigate allegations against staff working with children and with adults at risk. This includes activity relating to a staff member's conduct in their personal as well as their professional life.

4.4.2 The Managing Allegations Policy applies when it is alleged that a person who works with children or any adult at risk has:

- Behaved in a way that has harmed a child/adult at risk or may have harmed a child/adult at risk.
- Possibly committed a criminal offence against or related to a child/adult at risk.
- Behaved towards a child or children/adult at risk in a way that indicates they will pose a risk of harm if they work regularly or closely with children/adults at risk.
- Behaved or may have behaved in a way that indicates they may not be suitable to work with children/adults at risk.

4.4.3 Managing allegations against staff is a complex and sensitive area of the Trust's work, requiring a thorough process that involves close collaboration between the Human Resources department and the safeguarding team, as well as, when applicable, temporary staffing, the police and local authorities. The response to an allegation will vary according to the nature of the allegation and may include referral to the police, local authority and/or professional body.

4.4.4 The gesh Managing Allegations process has clear senior oversight from the GCNO and CMOs/Responsible Officers. Confidential records of allegations are held by Employee Relations and oversight of the process is held by senior members of the safeguarding team.

Allegations Against Staff

SGH	Q1	Q2	Q3	Q4	Totals
Children	0	0	0	0	0
Adults	2	1	4	2	9
ESHT	**Q1**	**Q2**	**Q3**	**Q4**	**Totals**
Children	1	0	1	1	3
Adults	3	3	1	3	10

4.5 FGM Mandatory Reporting

4.5.1 Female Genital Mutilation (FGM) is illegal in England and Wales under the FGM Act (2003). It is classified as a form of child abuse and violence against women.

4.5.2 Regulated health professionals in England and Wales are required to report any known cases of FGM in individuals under 18 that they identify in the course of their professional work to the police.

4.5.3 During the year 2024/25, There was 1 referral for individuals under the age of 18 across the Group.

FGM Reporting

SGH	Q1	Q2	Q3	Q4	Totals
Disclosures			18	27	45
Reportable disclosures	0	0	0	1	1
ESTH	**Q1**	**Q2**	**Q3**	**Q4**	**Totals**
Disclosures	8	5	3	5	21
Reportable disclosures	0	0	0	0	0

4.6 Prevent

4.6.1 The Prevent Duty, established under the Counter-Terrorism and Security Act (2015), mandates that all specified authorities give “due regard to the need to prevent people from being drawn into terrorism.” Under this Duty, NHS organisations are required to provide appropriate training, ensuring

staff are aware of Prevent and radicalisation, and can recognise the vulnerabilities that may lead to a person becoming radicalised.

4.6.2 There is online training which ensures that staff are aware that Prevent activity is not exclusive to adherents of any specific religion or ideology and highlights the growing importance of the far-right terrorist threat. Quarterly Prevent return are made to NHS England as part of the national assurance programme. The Safeguarding team also attend the NHS England Safeguarding Adult Prevent Provider Forum on a quarterly basis.

4.6.3 The principal reference to the NHS in the Government's updated Counter Terrorism Strategy, Contest: Home Office (June 2018) refers in the main to Mental Health services but Prevent nonetheless remains an important area of the Trust's work. The Group made no Prevent referrals during 2024/25.

4.7 Modern Slavery

4.7.1 The NHS has a significant role in addressing modern slavery, encompassing both preventing it in its own operations and supply chain and supporting potential victims. This duty includes ensuring compliance with the Modern Slavery Act (2015), implementing robust risk assessments and fostering a culture where staff are empowered to report concerns.

4.7.2 Where possible Modern Slavery is identified, referrals are made through the National Referral Mechanism, a framework for identifying victims of human trafficking or modern slavery and ensuring hey receive appropriate support. The lack of identification of anyone experiencing Modern Slavery at EStHH requires further investigation to ensure that staff have adequate knowledge and skills.

Modern Slavery Referrals

Modern Slavery	Q1	Q2	Q3	Q4	Totals
SGH	0	1	3	1	5
ESTH	0	0	0	0	0

4.8 Audit

Hospital Discharges

4.8.1 The most prevalent theme in safeguarding referrals completed in respect of care and treatment at SGH and ESTH in 2023/24 were related to discharge, and whilst the number of concerns about discharge are relatively low in comparison to the number of people discharge across gesh each day, the impact that a poor discharge can have on a person's health, wellbeing, and life can be significant.

4.8.2 An audit was completed in response to this which identified some good practice across gesh. It was identified that in 100% of the cases audited there was a clearly documented discharge pathway within the records, highlighting good practice in ensuring that the discharge pathway for each patient is clearly defined and documented.

4.8.3 Another area of good practice was the communication with the patient and/or their carer in the discharge process. There was clear documentation within 92.5% of cases within Epsom and St Helier and 88.2% of cases within St George's Trust that the discharge plan had been communicated to the patient and their carer.

4.8.4 The audit identified areas for development. This included use of the Safer Discharge Checklist, and documentation associated with mental capacity and best interest decisions. The audit also incidentally identified areas of development for documentation and record keeping across services and admissions.

4.8.5 An action plan has been developed to address these areas of development.

Action Plan for Hospital Discharge Audit

	Action	Responsible lead	Completion target
1	Safer Discharge poster to be developed and disseminated gesh wide	SGA team	March 2025
2	gesh Safer Discharge Checklist to be implemented via electronic systems	Divisional Leads	June 2025
3	Review of admission documentation to ensure that discharge planning is considered from the point of admission	Fundamentals of care team	December 2025
4	Divisions to develop spot audit program for each area to review the quality of documentation and accuracy of record keeping as per Trust policy	Divisional Leads	December 2025
5	Share findings of the Discharge Audit with Divisional Governance Leads	SGA team	April 2025

TEP plans for patients with a Learning Disability - SGH

4.8.6 An audit of Treatment Escalation Plans (TEP) was undertaken with the following outcome.

TEP review results

TEP review	Q1	Q2	Q3	Q4	Total
Patients with TEP in place	60	13	40	43	**156**
For full resuscitation	43	29	26	27	**125**
DNACPR in place	16	13	13		**42**
DNACPR requiring review due to: • MCA decision for TEP • LD listed as rational for DNACPR	1	0	1	0	**2**
Patients without DNAR/TEP decision		53	88	98	**239**

4.8.7 The LD liaison team continues to work with clinical services and wards to ensure that appropriate discussions, or attempted conversations, with the patient and members of their family, or care workers, are documented.

4.9 Safeguarding Risks

4.9.1 The following safeguarding risks we identified and managed during 2024/25.

Safeguarding risks

SGH		ESTH	
Risk	**Update**	**Risk**	**Update**
2805 Non-compliance with Level 3 Adult safeguarding training			To add to ESTH
2604 Decision making within the MCA legal framework	To redefine the risk for both Trusts		
T2682 non-compliance with Oliver McGowan mandatory training	To agree where this risk should sit: CNO or Education risk register		To add to ESTH

	Not applicable to SGUH	**2168** Safeguarding Team Activity	
	Not applicable to SGUH	**2167** Safeguarding Operational clinical capacity impact ability to fulfil statutory function	Close risk as duplication of 2168
	Not applicable to SGUH	**2166** Management and Strategic oversight of the Children looked after Community CNS team: no Named Nurse	Risk updated with named nurse. Proposal to close risk as fully mitigated

4.9.2 Risks relating to team staffing levels were closed as staff were recruited to the teams. Risks in relation to safeguarding level 3 training and allocation of the Mental Capacity Act are being reworked to better describe the risk and mitigations.

4.9.3 Current risks which have been identified for inclusion in a Group-wide risk register

- iClip implementation in ESTH is creating some difficulties with safeguarding referrals to local authority partners
    - The safeguarding team are mitigating this by reviewing all referrals for accuracy and maintaining close communication with the iClip team and safeguarding partners.
- Quality of DoLS referrals being submitted via the new IClip system is poor and does not contain the information needed for the legal process
    - The safeguarding team are working with clinicians to ensure the correct information is submitted and with nursing and medical leadership to identify learning needs.

4.9.4 The safeguarding team will lead an audit to look at the quality of the Deprivation of Liberty Safeguards process, with a focus on Making Safeguarding Personal, hearing the voice of the person.

4.9.5 A review of incidents relating to patients absconding will be conducted in collaboration with the Associate Director for Mental Health.

5.0 Partnership Working

Safeguarding Partnerships are statutory frameworks that enable local organisations and agencies to collaborate on safeguarding children and vulnerable adults. The partnerships aim to create a coordinated system where all agencies work together to identify, assess and respond to safeguarding concerns.

5.1 Local Safeguarding Partnerships

5.1.1 The safeguarding teams work regularly with four Local Safeguarding Children and four Safeguarding Adult Partnerships, engaging with and attending the following partnerships and sub-group meetings.

Safeguarding Children Partnerships subgroup attendance

Children's	Meeting	Q1	Q2	Q3	Q4
Sutton	Board	X	X	X	X
	Child Safeguarding Practice Review	X	X	X	X
	Quality assurance and Improvement		X		X

	MACE Strategic		X		X
Merton	Quality Assurance & Practice Review	X	X	X	X
	Hub Operations Board Meeting	X	X		X
	Promote and Protect Young People		X	X	X
	Prevention & Early Intervention	X	X		X
Surrey	Training Subgroup		X		X
	Board		X	X	
Wandsworth	Operational working group	X	X	X	X
	Safeguarding Practice Review Group	X	X	X	X
	MASH operational meeting	X		X	X

Safeguarding Adult Partnership subgroup attendance

Adults	Meeting	Q1	Q2	Q3	Q4
Sutton	Safeguarding Adults Board	X	X	X	X
	SAR Subgroup	X	X	X	X
	Performance and Workforce	X	X	X	X
Merton	SGA Board	X	X	X	X
	P&Q subgroup	X	X		X
	SAR subgroup	X	X	X	X
	Learning and Development Subgroup	X	X	X	X
Surrey	Safeguarding Adults Board	X	X		X
Wandsworth	Safeguarding Adults Board	X		X	X
	SAB Community Forum	X	X	X	X
	Performance and Workforce	X	X	X	X

Learning Disability meetings

LD	Meeting	Q1	Q2	Q3	Q4
SWL ICB	LeDeR Governance	X		X	X
	Clinical Reference Group LD/ASD	X		X	X

5.2 Statutory Reviews

5.2.1 Safeguarding Reviews are a mandated process to investigate a serious safeguarding incident or death, particularly where there are concerns that partner agencies could have worked more effectively to protect an adult or child.

5.2.2 The purpose is to learn from the incident, identify areas for improvement in practice and prevent future harm, rather than apportion blame.

5.2.3 The following tables provide an overview of reviews undertaken during the reporting period that involved gesh services.

Safeguarding Children Practice Reviews

Borough	Themes	Learning	gesh Actions	RAG
Sutton	1. Unseen Child 2. Parental age difference, ethnicity and culture 3. Joint working between agencies 4. Neglect 5. Routine enquiry and the impact on children	1. Collaborative working between agencies across boroughs 2. 0-19 service Transfer ins 3. Neglect 4. Invisible fathers/Hidden men	Updated WNB policy. Training	

Safeguarding Adult Reviews

Borough	Themes	Learning	gesh Actions	RAG
Sutton	Self neglect. Impact of Covid 19 on early help. Lack of escalation and partnership working	Legal literacy MCA. Think Family. Team around the person. Trauma informed care	Case studies developed for training	
Surrey	Support for mental health. Suicide prevention. Referrals to adult social care. Impact of ACES.	Suicide prevention to include impact of ACEs	None currently identified.	

Domestic Homicide Reviews

Borough	Themes	Learning	gesh Actions	RAG
Surrey	Interface between agencies / information sharing. Professional curiosity. Impact of Covid 19		DA training	

Surrey	MH, DA, neurodivergence, child to parent violence. Perceived non-engagement.	Think family. Reasonable adjustments	7 minute learning completed. Case study developed for training. Professional curiosity explored in training. Reasonable Adjustments flag.	

6.0 Safeguarding Activity

6.1 Safeguarding Children

6.1.1 Safeguarding children is the action taken to promote the welfare of children and protect the From harm and is everyone's responsibility. Safeguarding and promoting the welfare of children can Be defined as:

- protecting children from maltreatment
- preventing impairment of children's health or development
- ensuring that children grow up in circumstances consistent with the provision of safe and effective care; and
- taking action to enable all children to have the best outcomes

6.1.2 Clinicians working directly with children are responsible for gathering information and communicating safeguarding concerns directly to the local authority via the multi-agency safeguarding hub. The safeguarding team are an advisory service, supporting clinicians with professional curiosity, documentation of concerns, statutory duties such as referrals, conference reports, supervision and training and escalation of families where it is felt that the multi-agency response is insufficient.

6.1.3 The safeguarding team supports clinicians with case management for children admitted to hospital (including long stay ED patients) with safeguarding concerns, frequent attenders to the EDs, children under community services requiring case escalation and adults in the hospital where there are concerns for children under their care.

6.1.4 SGH Emergency Department activity

SGH Reason for attendance at ED

ED Attendance	Q1	Q2	Q3	Q4	Total
Child subject to a Child Protection Plan	30	34	34	32	**130**
Child Looked After	89	65	71	55	**280**
Bullied or assaulted	48	46	44	60	**198**
Self-harm	59	25	41	41	**166**
Attempted suicide	26	15	24	22	**87**
Alcohol/drug misuse	19	20	35	21	**95**
Adults (who care for children) with domestic abuse	28	23	11	15	**77**
Adults (who care for children) with mental ill-health	25	64	44	40	**173**
Adults (who care for children with substance misuse)	13	18	19	14	**64**

6.1.5 Parental and children's/young people's mental health continues to be the leading reason for safeguarding referrals, with a high volume of cases involving self-harm, low mood, suicidal ideation, and suicide attempts. These complex presentations highlight the growing mental health needs of both children and their families and the associated safeguarding risks.

6.1.6 In response, we maintain close collaboration with our mental health colleagues across Southwest London and Surrey to ensure robust, safe discharge planning and to escalate concerns when necessary. Despite this, we continue to encounter challenges relating to delayed discharges, largely due to the complexity of cases and the limited availability of appropriate specialist provisions.

RedThread

6.1.7 RedThread is a youth work charity providing support to young people with a range of vulnerabilities. RedThread's Youth Violence Intervention Programme is funded by The Mayor's Office of Policing and Crime, and several trusts and foundations. They also partner with SOLACE domestic abuse charity to provide a youth Independent Domestic Abuse Advisor (IDVA) who works with young women affected by domestic violence, and a Comic Relief funded young women's worker who supports young women affected by gang activity.

6.1.8 Whilst RedThread has developed a significant public profile in respect of their work in relation to Knife crime, and this forms an important part of their work at SGH, they work with young people aged 11-25 attending SGH for any reason associated with youth violence including domestic violence, Sexual violence, exploitation, and non-weapon related assaults.

6.1.9 The team work proactively and flexibly with young people who have been admitted to SGH and Seek to make use of the 'teachable moment' when a young person is hospitalised, to co-produce a Longer term intervention with them.

SGH Inpatient activity

6.1.10 The Children and Young People's Safeguarding CNS team continue to be visible and accessible, aiming to create a culture of psychological safety for staff to raise concerns. The team act as an advisory service for clinicians across the trust, frequently contacted for safeguarding advice via email, telephone and our bleep system. The Safeguarding CNS's assist in the co-ordination of inpatient cases where there are acute safeguarding concerns in partnership with the clinical team responsible for the child's care.

SGH Inpatient Safeguarding Activity

	Q1	Q2	Q3	Q4	Total
Total: CYP admissions with safeguarding concerns (including injured children)	55	29	76	58	218
CYP admitted to hospital with an injury	20	4	12	4	40
Referrals to CSC (excluding notifications for children/young people already known)	32	26	25	20	103
CYP admissions for children on CPP *	4	1	6	3	14
CYP referred to CAMHS & safeguarding concerns*	9	2	3	4	18

SGH Primary admission reason for CYP with safeguarding concerns

	Q1	Q2	Q3	Q4	Total
Medical (physical health)	21	7	42	16	**86**
Major Trauma	13	3	9	15	**40**
Injury	7	2	2	4	**15**

Mental Health (including behavioural change)	9	2	3	5	**19**
Elective Surgery	1	4	2	0	**7**
Emergency Surgery	1	1	6	3	**11**
Neonatal Admission	2	5	8	6	**21**
Suspicion of NAI	1	0	2	1	**3**

SGH Primary safeguarding concern for inpatient safeguarding

	Q1	Q2	Q3	Q4	Total
Physical Abuse	14	7	8	13	**42**
Emotional Abuse inc DA	10	3	9	2	**24**
Care & Support – requires care package or placement	8	4	6	3	**21**
Neglect	7	5	30	12	**54**
Care & Support, - Disabled Child	7	4	4	1	**16**
Contextual Harm	4	2	2	5	**13**
Major Trauma – Injury Severity	3	1	3	6	**13**
Adult Patient unable to care for child	1	1	1	2	**5**
Environmental – Housing	1	2	2	1	**6**

6.1.11 It should also be noted that the highest themes of neglect and physical abuse are in line with national statistics. NSPCC note that for neglect, research suggests around 1 in 10 children in the UK have been neglected around 1 in 14 children in the UK have been physically abused.

ESTH Emergency Department Activity

ESTH Reason for ED Attendance

	Q1	Q2	Q3	Q4	Total
Bullied or assaulted	20	24	26	29	**99**
Self Harm	24	37	46	48	**155**
Attempted suicide	24	37	75	56	**192**
Drug/alcohol misuse	31	41	38	40	**150**
Domestic Abuse	17	20	20	19	**76**
Adults (who care for CYP) with MH	68	135	126	128	**457**
Adults (who care for CYP) with substance	56	56	39	46	**197**

ESTH Total Safeguarding Referrals

	Q1	Q2	Q3	Q4
Sutton	238	247	280	**284**
Surrey	150	229	255	**264**
Merton	51	74	80	**56**
OOA	94	70	49	**64**
Info. Sharing	656	672	806	**718**
Total	1189	1292	1470	**1386**

6.1.12 The safeguarding team review all paediatric ED attendances to ensure appropriate referrals are made and have identified numerous missed referrals or actions. Data has been collated from July 2024 and is used to inform discussion at ED liaison meetings.

6.1.13 There continues to be a concerning number of missed referrals and incomplete information-sharing forms that should be submitted to Children's Social Care. These gaps in documentation and communication present a potential risk to timely safeguarding responses and coordinated multi-agency working.

ED spreadsheet Triaging: Identified Missed actions and Liaison

	Q1	Q2	Q3	Q4	Total
Children looked after (CLA) Liaison		34	33	16	**83**
Missed ED SN/HV Liaison (Health)		114	122	87	**323**
Missed ED info share to CSC		52	68	64	**184**
Missed ED Safeguarding Referrals		20	43	38	**101**
Specialist Teams Liaison		48	49	48	**145**
Education DSL Liaison		6	16	11	**33**
Elective Home Education		31	23	31	**85**
Drugs and Alcohol		3	2	1	**6**

6.1.14 To address this issue and reinforce our internal safeguarding procedures, a Standard Operating Procedure (SOP) has been developed. This SOP clearly outlines the processes and expectations of when a referral or information sharing form needs to be completed dependant.

6.1.15 Safeguarding checklists are embedded at both triage and prior to discharge to prompt clinicians to consider safeguarding throughout the child's journey through the emergency department. There are information sharing prompts within adult EDs to ensure practitioners 'Think Family' and to see the child behind the adult.

6.1.16 It was identified that not all 16–17-year-olds being seen in the adult EDs are being triaged with a paediatric casualty card, which supports with ensuring clinicians 'think safeguarding' and complete the safeguarding checklist when required. This has been an ongoing focus within our weekly ED safeguarding meetings.

6.1.17 Weekly Safeguarding Meeting The Epsom Safeguarding Meeting was temporarily stepped down to allow for review of its structure, purpose, and effectiveness with consideration is given to replicating the model used successfully at St Helier Hospital.

6.1.18 By mirroring this model, the aim is to strengthen the Epsom meeting's function as a space for reflective practice, complex case discussion, and inter-professional collaboration. The revised structure is expected to improve engagement, consistency, and clarity of purpose, ultimately supporting more robust safeguarding responses across the site.

ESTH Inpatient activity

6.1.19 The team leads the coordination of inpatient safeguarding cases, working in close partnership with the clinical teams responsible for each child or young person's care. A key priority is to build clinical staff capacity and confidence in managing safeguarding cases independently. This approach aims to empower staff to address safeguarding challenges effectively and to foster a proactive, supportive environment for safeguarding care.

6.1.20 There has been a noticeable rise in cases where the safeguarding concerns for children have originated due to the admission of a parent to an adult ward. In several instances, the Children's Safeguarding Team has had to step in and take the lead in managing these concerns, particularly when the adult's physical or mental health has significantly affected their ability to care for their

children. This highlights the critical need for a more integrated and proactive approach within adult services, to ensure that the needs of children are not overlooked, and that early support is offered to prevent escalation.

6.1.21 By embedding the "Think Family" approach, we aim to promote better outcomes for families, improve communication and collaboration between adult and children's services, and ensure that safeguarding is a shared responsibility across all teams involved.

ESTH Inpatient activity

	Q1	Q2	Q3	Q4	Total
CYP admissions with safeguarding concerns	23	14	21	16	**74**
CYP admitted to hospital with an injury	4	3	5	3	**15**
CYP referred to CAMHS & safeguarding concerns	33	32	34	40	**139**
Referrals completed by Ward	55	29	52	63	**199**

6.1.22 There continues to be a high number of children admitted to paediatric wards due to mental health concerns, with a significant proportion presenting with issues such as self-harm and suicide attempts.

6.1.23 In addition, there has been a sustained pattern of frequent attendance and prolonged admissions among Children Looked After (CLA). These cases are further complicated by the 6.1.24 nationally recognised shortage of suitable placements, which continues to pose significant challenges. The lack of appropriate and timely placement options often results in extended hospital stays, which can negatively impact the emotional and psychological wellbeing of this already vulnerable group.

6.2 Community Services - Children

6.2.1 Sutton children's community services are provided by Sutton Health & Care (SH&C), a provider alliance, formed of partnerships between London Borough of Sutton, ESTH, Sutton Primary Care Networks and South West London & St George's Mental Health Trust. and care partnership providing community health and sexual health services in Sutton. The children's services provided by SH&C are:

- Children's therapies
- Health visiting
- School nursing
- Special Needs School Nursing
- Children's continence service
- Children Looked After

6.2.2 Safeguarding training and supervision to these services is delivered by and 'in house' Safeguarding team employed by London Borough of Sutton. They have experienced long periods of Named Nurse absence and plans are in place to offer specialist support to the team from the gesh Group team. Safeguarding performance reporting happens via SH&C arrangements, with monthly and quarterly reporting on training, supervision and safeguarding activity.

6.2.3 The SH&C safeguarding team have robust relationships with the Sutton Children's First Contact Service, and the team has oversight of referrals into the Multi-agency Safeguarding Hub (MASH). Twice weekly meetings are taking place in relation to the numbers of domestic abuse referrals that fall outside of the MARAC process, where there is SH&C safeguarding attendance. The team also attend

the Multi Agency Child Exploitation (MACE) panel and a monthly MDT with the ESTH maternity team to discuss vulnerable families.

6.2.4 Supervision compliance has remained high across the year, with supervision offered to:

- Health visiting
- Infant feeding
- School nursing
- Children's nursing
- Team leaders
- SLT
- OT
- Physio
- Dietician
- Special school health teams
- Sexual health services

6.2.5 SH&C were commissioned to deliver children's nursing services to Greenmead and Perseid special schools in Wandsworth and Merton. Safeguarding supervision for SH&C teams in these schools is provided by the gesh safeguarding service.

6.3 Safeguarding Adults

6.3.1 Safeguarding duties apply to an adult who:

1. Has need of care and support (whether or not the Local Authority is meeting any of those needs).
2. Is experiencing, or at risk of abuse or neglect: and
3. As a result of those care and support needs, is unable to protect themselves from either risk of, or the experience of abuse and neglect.

6.3.2 The safeguarding adults team work together to:

- Ensure the Trust has safeguarding arrangements in place as defined by the Care Act (2014)
- Ensure that the process of protecting adults with care and support needs is integral to all health care provision within the Trust
- Ensure that 'making safeguarding personal' is central to the way the SGH staff respond to people with care and support needs who may be in vulnerable circumstances and at risk of abuse or neglect by others
- Implement national and local guidance to safeguard adults and play an integral part in the Wandsworth and Merton Safeguarding Adults' Boards
- Ensure SGH is compliant with its duties towards people under the statutory legislation including the Mental Capacity Act (MCA) 2005 and Care Act (2014)

6.3.3 During the year, Standard Operating Procedures have been reviewed and updated for each work area within the team (adult safeguarding, domestic abuse and FGM, mental capacity).

Referrals to the SGH safeguarding adults team

Borough where abuse or neglect reported to have taken place	Q1	Q2	Q3	Q4	Total
Wandsworth	115	133	134	165	**547**
Merton	36	55	65	61	**217**

Lambeth	19	14	21	20	**74**
Croydon	15	10	26	14	**65**
Sutton	12	11	15	15	**53**
Surrey	6	8	3	13	**30**
Kingston	3	9	9	7	**28**
Richmond	2	5	1	1	**9**
Other boroughs	8	20	14	15	**57**
Total	**216**	**265**	**288**	**311**	**1080**

Types of abuse reported to SGH Safeguarding Team

Type of abuse	Q1	Q2	Q3	Q4	Total
Neglect – discharge concerns	6	5	7	9	**27**
Neglect – absconding	0	2	3	4	**9**
Neglect – pressure ulcer	12	18	19	20	**69**
Neglect – All other types	46	45	34	52	**177**
Sexual abuse	1	2	3	3	**9**
Emotional/psychological	1	5	2	2	**10**
Information and Advice	58	81	90	109	**338**
Financial	17	30	20	18	**85**
Self-neglect	29	33	45	48	**155**
Domestic abuse	35	22	34	25	**116**
Physical	11	15	23	17	**66**
Other	0	7	8	4	**19**
Total	**216**	**265**	**288**	**311**	**1080**

6.3.4 the most common referral type received in were referrals for information and advice. Some examples of these referrals include:

- requests for assessments for care packages
- requests for housing support
- requests for Mental Health Act assessments and/or mental health crisis support
- requests to support with making DWP applications
- requests for support when main carer has been admitted to hospital and the cared for person is in the community
- support with Police contact
- support with contact Local Authority colleagues
- case discussion

6.3.5 The adult safeguarding team have worked over the year to educate Trust staff in adult safeguarding and when referrals are more appropriate for other teams. The training offer, increased visibility on the ward areas, and consistent messaging from the team will result in increased knowledge within clinical areas and a reduced reliance on the specialist liaison team.

Types of abuse reported to ESTH Safeguarding Team

Type of abuse	Q1	Q2	Q3	Q4	Total
Neglect – discharge concerns	1	4	2	2	9
Neglect – absconding	12	8	8	10	38
Neglect – pressure ulcer	20	30	18	31	99

Neglect – All other types	57	49	73	79	258
Sexual abuse	3	9	8	4	24
Emotional/psychological	16	12	10	7	45
Information and Advice	12	31	78	1	122
Financial	10	16	9	18	53
Self-neglect	87	87	84	76	334
Welfare Concern	70	64	32	33	199
Physical	54	51	31	33	169
Other categories	169	179	203	210	761
Total	558	592	556	539	2245
Domestic abuse	51	52	57	48	208
Total	558	592	556	587	2453

Complexity and Acuity

6.3.6 Alongside the very high numbers of safeguarding concerns, the intensity and complexity of some presentations is increasing. With significant psychosocial and community pressures, system issues and cost of living crisis, many of our population have had issues in accessing or staying in touch with relevant services. Concerns regarding independence and or autonomy are also high. This means that people may present later, or with more complex needs requiring a multi-agency response and negotiation, highly complex risk management and mitigation plans and potential for extended length of stay.

Concerns about our care

6.3.7 Neglect and self-neglect continue to be the areas of greatest concern regarding adult patients attending all sites. This is informing the training programmes, including additional work on understanding mental capacity in the context of self-neglect. Details of the numbers of people attending who are experiencing abuse can be found in the Site Safeguarding Reports.

6.3.8 Additional information is being shared with clinical teams including signposting to learning and training provided by the Local Safeguarding Partnerships.

Concerns raised regarding care at SGH

Type of abuse	Q1	Q2	Q3	Q4	Total
Neglect: Discharge related	6	5	4	8	23
Neglect: Pressure area	4	12	11	15	42
Neglect: Absconding	0	2	3	3	8
Neglect: other	1	2	6	8	17
Sexual abuse	0	1	1	0	2
Emotional	0	0	1	1	2
Financial	0	1	0	0	1
Physical	2	2	4	5	13
Discriminatory	0	0	1	0	1
Total	**13**	**25**	**31**	**40**	**109**

Outcomes following investigation

	Q1	Q2	Q3	Q4	Total
Substantiated	5	4	1	2	**12**

Not substantiated	2	6	5	17	**30**
Ongoing	19	25	27	19	**90**
Threshold not met	10	15	24	32	**81**

Neglect: Pressure area

6.3.9 The number of concerns reported about pressure ulcers acquired within SGH has increased significantly throughout the year. The concerns raised relate to multiple clinical areas. Work is being led by the Deputy Chief Nurse and Fundamentals team to address the increase. However, it should be noted that, following investigation, the majority (66.7%) of the safeguarding concerns reported about pressure ulcer development within the Trust were closed with no evidence of abuse or neglect occurring.

6.3.10 The adult safeguarding team have recommenced attendance at the internal Pressure Ulcer Prevention Steering Group and have plans to work with the TVN service in identifying ways to ensure that body maps and appropriate skin checks are completed when patients arrive within a clinical area of the Trust.

Neglect: Discharge related

6.3.11 The nature of the concerns from this quarter relate to patients being discharged from St George's University Hospital NHS Trust without appropriate community referrals. Of the 8 concerns reported in Q4, 5 were closed at screening with no indication of abuse or neglect from the Trust. The team are continuing to liaise with clinical teams and the Local Authority to determine whether the 3 remaining concerns will progress to a Section 42 Enquiry or be closed at screening.

Concerns regarding care ESTH care

Type of abuse	Q1	Q2	Q3	Q4	Total
Neglect: Discharge related	6	9	9	8	**24**
Neglect: Pressure area	4	3	1	0	**8**
Neglect: Absconding	4	0	1	0	**5**
Neglect: other	7	9	5	4	**25**
Sexual abuse	0	1	1	1	**3**
Emotional	0	0	0	0	**0**
Financial	1	0	0	0	**0**
Physical	3	3	0	0	**6**
Total	**25**	**25**	**17**	**13**	**66**

Outcomes following investigation

	Q1	Q2	Q3	Q4	Total
Substantiated	14	16	10	9	**49**
Not substantiated	1	3	2	2	**8**
Ongoing	7	4	1	2	**14**
Threshold not met	3	2	4	0	**9**

6.3.12 The 13 concerns that progressed to a Section 42 Enquiry all relate to the Medicine Directorate. The Clinical Quality Safeguarding Matron continues to provide support to the wards in managing and collating information to respond to concerns and Section 42 Enquiries.

6.3.13 After a break due to vacancies and changes in social care, weekly meetings with the Sutton and Surrey Safeguarding Teams to review concerns have re-commenced. During the weekly

meetings the team are able to review medical records and Datix's and close concerns with any learning shared with the Divisions by the team or the Clinical Quality Safeguarding Matron for medicine

6.3.14 There were considerably more safeguarding concerns substantiated at ESTH than at SGH. The team will look at the concerns to establish whether this is due to e.g., poorer adherence to safer discharge processes, or whether the local authorities where the hospitals are situation are applying thresholds differently.

6.4 Community Services – Adults

Referral numbers

Borough where abuse or neglect reported to have taken place	Q1	Q2	Q3	Q4	Total
Sutton Health	92	82	47	73	**294**
Surrey Downs	211	159	112	114	**596**
Total	303	241	159	187	**890**

Types of abuse reported to SHC & SDHC Safeguarding Team

Type of abuse	Q1	Q2	Q3	Q4	Total
Neglect and Act of Omission	161	131	78	109	**479**
Sexual abuse	0	2	0	2	**4**
Emotional/psychological	0	4	5	2	**11**
Financial	7	7	4	6	**24**
Self-neglect	104	78	57	56	**295**
Welfare Concern	4	0	0	0	**4**
Domestic abuse	11	8	3	5	**27**
Modern Slavery	1	0	0	0	**1**
Physical	12	6	7	3	**28**
Organisational	6	4	5	4	**19**
Other	9	1	0	0	**10**
Total	**315**	**241**	**159**	**187**	**902**

6.4.1 Additional activities included the provision of advice via phone and email consultations, supporting the timely application of safeguarding principles. Common themes addressed were care refusals, domestic abuse, the Mental Capacity Act (MCA), complaints, requests for Mental Health Act assessments, mental health crises, assistance with escalating concerns to the police, and patient safety issues.

6.4.2 Notably there has been an increase in concerns relating to care refusal combined with mental health challenges, and MCA-related concerns.

Concerns regarding care within SHC and SDHC

Type of abuse	Q1	Q2	Q3	Q4	Total
Neglect: Discharge related	0	1	0	1	**2**
Neglect: Pressure area	0	1	1	1	**3**
Neglect: other	16	1	0	3	**20**
Physical	2	0	0	0	**2**
Total	**18**	**3**	**1**	**5**	**27**

Outcomes of concerns following investigation

	Q1	Q2	Q3	Q4	Total
Substantiated	2	1	1	1	**5**
Not substantiated	3	0	0	1	**4**
Ongoing	11	2	0	3	**16**
Inconclusive	2	0	0	0	**2**

6.5 Mental Capacity Act

6.5.1 The Mental Capacity Act 2005 (MCA) and the Code of Practice 2007 protects the rights of People aged 16 years and over to make their own decisions. The MCA provides a statutory framework to empower people who are not able to make their own decisions, and support those who are to be the primary decision maker about their treatment and care. It makes it clear who can take decisions on behalf of others, in which situations, and how they should go about this. It also sets out guidance which enables people (18 years and over) to plan for a time when they may lose capacity.

6.5.2 Oversight of the MCA sits with the safeguarding team, and the core aims are to:

- Ensure that the Trust adheres to legal and statutory duty regarding MCA
- Place capacity and consent at the heart of patient care, ensuring patients are heard at each stage of their episode of care
- Ensure that colleagues have access to high quality training relating to the MCA
- Ensure that Deprivation of Liberty Safeguard applications are applied for when required with correct assessments and rationales in place

DoLS applications

SGH	Q1	Q2	Q3	Q4	Total
Urgent Authorisations	62	71	95	87	**315**
Standard Authorisations	4	1	2	5	**12**
ESTH	**Q1**	**Q2**	**Q3**	**Q4**	**Total**
Urgent Authorisations	176	144	145	135	**600**
Standard Authorisations	2	6	0	2	**10**

Case complexity - SGH

	Q1	Q2	Q3	Q4	Total
MCA cases with legal considerations	3	7	6	9	**25**

6.5.3 The team have worked jointly with the Group legal team, external solicitors, and the clinical care groups when cases require consideration of the courts. It is anticipated that this level of support will continue to increase over time as clinical areas are identifying increasingly complex patients. These cases involve a considerable amount of time for the safeguarding and clinical teams, alongside the financial implications of instructing external legal teams.

6.5.4 There is a regular meeting with the DoLS teams in Wandsworth to review all Wandsworth DoLS referrals made by the Trust. This meeting assists the team in communicating any updates and requesting prioritisation of referrals as required.

6.5.5 Discussions have been held with the Merton DoLS Team Manager within Q4 2024/25. It was confirmed that these touch base meetings were in place previously. However, have not been in place

over recent quarters due to changing in staffing within the Merton team. These touch base meetings have been confirmed to restart in April 2025.

6.6 Maternity

6.6.1 Pregnant mothers, unborn babies and young infants are particularly vulnerable to abuse. The Maternity Safeguarding Teams recognise the potential for the perinatal period to exacerbate vulnerability and abuse for mothers and babies.

6.6.2 The Trust employs an experienced Named Midwife who leads on child safeguarding support and supervision for midwives. The maternity safeguarding team consists of specialists in safeguarding, mental health, and substance misuse and work closely with other midwives working with vulnerable groups such as young people. The SGH team have experiences long periods in the year without a Named Midwife and have accessed support from the senior team and external supervision.

6.6.3 There is a monthly multi-disciplinary maternity safeguarding meeting, attended by colleagues from Wandsworth and Merton Children's Social Care and Health Visiting Teams. At this meeting, information is shared regarding high-risk women to inform safety planning.

SGH Maternity safeguarding referrals

Category	Q3	Q4
Number of children Social Care referrals	37	42
Maternity referrals for the unborn to the Safeguarding team	130	158
Number of unborn/child on initial child protection plan/Review Child Protection Conference and remains on the plan	20	42
Number of unborn/children on Child in Need plan	11	9
Child Protection plans in place for the unborn	20	25
Number of cases where separation of mother and baby was the outcome of any legal proceedings	0	1
Strategy Meeting	6	14

Complexity in the Maternity Safeguarding Referrals

6.6.4 The rise in maternity safeguarding referrals reflects not just an increase in volume, but also a significant escalation in complexity. Recent cases have included scenarios such as a father imprisoned for murder, women delivering babies on the street or in unsuitable environments (including one with only a dog present), and mothers with no antenatal care and significant untreated mental health needs. The team have supported women who have been trafficked, those with no recourse to public funds, and individuals already well known to social care with ongoing child protection concerns.

6.6.5 Another emerging complexity has been a notable increase in cases involving homelessness. A significant number of women, upon admission to the postnatal ward has disclosed being of no fixed abode. One particularly complex safeguarding case involved a woman who remained on the postnatal ward for 25 days due to housing issues which presented substantial challenges in terms of discharge planning, safeguarding coordination, and ward capacity.

SGH Teenage mothers' referrals and appointments

Young Mother's Appointment (Jade Team)	Q3	Q4
Number of teenage mothers booked	24	22
Number of clinic sessions	13	13

Number of teenage mothers who DNA	8	15 apts
Number of referrals received	4	26
Number of teenage mothers seen in the Jade Team clinic	44	53
Number of Children Social Care referrals	20	24
Number of unborn /child protection plan	3	6
Child Protection plans in place for the unborn	3	6 + 6 ongoing

6.6.6 Mental Health Referrals to the Specialist Perinatal Mental Health

Category	Q3	Q4
Mental Health Referrals	110	120

People are presenting in pregnancy with significant mental ill-health, including suicidal ideation, bipolar, previous psychosis, severe anxiety and depression and PTSD.

6.6.7 Domestic Abuse

Category	Q3	Q4
Domestic abuse bookings and referrals	5	20
Referrals to the Safeguarding team due to DV	5	25
Domestic abuse cases	20	25

6.6.8 There has been an increase in the number of identified cases of domestic abuse. Increases may be attributed to:

- Improved awareness and identification among midwives and other health professionals.
- Enhanced referral pathways, including the support of the Hospital IDVA and the transition to the CERNER maternity system, which includes routine enquiry at every antenatal contact.
- Increased movement of women into the area, including those from other NHS Trusts, or women admitted to local women's refuges.

ESTH Maternity

6.6.9 The Trust employs an experienced Named Midwife who leads on child and adult safeguarding support and supervision for midwives. The maternity safeguarding team consists of specialists in safeguarding, mental health, and substance misuse and work closely with other midwives working with vulnerable groups such as young people.

6.610 A monthly multi professional vulnerable women's forum is conducted each month and has representation from children's social care, specialist health visitors, midwife counsellor, IDVA, and ward managers.

6.6.11 As with SGH, ESTH are seeing an increase in asylum seekers and homelessness.

ESTH Maternity safeguarding referrals

Category	Q1	Q2	Q3	Q4
Number of children Social Care referrals	53	55	71	59
Maternity referrals for the unborn to the Safeguarding team (Ruby Team)	256	267	261	261
Number of unborn/child on initial child protection plan/Review Child Protection Conference and remains on the plan	4	5	4	3

Number of unborn/children on Child in Need plan	7	3	3	2
Unborn/born open to assessment (S47, or pre birth)	9	1	3	6
Number of cases where separation of mother and baby was the outcome of any legal proceedings	2	0	1	0
Strategy Meeting	5	12	18	20

ESTH Teenage mothers' referrals and appointments

Young Parent Appointment	Q1	Q2	Q3	Q4
Number of teenage mothers booked	4	2	5	2
Number of clinic sessions	16	16	16	16
Number of referrals received	4	2	5	2

ESTH Mental Health Referrals to the Specialist Perinatal Mental Health

Category	Q1	Q2	Q3	Q4
Mental Health Referrals	202	198	197	190

6.6.12 People are presenting in pregnancy with significant mental ill-health, including suicidal ideation, bipolar, previous psychosis, severe anxiety and depression, EUPD and PTSD. The Ruby team, triage each referral to ensure that women and birthing people have appropriate birth planning discussions around support including referral to the local perinatal mental health services, medication and risk factors.

6.6.13 ESTH Domestic Abuse

Category	Q1	Q2	Q3	Q4
Domestic abuse maternity cases heard at MARAC	8	6	4	5
Domestic abuse cases identified at booking	30	39	31	18

6.7 Domestic Abuse

6.7.1 The Domestic Abuse Act (2021) defines domestic abuse as:
Behaviour of a person ("A") towards another person ("B") is "domestic abuse" if:

- A and B are each aged 16 or over and are personally connected to each other, and
- the behaviour is abusive.

6.7.2 Behaviour is "abusive" if it consists of any of the following

- physical or sexual abuse
- violent or threatening behaviour
- controlling or coercive behaviour
- economic abuse
- psychological, emotional, or other abuse

It does not matter whether the behaviour consists of a single incident or a course of conduct.

6.7.3 The Act acknowledges that children who see, hear, or experience the effects of domestic abuse, and who is related to the person being abused or the perpetrator is also to be regarded as a victim of domestic abuse. Children will no longer be viewed as bystanders of domestic abuse, but victims in their own right.

6.7.4 The Domestic Abuse and FGM CNS currently completes work on referrals that meet the criteria for adult safeguarding, referrals that do not meet the criteria for adult safeguarding, referrals with no

consent to an IDVA, work alongside the IDVA, Clare's Law research, MARAC research and meetings, FGM cases for females not receiving support from maternity or specialist gynae teams and facilitates training for Domestic Abuse and FGM within the Trust.

SGH Domestic Abuse Referrals to the Adult Safeguarding Team

	Q1	Q2	Q3	Q4	Total
Total	**78**	**105**	**106**	**56**	**345**

MARAC

6.7.5 The Domestic Abuse CNS attends the Multi-Agency Risk Assessment Conference's (MARAC) for Wandsworth and Merton. They provide written research for the Lambeth MARAC meetings and the CNS attends the Lambeth meeting if required.

SGH MARAC Cases

	Q1	Q2	Q3	Q4	Total
SGH MARAC referrals	31	33	27	12	**103**

SGH IDVA Service

6.7.8 The Independent Domestic Violence Advocate (IDVA) is a vital aspect of work to support victim/survivors of Domestic Abuse. Emergency Department/Major Trauma Centre services are commissioned via the Mayor's Office of Policing and Crime. The IDVA services are provided by Solace and Victim Support. Solace provides a service to people aged 25 years and under, and Victim Support provide a service to all those aged 26 years and over.

6.7.9 The Victim Support IDVA has provided feedback on referrals to their service. It was confirmed by Victim Support that the number of referrals made by SGH are the highest number of referrals for any of their co-located London hospital IDVA teams. This is being looked at internally at Victim Support to enable them to advocate for funding for a second co-located IDVA at SGH.

SGH IDVA referrals

	Q1	Q2	Q3	Q4	Total
IDVA referrals	60	77	70	32	**230**

ESTH IDVA Service

6.7.10 The number of IDVA referrals is declining, which could be attributed to reduced visibility on-site. There are plans to review training and assess whether Domestic Abuse Liaison Champions training might enhance the effectiveness of messaging. A new IDVA for STHH started in Q3, funded by the Mayor's Office of Policing and Crime.

6.7.11 Surrey County Council are no longer funding a hospital based IDVA and further work will be undertaken to review the impact of this on victim-survivors and staff confidence in exploring routine enquiry and acting on MARAC flags on patient notes.

ESTH IDVA referrals

	Q1	Q2	Q3	Q4	Total
STHH	27	31	46	31	135
EGH	23	21	24	17	**85**

6.8 Learning Disability

6.8.1 A Learning Disability (LD) is a label given to a group of conditions that present in childhood and Impact on the way that individuals develop in core areas. While LD impacts daily life for our patients,

there is no specific trajectory a degree of intellectual impairment will follow. Some of this patient population have jobs, attend college, live independently or with limited care support, others may need more intensive care, through to individuals who need 24-hour care and support for complex physical and behavioural needs.

6.8.2 The Learning Disability team work to:

- Provide support for our patients, their families, loved ones and wider system partners involved in their care by navigating health services
- Advocating for reasonable adjustments and ensuring parity of access to services
- Maximise psychosocial engagement and quality of life during admission
- Support learning from lives and deaths review processes
- Review Treatment Escalation Plans.
- Understand system barriers to accessing care and review/streamline pathways.
- Ensure safe and timely discharge.
- Work strategically across Learning Disability networks to identify and mitigate gaps in systems.

6.8.3 The SGH Learning Disability Liaison Service is lead by a Clinical Nurse Specialist with 2 LD Nurse's and an HCA. Service provisions within the LD at ESTH remain challenging with one LD lead in post at St Helier Hospital. Surrey and Borders Partnership Mental Health Trust provide an in-reach service to Surrey patients at Epsom General Hospital.

6.8.4 The service provisions across the gesh are being reviewed to consider how an equitable and consistent service can be delivered across the Group.

SGH LD service

6.8.6 The launch of the ED LD training was well received, with assistance from a Learning Disability patient. The LD Champions training went ahead in March and although the numbers were low the training was well received. Training sessions have been scheduled with NICU and CTICU. Training focuses information on learning disabilities, how to flag patients on iClip Pro, communication techniques, information on the LD liaison team, how to refer and the application of the Mental Capacity Act 2005.

6.8.7 The LD bedside pack is now being used on wards for LD patients to aid communication between the ward and the patients, and the LD Liaison Team is creating a discharge pack to be distributed to all discharge co-ordinators, which will include easy read discharge letter. The LD Liaison support worker continues to receive a large charitable donation from Beauty Bank of personal hygiene products for LD patients.

6.8.8 SGH LD Referrals

Category	Q1	Q2	Q3	Q4	Total
Total referrals to the team	132	193	160	145	**630**
Accepted referrals with LD	102	154	131	138	**525**
Referrals for patients without LD	20	39	18	5	**82**
Referrals for patients with Autism w/o LD	10	8	11	2	**31**

6.8.9 The team continue to receive referrals of cases that require complex pathway planning for patients with OP procedures, X-Ray, MRI and / or CT scans.

6.8.10 Reason for Referral & Continued Contact

Reason for Referral & Continued Contact	Q1	Q2	Q3	Q4	Total
Admission support	79	78	79	85	**321**
OP appointment support	49	46	52	39	**186**
LD Screen	25	50	35	3	**113**
Pathway Planning	66	54	52	21	**193**

6.8.11 We monitor patients upcoming appointments, which are included in calendar planning to provide reminders and support clinical service pathway planning with reasonable adjustments.

6.8.12 Reason for admission

	Q1	Q2	Q3	Q4	Total
Respiratory	n/r	9	21	23	**53**
Constipation	n/r	3	7	3	**13**
Seizures	n/r	7	6	22	**35**
Infection	n/r	7	13	3	**23**
Surgical (planned)	n/r	15	24	23	**62**
Social	n/r	1	0	2	**3**
Other	n/r	26	32	4	**62**

LeDeR (Learning from lives and deaths review)

6.8.13 LeDeR is a national improvement programme that aims to improve the health and reduce health inequalities in this population. The programme focuses on reviewing the lives and deaths of individuals with learning disabilities or autism to identify areas for service improvement.

6.8.14 The LD Liaison Team completes a LeDeR proforma for all deaths of adult patients with a Learning Disability. As part of the LeDeR review process the team collate information for patients who had contact with our services, or were an inpatient, prior to their death. The LD team are members of the Southwest London LeDeR steering group attending quarterly meetings.

6.8.15 LeDeR processes involving SGH patients

	Q1	Q2	Q3	Q4	Total
LeDeR Referrals (from SGH)	2	5	5	9	21
LeDeR Reports Received	0	2	1	2	5
LeDeR Meetings	1	1	0	0	2

6.8.16 The reports highlighted the following good practices at SGH:

- the patient was seen in a timely manner and given appropriate resuscitation. Required investigations were undertaken, except blood culture.
- The family and patients were given good support, with faith recognised and wishes respected.
- Good reasonable adjustments were put in place for patients. For example, personalised information in simple language with pictures to help him understand about safe eating and medical conditions. The patient was seen and assessed by many professionals during the last couple of years, these were responsive to the patient's needs and followed up in a timely manner.

6.8.17 We are awaiting the outcomes of 7 LeDeR reports.

TV Access

6.8.18 Patients with learning disabilities can often struggle being in a new environment, particularly in hospital, which can result in high levels of anxiety, angry outbursts and at times behaviour that ward staff find difficult to manage. Various forms of distraction are used including the TV.

6.8.19 Access to TV can provide a distraction as something familiar to patients which can have a calming effect and reduce anxiety and behaviour outbursts. Having access to the TV has helped to:

- Reduce behaviour that challenges.
- Improve patient's mental health, by having something to focus on that they are familiar with.
- Allows carers some respite.
- Supports carers in providing distraction and comfort for the patient.
- Provides an activity for patient.

6.8.20 Funding for TV access has been made available from the Hospital Charity's Learning Disabilities Initiatives fund and the LD liaison team is grateful for their support.

Support work

6.8.21 The LD Support Worker has been instrumental in supporting wards ensuring patients with complex needs had 'all about me' documents completed to enable good quality care for these admitted patients. The LD team continue to receive a sizable charity donation of personal hygiene products from Beauty Bank due to the LD support worker's contribution. The LD support worker continue to also provide the following activities for patient:

- Walks around the hospital and the grounds
- Visits to the hospital gardens
- Feeding the fish at the pond (arranged with facilities)
- Preparation for discharge (writing list of resources the patient needed for 'things that needed to be done' on discharge i.e., change of address)
- Visit to the coffee shops to support the patient have time off the ward
- Taking a patient to 3rd floor to play the piano
- Arts and crafts
- Board games
- Reading with or to patients

ESTH LD Service

6.8.22 The team received the Sutton Advocacy for All roadshow report. The report includes the findings of individuals with a learning disabilities experience of hospital, speaking to 47 people who access ESTH services.

6.8.23 In response to a request for support in completing hospital passports and to answer questions about accessing acute hospital services, the Lead for Learning Disabilities and Autism visited Sutton Mencap's 'tea and cake' session where practical support and guidance was given to complete hospital passports and answer any questions local individuals with learning disabilities have.

6.8.24 The Lead also visited Sutton Mencap's parents and carers forum with the Clinical Lead for Learning Disabilities, Dr Robert Calverley, to listen to the experiences of parents and carers locally when supporting individuals with learning disabilities accessing hospital services.

LD Training

6.8.25 Bespoke teaching was delivered to:

- psychiatry liaison services
- pharmacy services
- consultant anaesthetists
- newly qualified nurses on their preceptorship programme
- LD Champions

6.8.26 ESTH LD Referrals

Category	Q1	Q2	Q3	Q4	Total
Referrals to the team	135	167	170	120	592
New referrals and interventions for known patients	120	151	151	108	530
Inappropriate Referrals	12	16	16	12	56
Referrals for Autistic People without LD	3	10	9	4	26
No. of LeDeR referrals	3	1	3	0	7

6.8.27 Reason for Referral & Continued Contact

	Q1	Q2	Q3	Q4	Total
A&E support (those not admitted)	-	-	17	30	47
Inpatient admission support	95	114	101	42	352
Outpatient appointment support	25	21	16	27	89
Pathway Planning	3	6	8	7	24
Other work (BIM/MDT/MCA)	5	10	15	13	43

7.0 Priorities for 2025/26

7.1 The following areas are set as priorities for 2024/25 and will form the basis of the safeguarding workplan:

Priority	Activity
Training	• Deliver flexible and accessible level 3 training offer standardised across the Group • Agree training passport with MAST team to support accurate reporting
Supervision	• Roll our supervision implementation plan across adults and children's services • Agree supervision passport with MAST team
Policy development	• Full suite of up to date safeguarding policies
One risk register	• Create single safeguarding risk register with oversight at safeguarding operational meetings and Group Committee
LD PPEG & Steering Group	• Re-establish the LD Steering Group for the Group • LDPPEG increase the membership of this group and are working in partnership with the Trust patient and public involvement and engagement programme and Merton Mencap
MCA/DoLS audit	• Carry our rolling programme of DoLS audit and update input to ward accreditation programme
DA & MARAC	• Review MARAC attendance and look for opportunities to maximise DA support across the Group
Safe Discharge	• Implement audit action plan and carry out rolling audit programme

8.0 Recommendations

The Group is asked to:

a. Note the safeguarding activity for the reporting period
b. Note the priorities for 2025/26

Appendix 1: Safeguarding Assurance and Accountability Framework

A1 Leadership	SGH	Action	ESTH
A1.1 We have a Board level executive Director/s who holds accountability within the organisation for the Safeguarding Accountability and Assurance Framework (SAAF) ~			
Prevent Duty Modern Slavery Child Protection Information System and Looked After Children Domestic Abuse Duty Serious Violence Duty	GCNO		GCNO
A1.2 We employ or have access to provide strategic safeguarding advice, expertise and guidance via:			
Named safeguarding practitioners	Y		Y
A designated nurse for children	Y		Y
A designated doctor for children	Y		Y
A designated nurse for looked after children	Y		Y
A designated doctor for looked after children	N	Risk Register in CWDT / ICB	y
A designated professional for adults	Y		Y
A1.3 We have a policy regarding internet and social media use which addresses safeguarding.	Y		Y
A1.4 We comply with the information requests and safeguarding data returns to NHS England, including for the Prevent Duty and Looked After Children initial and review health assessment reporting obligation.	Y		Y
A1.5 We have a safeguarding team in place in accordance with specification set out in the intercollegiate documents for adults, children and Looked After Children.	Y		Y
A2 Training			

A2.1 We have a safeguarding training strategy which underpins the safeguarding intercollegiate documents and relevant national guidance and which covers all staff, volunteers and external contractors.	Y	Y
A3 Recruitment and HR		
A3.1 We meet safe recruitment standards i.e. NHS Employers Disclosure and Barring Service checks for employed staff and volunteers.	Y	Y
A3.2 We have included safeguarding responsibilities in all job descriptions.	Y	Y
A3.3 Safer recruitments standards are monitored by the Executive Director and action taken where they fall short of expectations.	Y	
A3.4 We manage requests for access from volunteers, paid/unpaid charity fundraisers, celebrities and "friends of the organisation".	Y	Y
A3.5 We have systems in place to report unsafe practice to external professional regulators and bodies.	Y	Y
A3.6 We have a managing allegation against staff policy which include referrals for Local Authority Designated Officer (LADO - child abuse) and Person in Position of Trust (PiPoT - adult abuse) are aligned with Local Safeguarding Adults Boards and Childrens Safeguarding Partnerships.	Y	Y
A4 Integracy working		
A4.1 We are actively engaging with all aspects of the inter/multi-agency work of the local safeguarding strategic groups including multi-agency risk assessment conferences (MARAC); multi-agency public protection arrangements (MAPPA); local domestic homicide review (DHR) panels, community safety partnership (CSP); domestic abuse forum and Prevent Channel panels.	Y	Y
A5 Implementing shared learning		

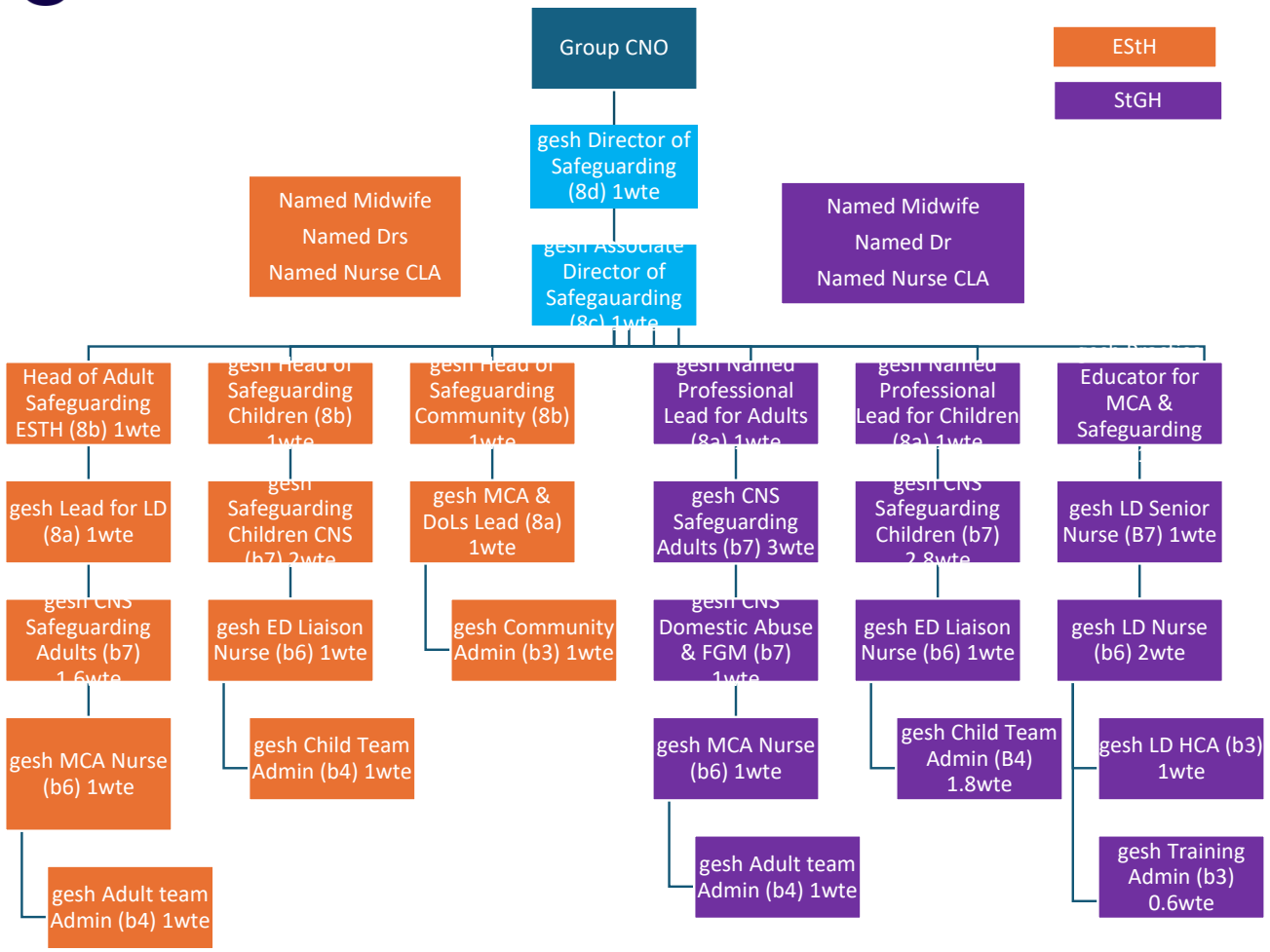
A5.1 We initiate local and engaged with place-based, system-led, regional and national safeguarding investigations, multi-agency case review and safeguarding practice reviews	Y		Y	
A5.2 We can consistently evidence learning has been embedded into practice.	Y		Y	
A6 Patient Engagement				
A6.1 We have appropriate and accessible information about our safeguarding duties and provide this for our population.	Y		Y	
A7 Supervision				
A7.1 We deliver or provide safeguarding supervision in line with the intercollegiate documents for:				
Children	N	Action plan in place	N	
Looked After Children	Y		Y	

A1 Leadership	SGH	Action	ESTH	Action
A1.1 We have a Board level executive Director/s who holds accountability within the organisation for the Safeguarding Accountability and Assurance Framework (SAAF) ~				
Prevent Duty	GCNO		GCNO	
Modern Slavery				
Child Protection Information System and Looked After Children				
Domestic Abuse Duty				
Serious Violence Duty				
A1.2 We employ or have access to provide strategic safeguarding advice, expertise and guidance via:				
Named safeguarding practitioners	Y		Y	
A designated nurse for children	Y		Y	
A designated doctor for children	Y		Y	
A designated nurse for looked after children	Y		Y	
A designated doctor for looked after children	N	Risk Register in CWDT / ICB	y	
A designated professional for adults	Y		Y	

A1.3 We have a policy regarding internet and social media use which addresses safeguarding.	Y		Y	
A1.4 We comply with the information requests and safeguarding data returns to NHS England, including for the Prevent Duty and Looked After Children initial and review health assessment reporting obligation.	Y		Y	
A1.5 We have a safeguarding team in place in accordance with specification set out in the intercollegiate documents for adults, children and Looked After Children.	Y		Y	
A2 Training				
A2.1 We have a safeguarding training strategy which underpins the safeguarding intercollegiate documents and relevant national guidance and which covers all staff, volunteers and external contractors.	Y		Y	
A3 Recruitment and HR				
A3.1 We meet safe recruitment standards i.e. NHS Employers Disclosure and Barring Service checks for employed staff and volunteers.	Y		Y	
A3.2 We have included safeguarding responsibilities in all job descriptions.	Y		Y	
A3.3 Safer recruitments standards are monitored by the Executive Director and action taken where they fall short of expectations.	Y			
A3.4 We manage requests for access from volunteers, paid/unpaid charity fundraisers, celebrities and "friends of the organisation".	Y		Y	
A3.5 We have systems in place to report unsafe practice to external professional regulators and bodies.	Y		Y	

A3.6 We have a managing allegation against staff policy which include referrals for Local Authority Designated Officer (LADO - child abuse) and Person in Position of Trust (PiPoT - adult abuse) are aligned with Local Safeguarding Adults Boards and Childrens Safeguarding Partnerships.	Y		Y	
A4 Integracy working				
A4.1 We are actively engaging with all aspects of the inter/multi-agency work of the local safeguarding strategic groups including multi-agency risk assessment conferences (MARAC); multi-agency public protection arrangements (MAPPA); local domestic homicide review (DHR) panels, community safety partnership (CSP); domestic abuse forum and Prevent Channel panels.	Y		Y	
A5 Implementing shared learning				
A5.1 We initiate local and engaged with place-based, system-led, regional and national safeguarding investigations, multi-agency case review and safeguarding practice reviews	Y		Y	
A5.2 We can consistently evidence learning has been embedded into practice.	Y		Y	
A6 Patient Engagement				
A6.1 We have appropriate and accessible information about our safeguarding duties and provide this for our population.	Y		Y	
A7 Supervision				
A7.1 We deliver or provide safeguarding supervision in line with the intercollegiate documents for:				
Children	N	Action plan in place	N	Action plan in place
Looked After Children	Y		Y	
Adults	N	Policy updated	N	Policy updated

Appendix 2: Safeguarding Team Structure



Appendix 3: Safeguarding Children Supervision Delivery Plan

Section 11 of the Children Act 2004 requires organisations and individuals to ensure that their services and functions promote and safeguard the welfare of children. To fulfil these responsibilities, it is the duty of healthcare organisations to ensure that all health staff has access to appropriate safeguarding training, learning opportunities, safeguarding children supervision and support to facilitate their understanding of the clinical aspects of child wellbeing and information sharing.
The purpose of Safeguarding Children Supervision is to create a structured space for practitioners to reflect on their practice, address any concerns, and explore potential actions or safety plans for children and families. This supervision process is designed to promote a "think family" approach, with a child-centred focus that helps practitioners to truly capture and understand the child's perspective.
Effective supervision supports clinicians in critically reflecting on their practice, enabling them to offer informed support to children and families at risk. It provides an in-depth opportunity to discuss cases, assess challenges, and consider protective measures. Health professionals working with children hold a vital role in the multidisciplinary team, contributing to the identification, prevention, and protection of children and young people from harm.
An essential framework used in effective supervision is the "Signs of Safety" tool, which assists in mapping out family strengths, identifying current and potential concerns, and determining actions needed to safeguard children. This tool allows clinicians to systematically assess and review areas of concern, outline existing and future risks, and work with supervisors to develop actionable plans to ensure the safety and well-being of children and families.
By discussing cases with the safeguarding team or supervisor, practitioners can collaboratively devise an action plan tailored to the specific needs and risks of each child and family. This ensures that appropriate, targeted measures are in place to safeguard and support children, addressing each unique situation with the depth and diligence required.

Currently, the integration of safeguarding children supervision needs to be systematically established throughout the Epsom and St Helier University Hospitals NHS Trust (ESTH) to ensure a consistent, organisation-wide approach to supporting and safeguarding children and families. The following is a detailed, phased plan to embed safeguarding children supervision within various areas of the Trust. This plan will focus on gradually implementing safeguarding supervision and supportive structures in each department to foster a culture of safety and accountability.

The safeguarding children supervision delivery plan will be implemented within the specified timeframes to ensure comprehensive oversight and accountability. Success will depend on strong commitment from divisional leads and directors, whose support is essential for effective implementation. Engaging leadership at all levels will help integrate safeguarding practices consistently across departments, reinforcing our organisation's dedication to safeguarding children, young people and their families.

Paediatrics Phase 1: Paediatric Areas	
Teams	**Timescale**
Paediatric Areas *(Paediatric Emergency Department/ Outpatients/ Wards/ Paediatric Assessment units)* Weekly safeguarding children supervision to be embedded for all paediatric areas across site at both Epsom and St Helier.	Q2 (July – September 2024)
Specialist and case-holding teams *(Clinical Nurse Specialist and Children's community Nurses)* Quarterly safeguarding supervision to be arranged for specialist teams	Q3 (October – December 2024)
Queen Mary's Day Surgery Quarterly Safeguarding supervision to be provided to the department via their quarterly study day.	Q3 (October – December 2024)
Paediatric Allied Health professionals *(Therapies, Audiologist)* Quarterly Safeguarding supervision to be provided to the AHP's.	Q3 (October – December 2024)
Neonatal Departments *(Special Care Baby Unit/ Neonatal Unit)* Monthly safeguarding supervision to be arranged for Neonatal departments.	Q4 (January – March 2025)

Phase 2: Critical Areas	
Critical areas/ Teams who see both Children and Adults (*Psych Liaison, Fracture clinic, Eye Casualty)* Quarterly safeguarding supervision will be scheduled for all high-priority areas.	Q4 (January – March 2025)
Adult and Paeds Emergency Department EGH – Weekly Safeguarding ED meetings STH – 1st and 3rd Thursday of the month Safeguarding Multi-agency Safeguarding ED meeting	Q2 (July – September 2024)
Phase 3: Adult Areas	
All adult areas in line with intercollegiate document and trust training needs analysis Weekly Drop in Safeguarding Supervision to be provided for all Adult areas band 7 and above.	Q1 (April –June 2024)
Medical Teams	
The Named Doctors for Safeguarding facilitate peer review sessions, with 1-hour monthly sessions held at Epsom and 2-hour bi-monthly sessions at St. Helier. The medical teams are also invited to attend the planned safeguarding children supervision sessions which are held across site as detailed in the delivery plan.	Established and ongoing

Maternity	
The maternity safeguarding team are all trained safeguarding supervisors. **Supervision for maternity staff is provided in a variety of ways** **Vulnerable women's forum:** Multi-professional meeting. Attended by the safeguarding team and the midwife counsellor. Invite extended to whole maternity team. Regular attenders are ward and community managers. **Daily huddle and ward walk:** Each day a member of the safeguarding team attends the safety huddle on delivery suite. Following this they attend the ward areas to discuss any concerns and support with plans for any family known to the safeguarding team or to support where new concerns have been noted for other families, **Formal supervision:** The safeguarding team are offered supervision (every 3 months) with the named midwife for safeguarding. This is extended to the whole maternity team if they want to access this. When midwives are known to be holding a particularly difficult case, supervision will be scheduled with them. **Adhoc Supervision:** The maternity safeguarding team are available at any point for adhoc supervision. This often takes place over the phone following team members concerns being raised by email or phone call. Supervision forms part of the maternity safeguarding yearly update with me or the team, which all staff have to attend. Compliance for this is with our practice development midwives. Therefore, we know that all staff access supervision once yearly (midwives, support workers , obstetric doctors/consultants). Supervision notes are added to the maternity badger record in the supervision template.	Established and ongoing

