Outstanding care every time

NHS
St George's University Hospitals
NHS Foundation Trust

Council of Governors Meeting
24 September 2025

Agenda and papers

Governors Visit Report

Date of Visit: Thursday 21 August
Attendees: Sarah Forester, Afzal Ashraf, John Hallmark
Accompanied by: Cat Matron

Overview

The visit encompassed Amyand Ward, Caesar Hawkins Ward and Hebden Ward. It covers broader observations across other areas of the hospital. The team noted strong staff commitment, high morale, and good patient care practices, but also identified recurring structural and operational challenges which continue to affect service delivery and staff wellbeing.

Ward Observations

1. Amyand Ward

Ward Manager: Juliette (in post for nearly 10 years)

- **Staffing & Appraisal:** Staff appraisals are up to date and of a high standard. The team includes 49 staff representing 21 nationalities, which is celebrated internally. Redeployed staff from a recently closed ward are being supported effectively. Use of agency/bank staff is minimal and generally restricted to specific mental health support needs.
- **Patient Flow & Accreditation:** The ward holds Silver accreditation, narrowly missing Gold due to estate-related issues (notably, the drug cupboard). It primarily admits patients from Richmond Medical Assessment Unit. Although the ideal patient stay is 5–7 days, lengths of stay are currently extended due to wider hospital flow problems exacerbated by recent bed closures.
- **Patient & Family Engagement:** Open visiting for carers and family is encouraged, with clear evidence of involving relatives in care planning.
- **Safety & Environment:** A recent audit led by Juliette addressed falls incidents, with findings and actions pending. There is also focus on pressure area care. Concerns were raised about the absence of a doctors' office and dedicated patient meeting space, forcing doctors to use worktops for computer updates. Space reorganisation is reportedly underway, but timelines and likely success remain unclear.

2. Caesar Hawkins Ward

Ward Manager: Cynthia

- **Ward Profile:** A respiratory ward characterised by longer patient stays, including those requiring tracheotomy or other respiratory support. Patients often present with long-term conditions and are admitted from a wide geographical area.
- **Staffing & Morale:** Staffing is stable, appraisals are current, and there are no vacancies. The ward has a calm, organised atmosphere with a noticeably different feel compared to Amyand.
- **Accreditation & Facilities:** Silver accredited; Gold was missed due to an infection control issue linked to outdated estates infrastructure (notably the toilet and sluice area).
- **Culture & Support:** Staff reported feeling well supported and free to escalate concerns to senior nurse leaders (Jo Hunter and Nicola Copeland). There is strong

collaboration with medical colleagues, with 24/7 consultant cover aiding decision-making. Occasional psychological support is available for patients.
- **Innovation:** The ward is part of the new “Hyper Performing Ward” project aimed at improving quality outcomes.

3. Other Observations

- **Hampton Ward:** Awarded Gold accreditation for two consecutive years. The ward displayed strong management and organisation. However, as with the respiratory ward, delayed discharges due to external coordination with councils and care homes remain a serious issue, often resulting in patients occupying beds unnecessarily for weeks.
- **Heberden Ward:** Staff reported increasing problems with difficult, abusive, and sometimes violent patients and visitors (often family members). While staff manage these challenges professionally, there is a need for Trust-level strategic intervention before such behaviours generate unsustainable pressures and anxiety.
- **Lift Outages:** The team was unable to visit one ward due to delays caused mainly by non-functioning lifts. Of the two banks of four lifts used, only one in each was operational. Staff confirmed this is a persistent, long-term problem across the hospital. This represents a major concern for both patients (including expectant mothers observed in distress) and staff, raising questions about the hospital’s long-term estates management strategy.

Key Strengths

- Highly competent, motivated, and stable ward leadership (notably Juliette, Cynthia, and Katrina).
- Strong appraisal systems and robust staff morale, supported by inclusive multicultural teams.
- Clear culture of open communication and escalation, with confidence in senior nurse leadership.
- Demonstrated commitment to patient and family involvement in care planning.
- Active participation in innovative quality improvement initiatives (e.g., Hyper Performing Ward project).

Key Concerns

- Estates-related issues (drug cupboards, toilets/sluices, lack of doctors’ office/meeting rooms, lift failures) are recurrent barriers to both safety and accreditation.
- Delayed patient discharges due to systemic problems in coordination with external agencies, causing unnecessary bed blocking.
- Increasing prevalence of difficult and abusive behaviour from some patients and visitors, requiring a Trust-wide strategic response.
- Hospital-wide estates failures, particularly the chronic lift issues, which directly affect patient dignity, safety, and operational efficiency.

Conclusion

The visit, like all others was highly informative and mostly encouraging for the Governors. It highlighted the dedication, skill, and motivation of staff across wards, underpinned by strong leadership and team culture. These strengths, however, are being undermined by persistent estates-related shortcomings and systemic discharge delays, which are outside the control of individual wards. The Trust may wish to consider:

1. Resolving chronic estates issues (especially lift functionality and ward infrastructure).
2. Developing a coordinated strategy with external agencies to address discharge delays.
3. Implementing a proactive policy to manage the rising incidence of abusive patient and visitor behaviour.

Visit to Support Services 16.09.2025
Shuile Syeda, John Hallmark, Judi Gasser

A very interesting tour, meeting a range of vital support services. Everyone was passionate about their work and the contribution they make to staff and patients' wellbeing: a lot of unsung heroes.

Security
We were shocked to hear how much violence there is in ED. Security all wear bodycams; we saw some disturbing video footage and our security guards do get injured

Porters:
Porters also experience a lot of abuse, **often from other more senior staff**, which is disgraceful
Porters told us they need a more robust tech system in order to meet thier KPIs and 2 way communication would help (so they can talk to Control)

Marcel. Head of Catering
So passionate about his department's purpose: to feed the workforce the right food to keep them fuelled for long shift, at a good price. Some staff only get a 30 min break, so service needs to be efficient. Opening hours have reduced in recent months; no longer open nights or weekends. (too expensive; catering staff were getting double time on a Sunday).

Food waste is an issue across the NHS- Marcel is trying to reduce. Ingredients serve 1,000 - 1,200 people every lunchtime, 400 people choose the salad bar every lunch time.
Trying to encourage people to eat healthy meals St George's is an Exemplar trust- training others.
They make their own yoghurt/ ice cream with an amazing new machine; very low energy.

Patients' food is made off site by Apetito; blast frozen in South Wales and regenerated on site.
Marcel has visited the factory and checked every stage of the journey. Food should be good quality if regenerated and served correctly; he is keeping an eye on Mitie Service, making sure patients have the menu. Food is one of few things a patient has control over in hospital.
Marcel checks every complaint; has it been warmed/ served/ presented wrong
So passionate, wants to make patients' life a little bit better.

Q1. There will be a patient led assessment on the care environment 13-15th October - will we get results?

Medical physics
Team of 15 repairs MRIs ultrasounds etc; they are trained to fix just about everything
St George's has 28,000 assets, most fixed in house: only 1,600 under external contracts
They also generate some income through repairing for other trust around the country

Ultrasound team
Conduct regular testing so they can predict need for new ones
Invented new test device for thyroid biopsies, a ‘phantom’ to mimic a real neck, for training now training internationally
MRI now uses AI, cuts scan time in half

What would improve things? more people because they innovate
More people to investigate and solve problems to enable clinicians to work smarter
e.g. someone wrote a new program for equipment library; saves loads of time

Energy centre- contractor = Centrica
Gas powered boilers to make steam to heat the building saves c£3m but bad for carbon emissions.
Looking for sustainable solutions, maybe hydrogen

St George's University Hospitals
NHS Foundation Trust

Council of Governors

Agenda

Meeting in Public on Wednesday, 24 September 2025, 13:15 – 15:40

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

Feedback from Governor visits					
Time	**Item**	**Title**	**Presenter**	**Purpose**	**Format**
13:15	-	Feedback from visits to various parts of the site	Governors	Note	Verbal
	-	Feedback on governor community engagement	Governors	Note	Verbal

1.0 Introductory items					
Time	**Item**	**Title**	**Presenter**	**Purpose**	**Format**
13:30	1.1	Welcome and Apologies	Chair	Note	Verbal
	1.2	Declarations of Interest	All	Note	Verbal
	1.3	Minutes of previous meeting	All	Approve	Verbal
	1.4	Action Log and Matters Arising	All	Note	Verbal
	1.5	Group Chair's Update: Group CEO recruitment	Chair	Update	Verbal

2.0 Strategy					
Time	**Item**	**Title**	**Presenter**	**Purpose**	**Format**
13:40	2.1	Group Chief Executive's Report	Interim GCEO	Update	Report

3.0 Quality and Performance					
Time	**Item**	**Title**	**Presenter**	**Purpose**	**Format**
13:55	3.1	Care Quality Commission Inspection Reports	MD-SGUH	Review	Report
	3.1.1	St George's Hospital (Tooting) final report			
	3.1.2	Queen Mary's Hospital final report			
14:15	3.2	SGUH Operational Performance and Priorities	MD-SGUH	Review	Report

4.0 Finance					
Time	**Item**	**Title**	**Presenter**	**Purpose**	**Format**
14:35	4.1	Finance Update	Committee Chair	Discuss	Report

5.0 People					
Time	**Item**	**Title**	**Presenter**	**Purpose**	**Format**
14:50	5.1	People Strategy implementation – Update	GCPO	Discuss	Report

St George's University Hospitals
NHS Foundation Trust

6.0 Membership Engagement					
Time	**Item**	**Title**	**Presenter**	**Purpose**	**Format**
15:10	6.1	Membership Engagement Committee Update	Committee Chair	Discuss	Report
15:20	6.2	Annual Members Meeting (plan update)	DM	Update	Verbal

7.0 Governance					
Time	**Item**	**Title**	**Presenter**	**Purpose**	**Format**
15:30	7.1	Governors Elections 2025/2026	GCCAO	Update	Report

8.0 Closing Items					
Time	**Item**	**Title**	**Presenter**	**Purpose**	**Format**
15:35	8.1	Any Other Business	All	Note	Verbal
	8.2	Council of Governors Calendar of Events	All	Note	Report
	8.3	Reflections on Meeting			

St George's University Hospitals
NHS Foundation Trust

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

Membership and Attendees		
Members	**Designation**	**Abbreviation**
Mark Lowcock	Trust Chair	Chair
Nasir Akhtar	Public Governor, Merton	NA
Alfredo Benedicto	Appointed Governor, Merton Healthwatch	AB1
Ashok Bhat	Public Governor, Rest of England	AB2
James Bourlet	Public Governor, Rest of England	JB
Luisa Brown	Public Governor, Merton	LB
Sandhya Drew	Public Governor, Rest of England	SD
Dympna Foran	Staff Governor, Nursing and Midwifery	DF
Sarah Forester	Appointed Governor, Healthwatch Wandsworth	SF
Judith Gasser	Appointed Governor, Wandsworth Council	JG
John Hallmark	Public Governor, Wandsworth	JH1
Hann Latuff	Public Governor, Merton	HL
Julian Ma	St George's University of London	MA
Jackie Parker	Public Governor, Wandsworth	JP
Augustine Odiadi	Public Governor, Wandsworth	AO
Jackie Parker	Public Governor, Wandsworth	JP
Abul Siddiky	Staff Governor, Medical and Dental	AS
Huon Snelgrove	Staff Governor, Non-Clinical	HS
Shuile Syeda	Appointed Governor, Merton Council	SS
Ataul Qadir Tahir	Public Governor, Wandsworth	AQT
In Attendance		
Natalie Armstrong	Non-Executive Director	NA
James Blythe	Interim Group Chief Executive Officer	IGCEO
Pankaj Davé	Non-Executive Director	PD
Elizabeth Dawson	Group Deputy Director of Corporate Affairs and Head of Corporate Governance	GDDCA
Andrew Grimshaw	Group Chief Finance Officer	GCFO
Richard Jennings	Group Chief Medical Officer	GCMO
Stephen Jones	Group Chief Corporate Affairs Officer	GCCAO
Yin Jones	Non-Executive Director	YJ
Ralph Michell	Group Chief Transformation Officer	GCTO
Andrew Murray	Non-Executive Director	AM
Michael Pantlin	Group Deputy Chief Executive Officer	GDCEO
Kate Slemeck	Managing Director - SGUH	MD-SGUH
Victoria Smith	Group Chief People Officer	GCPO
Nicola Shopland	Site Chief Nurse – St Georges Hospital	NS
Anna Missir	Governors and Membership Engagement Officer	GMEO
Apologies		
Chelliah Lohendran	Public Governor, Merton	CH
Sophia Agha	Associate Governor (Young Members)	SA
Georgina Sims	Appointed Governor, Kingston University	GS
Afzal Ashraf	Public Governor, Wandsworth	AAs
Claire Sunderland Hay	Associate Non-Executive Director	CSH

St George's University Hospitals NHS Foundation Trust

Minutes of the Meeting of the Council of Governors (In Public)
Thursday, 17 July 2025, 17:30 to 19:30
Hyde Park Room, Lanesborough Wing, St George's Hospital

Membership and Attendees		
Members	**Designation**	**Abbreviation**
Mark Lowcock	Trust Chair	Chair
Afzal Ashraf	Public Governor, Wandsworth	AA
Ashok Bhatt	Public Governor, Rest of England	ABh
Luisa Brown	Public Governor, Merton	LB
Judith Gasser	Appointed Governor, Wandsworth Council	JG
John Hallmark	Public Governor, Wandsworth	JH
Hann Latuff	Public Governor, Merton	HL
Augustine Odiadi	Public Governor, Wandsworth	AO
Huon Snelgrove	Staff Governor – Non Clinical	HS
Sophia Agha	Associate Governor (Young Members)	SA
In Attendance		
Julie Alexander	Director of Strategy	DoS
Ann Beasley	Non-Executive Director	AB
Pankaj Davé	Non-Executive Director	PD
Elizabeth Dawson	Group Deputy Director of Corporate Affairs and Head of Corporate Governance	GDDCA
George Harford	Site Chief Finance Officer	CFO – SGUH
Richard Jennings	Group Chief Medical Officer	GCMO
Yin Jones	Non-Executive Director	YJ
Barbara Mathieson	Corporate Governance Manager	CCG
Kate Slemeck	Managing Director - SGUH	MD-SGUH
Victoria Smith	Group Chief People Officer	GCPO
Claire Sunderland Hay	Associate Non- Executive Director	CSH
Arlene Wellman	Group Chief Nursing Officer	GCNO
Apologies		
Nasir Akhtar	Public Governor, Merton	
Alfredo Benedicto	Appointed Governor, Merton Healthwatch	
Sandhya Drew	Public Governor, Rest of England	
Dympna Foran	Staff Governor, Nursing and Midwifery	
Sarah Forester	Appointed Governor, Healthwatch Wandsworth	
Julian Ma	Appointed Governor, St Georges University of London	
Lucy Mowatt	Public Governor, Wandsworth	
Chelliah Lohendran	Public Governor, Merton	
Ataul Qadir Tahir	Public Governor, Wandsworth	
Jackie Parker	Public Governor, Wandsworth	
Abul Siddiky	Staff Governor, Medical and Dental	
Shulie Syeda	Appointed Governor – Merton Council	
Jacqueline Totterdell	Group Chief Executive Officer	
Andrew Grimshaw	Group Chief Finance Officer	
Stephen Jones	Group Chief Corporate Affairs Officer	
Ralph Michell	Group Director of Transformation	
Natalie Armstrong	Non-Executive Director	
Peter Kane	Non-Executive Director	
Andrew Murray	Non-Executive Director	

Feedback from Governor visits
Feedback from visits to various parts of the SGUH site Governors had undertaken a number of visits across the SGUH site since the previous meeting, and they expressed thanks to the staff who had facilitated them and for taking time out of their schedules to talk to them about the care provided. The Chair invited Governors to raise any further points aside from those covered within the report. The following points were raised and noted during discussion: HS noted that the report was very positive, however it did not include any feedback on staff morale. Feedback on concerns relating to issues with IT and the delays with items from Pharmacy which led to issues with patient flow which had been highlighted during the visits, also needed to include. He highlighted that there seemed to a be lack of clarity amongst staff as to the role of Governors. There were also comments that the feedback report would benefit from including some verbatim statements made by staff. The Chair confirmed that the Board was aware of staff morale concerns and these were received via multiple forums. The MD-SGUH said that on the walkabouts that she undertook staff were typically sharing concerns relating to services feeling pressured, the ongoing financial situation, ward closures and resulting concerns around jobs. Overall, there was a feeling currently that issues with flow were better than they had been. Also, it was important to triangulate the information/feedback which was being shared from a range of different sources. The GCMO commented that feedback from staff was often three dimensional and that different messages were received. An example was that a recent Health Inequalities Forum staff morale was very good and there was a great deal of enthusiasm for the subject being discussed. The Chair and MD- SGUH commented that they had undertaken an overnight walk about with members of the trust's Security Staff. This had involved some very interesting and insightful conversations. ABh commented that he was very impressed with a recent visit to the A&E department. He had been able to have frank and open discussions with staff. Violence and Aggression from patients and families was one of their top concerns. Staff confirmed that they felt able to raise concerns. LB particularly noted that four wards had received Gold accreditation and one Platinum. These were outstanding achievements. There had also recently been several recognition events for staff who completed 25 years of service within SGUH. Staff were feeling valued, and the visits overall were impressive. The Chair thanked the Governors for the feedback from the visits across SGUH which they had undertaken. He said that it was valuable part of their role and led to useful discussion.

1.0	OPENING ADMINISTRATION	Action
1.1	**Welcome and Apologies** The Chairman welcomed everyone to the meeting. Apologies were received as above. The Council of Governors wished Chelliah Lohendran well following a recent hospital stay. It was confirmed that the meeting was quorate.	
1.2	**Declarations of Interest** There were no new declarations of interest.	

1.3	**Minutes of the Public meeting held on 22 May 2025** The minutes of the meeting held on 22 May 2025 were approved as a true and accurate record.	
1.4	**Action Log and Matters Arising** The Council of Governors reviewed the action log and matters arising: • **COG 12.03.25/2 SGUH Operational Performance - Never Events** PSIRF training part 2 to be organised for Governors – Training was held on 24 June 2025 **To be closed** • **COG 12.3.25/3 Finance Update Training session to be provided on finance pressures 25/09/2025** The first part of finance information sharing session was delivered as part of the new governor's induction session. A follow up session was planned for early autumn 2025. **To be closed** • **COG.22.5.25/2 Points raised from governor visits.** Noted that the MD–SGUH had discussed the points relating to the Discharge Lounge at SGUH with the team. It was also confirmed that the GCMO had raised the concern around delays in pharmacy dispensing with the Chief Pharmacist. **To be closed**	
2.0	**STRATEGY**	
2.1	**Group Chief Executive Officer's (GCEO) Report** The MD-SGUH presented the GCEO Report on behalf of Jacqueline Totterdell and highlighted the following key points: **NHS 10 Year Plan:** This document had recently been published and shared the vision for the NHS for the next 10 years. The Executive were currently working through the document to identify the opportunities which it presented and agree with the Board those which the Group should be taking forward. There was a general view that the plan did was light on details on implementation but the three main themes of Hospital to Community, Treatment to Prevention and analogue to digital were as expected. A focus was needed on how to move away from acute services to more care being provided via Primary Care or Community Services. This would involve acute trusts agreeing to see how they could support this shift in services, possibly through providing additional Consultant support and advice at a local level. **Other points of focus:** **Finance:** This was an item later on the agenda but this continued to be an area of high scrutiny. **National Maternity briefing**: The Secretary of State had announced a national review of maternity with 10 NHS trusts selected as part of this. The full list of trusts was yet to be announced but it was not anticipated that SGUG would be included. **SGUH Veterans Accreditation** – SGUH had recently achieved the Gold Standard with this scheme. The Chairman invited comments and questions from Governors on the GCEO report.	

	JH asked how the NHS 10-year plan would be delivered and particularly how the move to deliver more health care at a local level would be achieved. The MD-SGUH confirmed that the expectation was that this would be achieved via more joint working with the local place especially with Wandsworth. Further details around expectations were awaited but that there should be some flexibility around local delivery. HL raised a question as to when the reports from the various CQC Inspections at SGUH were due to be received. The MD-SGUH confirmed that the trust had yet to receive the draft reports but these were expected shortly and there would then be a period of fact checking before they were finalised and published by the CQC. Action plans linked to the points raised in the initial letter following the visits had been drawn up and were being worked through. These would be revised as necessary with any further actions included highlighted from the full CQC Reports, once received. **The Council of Governors noted the GCEO report.**	
2.2	**Group Strategy Update and Corporate Priorities** The Group Director of Strategy shared an update on the progress of the Group Strategy. It was recognised that there were a number of ongoing external changes taking place which could affect the deliver of the strategy. This included the recent publication of the NHS 10 Year Plan. A stocktake had take been undertaken across the CARE Framework and it was felt that there had been mixed progress in respect of the various aspect of the strategy. One of the main challenges continue to relate to finance. More also needed to be done to ensure that the right care could be delivered to patients in the most appropriate place. There needed to be an increase in moving the provision of services within costly acute care settings to primary/ community care. Whilst it was recognised that staff morale was better than it had been and higher than at some other trusts, it was acknowledged that it was important to try and maintain this. PD shared details of the recent review of the Group Strategy which had taken place at a Board Development Day. The overall conclusion was the strategy continued to be appropriate for gesh but that delivery was hard with a number of challenges being highlighted. Working in partnership needed to be fully imbedded in order for the strategy to be delivered. This included continuing to develop key stakeholder links between hospital, primary care and community services. The ICBs needed to be part of this ongoing transformation work as the have a clear role to play and to facilitate clinical services reconfiguration work. A major issue which continued to need work across the area was the number of patients continuing to be in acute services but with no criteria to reside. Along with causing issues with flow, staying in hospital for longer than needed was not good for patients. More work was needed to be undertaken in the field of digital transformation, including possibly the greater use of Artificial Intelligence to support patient care. However, questions in relation to security/ confidentiality needed to be addressed. Other views included that Ward to Board work needed to be standardised across the group along with more integration and alignment of work of the CIP Programme. AA noted that there were a lot of external factors which could at the present time be holding back the delivery of the strategy but it also needed to be recognised some related to cultural changes needed and that these often take time.	

	The GCPO confirmed that although the most recent staff survey results were positive, and elements were moving in a positive direction, it needed to be recognised that staff were operating within a very stressful environment. Opportunities to keep staff informed included monthly Executive Question Time meetings held over Zoom which were an open forum for queries to be raised. The GCPO shared some other examples of actions taking place across the trust: • Running Consultant meetings – where there was an opportunity to discuss strategic issues. • Use of surveys, with the Pulse Survey which was undertaken on a quarterly basis due to be relaunched. Although there was an argument that within the NHS too many surveys were used • Via the Intranet • Introduction of new apps – and circulating information via phones as it was recognised that not all staff have access to PCs at work. • Local Team Leadership was always important when encouraging staff engagement. • Talent Board – opportunities to shadow main board – run in parallel and feedback – experience of operating in Board environment. The MD-SGUH that the delivery of the Care Strategy underpinned through continuous improvement work was beginning to take place and this would drive more patient satisfaction. Examples of key improvements included delivery of the frailty services and increasing the provision of SDEC which was able to treat 70% of patients the same day which reduced the need for admissions. To conclude the item the Chair reminded the meeting of the importance of working with key stakeholder including local authorities to make improvements for the local population which the trust serves.	
3.0	**QUALITY AND PERFORMANCE**	
3.1	**SGUH Operational Performance and Priorities** The MD-SGUH led the update on the current operational performance. It was confirmed that overall, the performance within April and May 2025 was mostly reasonably good, however it was confirmed that RTT (Referral to Treatment Time) remained challenged. There was no additional funding available to run Waiting List Initiatives in order to reduce the backlogs. SGUH was benchmarking well against other trusts. The Government had recently introduced a new performance framework and therefore it was expected that this would be an area of local, regional and national focus. A lot of work was currently required to manage expectations from the national level. Specific performance related work included the continued focus on trying to reduce the length of stay for inpatients. 80 inpatient beds had been closed across the sites with theflow of patients through the trust maintained. Other work which had been put in place had been the stepping up in the SDEC (Same Day Emergency Care) provision which was diverting some activity away from the ED. There had also been an expansion of frailty work provided at the front door which had really helped to reduce the number of patients who were having to be admitted. **Queen Mary Roehampton** MD-SGUH reminded the Council that the temporary theatres at QMH had been installed on the site post the pandemic to produce extra capacity to undertake surgery with the aim of reducing the backlogs. The facilities were very expensive to run and were not cost effective. They were currently run off generators which were causing noise	

	pollution and were therefore not sustainable. It was estimated that it would cost between £2 and £3 million to connect to mains services. The decision had therefore been taken to close the facilities and consultation with the affected staff was about to begin, as were briefings for stakeholders. Surgery would be transferred to take place at SGUH and possibly other sites across the Group with staff being redeployed. **Birth Centre at SGUH** It had been recognised that there had been a decline in the use of the dedicated birth centre at SGUH over a number of years. The number of births taking place there had reduced from approximately 480 per year to around 200 possibly linked to the national declining rate in births. Also, the number of high-risk births was increasing. Only low risk births were able to take place within a Birth Centre under the care of Midwife Team. Discussions were therefore beginning regarding the possibility of closing the Birth Centre at SGUH. Other facilities were available with the local area. The GCNO also confirmed that it was possible to have a "Birth Centre" experience within the main Delivery Suite, with a dedicated room with a birthing pool etc. JD stressed that if official engagement with stakeholders and the wider public were to begin, they must be very clear as to what was being proposed and to outline the difference between the Birth Centre and the main delivery suite. The MD-SGUH confirmed that no official stakeholder engagement had been undertaken yet and would only begin if and when a full plan was available. She agreed that it would be important for people to understand how the decision had been informed and to clearly communicate the facts. Following a further question from the Governors it was confirmed that according to the Birth Rate Plus figures, SGUH did have sufficient midwives overall to deliver care. On occasions however there was reduction in a number of staff available to deliver services and therefore, there was a need to improve processes and rostering to ensure appropriate cover at all times.	
3.2	**Maternity Services** The GCNO presented the Maternity Services Update Report, confirming that an Integrated Improvement Plan for maternity had now been produced. This brought together all the required actions from the various reports including Ockenden and inspections by the CQC. The intention was to monitor the plan at the Maternity Improvement Group and Quality Committee. The single, unified plan replaces the previously fragmented action lists with a coherent, accountable, and time bound approach to maternity improvement. The expectation was that each action is clearly owned and tracked, enabling clear oversight and being able to more easily evaluate the impact of change through improved safety governance, transparency, and maternity performance metrics. One of the main concerns within the maternity services which had been highlighted over the last couple of years was that there needed to be a change in leadership structure. The papers received for the meeting outlined the new leadership structure, including the introduction of a substantive Group Chief Midwifery Officer (GCMiO) role. This role will provide senior strategic leadership across both sites, ensuring that there is strong alignment with the Site Directors of Midwifery, promoting collaborative, system-focused leadership across the Group, with a focus on quality, safety, and workforce sustainability. Interviews for the post would be taking place on Friday 25 July 2025. The GCMO confirmed that there would continue to be site specific clinical leads for Obstetrics. It needed to be recognised that these roles should be well supported due to the local and national focus on maternity services.	

	The Chair also noted the many challenges which continued to face the leadership within both the Group's Maternity Services and stressed the importance of these roles being well supported by the Executive Team.	
4.0	**Finance**	
4.1	**Finance Update** AB and the SGUH - CFO presented the finance update. They confirmed that the trust and the wider NHS continued to be in a difficult position financially. There was a continuing need to try and reduce spend across the whole of the organisation. The key points from the finance update included: **Month 2 (May 25) - Financial Position:** • The trust was on plan at month 2. • Some support had been utilised at SGUH to support the plan. • Delivery of the Cost Improvement Programme (CIP) continues to be increase, but the scale of the overall requirement remains very challenging. **Income and Expenditure (I&E) Forecast to year end** • Whilst progress was being made, the scale of the challenge continues to increase as the phasing of CIPs increases. • NHSE are increasing scrutiny on overall delivery of the plan. **CIP delivery and forecast** • Progress is being seen on the Tier2 projects, but noted greater assurance is required on delivery. **Cash** • Current cash forecast, based on a range of scenarios for CIP delivery look robust. • Material risks exist and if the trust were to move away from plan, then cash would come under material stress very quickly, especially if Q3 and Q4 Deficit Support Funding was withdrawn. **NHSE Planning review.** • NHSE have indicated they will be launching a rapid review of 2025/26 and then building medium term sustainability plans off this. AB confirmed that the Group Finance Recovery Board was continuing to work hard to manage the CIP Programme and to ensure as many schemes as possible was moved to fully developed. However, the size of the ask relating to the requirement to making savings through CIPs should not be underestimated. There was a continuing to be manage income / expenditure and cash flow within the trust. It was noted that central deficit support funding would be available through the year for trusts who remain on plan. Also, there was a need to start to look at longer term financial plans covering the next two/three years. The following points were also noted: • The CIP requirement in year was £95m or 7.5% of the trust's annual budget. To date there were £34m CIP plans fully developed which was ahead of the same position in 2024/25 • Deficit support for Q1 2025/26 had been received. • There would be the need to for clinical teams to developed multi year plans and these need to link to the 10-year strategy. The MD-SGUH described the ways that staff were kept informed of the financial requirements of the trust and that these included running finance roadshows for budget holders and being the main area of focus at month Executive Question Time meetings. It	

	was recognised that it was important to continue to communicate with staff so that they fully understand the ongoing financial pressure which the trust is working under. Alongside this more needed to be done to recognise possible recurrent savings that would take costs out on an ongoing basis. Overall, there were too many services being run over too many sites across the local area and there was need for new work which would reduce spending. To do this a new clinical strategy for SWL was needed. Questions were raised relating to the impact of the impending industrial action expected to be taken by Resident Doctors. It was confirmed that there would be no additional funding available from central government. Whilst it was planned to run as many services as possible there would be some cancellations and income would be lost, and discussions were taking place with consultants regarding rates of pay for providing cover. Consultants providing cover would be on a discretionary basis. The GCMO confirmed that Consultant colleagues are often willing to provide support in order that vital services are maintained, and they are compensated for undertaking this additional work. However, it was confirmed that Consultants are not obliged to provide cover. In respect of the number of whole-time equivalent roles (wte) which were needing to be taken out of the numbers at SGUH, this was confirmed to be 600roles, and the reductions would take place across all areas and services and would include temporary bank and agency staff. To conclude the finance discussion, it was confirmed that the 7.5% savings requirement for the trust in year was a tremendous ask. As such there was a need to consider making savings in areas which may be considered as discretionary services. An example of this had been the decision to close the main restaurant at SGUH at the weekend. It was stressed that the trust did not wish to make these kinds of cuts and very carefully considered the decisions. **The Council of Governors noted the Finance update.**	
5.0	**GOVERNANCE**	
5.1	**Annual Report from External Auditors on Trust Annual Accounts 2024/25** The Council of Governors received and noted the Annual Report from Grant Thornton; the External Auditors, on the trust Annual Accounts for 2024/25. It was confirmed that there were no issues of concern raised. The trust Finance Team and the team at GT were thanked for their hard work on the production of the accounts and the external audit.	
5.2	**Proposal to develop a Governor Dashboard** The GDDCA presented the proposal to produce a Governor Dashboard of various metrics relevant to SGUH. The meeting was reminded of one of the main duties of the Council of Governors is to hold the Non-Executive Directors to account for the performance of the Board of Directors. Also, they have a duty to represent the views of members. In order to fulfil these aspects of their role they need to be provided with appropriate information which is presented in an accessible format. Governors had requested that a dashboard that a dashboard be developed which summarised key information. ABh commented that in current IQPR there was only a small amount of information shared relating to Patient Experience. He said that this was information which would be particularly useful to be shared with Governors and asked that this be increase in proposed dashboard.	

	Following a question from a NED it was confirmed that the information shared within the proposed dashboard would have been previously reviewed by the Board and its subcommittees prior to be presented to the Council of Governors LB noted that information which had been especially produced for the Council would help them to undertake their role of holding the NEDs accountable. To explore how a dashboard could be developed the following actions were proposed and agreed. • An information/training session should be held for all Governors to discuss how the trust Integrated Quality and Performance Report (IQPR) is produced, and how that data is used to inform discussions held by the Board. • A small Task and Finish Group is formed to develop a draft Governor Dashboard for consideration at the meeting of the Council to be held in December 2025 The Chair confirmed the need for Governor's input into the development of the dashboard in order for it to be a success and a useful tool to help them fulfil their role. He encouraged Governors to join the Task and Finish Group.	
6.0	**MEMBERSHIP ENGAGEMENT**	
6.1	**Membership Engagement Committee Update** The Council received and noted the update from the Membership and Engagement Committee. The GDDCA thanked the Governors for all their hard work on Membership Engagement and cited the recent successful "Meet your Governor event" which was held at SGUH. The Governors raised concern regarding the future of their role, following the recent announcement within the NHS 10 Year Plan that there would no longer be the need for Foundation Trusts to have a Council of Governors. The Chair confirmed that there would be no change proposed to the role of the Governors within the immediate future and therefore it was important for them to continue with promoting membership of the trust and engagement with members at the current time.	
7.0	**Closing Items**	
7.1	**Any Other Business** The GCNO reported that Natalia Henry, Group Chief Midwifery Officer, would be retiring in early August 2025. The Council of Governors asked that thanks be recorded to Natalia for the extreme hard work she had put into the role over the previous few years.	
7.2	**Council of Governors Calendar of Events** The Council received and noted the forward plan for meetings and events.	
7.3	**Reflections on the meeting** The Chair asked for reflections on the meeting. It was agreed that it had been a productive meeting with some useful discussions. The Chair confirmed that in2026/27 the summer meeting would be scheduled away from the peak holiday season so that greater attendance could be achieved.	

Date of next Meeting

St George's University Hospitals
NHS Foundation Trust

24 September 2025 13.30pm – 16.30pm Hyde Park Room, SGUH

Council of Governors - Public - 24 September

NHS
St George's University Hospitals
NHS Foundation Trust

Action Log

Action Ref	Section	Action	Due	Lead	Commentary	Status
COG 12.3.25/3	Finance Update	Training session to be provided on finance pressures	01/06/2025	GCFO	Finance part 2 scheduled for 13th October	PROPOSED FOR CLOSURE
COG 22.5.25/1	Quality and Performance	CQC Well Led Inspection – Letter in Advance of Report -The full final CQC report would be shared with the Council of Governors once received.'		GCCAO	Final report awaited	
COG.22.5.25/2	Points raised from governor visits	MD–SGUH confirmed that in respect of the Discharge Lounge, it was confirmed that it had recently been moved and more effort need to be made to encourage its use. It was confirmed that the team report to the site team, but work was needed to ensure that they felt more included. The MD-SGUH also confirmed that she would take the feedback away and would see what improvements could be made.		MD-SGUH/GCMO		PROPOSED FOR CLOSURE
COG 24.7.25/1	Points raised by Governors	It was agreed at the last meeting of the council that a holding of a training session of the IQPR be arranged and the set up of a task and finish group to design and propose a Governor Dashboard to follow the IQPR session.			The IQPR Session has been arranged for 30th September	PROPOSED FOR CLOSURE

Council of Governors

Meeting in Public on Wednesday, 24 September 2025

Agenda Item	2.1	
Report Title	**Group Chief Executive Officer's Report**	
Executive Lead(s)	James Blythe, Interim Group Chief Executive Officer	
Report Author(s)	James Blythe, Interim Group Chief Executive Officer	
Previously considered by	n/a	-
Purpose	**For Review**	

Executive Summary

This report summarises key events since the last Council of Governors meeting in July 2025, and provides updates to the Council on strategic and operational activity across the Trust. Specifically, this includes updates on:

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

Action required by Council of Governors

The Council of Governors is asked to note the report.

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NHS
St George's University Hospitals
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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				

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NHS
St George's University Hospitals
NHS Foundation Trust

Group Chief Executive Officer's Report

Council of Governors, 24 September 2025

1.0 Purpose of paper

1.1 This report provides the Council of Governors with an update on strategic and operational activity across the trust since the Council last met in July 2025.

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 published a new Planning Framework for the NHS in England on 8 September 2025. The new Framework moves away from annual funding settlements and planning cycles to focus on long-term strategic planning. Under the Framework, all trusts have been asked to prepare credible, integrated five-year plans, demonstrate how financial sustainability will be secured over the medium-term, and demonstrate robust triangulation between finance, quality, activity and workforce. These plans cover the period 2026/27 to 2030/31.

2.8 NHS England expects planning to be a collective activity which draws on input from staff, patients and local communities and has set out five principles for effective integrated planning: (i) planning should be outcome-focused in delivering tangible and measurable outcomes for patients and the public and improved value for taxpayers; (ii) planning should be accountable and transparent, with clarity of roles and responsibilities and with governance structures that support transparent decision-making and effective oversight; (ii) planning should be evidence based, and underpinned by robust analytical foundations including population health analysis, demand and capacity modelling, workforce analytics, and financial forecasts; (iv) planning should be multi-disciplinary, bringing together staff from across different functional areas to ensure that work is coordinated and that those responsible for delivery have shaped the content; and (v) planning should be credible and deliverable, setting ambitious but achievable goals clearly articulating the resources requires, and clear risk mitigation strategies.

2.9 The Framework sets out a key role for NHS trust boards in developing these medium-term plans – in setting direction, reviewing drafts, and constructively challenging assumptions and in ensuring that the planning process follows the five principles set out above. Our Group Board has already held a session considering the implications of the NHS 10 Year Plan and has discussed plans and potential timescales for the development of our medium-term plans, and will be discussing the development of the plan at each meeting through to submission. The Board will be using 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.

Provider Capability Assessment

2.10 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

2.11 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.

2.12 Trusts have until late October to carry out the self-assessment and submit this for NHS regional oversight. The assessments will then be reviewed and triangulated with other information sources and each trust will be given one of the following capability ratings:

- 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.

2.13 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

2.14 On 15 September 2025, the Department of Health and Social Care (DHSC) announced the 14 NHS trusts that will be reviewed as part of the national maternity and neonatal investigation. The list of trusts is available on the DHSC website. They have been chosen for investigation based on a range of metrics including CQC maternity patient survey data, perinatal mortality rates, as well as criteria to determine a diverse mix of trusts. St George's maternity service is not being reviewed as part of the national investigation. The stated purpose of the investigation 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. 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. The review is expected to produce an initial set of national recommendations by December 2025.

3.0 Our Trust

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. These reports are on the agenda of the Council of Governors meeting, so there will be an opportunity to discuss these in further detail.

3.2 As the Council of Governors 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.

National Oversight Framework

3.3 In June 2025, NHS England published its new National Oversight Framework (NOF). The NOF sets out how NHS England will assess NHS trusts and foundation trusts alongside a range of metrics for assessment. The NOF is intended to assist NHS England in identifying where trusts need additional support.

3.4 Under the NOF, trusts are assessed against 22 different metrics, each of which is assessed on a scale of 1 to 4 (with 1 being the highest rating). All individual metric scores are consolidated, averaged and quartiled to give a single overall segment of 1, 2 3 or 4. An adjustment is then made by NHS England to ensure that any organisation with an underlying financial deficit cannot be allocated to a segment higher than 3. The segment is then finalised, and as part of this NHS England considers the organisation's capability and segment to identify the most challenged providers, placing them in segment 5.

3.5 As part of this process, on 9 September 2025 NHS England published its NHS trust performance league tables, setting out where each provider ranks and the segment into which they have been placed. St George's was ranked 37 out of 134 acute trusts, with an consolidated score of 2.0 across the 22 metrics. The score would have placed St George's in the second quartile overall, but the financial override on account of the Trust's deficit means that it has been placed in the third quartile.

Artificial intelligence in the Emergency Department

3.6 Hands-free Artificial Intelligence (AI) technology that gives staff more time to see patients has been piloted at St George's in the largest, most extensive trial of its kind. Tech trialled in our Emergency Department (ED) halved the time it took clinicians to do paperwork, saving each an additional 47 minutes – the equivalent of one patient per shift. St George's was the only ED to

take part in the pilot, run by Great Ormond Street Hospital and funded by NHS England, examining how AI note-taking can free up time in the NHS. Health Minister Stephen Kinnock visited the ED at St George's earlier this month to see the pilot in action, and welcomed the innovation and its potential for improving efficiency.

Group Quality and Safety Governance Improvement Plan

3.7 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, with updates to the Board via the Quality Committee.

Equality, Diversity and Inclusion

3.8 The Group Board considered the latest Workforce Race Equality Standard (WRES) and Workforce Disability Equality Standard (WDES) reports at its meeting in September 2025. In relation to the WRES, 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. However, we continue to see under representation of global majority staff at more senior levels of the organisations. In relation to the WDES, 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 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.

3.9 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. The People Committee of the Board is monitoring performance against this, and it is also an area that the whole Board is focused on.

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.

Gesh CARE Awards 2025

4.2 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

4.3 The popular TV series, 24 Hours in A&E, is coming home to St George's, and filming started earlier 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

4.4 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. 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

4.5 Arlene Wellman, Group Chief Nursing Officer, left the organisation at the end of August 2025 to take up a new role with the Florence Nightingale Foundation. Arlene has been Group Chief Nursing Officer since February 2022, having previously served as Chief Nurse at Epsom and St helier. 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 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.

Welcome to Elaine Clancy

4.8 As the recruitment process for a substantive successor to Arlene will take some time, we delighted to have appointed Elaine Clancy as Interim Group Chief Nursing Officer, on secondment from her substantive position as Chief Nurse at South West London Integrated Care Board. Elaine is a trained adult, paediatric and A&E nurse, who has worked on the frontline in our Emergency Department at St George's and was previously Head of Nursing for Medicine at the Trust. Her more than 30 year career in the NHS has also seen her hold senior roles at the Trust and other hospitals and community providers in the capital. Elaine started in her new role on 15 September.

Thank you to Jacqueline Totterdell

4.8 After eight years at St George's and four at Epsom and St Helier, our Group Chief Executive Officer, Jacqueline Totterdell, is leaving the Group 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. Jacqueline joined St George's in May 2017, at a time when the Trust was one of only 15 trusts in the country in 'special measures' for both quality and finance. Jacqueline led the trust out of special measures for finance in December 2019 and out of special measures for quality in March 2020, navigated the Trust through the challenges of the Covid-19 pandemic and played a key role in the wider South West London system response to Covid, and has been a driving force behind the development of our hospital Group. Jacqueline has been an inspirational leader of the Trust and the wider Group and we wish her the very best as she takes on her exciting new role leading the NHS in Wales.

4.9 I am delighted to have been appointed as Interim Group Chief Executive Officer while the recruitment for a substantive successor to Jacqueline is undertaken, and I look forward to working with the Council of Governors over the coming months.

5.0 Recommendations

5.1 The Council of Governors is asked to note the report.

Council of Governors

Meeting on Wednesday, 24 September 2025

Agenda Item	**3.1**	
Report Title	**St George's Hospital CQC Inspection Update**	
Executive Lead(s)	Elaine Clancy, Interim Group Chief Nursing Officer	
Report Author(s)	Alison Benincasa, Group Director of Compliance	
Previously considered by	Group Board	05 September 2025
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 Council
The Council 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

Table of contents

Overall findings . . . 3

Ratings for this location . . . 3

Overall location summary . . . 3

Safe . . . 5

Effective . . . 5

Caring . . . 5

Responsive . . . 5

Well-led . . . 6

Acute services . . . 7

Maternity . . . 7

Overall service ratings . . . 7

Our view of the service . . . 7

People's experience of the service . . . 9

Safe . . . 9

Effective . . . 27

Caring . . . 36

Responsive . . . 43

Well-led 53
Surgery 66
Overall service ratings 66
Our view of the service 66
People's experience of the service 67
Safe 67
Effective 77
Caring 83
Responsive 88
Well-led 94
Urgent and emergency services 103
Overall service ratings 103
Our view of the service 103
People's experience of the service 104
Safe 105
Effective 120
Caring 125
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

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

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.

Acute services
Maternity

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

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.

Acute services
Maternity

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

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.

Acute services
Maternity

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

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

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.

Acute services
Maternity

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.

Acute services
Maternity

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.

Acute services
Maternity

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,

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

Acute services
Maternity

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.

Acute services
Maternity

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.

Acute services
Maternity

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

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.

Acute services
Maternity

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

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.

Acute services
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.

Acute services
Surgery

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.

Acute services
Surgery

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

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

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.

Acute services
Surgery

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

Acute services
Surgery

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

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

Acute services
Surgery

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.

Acute services
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.

Acute services
Surgery

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.

Acute services
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

Acute services
Surgery

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

Acute services
Surgery

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.

Acute services
Surgery

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.

Acute services
Surgery

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.

Acute services
Surgery

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

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

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.

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

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

Acute services
Urgent and emergency services

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.

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

Table of contents

Overall findings. . . . 3

Ratings for this location . . . 3

Overall location summary . . . 3

Safe . . . 4

Effective . . . 4

Caring . . . 4

Responsive. . . . 4

Well-led . . . 4

Acute services . . . 5

Surgery . . . 5

Overall service ratings . . . 5

Our view of the service . . . 5

People's experience of the service . . . 6

Safe . . . 6

Effective . . . 15

Caring . . . 20

Responsive . . . 24

Well-led 29

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,

Acute services
Surgery

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

Acute services
Surgery

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%.

Acute services
Surgery

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

Acute services
Surgery

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

Acute services
Surgery

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

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.

Acute services
Surgery

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.

Acute services
Surgery

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

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

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

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

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

Acute services
Surgery

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.

Acute services
Surgery

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

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

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.

St George's University Hospitals
NHS Foundation Trust

Council of Governors

Meeting in Public on Wednesday, 24 September 2025

Agenda Item	3.2	
Report Title	**SGUH Operational Performance**	
Executive Lead(s)	Kate Slemeck, Managing Director - St George's	
Report Author(s)	Ed Nkrumah, Group Director of Performance & PMO	
Previously considered by	N/A	
Purpose	**For Noting**	

Executive Summary

This report provides an overview of key operational performance measures and improvement actions at St George's Hospitals (SGUH), based on the latest available data. It highlights both the successes achieved during the month and the challenges affecting performance, which are listed below and summarised in the executive summaries.

The metrics and targets covered in this report are aligned with gesh strategic priorities relating to CARE, and with national priorities outlined in the following documents:

- NHS Priorities and Operational Planning Guidance
- NHS System Oversight Framework
- NHS Constitution and National Standard Contract

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 Trust 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.

In elective care, validation of the waiting list is helping improve data quality and enabling more accurate service planning. RTT Performance was maintained through June 2025 with long waits seeing some 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).

St George's University Hospitals
NHS Foundation Trust

Performance against urgent and emergency care (UEC) measures remains variable, with SGUH maintaining a compliant position against the 4-hour target (78%). UEC transformation remains a key priority for gesh, with several initiatives underway to improve flow, reduce 12-hour waits 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).

Data is presented using statistical process control, with benchmarking information included where available. The data quality status of each metric is also noted in the report.

The format and content of this report will continue to evolve in 2025/26 to reflect the Trusts' annual plans and any new guidance — such as the Performance Assessment Framework, which replaces the NHS System Oversight Framework.

Action required by Council of Governors

The Council of Governors is asked to:

1. 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

Regulated activities

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

Compliance with the Health and Social Care Act 2008 (Regulations 2014) and CQC Registration Regulations

St George's University Hospitals
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Equality, diversity and inclusion implications
Environmental sustainability implications

gesh

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

SGUH Operational Performance Report

July 2025

Outstanding Care, Together: Our strategy 2023 to 2028

Publication Date: 16/09/2025 | Contact: gesh.performance@stgeorges.nhs.uk

Executive Summary
Operational Performance

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

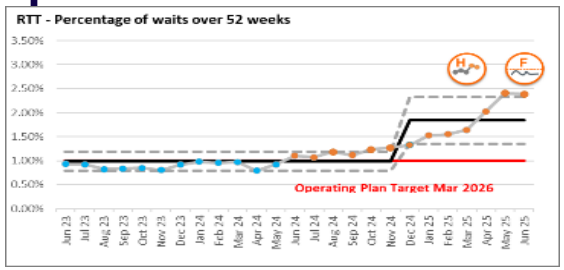
- Cancer 28 day Faster Diagnosis Standard performance was 75.4% in June 2025, below the 77% national target, due in part to a higher seasonal fluctuation.
- Cancer 62-day referral-to-treatment performance improved to 77% in June 2025 but remains below plan. A proposal for a short-term, high-volume solution 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 patient's 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.

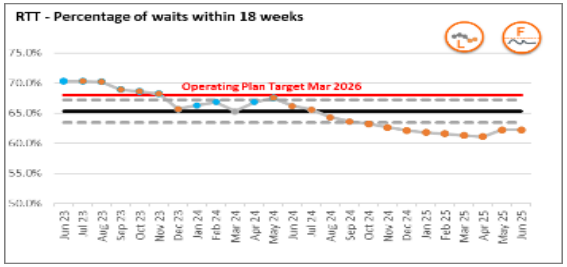
Operational Performance
Overview Dashboard

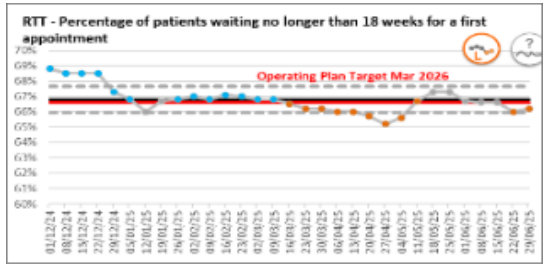
	St George's						
KPI	Latest month	Previous Month Measure	Latest Month Measure	Target	Variation	Assurance	Benchmark
RTT - Percentage of waits over 52 weeks	Jul 25	2.39%	2.47%	1.00%			3rd Quartile
RTT - Percentage of waits within 18 weeks	Jul 25	62.2%	61.2%	68.0%			2nd Quartile
RTT - Percentage of waits within 18 weeks for first appointment	Jul 25	66.2%	65.2%	66.6%			2nd Quartile
RTT- Waiting List – total children under 18	Jul 25	6716	6679	7715			-
Cancer - 28 Day Faster Diagnosis Standard	Jun 25	84.8%	75.4%	82.7%			3rd Quartile
Cancer 62 Day Referral to Treatment Standard	Jun 25	76.0%	77.0%	85.0%			Top Quartile
Diagnostics - 6 Week Waits	Jul 25	5.4%	4.3%	5.0%			Top Quartile
4 Hour Operating Standard	Jul 25	80.1%	78.6%	78.0%			Top Quartile
Over 12 Hours in ED from Arrival (%) Type 1	Jul 25	12.1%	10.3%	13.0%			3rd Quartile
Ambulance average Handover Time (min)	Jul 25	00:24:22	00:24:01	00:24:00			3rd Quartile

Operational Performance

Exception Report| SGUH Referral to Treatment (RTT)



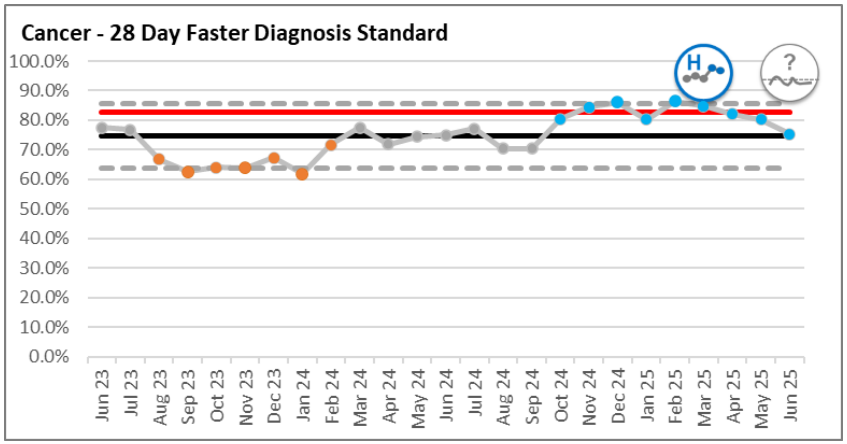


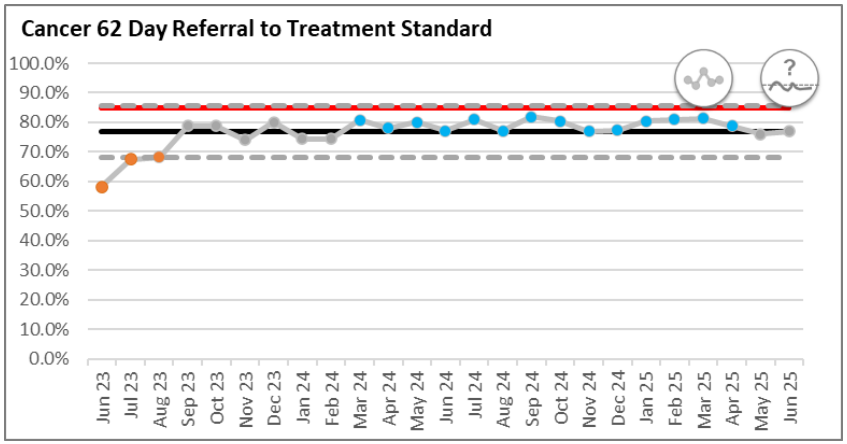


Site & Metric	Cause of variance/ non-compliance	Actions: Completed since last update, New, and Ongoing	Recovery Date	Data Quality
SGUH % waits over 52 weeks – above plan % within 18 weeks – maintained in June below plan % wait for first attendance – decrease through June	At the end of June 2025; Proportion 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 | SGUH 28 day and 62 day Cancer Performance

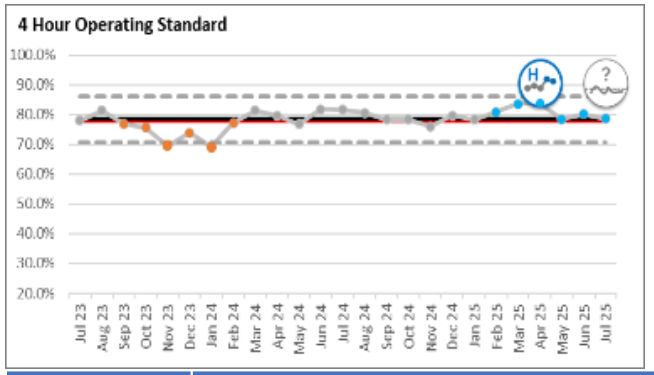


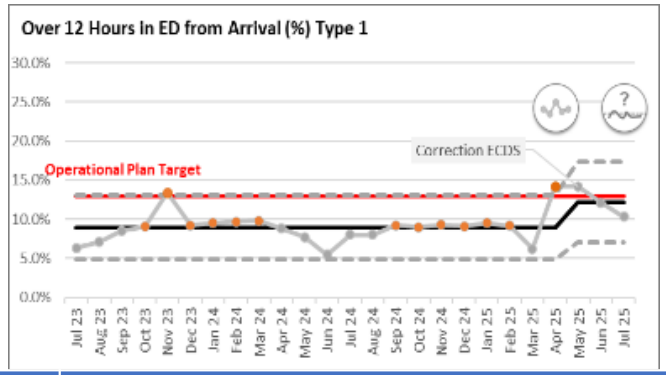


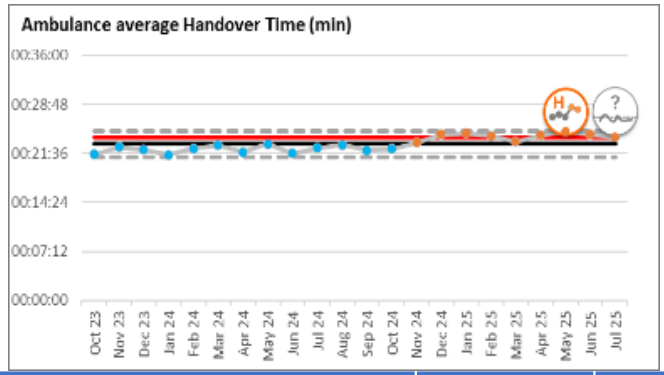
Site & Metric	Cause of variance/ non-compliance	Actions: Completed since last update, New, and Ongoing	Recovery Date	Data25 Quality
SGUH 28 Day – below trajectory of 82.42% 62 Day Normal variation below trajectory of 80%	**28 Day performance 75.4% for June 2025 – below monthly trajectory of 82.42%, driven 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 | 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 Productivity

Overview Dashboard

	St George's						
KPI	Latest month	Previous Month Measure	Latest Month Measure	Target	Variation	Assurance	National Benchmark
Implied Productivity Growth	Mar 25	3.1%	5.2%	-	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
Average delay to discharge	Jun 25	5.0	4.4	5.6			2nd Quartile
Theatre Utilisation (Capped)	Jul 25	83.0%	82.0%	85.0%			2nd Quartile
BADS All Daycase & Outpatient Procedures % of total procedures	Apr 25	81.9%	82.2%	83.6%			3rd Quartile
Outpatients Patient Initiatied Follow Up Rate (PIFU)	Jul 25	2.4%	2.5%	5.0%			Lowest Quartile
Outpatients Missed Appointments (DNA Rate)	Jul 25	9.9%	9.8%	8.0%			Lowest Quartile
First and Procedure Attendances as a proportion of Total Outpatients	Jul 25	52.5%	51.7%	49.0%			2nd 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.

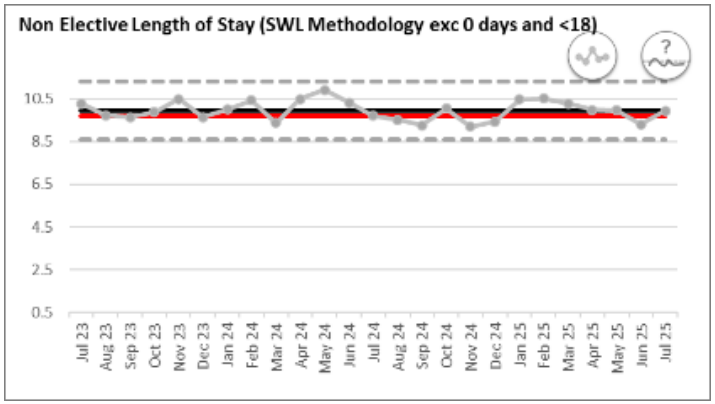
NHS England is expected to publish further detail on the methodology in September 2025, which will help identify key areas for improvement.

Summary and actions

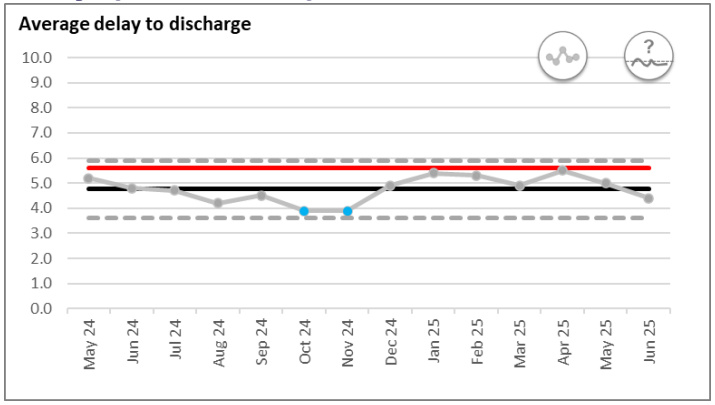
- The *Implied Productivity* national metric shows a 5.2% improvement in productivity in 2024/25 YTD Month 12 compared to same period the previous year (2023/24). This is driven higher weighted activity growth of 7.2% compared to cost growth of 1.9%.

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.

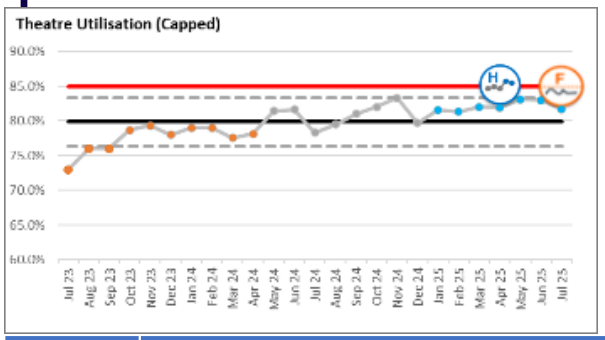


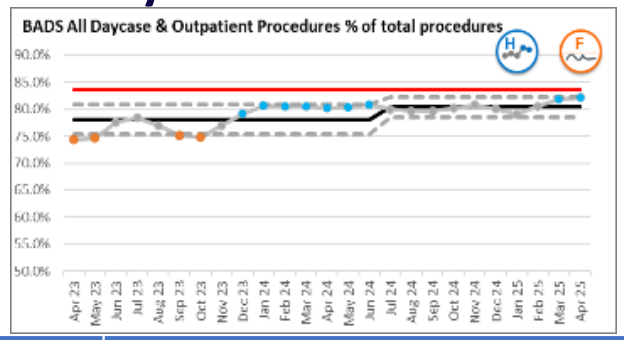
Acute hospital discharges and bed days after the Discharge Ready Date averaged over a complete month.
Numerator: The number of days from discharge ready date to date of discharge
Denominator: The number of patients with a delay of 1 or more days that have been discharged

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 & Daycase Procedure Rates





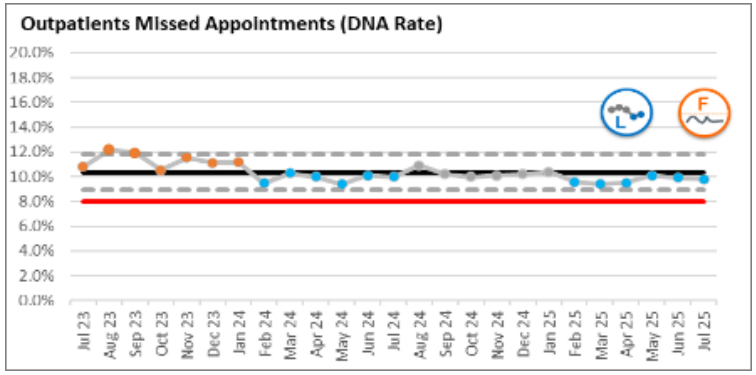
Metric	Reporting Month	Productivity Opportunity vs Top Quartile
Capped Theatre Utilisation	Jul-25	19 cases (based on an average case time of 124 min) to hit top quartile
Day cases and outpatient procedures (BADS)	Apr-25	433 cases opportunity to move to OP (3 month period)

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

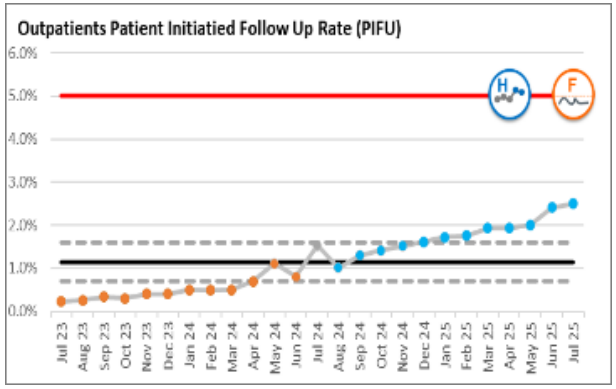
The methodology to calculate the opportunity to reduce the number of missed outpatient appointments is based on how your average missed outpatient appointments rate (from the last 6 months) compares to the national missed appointments profile for providers.

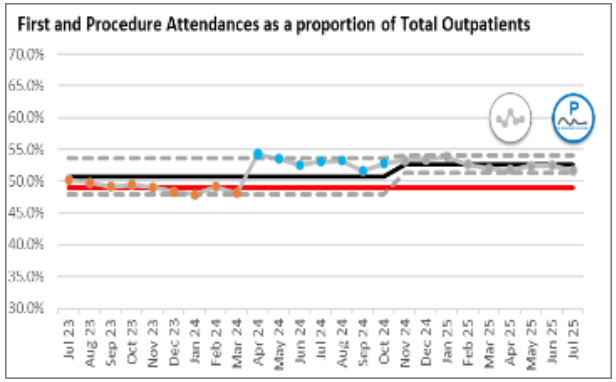
Site & Metric	Cause of variance/ non-compliance	Actions: Completed since last update, New, and Ongoing	Recovery Date	Data Quality

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

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

gesh

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

Appendices

13

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.

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	H	F	Highest Quartile
Number of Complaints Received	Jul 25	73	75	-			N/A
Number of re-opened complaints in month	Jul 25	0	5	-	L		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	H	?	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	H	P	2nd Quartile
Emergency Department Attendances per day	Jul 25	440	432	-			N/A
Mental health delays 4 Hour Breaches	Jul 25	138	158	-	H		N/A
Length of stay > 21 days (super stranded)	Jul 25	150	134	-	L		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	-	L		2nd Quartile

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

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	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).		
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
DNA Rates	Numerator: Outpatient missed outpatient appointments (DNAs) Denominator: Total outpatient appointments	Group and System Priority	Model Hospital
Advice and Guidance Rates	Utilisation of Specialised Advice. It is calculated based on the number of 'Processed Specialist Advice Requests' and is presented as a rate per Outpatient First Attendances.	Group, System and National Priority	NHS England Model Hospital
Never Events	Never Events are serious incidents that are entirely preventable	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
Falls	Number of unexpected events in which a person comes to the ground or other lower level with or without loss of consciousness	gesh Priority - Fundamentals of Care	Local Data
Pressure Ulcers	Number of patients with pressure ulcer (Category/Stage 3 & 4) in the Trust over a specific period of time.	gash 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

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

SGUH Council of Governors

Meeting on Wednesday, 24 September 2025

Agenda Item	4.1	
Report Title	**Finance Performance M4**	
Executive Lead(s)	Andrew Grimshaw, Group Chief Finance Officer	
Report Author(s)	GCFO, SCFOs	
Previously considered by	n/a	-
Purpose	**For Review**	

Executive Summary

- Month 4: SGH has reported on plan at month 4. In order to do this some additional non-recurrent benefit has been added to help support that position. This brings forward other planned benefits and mean the challenge for later in the year increases. The Trust remains committed to delivering the financial plan in 25/26.
- CIPs. Overall, on plan at month 4, although this is the month although SGH has utilised more non-recurrent actions to achieve this position given lower than planned levels of recurrent CIPs. This will cause pressure later.
- Workforce. SGH is 497 WTE adverse to plan, driven by lower levels of CIPs than the value expressed in the plan and increases in M12 24/25 not fully reversed back yet. There is an offsetting variance in TUPE of Corporate staff.
- The Council of Governors is asked to note that while the position is on plan the underlying position remains highly challenging, and looking at coming months our ability to remain on plan will be impossible to maintain unless more CIPs are identified.

Action required by SGUH Council of Governors

The Committee is asked to:

- Note the paper

Committee Assurance	
Committee	Council of Governors
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

[…]

Equality, diversity and inclusion implications

Environmental sustainability implications

[…]

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Council of Governors : 24th September 2025
25/26 M04 Financial Performance

GCFO, SGH Site CFO, ESTH Site CFO

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Introduction from GCFO

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Key messages

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Group M02 position

GESH

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	SGH		Comment
	Value	RAG	
I&E in month	£0.0m		STG - £4.8m mitigation in month to support baseline pressures and CIP under delivery
I&E cumulative	£0.0m		
I&E Forecast	£0.0m		SGH shows material risk against the year end forecast. Residual net risks have been reported at M4, but additional work is underway to mitigate this risk. The Trust Board in common remains committed to delivering the plan.
CIP fully developed	41.5%		Identification and delivery of the level of CIPs in the plan remains the trust's largest financial risk
CIP delivery	£0.0m		£7.2m of CIP mitigation to support YTD CIP delivery
Income	£0.3m Adv		YTD adverse variance due to underperformance on staff recharges offset by vacancies
Pay	£3.8m Adv		YTD adverse position reflects CIP underperformance of £4.5m offset by £1.4m of brought forward mitigation. £0.7m of Industrial Action pressure
Non-pay	£4.1m Fav		YTD favourable position reflects £7m of central mitigation to support baseline and CIP under delivery
Workforce	497 Adv		458 CIP shortfall in line with £ performance and stepped increase in CIP target in M4.
Cash in bank	£59.5m		largely in plan. Net inflow in month £8m.
BPPC (non-NHS %)	89%		SGH below 95% compliance for non-NHS payments. Delays in creditors being approved for payment remains the major challenge. Steps are being taken to improve this.
Capital	£7.7m Fav		Expecting to increase as year progresses

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SGH - Summary Reported Position

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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**

CIP	Plan £'000s	Actual £'000s	Variance £'000s	Plan £'000s	Forecast £'000s	Variance £'000s
Pay - Recurrent	8,739	1,883	-6,856	40,243	31,632	-8,611
Non-pay - Recurrent	4,668	2,098	-2,570	30,100	27,673	-2,427
Income - Recurrent	859	991	132	3,957	14,995	11,038
Recurrent Efficiencies	14,266	4,972	-9,294	74,300	74,300	0
Pay - Non-recurrent	2,128	2,197	69	9,805	6,651	-3,154
Non-pay - Non-recurrent	1,140	9,849	8,709	10,242	11,846	1,604
Income - Non-recurrent	206	725	519	953	2,503	1,550
Non-Recurrent Efficienc	3,474	12,771	9,297	21,000	21,000	0
Total	**17,740**	**17,743**	**3**	**95,300**	**95,300**	**0**

Key Metrics		Plan	Actual	Variance
Cash	£m	70,435	79,702	9,267
Capital	£m	-15,417	-7,700	7,717
BPPC volume non NHS	%	95.00%	89.40%	-5.60%

Summary

- The Trust is on plan at M4 and forecasting this as well.
- CIP is on plan primarily being delivered non-recurrently.
- WTE is adverse by 497 owing to CIP shortfall
- Cash largely in line with expectation.
- Capital is underspent by £7.7m
- BPPC is lower than the 95% target

SGUH Council of Governors

Meeting on Wednesday, 24 September 2025

Agenda Item	5.1	
Report Title	**gesh People Strategy 2024-26 Progress Report**	
Executive Lead(s)	Victoria Smith, Group Chief People Officer	
Report Author(s)	Victoria Smith	
Previously considered by	People Committee-in-Common	21 August 2025
Purpose	**For Noting**	

Executive Summary

The gesh People Strategy 2024-26 is a key enabler to delivering the gesh CARE Strategy, specifically the objective to develop 'empowered, engaged staff'. It is an ambitious and wide-ranging strategy, comprising of five key pillars, underpinned by a robust governance process.

The Strategy addresses the significant challenges currently facing the NHS and particularly how these impact on the workforce. At the heart of our strategy is a commitment to strengthening the quality of our services, investing in the development of our people, supporting staff wellbeing, developing an inclusive culture and enabling integrated working across the group. Within these broader goals are a number of key activities and deliverables with clearly-defined measures and timelines.

Through this strategy, we are aiming to make gesh one of the best places to work in London with a workforce equipped with the skills to provide high quality healthcare for our patients, now and in the future.

This report provides an update on progress made against the key pillars pf the People Strategy and includes our upcoming priorities. Please note, it does not cover every deliverable contained within the strategy, but rather some high priority areas, and those we believe are of interest.

In addition to the above, there are a couple of points which we would like to flag:

- Given that we are in the early stages of delivery, we are not yet able to assess the impact of the specific deliverables and interventions, however we hope to be able to do so in the upcoming months.
- The Strategy comprises of five specific strategic pillars, however the pillar Developing our workforce for the future is currently on pause. This is due to a number of factors, including the financial restraints on capital investments and our on-going work to re-assess how we collaborate with City St George's University of London. The 10 year plan provides new strategic direction for this pillar and we expect to refresh it shortly.

An update on our preparations for the launch of the 2025 Staff Survey is also included towards the end of the paper. Our aim is to exceed last year's response rate. We also aim to improve our engagement scores, however given the financial constraints and operational demands experienced by our staff the sector is expecting a dip in engagement overall.

Action required by SGUH Council of Governors
The Council is asked to: a. Note progress which has been made against the key deliverables of the Strategy b. Provide specific feedback on the key objectives and associated deliverables

Committee Assurance	
Committee	Council of Governors
Level of Assurance	Choose an item.

Appendices	
Appendix No.	**Appendix Name**
Appendix 1	[…]

Implications

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☐ Affordable Services, fit for the future
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[…]

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☐ 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

[…]

Equality, diversity and inclusion implications

The delivery of the gesh EDI Action Plan is an important part of the People Strategy and is tracked within the programme.

Environmental sustainability implications

[…]

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gesh People Strategy 2024-26

Progress Report

Council of Governors

September 2025

gesh People Strategy 2024-2026

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

Our vision is that by 2028 gesh will be among the top five acute trusts in London for staff engagement.

We will achieve this through a focus on the following areas:

- Get the basics right for all our staff
- Improve staff learning opportunities and wellbeing
- Ensure our culture is inclusive and driven by our values
- Develop our workforce for the future
- Embrace integrated ways of working

Our People Strategy sets out the actions we will take over 2024-2026 against these areas.

Get the basics right for all our staff

- Transform our HR function through improved processes and automation of key systems

Improve staff learning opportunities and wellbeing

- Improve line management and leadership
- Improve training and career development
- Reform the way we recognise and reward staff
- Keeping our staff healthy and safe

Inclusive culture driven by our value

- Deliver our Diversity and Inclusion Programme
- Develop a shared set of values across gesh
- Roll out High-Performing teams and continuous improvement

Develop our workforce for the future

- Develop new workforce models through Building Your Future Hospital
- Explore strategic collaboration with SGUL & City

Embrace integrated ways of working

- Enable collaboration across gesh

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Summary

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The Council of Governors is asked to:

- Note progress which has been made against the key deliverables of the Strategy
- Provide specific feedback on the key objectives and associated deliverables

gesh

Getting the basics right for our people

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This objective focuses on developing a more efficient and effective People function. This means maximising opportunities relating to digital interventions, improving and streamlining our operational processes, and delivering a responsive service with high quality information which meets the needs of our teams.

Key deliverable	Description	Progress to date	Upcoming priorities
Workforce Controls Programme	This agenda seeks to optimise how we manage our workforce, including better oversight, improved productivity and reduced spend.	• Key pillars of Workforce Controls Programme agreed • Pre-implementation work commenced (including PIDs, methodology, risks and review of key systems) • Overarching programme plan developed • Data Warehouse infrastructure live • People Digital Strategy developed (including roll out of Loop app in line with plan) • A number of key group posts in place to lead specific aspects of the agenda • ESR Manager Self Service implemented (c. 600 staff)	• Formally launch key workstreams and commence delivery against the plan • Complete roll out of Loop app across SGUH teams • Launch medical rostering (at SGUH)
Sickness absence management improvement initiative	This programme seeks to optimise the ways sickness absence is managed across the group. This includes making improvements to the operational running of the ER team and equipping managers with the knowledge and skills required to manage sickness effectively within their teams.	• Refreshed ER tracker in place to support more effective monitoring of all ER cases across gesh • Process in place to share sickness absence data with teams in a timely manner • Sickness absence challenge board pilot stood up at ESTH to strengthen monitoring of all cases	• Complete overarching review of all live sickness absence cases to ensure robust plans are in place to resolve as quickly as possible • Complete continuous improvement work to reduce processes associated with investigations (to reduce resolution time) • Develop and roll out gesh-wide sickness absence management training for staff to build capability across all teams

gesh

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Improving staff learning opportunities and wellbeing

The current challenges being place on the NHS inevitably impact on our workforce. Therefore, it is vitally important that we support the wellbeing of our people and provide them with the skills they need to thrive whilst they are at work. This objective focuses on both of these aspects, ensuring that we have a highly-skilled, happy and healthy workforce which is equipped to meet the demands of the current operating environment.

Key deliverable	Description	Progress to date	Upcoming priorities
gesh Leadership and Management Development Programme	This programme will combine the existing training into a joint leadership and management offer, to ensure our people have the skills needed to deliver excellent services.	• Engagement exercise conducted with senior teams across gesh and feedback incorporated into programme design • Existing content mapped to core competencies required by our staff to ensure alignment • Implementation plan developed with timelines, key deliverables and responsible leads	• Identify pilot areas for programme and launch (pilot due to run August-October 2025) • Complete consolidation of learning offer to support pilot • Formal programme go live launch (December 2025)
Apprenticeships Strategy	Apprenticeships play a vital role in supporting the development of our workforce across all areas and levels of seniority (both clinical and non-clinical). As a group, we receive an Apprenticeship Levy of £10.7m across a wide range of programmes. This supports us to address workforce gaps, develop future talent and upskill our staff. It also supports retention.	• Apprenticeships Strategy developed and launched across gesh • **273** live learners to date across **60** different programmes • **27.4%** of levy fund spent **(£2.9m)** • Strong focus on senior leadership and advanced professional development programmes	• Continue to promote apprenticeships across gesh to increase uptake • Focus on expanding levels 2-4 apprenticeships (entry level and early career) to support talent pipeline in these areas • Expand uptake in digital apprenticeships (currently 30 learners enrolled in digital programmes)

gesh

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University Hospitals and Health Group

Improving staff learning opportunities and wellbeing

Key deliverable	Description	Progress to date	Upcoming priorities
Health and Wellbeing	At gesh we run a highly impactful health and wellbeing offer. This is incredibly important to ensure that we are supporting our staff to enable them to provide the best possible care for our patients. This is patricianly important in the current operating environment where our people are faced with a number of significant challenges.	• Launched *What Matters to You* pilot across gesh (quality improvement programme to enhance wellbeing within teams) • Currently **200** Health and Wellbeing Champions trained at SGUH and **40** at ESTH to promote key initiatives within their teams • Group-wide Wellbeing Steering Group in place and first meeting held to develop and oversee strategy	• Complete *What Matters to You* pilot and scale across gesh • Launch Wagestream app to enable staff to support financial education and access to early salary instalments (September) • Roll out Health and Wellbeing Champions training and engagement programme at ESTH
Violence and Aggression	The NHS operates under a zero tolerance policy regarding violence and aggression towards its staff. This work aims to protect our staff from physical or verbal abuse, ensuring a safe environment for both staff and patients.	• A new Violence Reduction and Prevention policy has been developed with input from a large range of internal stakeholders • A task force is in place to review and improve all operational practices in this area, including liaison with police services	• Roll out the new policy and associated processes and training • Build confidence in how we apply sanctions on the front line • Continue to develop systematic measures that prevent colleagues being harmed
Sexual Safety	The NHS NHSE launched its first sexual safety charter in September 2023. The charter is an agreement of ten pledges including commitments to provide staff with clear reporting mechanisms, training, and support. This programme seeks to embed meaningful change across gesh.	• The charter was launched officially across gesh in 2024 with intranet resources, a toolkit, eLearning and OD events • An assurance framework is in place and being monitored regularly by a senior and committed working group	• A new sexual misconduct policy will be approved in Sept • Specialist training will be sourced for ER specialists and Sexual Safety Allies who operate in potential areas of concern • An anonymous reporting tool will be test for feasibility

gesh

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University Hospitals and Health Group

Developing an inclusive culture driven by our values

A positive culture where staff feel valued and included is crucial to a high performing organisation. This objective aims to promote an inclusive culture across gesh, maximising the contribution of our diverse and talented workforce.

Key deliverable	Description	Progress to date	Upcoming priorities
gesh Culture Forum	The Culture Forum aims to bring together a range of voices and perspectives to drive improvements in our working cuture across gesh.	• Two High Performing Teams workshops held with HR Senior Leadership Team and Heads of Services to socialise the key principles and develop a leadership behaviour framework. • Stakeholder engagement commenced to support development of new gesh values and behaviours (including with Group Executive and Culture Forum members)	• Complete further HPT workshops, develop and embed framework within team • Complete engagement exercise to inform development of single set of values and behaviours across gesh
Equality, Diversity and Inclusion (EDI) Action plan	The EDI Action Plan aims to create a more inclusive, fair and equitable healthcare system by addressing health inequalities in health outcomes, experience and access, and tackling discrimination and bias within the workforce and leadership.	• Six key EDI workstreams identified, including leadership commitment (to EDI), eliminating pay gaps and supporting internationally recruited staff • Engagement commenced to raise awareness of EDI action plan across teams • 28 actions (out of 59) are complete, and due dates set for outstanding actions • Talent Management Plan approved	• Roll out EDI workstreams • Agree EDI objectives for Board • Commence stakeholder engagement for Talent Management/Career Development programme • Implement recommendations from *Mend the Gap* review

gesh

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University Hospitals and Health Group

Embracing integrated ways of working

The People function plays an important role in supporting integrated working across gesh. It is imperative that we are able to deploy our people across different gesh sites, whilst adhering to a standard set of HR policies at all times. This means we will benefit from the collective knowledge and skills of our workforce whilst ensuring all of our people are managed in a fair and consistent manner throughout their employee journey.

Key deliverable	Description	Progress to date	Upcoming priorities
Single employment contract	This will enable our staff to work across different gesh sites, in both clinical and non-clinical areas. It will ensure we are compliant with key employment laws and practices.	• Single group employment contact in place (now issued to all new starters) • South West London Staff Sharing Agreement in place	• Develop mechanism for supporting/enabling cross-site working for our existing workforce • Promote process across the organisation
Integrated Corporate Services	Group Corporate Services will allow us to bring our teams together to support integration across gesh. This will help us to work more efficiently and to support financial sustainability.	• Majority of Corporate Services now integrated across gesh (Comms, Corporate Affairs, Corporate Nursing, Corporate Medicine, Strategy and Transformation) • People Function phases 1 and 2 completed (all in-scope roles fully integrated as group)	• Complete the integration of remaining Corporate Services • Achieve financial savings • People function: Complete design and implementation of phase 3
People policies	Creating a single set of People policies across gesh will ensure our staff are managed fairly and consistently at all times.	• 9 People policies consolidated as group policies and launched • 3 policies undergone review and awaiting formal approval	• Complete the consolidation of all in-scope People policies and roll out across gesh

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2025 Staff Survey Approach

September 2025

What We Did Well in 2024:
Driving participation and Engagement

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Strong leadership endorsement:
Direct and visible involvement from executives and senior managers, through personal messages and endorsements, site leadership working groups effectively signalled the survey's importance as an organisational priority.

Proactive accessibility measures:
Targeted on-site support, including visits to specific areas and offering alternative survey methods (paper, laptops), successfully addressed practical barriers to participation, particularly for staff with limited IT access.

Tailored communication strategy:
A multi-channel approach, combining department-specific "You Said, We Did" feedback with broader communications via posters, emails, and verbal promotion, ensured relevance and wide reach.

Engaging 'Staff Survey Day':
A dedicated day with interactive stalls across ESTH and SGUH created a vibrant, visible, and engaging environment, transforming participation into a collective experience.

Empowering manager support:
Comprehensive toolkits and FAQs provided to managers built their confidence, enabling them to effectively discuss the survey and motivate their teams.

Where We Need to Improve:
Enhancing trust and impact

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Building anonymity confidence:
We need to explicitly and consistently reinforce how anonymity is guaranteed, directly counteracting scepticism among staff.

Demonstrating actionable change:
A more robust and visible "You Said, We Did" framework, applied consistently at gesh, Divisional, and Service levels, is essential to prove that feedback leads to tangible improvements and to build trust.

Clarifying purpose and value:
A clearer, more compelling communication of the survey's strategic objectives, how past results have been utilised (within gesh and externally in the public sector), and future plans for improvement is vital to ensure staff understand its significance.

Addressing past disillusionment:
We must actively demonstrate that surveys are a genuine tool for workplace improvement for all staff, emphasising that their participation is indispensable, especially for those with previous negative experiences.

Mitigating workload barriers:
The pressure of clinical work and a general lack of time were identified as principal barriers to engaging in non-essential tasks such as the staff survey. We must ensure staff feel supported, not burdened, when asked to participate in the survey.

Response rates 2019 to 2024:
Higher response rates are achievable based on historic performance

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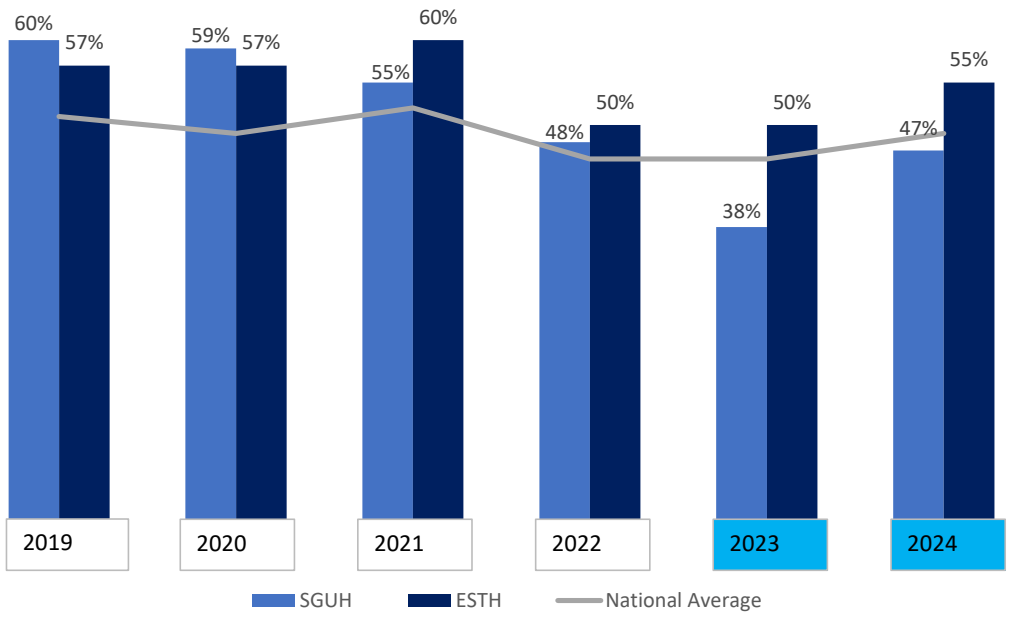

- SGUH peaked in 2019 at 60%, then declined sharply to 38% in 2023 before recovering to 47% in 2024 (2% below the national average).
- ESTH remained comparatively stable, ranging from 55% to 57% in early years, dipped to 50% in 2022–2023, and climbed to 55% in 2024 (6% above the national average).
- Across the 2019–2024 period, ESTH consistently performed closer to or above the national average, whereas SGUH showed more volatility and persistent gaps.

2025 Approach Rationale:
Building on what worked well last year

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

- Same framework as 2024 — delivered 47% (+9% vs 2023) response rate increase
- Targeted comms, protected survey time, senior leader advocacy
- Focus on impact narratives at individual, team, and org levels
- Weekly £20 voucher draw – 4 winners each week

Communication & Engagement Strategy:
Locally led, supported by Comms and HR teams

Mid-September onwards:

- “You Said, We Did” campaign
- Site-wide promotion via posters, HRBPs, OD and Comms teams

During Fieldwork (Oct – Nov):

- Managers’ toolkit and briefing pack
- Weekly divisional league tables
- Case studies and bulletin highlights
- Use of social media, drop-ins, and briefings
- Staff networks and wellbeing champions engaged

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Thank you.

For any other information, please see:

gesh

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Council of Governors

Meeting in Public on Wednesday, 24 September 2025

Agenda Item	6.1	
Report Title	**Report from the Membership Engagement Committee**	
Executive Lead(s)	Stephen Jones, Group Chief Corporate Affairs Officer	
Report Author(s)	Jackie Parker/ Anna Missir	
Previously considered by	n/a	-
Purpose	**For Noting**	

Executive Summary
The Council of Governors is asked to note the matters considered by the Membership and Engagement Committee at its meeting on 16 September 2025.

Committee Assurance	
Committee	Not Applicable
Level of Assurance	Not Applicable

Appendices	
Appendix No.	**Appendix Name**

Implications				
Group Strategic Objectives				
☐ Collaboration & Partnerships		☐ Right care, right place, right time		
☐ Affordable Services, fit for the future		☐ Empowered, engaged staff		
Risks				
N/a				
CQC Theme				
☐ Safe	☐ Effective	☐ Caring	☐ Responsive	☐ Well Led
NHS system oversight framework				
☐ Quality of care, access and outcomes		☐ People		
☐ Preventing ill health and reducing inequalities		☐ Leadership and capability		

☐ Finance and use of resources	☐ Local strategic priorities
Financial implications	
N/a	
Legal and / or Regulatory implications	
N/A	
Equality, diversity and inclusion implications	
As set out in paper.	
Environmental sustainability implications	
N/A	

Report from the Membership and Engagement Committee

Council of Governors, 24 September 2025

1.0 Purpose of paper

1.1 This report sets out the key matters considered by the reconstituted Membership and Engagement Committee at its meeting on 16 September 2025.

2.0 Progress Report

2.1 **Update on activity since last meeting**

The Committee met on 16 September 2025.

At its meeting in June Luisa Brown was welcomed as an observer and as a member of the committee in September. It is also hoped that Ashok Bhat will join future meetings of the committee as an observer with a view to becoming a member.

The 1-year Member Engagement Strategy was prepared with the Committee in Summer 2024 and agreed by Council in September of the same year. Whilst behind schedule progress is being made and with the involvement of governors, we believe that we will still be able to deliver on most areas within the plan. As the Committee agreed in June 2025 some elements, such as the members survey, have been removed.

During the year a key success has been the increase in numbers at the 2024 Annual Members Meeting – linked to the 'Bring A Friend' element, which was led by governors, and direct emails to members. A number of new member sign-ups were received in the days following the AMM. The website pages have also been refreshed and is continued as an on-going process. We also appointed our first Associate Governor (Young Members) Sophia Agha. The Meet Your Governor Event in the Grosvenor Wing was well supported by governors and led to several new member sign-ups. Two more events are planned before the end of the financial year, the first in December in the Atkinson Morley wing of St Georges hospital and the other during January in Queen Mary's Hospital.

Areas where we are yet to make the progress, we would have liked are the Member Talks or specific outreach sessions, but the latter is beginning to move forward with contact made with a number of groups.

The Membership page on the website has been refreshed and advertisements for the SW Lambeth membership recruitment has been added. This advertisement has been used as a leaflet drop campaign in and around the SW Lambeth area which has begun to see an increase in members for the constituency.

2.2 **Update on 2024-25Strategy**

The Committee received an update on the 2024-2025 Strategy from the Governors and Membership Engagement Officer (GMEO) that provided them with information on the following objectives:

Objective 1: Improve the quality of two-way engagement with members

Constituency-specific email addresses - are now operational, enabling members to contact governors directly. This has generated meaningful interaction and improved responsiveness.

Member's newsletter 'Connected' relaunched

The members newsletter 'Connected' has been successfully relaunched with issue three being produced for release in December. The aim of monthly issues proved a little too ambitious, and it was agreed by the Committee that a quarterly newsletter was more achievable and welcomed by the members as not having repetitive information overwhelming inboxes. There was also talk of 'piggy backing' on the Trust newsletter that was due to be reinstated but this has not happened, and we went ahead with our quarterly issue.

(MYG) Meet Your Governor events (both hospitals)

There were two MYG events arranged for May this year. There was excellent uptake for the St Georges event but very little interest for Queen Mary's with only one governor available. The St George's event took place in the reception areas of Grosvenor wing which saw very good governor engagement and a good number of new members sign up. It was expected that in September 2025 the engagement event, in addition to the AMM, would be Freshers Week at City St George's and contact has now been made with the student union. Work has begun in arranging more MYG events at both hospitals St Georges in December in the Atkinson Morley wing and January 2026 at Queen Mary's.

Objective 2: Ensure our membership is representative of the communities we serve – with a focus on engaging with younger members

In March 2025, the Council confirmed the appointment of Sophia Agha as the first Associate Governor (Young Members), following a process initiated in December 2024.

Sophia has since become an active and valued contributor to the Committee, helping shape our approach to younger members. Some of Sophia's ideas have included Fresher's Week as noted above, Volunteer days, Health awareness campaigns and St George's medical students' hackathon-style competitions amongst others as part of our 2025 -2028 plan.

Governors also wished to focus on increasing our members from a BME background to reflect the community the trust serves. We have reached out to the EDI team for guidance on how this might be achieved and a meeting with the team has now been arranged.

Objective 3: Maintain and where possible increase our membership, perhaps with a focus on increasing numbers in SW Lambeth

The "Bring a Friend" initiative was first used at the Annual Members Meeting (AMM) in 2024 and was extended to other events including Diwali, Christmas celebrations, and Armed Forces Day. Whilst this was successful at the AMM, and is being repeated for 2025, we have not seen any significant member engagement at any of the other events that governors have been invited to. A priority for the team is to work with the Communications Team to ensure that we are able to provide more notice of these events.

Good connections have been made with the Patient Partnership Engagement Group (PPEG) lead, Wendy Doyle. In April this year Wendy reached out to the GMEO for help in assigning a governor to three workstreams:

- Carers
- Accessible Information Standard
- Patient Equality, Diversity and Inclusivity

John Hallmark is a member of PPEG and Afzal Ashraf has been linked with the Armed Forces Community. Governors Alfredo Benedicto and Jackie Parker have offered their support with the Carers and Accessible Information Standards and have also become more involved with the St George's Charity.

There were no volunteers for the Patient Equality, Diversity and Inclusivity workstream so it was agreed by the committee that this could be put out to the wider group of governors for a volunteer.

Governor Sarah Forester also has links with the Age Concern Wandsworth.

Despite the activity, South West Lambeth remains under-represented although there has been some success with 10 new members from South West Lambeth in recent months. A social media campaign at the time of the last governor elections did not yield the desired results but this will be repeated for the upcoming elections supported by the targeted leaflet drop across GP surgeries and local networks.

2.3 **Draft Membership Engagement Strategy 2026-2028**

The committee received the draft Membership Engagement Strategy 2026-2028 from the Group Deputy Director of Corporate Affairs (GDDCAO) who highlighted the following:

It was proposed that the core objectives of the strategy remain broadly the same with one addition to objective 2:

- **Objective 2: Ensure membership reflects the diversity of our communities, with a particular focus on engaging younger members and those from a global majority background**

Its believed that two of the main factors in not realising all of the actions in the 2024-25 plan were the unavoidable issues of reduced staff capacity and the hiatus in the meetings of the Membership Engagement Committee, there is learning from the past year that we have used when drafting the 2026-28 plan – some of which are linked to these two elements. The result of this is that the draft Strategy has a greater focus on advanced planning, with events scheduled a year in advance, more explicit reference to who is responsible for the activity and making use of low cost or cost neutral approaches. Our aims in focusing on these areas is to ensure that we are better placed to meet any unexpected reduced capacity from staff and governors, to take into account the potential for reduced resources due to the Cost Improvement Plans required across the Trust and to allow governors to plan in advance.

Objective 1: Improve the quality of two-way engagement with members

Key changes to this element include:

- Setting explicit targets for the number of Meet Your Governor Events and Member talks with the annual programme set well in advance and a more explicit ask of governors.
- The issuing of the quarterly Member newsletter will also be scheduled for each year with core topics planned in advance.

- Making use of social media with the success measure of at least one governor post per month.
- More consistent governor links with patient groups and an established database of external groups that governors have committed to engaging with.

Objective 2: Ensure our membership is representative of the communities we serve – with a focus on engaging with younger members and those from a global majority background

The key change to this element is the addition of a focus on those from a global majority background so that the membership is more representative of the community we serve. There is also an explicit reference to holding two young member engagement activities per year.

Objective 3: Maintain and where possible increase our membership, perhaps with a focus on increasing numbers in SW Lambeth

The key change to this element is the addition of the success measure of all governors having attended at least two engagement opportunities per year.

Feedback from the Committee will be incorporated into the draft strategy before final review at their next meeting and submission to the Council for approval in December.

3.0 Recommendations

3.1 The Council of Governors is asked to note the update on the matters considered by MEC at its September meeting and to consider the action points for governors.

Council of Governors

Meeting on Wednesday, 24 September 2025

Agenda Item	7.1	
Report Title	**Elections to the Council of Governors**	
Executive Lead(s)	Stephen Jones, Group Chief Corporate Affairs Officer	
Report Author(s)	Elizabeth Dawson, Group Deputy Director of Corporate Affairs	
Previously considered by	n/a	-
Purpose	**For Noting**	

Executive Summary

At the meeting of the Council in May, the options were considered for filling two vacancies that had arisen on the Council, one in the Rest of England Constituency and one in the Allied Health Professionals and Other Clinical and Technical Constituency.

In line with the Trust's Constitution, it was agreed that, for the Rest of England constituency vacancy, the next highest candidate in the elections held in January 2025 should be approached to fill the vacancy until the original term of office ends in January 2027, and that the vacancy in the Allied Health Professionals and Other Clinical and Technical staff constituency would be included in the elections due in the autumn 2025.

The autumn Council of Governors election process began on 16 September 2025 and will close with the announcement of the results on 1 December 2025.

Action required by Council of Governors

The Council is asked to:

a. Note the update on the elections to the Council of Governors
b. Promote the Council vacancies through their networks

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				
If we do not hold an effective elections process, there is a risk that we will not have a fully constituted Council of Governors, which would impact on the Council's ability to discharge its statutory duties of (i) holding the Non-Executive Directors individually and collectively accountable for the performance of the Board, and (ii) representing the interests of members and the public.				
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 cost of the running the election process for the 9 seats across 6 constituencies is £20k.				
Legal and / or Regulatory implications				
Holding elections to the Council of Governors is set out in the NHS Act 2026 (as amended by the Health and Social Care Act 2012). Provisions governing the conduct of elections are set out in the Trust's Constitution. Our obligations as set out in the Constitution are being met through this process.				
Equality, diversity and inclusion implications				
Through our governor elections we aim to have a diverse and inclusive Council, representative of our community.				
Environmental sustainability implications				
n/a				

Elections to the Council of Governors

Council of Governors, 24 September 2025

1.0 Purpose of paper

1.1 This paper sets out the process and timeline for the 2025/26 elections to the Council of Governors for those seats where governors will come to the end of their terms of office, to fill the vacancies on the Council left by the departures of Marie Grant (Rest of England) and by Atif Mian (Staff) as well as the long term vacant South West Lambeth seat.

2.0 Background

2.1 There are 25 governors on the Council comprised of:

- 15 elected by public members across Wandsworth, Merton, South West Lambeth and the Rest of England
- 6 stakeholder governors appointed by local organisations.
- 4 staff governors elected by different staff groups

2.2 The following governors reach the end of their term of office in January 2026:

Merton:	Nasir Akhtar
Wandsworth:	Afzal Ashraf, Lucy Mowatt and Ataul Tahir
Rest of England:	Sandya Drew
Non-Clinical:	Huon Snelgrove

None of these governors have completed the maximum of three consecutive terms of office (9 years) and may stand for re-election.

2.3 In the elections held in December 2024 – January 2025 for the Rest of England Constituency, Marie Grant, along with Ashok Bhat, was successful. At the end of March 2025, Marie informed us that due to a health issue she would need to stand down. Under the Trust's constitution, the next highest placed candidate can be approached where a vacancy arises outside of the normal term of office. Four candidates stood in the 2024/25 elections, so in order of number of votes cast, both remaining candidates were approached about the vacancy. Neither responded and therefore this vacancy is included in the election process currently underway.

2.4 In December 2023 – January 2024, elections were held for the vacant Staff Governor positions with Atif Mian being successful in the Allied Health Professionals and Other Clinical and Technical seat. As recorded at the May 2025 meeting of Council, Atif took the decision to stand down due to pressures of work. It was agreed at the Council meeting that considering the length of time since the previous election and the gap in the number of votes between Atif and the next highest place candidate, the second place candidate should not be approached on this occasion and the vacancy should be included in the next set of elections.

2.5 The South West Lambeth constituency has been vacant since 31 January 2024 and has not received any nominations in the previous two election processes, despite efforts by the Trust and by members of the Council of Governors to promote and generate interest in the election in this constituency.

2.6 The following vacancies are therefore included in the current election process:

Merton:	1 to be elected
Wandsworth:	3 to be elected
Rest of England	2 to be elected
South West Lambeth	1 to be elected
Staff: Non-Clinical	1 to be elected
Staff: AHP	1 to be elected

2.7 The Trust is required to appoint an independent Returning Officer to run and oversee the elections. The two companies on the government framework that provide this service were asked to submit a quote and Civica, who have run the process in previous years, were appointed.

3.0 Election Timeline

3.1 In order to ensure that newly elected Governors have the opportunity to undertake induction ahead of the commencement of their terms of office on 1 February 2026, we are running the elections in during Q3 2025/26. The timeline is as follows:

Notice of Election/nominations open	16 September 2025
Nominations deadline	14 October 2025
Summary of valid candidates published	15 October 2025
Final date for candidates to withdraw	17 October 2025
Notice of poll to be published	4 November 2025
Close of election	28 November 2025
Declaration of results	1 December 2025
Term of Office for new governors begins	1 February 2026

3.2 The notice of the election is sent to all members via email (where we have email details) and via post to all members. It will also be posted on the Trust website, and promoted via the Trust's social media channels. All governors are asked to promote the vacancies through their local networks and via social media.

4.0 New Governor Induction

4.1 With the earlier conclusion of the election process, new Governor induction will now be able to begin in January so key aspects of their onboarding are in place before their term of office begins. All new governors will also be allocated a 'buddy' from amongst the existing members of Council.

5.0 Recommendation

5.1.1 The Council is asked to:

a. Note the update on the process and timetable for the elections to the Council of Governors
b. Promote the Council vacancies through their networks

Board, Committees and Council of Governors Calendar 2025/26

St George's University Hospitals NHS Foundation Trust

Month	Date	Meeting	Time	Location / Format
May	1 May	Group Board Meeting (Public and Private)	08:30 - 16:00	QMH, Sheen and Richmond Rooms, Roehampton, SW15 5PN
	6 May	Governors Scheduled Visits – Surgical and Sites Services	14:30 – 16:30	Surgical and Site Services
	8 May	New Governors Induction	13:00 – 15:00	MS Teams
	22 May	Council of Governors Meeting	17:30 – 20:30	Hyde Park Room, St Georges Hospital
	30 May	Meet Your Governor – St Georges	09:30 – 16:30	Grosvenor Wing reception area St Georges
	30 May	Finance Committees-in-Common	09:00 – 13:00	MS Teams
June	10 June	Governors Scheduled Visits - Outpatient	10:00 – 12:00	Outpatients St Georges Hospital
	13 June	Infrastructure Committees-in-Common	11:30 -13:30	MS Teams
	TBA	Membership Engagement Committee	TBA	TBA
	19 June	People Committees-in-Common	09:00 – 12:00	MS Teams
	26 June	Quality Committees-in-Common	09:00 – 12:30	MS Teams
	27 June	Finance Committees-in-Common	09:00 – 13:00	MS Teams
July	3 July	Group Board Meeting (Public and Private)	09:15 – 15:30	Epsom General Hospital, Conference Room 1
	8 July	Governors Visits – Diagnostics - Postponed	11:00 – 13:00	Outpatients
	8 July	Governor/NED pre-meet	14:00 – 15:30	MS Teams and Blackshaw Annex room 1.013
	17 July	Council of Governors Meeting	17:30 – 20:30	Hyde Park Room, St Georges Hospital
	24 July	People Committees-in-Common	09:00 – 12:00	MS Teams
	25 July	Infrastructure Committees-in-Common	11:30 -13:30	MS Teams
	29 July	New Governor Induction part 2	13:00-14:30	MS Teams
	31 July	Quality Committees-in-Common	11:00 – 13:00	MS Teams
August	1 August	Finance Committees-in-Common	09:00 – 13:00	MS Teams
	21 August	Governors' visits – Senior Health	11:00 – 13:00	Senior Health
	22 August	Infrastructure Committees-in-Common	11:30 -13:30	MS Teams
	TBA	Membership Engagement Committee	TBA	TBA
	28 August	Quality Committees-in-Common	11:00 – 13:00	MS Teams
	29 August	Finance Committees-in-Common	09:00 – 13:00	MS Teams
September	5 September	Group Board Meeting (Public and Private)	09:15 – 15:30	St Helier Hospital, Whitehall Lecture Theatre

Board, Committees and Council of Governors Calendar 2025/26

St George's University Hospitals NHS Foundation Trust

Month	Date	Meeting	Time	Location / Format
	11 September	(Provisional) Governor/NED pre-meet	14:00 – 15:30	TBA
	16 September	Governors Visits - Support Services	14:30-16:30	Support Services
	18 September	People Committees-in-Common	09:00 – 12:00	MS Teams
	19 September	Infrastructure Committees-in-Common	11:30 -13:30	MS Teams
	24 September	Council of Governors Meeting	13:15–16:15	Hyde Park room, St Georges Hospital
	24 September	Annual Members Meeting	TBC	TBC
	25 September	Quality Committees-in-Common	11:00 – 13:00	MS Teams
	26 September	Finance Committees-in-Common	09:00 – 13:00	MS Teams
	30 September	IQPR Session For Governors	12:00 – 12:45	MS Teams
October	2 October	Group Board Meeting (Public and Private)	09:15 – 15:30	Epsom General Hospital, Conference room 1
	13 October	Finance part 2	15:30 – 17:00	MS Teams
	14 October	Governor Visits – Renal Services	14:30 - 16:30	Renal Services
	23 October	People Committees-in-Common	09:00 – 12:30	MS Teams
	24 October	Infrastructure Committees-in-Common	11:30 -13:30	MS Teams
	30 October	Quality Committees-in-Common	09:00 – 12:30	MS Teams
	31 October	Finance Committees-in-Common	09:00 – 13:00	MS Teams
November	5 November	Governor Visits - TBA	TBA	TBA
	6 November	Group Board Meeting (Public and Private)	09:15 – 15:30	Hyde Park Room, St George's Hospital
	TBA	Membership Engagement Committee	TBA	TBA
	20 November	People Committees-in-Common	09:00 – 12:30	MS Teams
	21 November	Infrastructure Committees-in-Common	11:30 -13:30	MS Teams
	27 November	Quality Committees-in-Common	11:00 – 13:00	MS Teams
	28 November	Finance Committees-in-Common	09:00 – 13:00	MS Teams
December	1 December	(Provisional) Governor/NED pre-meet	14:00 – 15:30	TBA
	4 December	Group Board Meeting (Public and Private)	09:15 – 15:30	QMH, Sheen and Richmond Rooms
		Meet Your Governor – St Georges Atkinson Morley Wing	TBA	TBA
	5 December	Governor Visits - TBA	TBA	TBA
	10 December	Council of Governors Meeting	14:00-17:00	Hyde Park Room, St Georges Hospital

St George's University Hospitals NHS Foundation Trust

Board, Committees and Council of Governors Calendar 2025/26

Month	Date	Meeting	Time	Location / Format
	11 December	People Committees-in-Common	09:00 – 12:30	MS Teams
	12 December	Infrastructure Committees-in-Common	11:30 -13:30	MS Teams
	18 December	Quality Committees-in-Common	09:00 – 12:30	MS Teams
	19 December	Finance Committees-in-Common	09:00 – 13:00	MS Teams
January	8 January	Group Board Meeting (Public and Private)	09:15 – 15:30	Epsom General Hospital, Conference room 1
	January	Meet Your Governor – Queen Marys Hospital	TBA	TBA
	19 January	Governor Visits - TBA	TBA	TBA
	22 January	People Committees-in-Common	09:00 – 12:30	MS Teams
	23 January	Infrastructure Committees-in-Common	11:30 -13:30	MS Teams
	29 January	Quality Committees-in-Common	09:00 – 12:30	MS Teams
	30 January	Finance Committees-in-Common	09:00 – 13:00	MS Teams
February	4 February	Governor Visits - TBA	TBA	TBA
	5 February	Group Board Meeting (Public and Private)	09:15 – 15:30	Epsom General Hospital, Conference room 1
	TBA	Membership Engagement Committee	TBA	TBA
	19 February	People Committees-in-Common	09:00 – 12:30	MS Teams
	20 February	Infrastructure Committees-in-Common	11:30 -13:30	MS Teams
	26 February	Quality Committees-in-Common	09:00 – 12:30	MS Teams
	27 February	Finance Committees-in-Common	09:00 – 13:00	MS Teams
March	4 March	Governor Visits - TBA	TBA	TBA
	5 March	Group Board Meeting (Public and Private)	09:15 – 15:30	Hyde Park Room, St Georges Hospital
	16 March	(Provisional) Governor/NED pre-meet	14:00 – 15:30	TBA
	19 March	People Committees-in-Common	09:00 – 12:30	MS Teams
	20 March	Infrastructure Committees-in-Common	11:30 -13:30	MS Teams
	25 March	Council of Governors Meeting	17:30-20:30	Hyde Park Room, St Georges Hospital
	26 March	Quality Committees-in-Common	09:00 – 12:30	MS Teams
	27 March	Finance Committees-in-Common	09:00 – 13:00	MS Teams